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Provision of Primary Healthcare among Internally Displaced Persons and Vulnerable Populations of Burma

2016 Proposal
Back Pack Health Worker Team

Project title:	The Provision of Primary Healthcare among Internally Displaced Persons and Vulnerable Populations of Burma
Project Programs:	A. Medical Care Program B. Community Health Promotion and Prevention Program C. Maternal and Child Health Program
Target Population:	**228,000** people living within the Mon, Kayah, Kayan, Karen, Shan, Kachin, Pa O, Chin and Arakan areas
Project Duration:	January to December 2016
Budget requested:	**44,000,000** Thai Baht **(1,294,118 USD)**
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I. Overview

(i) Background on the Conflict and Internal Displacement in Burma

The armed conflicts in Burma date back to the time of its independence in 1948 and have been virtually continuous since then through subsequent Burma governments. The key issues are related to the non-Burman people and their social, economic, and political aspirations. During the British colonial period, the non-Burman people were generally administered separately and differently by the British from those in the predominately Burman area, i.e., Ministerial Burma. As the inducement to become part of a post-independence Burma, certain non-Burman groups were promised local autonomy and ethnic quality, and also the right of secession from Burma if, after ten years, they felt that their aspirations were not realized.

During the ensuing fourteen years, non-Burman people were unable to receive either local autonomy or ethnic equality, and thus in 1962, commenced a meeting to speak to this issue and the alternatives available to them. Immediately, the Burma military mounted a coup under the rationale that the country was on the verge of breaking apart based along ethnic lines and the then-civilian government was not effectively confronting this issue. Consequently over the next fifty years, many non-Burman groups formed political/armed groups to initially fight for independence and later for local autonomy as manifested in some equitable form of political power sharing. Such power sharing included significant executive, legislative, and judicial authority devolved to the constituent ethnic and multi-ethnic states; equitable representation at the Union level in both houses of parliament, government ministries, and the military; and a fair allocation of state resource revenues. However, successive Burma military and Burma military-supported civilian governments have held political power since 1962 in an attempt to confront the ethnic issue primarily through military means, feeling that democratic civilian governments lack the capabilities to prevent a “disintegration of the Union”.

While there were a number of ceasefire agreements concluded with ethnic armed organizations (EAOs) during the 1990s, no efforts were made by the Burma Government to address the underlying political issues. In 2009, the Burma Government gave the ceasefire groups the choice of converting to border guard/peoples militia forces under the control of the Burma military, or giving up their weapons and “returning to the legal fold”. If they chose neither, then the ceasefire agreements with the government would be voided and the former ceasefire groups would be then considered by the Burma Government as belligerents. While some ceasefire groups did convert to border guard/peoples militia forces, others were attacked by the Burma military and have continued to fight a defensive war up through the present time.

The new civilian Burma Government, elected in 2010, saw the ethnic situation as hampering the transition to a democratic country. Thus, it initiated negotiations with the EAOs, resulting in a series of individual temporary ceasefire agreements to begin a process of national reconciliation. These ceasefire talks between the EAOs and the Burma Government made some progress toward a more permanent Nationwide Ceasefire Agreement (NCA) which was signed by eight EAOs in October 2015. Other EAOs said they would sign the NCA only if it included all EAOs and the NCA was truly “nationwide”.

It should be mentioned that the NCA is only the first step of the *Seven Step Roadmap*:

1. Signing of the NCA
2. Drafting and reaching agreement on the framework for a Political Dialogue, Military Code of Conduct, and Joint Ceasefire Monitoring Mechanism
3. Launching of the Political Dialogue with key stakeholders
4. Holding of a Union Peace Convention

5. Signing of a Union Peace Accord
6. Ratification of a Union Peace Accord

Overarching issues to this *Seven Step Roadmap* are disarmament, demobilization and reintegration (DDR) and security sector reform (SSR), These two issues relate to when and under what conditions that the EAOs give up their arms and be integrated back into Burmese society and how should the Burma military, police, and related Burma Government security sector actors be structured within a federal union. The EAOs consider DDR to be accomplished in concert with SSR and carried out only after the successful implementation of a Union Peace Accord. While the Burma Government, especially the Burma military, sees no necessity for SSR and wants DDR before the completion of the *Seven Step Roadmap.*

Despite the ceasefire and peace negotiations, the Burma military has engaged in offensive military operations in Kachin and Shan States. Thus, the Burma military continues to use force to bring about a military solution to the ethnic issue. Continued offensive operations by the Burma military has increased the number of internally displaced persons (IDPS) in Shan and Kachin States, discouraged refugees from considering returning to Burma, and not contributed to confidence building among the EAOs. If the Burma military does not cease their offensive military operations and expanding their reach, manpower, and armaments in the ceasefire areas, ceasefire EAOs may resort again to fighting to protect their people. To partially address this issue, the EAOs and the Burma Government are now conducting negotiations about both a Military Code of Conduct and a ceasefire monitoring mechanism to protect the peace during the transitional period from the NCA through the political dialogue up to the implementation of a Union Peace Accord.

IDP children in Shan State

It is hoped that 2016 will be year not only for a move toward a true democracy with the new Burma Government, but also a year that sees a genuine road to durable peace in Burma through productive and genuine negotiations between the Burma Government/ military and the EAOs about equitable power sharing – political, military, territory, and resource - and ethnic equality. However, there is still a very long road until the security situation is one of a country at peace where health workers and villagers can freely enjoy the right to health.

(ii) The General Health Situation in Burma

Health in Burma is another casualty of decades of government misrule, ethnic conflict, centralized decision making, and the exodus of qualified health professionals. There has been, and continues to be, a shortage of qualified physicians, nurses, midwives, and community health workers as well as inadequate medicine, medical equipment, and hospital/clinic beds. Hospital facilities are run down and require renovation. The reliability of electricity in health facilities is a constant problem. Also, people living in armed conflict and remote areas have no reasonable access to health care within a few days' walk. Many rural and urban areas lack clean water and proper sanitation. There is no real Burma Government healthcare scheme and patients must pay for medicine, food, blankets, and bribes to medical personnel.

For the 2014-15 fiscal year, the Burma government allocated 3.4 percent of General Government Expenditures to health care. This was an increase from the one percent for the years prior to 2012. However, questions have arisen as to how much of this spending actually occurred and what has been the impact upon the before-mentioned health infrastructure and health indicators from any spending. Also much of this spending has been in the urban, not rural, areas where most of the ethnic people live.

Global data from the World Bank for 2013 show Myanmar as the country with lowest health expenditure per capita (current USD). Consequently, the country has some of the worst health indicators in the world. The main causes of morbidity and mortality in the country are overwhelmingly preventable from disease entities such as malaria, malnutrition, diarrhea, acute respiratory illnesses, tuberculosis, and HIV/AIDS.

(iii) The Health of Internally Displaced Persons (IDPs)

The Internal Displacement Monitoring Centre (IDMC) estimates that there were up to 662,400 IDPs in Burma as of March 2015. Armed conflict and development-induced displacement continue to be the key underlying drivers for these large numbers of IDPs.

While the health indicators of Burma's population rank amongst the poorest globally, the health of IDPs within Burma is even a more serious cause for concern. Health indicators for the rural ethnic and IDP populations in eastern areas of the country are demonstrably worse than Burma's national rates. IDPs face harsh living conditions in the jungle: their means of survival are a constant challenge. In addition to dealing with the burden of protracted conflict and the high frequency with which they are forcibly displaced, access to the healthcare system of the Burma Government is either extremely limited or non-existent.

These remote and conflict-affected regions of Eastern Burma continue to face critical health challenges and are characterized by high morbidity and mortality rates. This is especially true in respect to the high mortality rates for infants and among children under 5 years of age, and deaths across all age groups attributable to largely preventable diseases such as diarrhea, malaria, and acute respiratory infections.

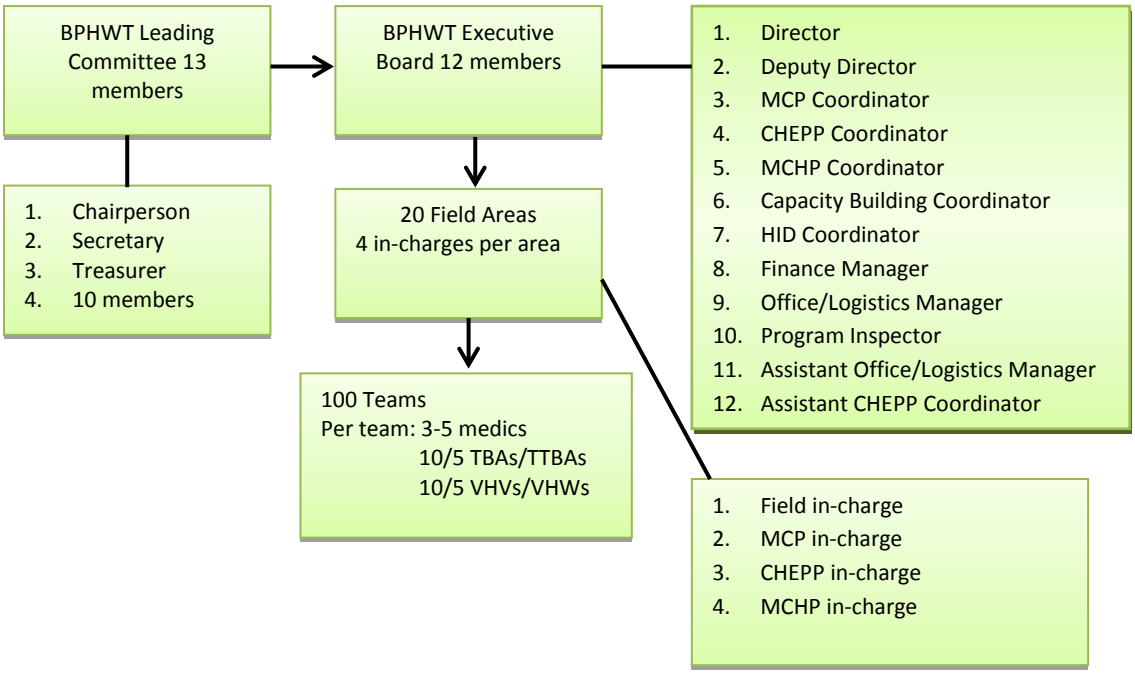
Consequently, there will be the continuing need for primary health care by the IDPs and other vulnerable people in Eastern Burma which can only be currently met through the ethnic health organizations (EHOs) and health community-based organizations (HCBOs), not through the Burma Government. Humanitarian organizations must recognize that that the situation in the conflict areas is in the initial stage of peacemaking with the signing of a NCA by some EAOs. There must be movement from peacemaking to peacekeeping, and only then hopefully to true peace building. It will be only after the successful implementation of a Union Peace Accord that the EAOs will be ready to disarm, demobilize, and reintegrate back into a democratic Federal Union of Burma/Myanmar. Until then, the EAOs will retain their arms and administrative control over, and access to, their respective ethnic areas. Thus, the effective delivery of healthcare services to people living in the EAO-controlled areas, especially IDPs, will be through EHOs/HCBOs.

II. Back Pack Health Worker Team

The BPHWT was established in 1998 by Karenni, Mon and Karen health workers to provide healthcare to IDPs, living along the eastern border of Burma, affected by many decades of civil war. During the first six-month term of 2015, the Back Pack Health Worker Team (BPHWT) continued to provide healthcare in 20 field areas, with 100 teams assigned to a target population of over 213,000 people to Karen, Karenni, Mon, Shan, Chin, Kachin Arakan states, and Pegu and Tenasserim

Division.There are currently 1,321 health workers living and working in the BPHWT target areas inside Burma; comprised of 360 (M-182, W-178) medics,494(M-51, W-443)Traditional Birth Attendants (TBAs), 127 (M-8, W-119)Trained Traditional Birth Attendants (TTBAs) and130(M-47, W-83)Village Health Volunteers (VHVs), 210 (M-53, W-157)Village Health Workers (VHWs).

(i) Organizational Structure of the BPHWT



(ii) Governance: As depicted in the Organizational Structure, the BPHWT is governed by the Leading Committee which is elected every three years by the BPHWT members. The Leading Committee is comprised of 13 members who serve a three year term. The Leading Committee appoints an Executive Board of 10 members. This Executive Board is required to meet monthly and make decisions on current issues and planned activities of the BPHWT. The BPHWT has a range of documents that guide the leadership, management, healthcare delivery, health information systems, and human resources of the organization. Full copies of any of these documents are available upon request.

The BPHWT Constitution: The Constitution provides the framework for the operation of the BPHWT through thirteen articles that define: the organization's name, vision, mission statement, organizational identification, symbol, goals, objectives, policies and principles, actions and implementation, monitoring and evaluation, membership, election of the Leading Committee, amendments to the Constitution and organizational restructuring, employment of consultants, and job descriptions for positions.

Vision: The vision of the Back Pack Health Worker Team is targeting the various ethnic nationalities and communities in Burma to be happy and healthy society.

Mission: The Back Pack Health Worker Team is organized to equip people with the skills and abilities necessary to manage and address their own healthcare problems, while working towards the long-term sustainable development of a primary healthcare infrastructure in Burma.

Goal: The goal of the Back Pack Health Worker Team is to reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare.

Financial Management and Accountability: The BPHWT has written financial policies and procedures guiding the Leading Committee, Executive Board, program coordinators, and field staff about financial management and accountability; the production of annual financial reports; and the requirement for an annual, independent audit. These documents establish the financial records to be kept; the management of bank accounts; the procedures for cash withdrawals, deposits transfers, receipts, disbursements and general administration funds; and liquidation of cash assets. There are also regulations for payments for board, lodging, travel and honorariums for services rendered.

(iii) Service System: Since 1998, the Back Pack Health Worker Team has been working towards developing an accessible, community-based, primary healthcare service system within the BPHWT field areas based on the health access indicators.

Health Access Indicators for a Community-Based Primary Healthcare System

Population	Health Service	Health Workers	Ratio (Workers/Pop)	Ideal Number of Workers
2000	BPHWT (Community-based primary healthcare unit)	BPHWT Health Worker	1:500	4
		Traditional Birth Attendant/Trained Traditional Birth Attendant	1:200/400	10/5
		Village Health Volunteer/Village Health Worker	1:200/400	10/5
Total Members Per Team				**24/14**

(iv) Gender Policy and Analysis: During 2014, seventy-nine percent of the BPHWT staff was women, excluding Traditional Birth Attendants (TBAs). However, the organization has a gender policy, which aims to improve equity for women across all levels of the organization. The table below depicts the current targets and actual percentage of women across organizational tiers. To date, the BPHWT meets or exceeds all gender equity targets for organizational tiers.

Gender Analysis of the People Working within the BPHWT

Category	Total # of Workers	Total # of Women	Women Actual %	Women Target at Least %
Leading Committee/Executive Board	15	6	40%	30%
Office Staff	14	4	29%	30%
Field Management Workers	55	25	46%	30%
Field Health Workers	296	175	75%	30%
TBA/Trained Traditional Birth Attendants	696	635	91%	Target not set
VHV/Village Health Workers	276	180	65%	30%
Organizational Total	**1,352**	**1,025**	76%	Target not set
Total Organization excluding TBAs/TTBAs			**79%**	**30%**

III. Back Pack Health Worker Team Programs

The Back Pack Health Worker Team aims to improve health through the delivery of primary healthcare and public health promotion. The BPHWT provides Medical Care, Community Health Education and Prevention, Maternal and Child Healthcare, and Water and Sanitation Programs in the targeted field areas. Integrated through these primary healthcare programs, are the Health Information and Documentation and the Capacity Building Programs.

BPHWT covered population during January to June 2015:

No	Township Names	MIMU Population	BPHWT Covered Population
1	Loikaw	128,837	9,324
2	Hpruso	29,315	5,457
3	Demoso	78,990	2,200
4	Mese	6,313	2,466
5	Pekon	103,665	4,239
6	Pinlaung	192,277	1,440
7	Htantabin	117,662	1,580
8	Thandaunggyi	96,064	8,325
9	Kyaukkyi	113,311	7,020
10	Shwegyin	107,251	1,989
11	Moon	-	4,040
12	Bilin	180,232	15,654
13	Thaton	237,741	3,967
14	Hpapun*	35,019	26,107
15	Hlaingbwe	265,622	11,056
16	Kawkareik	219,692	19,831
17	Kyainseikgyi	254,397	26,871
18	Ye	263,260	10,450
19	Mongkaing	74,233	8,069
20	Kyethi	74,215	3,904
21	Mongton	70,100	3,861
22	Namhkan	107,009	5,418
23	Namhsan	71,984	3,642
24	Mawkmai	33,840	5,084
25	Mansi*	52,946	3,370
26	Nanyun	51,906	3,217
27	Paletwa	96,899	4,432
28	Yebyu	122,106	2,335
29	Dawei	146,271	1,992
30	Palaw	130,445	2,029
31	Tanintharyi	106,884	3,972
	Total	**3,568,486**	**213,341**

(i) Medical Care Program (MCP)

Over the last 16 years, the most common diseases treated by the BPHWT have been malaria, acute respiratory infections (ARI), worm infestation, anemia and diarrhea. During 2014, the BPHWT treated about 84,914 cases. All data from the field is carried back to the office by the health workers, as they come to attend the six monthly meetings of the BPHWT. The BPHWT teams follow the treatment protocols outlined in the Burmese Border Guidelines (BBG). The Health Information and Documentation Program collects and analyzes the health data and provides refresher courses for field health workers (assisted by international consultants from partner organizations), and forms the main content of capacity building in the Medical Care Program.

MCP Objectives and Activities:

Objective 1: Provide essential drugs and treat the common diseases
Activity 1.1: Maintaining the existing number of BP teams
Activity 1.2: Provide medicine and medical supplies
Activity 1.3: Treat common diseases and minor injuries
Activity 1.4: Provide ITNs, malaria rapid diagnosis tests (RDTs) and malaria medicine

Objective 2: Respond to disease outbreaks and emergency situations
Activity 2.1: Purchase emergency medical supplies and immediately take action

Objective 3: Improve patient referral systems
Activity 3.1: Refer patients to the nearest hospitals or clinics

Objective 4: Promotion awareness of mental health in communities
Activity 4.1: Conduct mental health workshop
Activity 4.2: Provide mental health counseling to communities

MCP Strategy & Methodology:

- BPHWT selects target areas based upon community requests and other criteria outlined in the BPHWT constitution, including that at least two experienced health workers from the community must be available and willing to form a BP team in the requested target area. In each target area, the MCP will focus on the six most prevalent conditions: malaria, ARI, diarrhea, dysentery, anemia and worms. Within each six month term, each BP team must go to each village in their BP tract at least two times; and BP health workers must spend at least three days in each village.

- To prevent and decrease incidences of malaria, insecticide-treated mosquito nets (ITNs) will be provided, but ITNs cannot be provided for the entire target population. Therefore, providing ITNs will be prioritized to households with pregnant women and children under five years of age. In order to confirm cases of *Plasmodium falciparum* (Pf) malaria, the BPHWT began using small, portable Rapid Diagnosis Tests (RDTs) in 2005. At that time, there weren't sufficient amounts of RDTs available to cover all field areas but by 2009, all target areas were provided with these RDT kits, and the BPHWT began to give first-line malaria treatment to patients according to the BBG protocol. The BPHWT has been using RDT kits SD of Bio-line to check for both Plasmodium vivax (Pv) and (Pf) malaria since the second six month period of 2013.

- In an effort to combat the drug-resistant malaria prevalent in the target areas, the BPHWT has adopted WHO recommended Artemisinin-based combination therapy (ACT) as first-line treatment for malaria. Since 2013, the BPHWT has started using Coartem for malaria treatment.

- Although the BBG has not been updated since 2007, the BPHWT will update treatment protocols according to newly released WHO recommendations at every six month meeting.

- The BPHWT will purchase emergency medical supplies and immediately take action in cases of emergency humanitarian situations as outlined in the BPHWT constitution, such as natural disasters, epidemics, armed conflicts and famine.

- Every six months, the BPHWT field in-charges and program in-charges of each field area must report to the main office to share their data, participate in the general meeting and attend workshops. During the general meeting and workshops, all participants will discuss updating protocols and responding to challenges, and upgrade skills and knowledge. Afterwards, the in-

charges will head back to their target areas and conduct field workshops for the health workers in their field area, and update them on the meeting decisions and new treatment protocols.

- The BPHWT tries to refer serious cases to the nearest clinic or hospital, but referrals are constrained by security concerns, physical environment challenges, availability of clinics and hospitals, and high transport and hospital costs. However, the referral system is improving as BP health workers are becoming more skilled at recognizing emergency danger signs and referring patients earlier, as the security situation improves in some ceasefire areas allowing more freedom to travel, and as infrastructure links are improving.

- In 2015, BPHWT began a pilot mental health project. For a long time, BPHWT have struggled with how to provide prevention and treatment of mental health problems in their areas. In particular, they have been concerned by the impact of of misuse of alcohol and other drugs, and suicide. BPHWT health workers will now be trained in the "Common Elements Treatment Approach" to provide community based treatment of mental health problems. The treatment has been shown to be useful for treating depression and stress for former political prisoners. BPHWT is working with John Hopkins University to adapt the treatment for Karen communities. People with more complex mental health problems will be referred. After the pilot, BPHWT will look for new donors to support expansion of the project across all teams and ethnic groups as part of integrated primary health care.

Upgrade the Stationary Back Pack Teams:

Compared to the past, the current security situation in some BPHWT target areas is getting somewhat better, Consequently in 2013, the BPHWT began to establish stationary Back Pack teams in more stable areas. Presently, there are thirty-seven stationary Back Pack teams. Although they are stationary Back Pack teams, the health workers still travel around the villages and provide health services: the difference is that these stationary teams, up until now, use a particular village as their base to store medicine and supplies.

During 2016, the BPHWT plans to upgrade these stationary Back Pack teams. Each of these teams aims to have five health workers: two CHWs, two MCH workers, and one medic. These health workers will work with five Trained Traditional Birth Attendants (TTBAs) and five Village Health Workers (VHWs).

At the stationary locations, the BPHWT plans to build infrastructures, including solar panels, warehouses, safe latrines, waste management systems, inpatient beds, examination/consultation rooms, improved water supplies, cool storage pharmacy rooms with pharmacy management systems, essential medicine, and medical supplies/equipment for these stationary Back Pack teams. In addition, there is a referral system which closely coordinates with local village health committees. The referral system strategy is explained under the MCP's strategies.

The purpose of this *Stationary Back Pack Team Strategy* is to improve healthcare service and provide more effective health care to communities. The stationary Back Pack teams will provide both treatment and preventative health care as well as secure facilities to store medicine and medical supplies/equipment.

The estimated of the budget for each stationary Back Pack team is **522,000** Thai Baht per year. Thus, a budget will be proposed to any available innovation funds. The BPHWT plans to upgrade ten stationary Back Pack teams should the proposal for innovation funds is successful.

(ii) Community Health Education and Prevention Program (CHEPP)

The CHEPP aims to enable and empower the internally displaced and vulnerable communities, with skills and knowledge related to basic primary healthcare concepts to improve hygiene, water supplies, sanitation systems, nutrition and other health-related issues, especially the prevention and control of communicable diseases. Capacity building occurs through peer education trainings in schools and Village Health Workshops. The Water and Sanitation sub-program provides gravity-flow water systems to communities. The School Health sub-program distributes Vitamin A and de-worming medication, builds safe water supplies, and constructs latrines in schools. The Village Health Workers sub-program provides the community with the health knowledge to be able to take independent measures to improve hygiene conditions, develop water and sanitation systems, improve nutrition, and manage basic healthcare. In order to improve community accessibility of health services, the BPHWT has set a target to recruit five Village Health Workers (VHWs) for each BP team so that they can assist the mobile health workers in monitoring patients and providing basic medical care when the health workers are not in the vicinity, with each VHW serving a population of about 400 people. In the past, ten Village Health Volunteers (VHVs) were recruited and provided with a month of training. Currently, the BPHWT is upgrading the VHVs' skills to become VHWs and recruiting new VHWs. The VHW training is three months long and will give them the skills to help treat the three main diseases in BPHWT target areas: malaria, acute respiratory infection and diarrhea. One of the most important responsibilities of VHWs is ensuring that anyone with a fever gets a malaria test within 24 hours.

Installing water system to communities

CHEPP Objectives and Activities:

Objective 1: Reduce the incidences of malnutrition and worm infestation
Activity 1.1: Distribute de-worming medicine to children between the ages of 1 to 12 years old
Activity 1.2: Distribute Vitamin A to children between the ages of 6 months to 12 years old

Objective 2: Improve health knowledge of students and communities
Activity 2.1: Provide school health education
Activity 2.2: Organize village health workshops for the community

Objective 3: Improve community level knowledge and participation in health
Activity 3.1: Organize Village Health Worker trainings
Activity 3.2: Establish Village Health Committee
Activity 3.3: Organize Village Health Committee meeting quarterly

Objective 4: Improve water and sanitation systems in the community to reduce water-borne diseases
Activity 4.1: Build community latrines
Activity 4.2: Install gravity flow water systems
Activity 4.3: Install shallow well water systems
Activity 4.4: Install school water filters

CHEPP Strategy & Methodology:

- Every six months, a BP health worker coordinates with the VHV/VHW and Village Health Leader to gather all children in the village to provide vitamin A and de-worming medicine. The VHVs/VHWs will take charge of providing vitamins to the children, recording each child's intake of supplements and other medicines, and monitoring each child's health status. Around 10,000 children will benefit from this intervention.

- Through school health education, a total of around 50,000 students will be oriented on Water and Sanitation Hygiene (WASH) by the BP health workers. The School Health Sub-Program is an aspect of the CHEPP which uses a child-to-parent model to influence not only the health awareness, behavior, and practices of the student, but also that of the parent through the student. The students are also provided with personal hygiene kits which include toothpaste, a tooth brush, nail clippers, and scissors to cut hair. They are taught the proper use of these items. The BPHWT's school health education sessions provides the students with information about malaria prevention, diarrhea prevention, hygiene, nutrition, influenza awareness, HIV/AIDS education, and drinking water systems. Filter systems linked to a large water dispenser are placed in the schools so that school children will have access to clean drinking water.

- BP health workers must conduct three Village Health Workshops in their BP tract each six-month term. The aim of these workshops is to provide the community with health education, identify community problems, and brainstorm solutions through a Participatory Learning and Action (PLA) approach. Health workers must raise the community problems and solutions at each six-month field meeting and subsequently, the field in-charges raise the collective issues at the following six-month general meeting for discussion and future planning.

- The BPHWT health campaigns focus on raising awareness about HIV/AIDS. On World AIDS Day on December 1st, BP health workers in all field areas will organize events to promote awareness and reduce cultural stigma of HIV/AIDS. In addition to HIV/AIDS, other public health issues are also discussed. Pamphlets are used to promote safe health practices.

- Since VHVs/VHWs must stay in villages to help the health workers monitor patients, provide health education and other basic health care, they are provided with VHW handbooks and VHW kits which contain medicines and supplies for the VHWs to treat the common illnesses of malaria, ARI and diarrhea, as well as vitamins and basic first aid supplies.

- Gravity-flow water systems, water filters and protected shallow wells will be constructed in the targeted areas with the help of external technical specialists and the community members. The VHVs/VHWs supervise the construction together with the villagers. In the BPHWT areas, the water systems are maintained by the community members themselves. The Village Committees, composed of the village leader and 7 to 11 respected members of the community, will be responsible for ensuring the maintenance of the water systems and for deciding and coordinating community activities.

(iii) Maternal and Child Healthcare Program (MCHP)

The MCH Program aims to improve the health of women and children, ensure safe deliveries, and provide family planning advice and contraceptive supplies to people within the field areas. A two-tiered system is utilized, but it is important to emphasize the integrated nature of this approach. Back Pack health workers are the primary providers of medical services in their target areas, while communities chosen Traditional Birth Attendants/Trained Traditional Birth Attendants (TBAs/TTBAs) receive additional training from BP health workers. This training introduces the TBA/TTBA to (or reviews) important elements of pre- and postnatal care, clean delivery and aseptic technique, family planning counseling, and emergency obstetric care (EmOC).

In the Maternal and Child Healthcare Program, capacity building is delivered through the six-monthly Maternal and Child Healthcare refresher training course attended by MCH Supervisors, 20-day TTBA training courses and 3-day TBA/TTBA workshops every six months in field areas. The BPHWT has had specific criteria to recruit new TBAs; the TBAs must have had the experience of delivering at least five babies and must have attended at least two TBA workshops. Additionally, they must be recommended by the communities. As a result, the TBAs who are working in the MCHP already have the experience of delivering five babies or more and are trusted by the communities. However, the number of TBAs is dwindling as most of the TBAs are old and there is a decline in new recruitment due to BPHWT's strict criteria.

Organizing TBA/TTBA workshop in field an area

Consequently, the BPHWT has initiated a new standard in 2012 and to start TTBA training to recruit new younger people, and upgrade the former TBA training with a longer and more advanced curriculum. Moreover, in one of BPHWT's efforts to lead the convergence of the extensive border-based health system with the government of Burma's health system, the BPHWT plans to enroll and support forty trainees for two state-administered Auxiliary Midwife (AMW) trainings in Karen State, and will facilitate the standardization of BPHWT and the state administration curricula. Upon completion of this training, the AMWs will work for the BPHWT and implement MCH programs in their respective areas, while being supervised by a midwife appointed by the state administration.

TBAs/TTBAs have access to and regular communication with Back Pack medics for the majority of the time. Twice a year, MCH field supervisors travel to the BPHWT headquarters for activity reporting, resupply and workshops. Where there is no stable clinic setting, the interventions with the greatest potential to decrease the maternal mortality rate (MMR) are not feasible, hence, the BPHWT accordingly focuses on the most effective interventions that can be implemented in a mobile community-based setting. Working together, the TBAs/TTBAs and medics increase people's access to important maternal and child healthcare. These include interventions for reducing neonatal and infant mortality (i.e. iron/folate distribution, clean delivery, etc) and services that contribute to the reduction of MMR, such as the provision of safe deliveries and the referral of EmOC cases.

MCHP Objectives and Activities:

Objective 1: Increase maternal and child healthcare

Activity 1.1: Distribute de-worming medicine to pregnant women
Activity 1.2: Distribute folic acid and ferrous sulphate tablets to pregnant women and women
Activity 1.3: Train Emergency Obstetric Care (EmOC) workers
Activity 1.4: Provide EmOC supplies
Activity 1.5: Provide nutrition food to pregnant women
Activity 1.6: Provide antenatal care (ANC) to pregnant women
Activity 1.7: Provide obstetrics gynecology (OG) instruments to skilled MCH workers
Activity 1.8: Refer serious obstetric cases

Objective 2: Raise awareness among the community on family planning and provide them with family planning supplies

Activity 2.1: Provide family planning supplies

Activity 2.2: Provide family planning education
Activity 2.3: Organize Reproductive Health Awareness workshop
Activity 2.4: Provide joint Information Education Communication (IEC) materials

Objective 3: Improve the knowledge and skills of TBAs/TTBAs and MCHP supervisors
Activity 3.1: Conduct TTBA training and TBA/TTBA workshops
Activity 3.2: Conduct TBA/TTBA workshops
Activity 3.3: Provide safe birthing kits (TBA/TTBA kits & maternity kits)

Objective 4: Every newborn baby attended by TBAs/TTBAs, MCH workers, & health workers will have birth record.
Activity 4.1: Provide delivery records

Objective 5: Promote awareness of gender based-violence in the communities
Activity 5.1: Conduct post-rape care training to MCH workers
Activity 5.2: Organize community awareness raising workshop
Activity 5.3: Provide primary care to survivors of SV

MCHP Strategy & Methodology:

- TBAs/TTBAs are trained to identify risk factors and danger signs to facilitate early referral to a health worker, or the nearest clinic - whichever is more easily accessible. However referral will often be constrained by security challenges, physical environment challenges, availability of clinics and hospitals, and high transport and hospital costs.

- ANC requires at least four visits by the MCHP worker and/or TBA/TTBA and includes malaria screenings; general examination; monitoring of danger signs; nutrition, hygiene and family planning education and counseling; and the provision of a maternity kit.

- Postnatal care (PNC) requires at least three visits by the MCHP worker and/or TBA/TTBA and includes: puerperium care, neonatal exam, issuance of delivery certificate, education and counseling (breastfeeding, infant care, nutrition, hygiene and vaccination etc).

- OG instruments for safe deliveries will be provided to MCH workers who have completed the MCH refresher training course.

- Family planning supplies such as condoms, the contraceptive pill and the contraceptive injection will be provided by the MCHP health workers to communities which request these services. MCHP health workers will distribute around 30,000 condoms in their areas under the knowledge and skills of TBAs/TTBAs and MCHP supervisors.

Explaining family planning methods

- Since TBAs are being phased out, only TTBA trainings will be conducted, but TBA workshops will continue until all TBAs have been upgraded to TTBAs. In rural Burma, TBAs/TTBAs are usually the first ones who help pregnant women and their families with the delivery of their babies. In many areas where midwives are not available, in part due to the fact that they are not trusted by the community if they are not from within the community. The TBAs/TTBAs are at the forefront for ensuring the sustainability of local reproductive healthcare. It is thus important that the skills of TBAs/TTBAs are improved so they can perform safe and aseptic

deliveries and provide proper maternal and reproductive healthcare to these vulnerable communities. The TTBA training will target previously trained TBAs and TBAs who have had significant years of practical experiences in child deliveries. As they already have practical experience and knowledge, the aim is to enhance their skills and knowledge in sterilization and accepted aseptic techniques. The training will focus on providing safe delivery under aseptic conditions and will correct any misconceptions or misguided practices they might have. The training will also help develop and build upon the pre-existing extensive skills and experience of TBAs who are respected by their communities for their indigenous knowledge. These skills have been acquired through apprenticeship and/or on-the-job training in a local community, and typically passed on from generation to generation. The training will teach participants how to cut umbilical cords in a sterile procedure, when to provide pregnant women with iron and folic acid, and how to detect early high-risk or difficult pregnancies. Training will also include antenatal care, intranasal (delivery) and PNC for mothers and infants, referral systems for difficult pregnancies and other conditions, neonatal care, nutrition, delivery records, vaccination/immunization, health education, and breastfeeding. Training also focuses on educating and breaking traditional misconceptions related to pregnancy that communities often harbor.

- Each participant of the TTBA training will be provided with a TTBA kit that is similar to the kit given to a midwife within the government structure. This will help ensure a safe and aseptic delivery.

- In addition to the TTBA kits, maternity kits containing tools and medicines like folic acid, vitamin A, cotton, povidone, albendazole, and pack of plastic bags to ensure a healthy pregnancy and postnatal conditions will be distributed by BPHWT to all TBAs/TTBAs. Given that in these rural areas in Burma, most births are assisted by TBAs, access to this kit helps to ensure safe and aseptic conditions. All TBAs/TTBAs are trained in the use of this basic equipment.

- All deliveries will be documented by TBAs/TTBAs and MCHP workers. The BPHWT asks mothers to keep a copy of their child's delivery record so that the child may have possible citizenship if the political and security situation changes in the future, which will entitle children to access formal education and to get national ID cards. If the mothers' copy is lost or destroyed, the BPHWT also maintains a copy of all delivery records at the central office.

- AMWs are trained and recognized by the state administration, and also have more advanced training than the BPHWT TBAs. They assist midwives with clinical work; controlling communicable diseases; providing domiciliary care of pregnant women and postnatal care; providing domiciliary delivery of normal labor cases; providing environmental sanitation education, health education and nutrition promotion; collecting vital statistics; and recording and reporting births. Since midwives and AMWs are trained and recognized by the state administration, they can travel freely and much more securely than the BP health workers and TBAs/TTBAs. This health convergence initiative has begun with the BPHWT negotiating with Burma government Township Medical Officers in Karen State to help enroll twenty recruits for each AMW training (two trainings in 2014). The community health development committees in each township will manage the training while state-appointed midwives will conduct the training in coordination with the Pa An hospital. Each Midwife Trainer has

AMW training in Pa An

a Midwife certificate, at least three years of teaching experience, training and supervision skills, fluency in Burmese and Karen, and understanding of the situation of the areas with difficult access. The BPHWT support will include contributing funding for the training, reviewing and revising the curriculum, and facilitating the standardization of the BPHWT and the state administration curricula. The focal point of standardization will be upgrading the current AMW curriculum in order for AMWs to perform deliveries and not just assist midwives, which is the current government policy. Once the AMW curriculum and training is changed, then AMWs will be more skilled and knowledgeable than BPHWT TBAs/TTBAs. Upon completion of this training, AMWs will commit to working and living in their communities in order to implement a MCH program in their respective areas, while working under the supervision of state-appointed midwives. Financial support for this health convergence initiative will initially come from award earnings from Stichting Vluchteling's Van Heuven Goedhart Award to the current BPHWT Director, Saw Win Kyaw. This prestigious award honors the work of a notable refugee or IDP and was previously awarded to the BPHWT Chairperson, Dr. Cynthia Maung. Part of the prize money will support the two AMW trainings, but future AMW trainings will be supported through the BPHWT's core funds. If this initiative is successful, the BPHWT plans to upgrade all TBAs/TTBAs to become AMWs in Karen State and other BPHWT target areas.

- AMW training will be four months long, followed by a three month practical which will take place in Mae Tao clinic. Afterwards, the AMWs will be supervised by the midwives and implement MCH programs in their respective areas. One AMW will serve a target population of about 400 people. The kits will be provided for them.

- The BPHWT is planning to integrate medical care and basic counseling for survivors of gender based violence into their Maternal and Child Health services in 2016. The BPHWT will also work with local women's organizations for community education and referral for protection. Ethnic Women's Organizations have been providing protection and advocacy on this issue for a long time, and health workers wish to respond to the health impacts of violence against women in their communities. It has worked on this issue before, in 2011 and 2012, but struggled to find a donor. In 2016, the project will be supported by the Women's Refugee Commission and the US Centre for Disease Control.

(IV) Capacity Building Program

The Back Pack Health Worker Team (BPHWT) organizes short training courses in order to upgrade health workers' skills and knowledge, which are attended by BP field in-charges, field MCHP supervisors, TBA trainers, other BP health workers and invited technical consultants from NGOs and INGOs. The BPHWT also organizes community health worker and refresher training courses, in collaboration with local health organizations and short management courses for office staff.

CBP Objectives and Activities:

Objective 1: Improve health workers' and staff members' knowledge and skills

Activity 1.1: Conduct Community Health Worker (CHW) training
Activity 1.2: Conduct medic refresher training course
Activity 1.3: Conduct organizational development training
Activity 1.4: Organize field workshops
Activity 1.5: Organize field meetings
Activity 1.6: Organize workshops and meeting at the head office
Activity 1.7: Attend local and international conferences and meetings
Activity 1.8: Attend local and international short course
Activity 1.9: Conduct computer training for field interns
Activity 1.10: Organize internship program

Objective 2: Promote gender equality in leading positions
Activity 2.1: Regularly review and adopt gender policies
Activity 2.2: Hold the BPHWT general election triennially

CBP Strategy & Methodology:
- An important aspect of BPHWT's capacity building is to attend local and international conferences and trainings to gain knowledge and skills to become more self-sufficient; and also raise public awareness of the BPHWT and advocate on the larger health issues of Burma.

- The BPHWT aims to improve equity for women across all levels of the organization and therefore sets a target to have a minimum of thirty percent of women at each organizational level.

- Every three years, the BPHWT will hold a general election for leading positions such as the Leading Committee, health program coordinators, and field in-charges.

(V) Health Information and Documentation

The BPHWT collects health information, documents evidence of the health situation and assesses the community needs in eastern Burma. This integrated program also plays a role in monitoring and evaluation of the programs. The BPHWT assesses health needs annually and conducts impact assessment surveys every two years, to compare and evaluate the annual program outcomes. Documentation includes photos, videos and written reports.

HID Objectives and Activities:

Objective 1: Assess and document community health situation and needs
Activity 1.1: Conduct community needs assessment and impact assessment
Activity 1.2: Provide Health Information and Documentation (HID) materials
Activity 1.3: Conduct services mapping training

Objective 2: Standardize health data collection processes
Activity 2.1: Analyze data collected by BP health workers

Objective 3: Make evidenced-based health status comparisons among the target community
Activity 3.1: Organize field meetings
Activity 3.2: Organize field workshops

Objective 4: Raise awareness of the community health problem
Activity 4.1: Produce health Information Education Communication (IEC) materials for Village Health Workshops

Objective 5: Advocate local and international organizations about the health situation in Burma
Activity 5.1: Organize Health Program Coordination and Development Seminars


Enter collected data into computer

HID Strategy & Methodology:

- Health information and documentation training is crucial to the functioning of community-based health organizations. The BPHWT builds the capacity of its staff by providing training in indicator development, data form design, data management, and data analysis in order to conduct regular monitoring and evaluation activities.

- The BPHWT has been conducting regular HID training

in Mae Sot and other border areas for many years. The BPHWT intends to continue to conduct annual and monthly workshops to build capacity for standardizing case definition data collection. Additionally, as staff becomes more evidence-based driven, additional skills are needed for program staff and the HID Coordinator to understand how to determine their data needs and then how to interpret and use it.

- A majority of the IDPs are prone to gastrointestinal diseases partly because of unhygienic practices and limited knowledge of the effects of these practices on their health. To address this, the VHVs/VHWs and BP health workers will provide families with WASH education, focusing on the maintenance of latrines, consumption of potable water, water-related diseases, and other topics. The VHVs/VHWs and BP health workers will ensure that the information is culturally sensitive and appropriate to the conditions of the IDPs. Existing information and materials from the government and other groups on these topics will be reproduced and provided.

- The BPHWT collects health information, documents evidence of the health situation, and assesses the community needs in Eastern Burma. This integrated program also plays a role in monitoring and evaluation of the programs. The BPHWT assesses health needs annually and conducts impact assessment surveys every two years to compare and evaluate the annual program outcomes. Documentation includes photos, videos, and written reports.

IV. Health Convergence Initiative

Spurred by the ongoing peace process in many ethnic areas of Burma, the BPHWT and other ethnic health organizations (EHOs)/health community-based organizations (HCBOs) have been working to converge this extensive border-based health system with the other ethnic health systems inside Burma and the Burma Government's health system to provide better health care, access more of the population, improve health systems and policy, and gain Burma Government recognition/accreditation of border-based health organizations and their workers. This is a slow process as convergence needs to occur at the system, policy, structural, and program levels, and be aligned with progress in the ongoing ceasefire and peace negotiations between the Burma Government and the ethnic armed organizations (EAOs).

This collaborative initiative began in May 2012 with the establishment of the Health Convergence Core Group (HCCG) consisting now of nine EHOs/HCBOs:

- Backpack Health Worker Team (BPHWT)
- Burma Medical Association (BMA)
- Chin Public Affairs Committee (CPAC)
- Karen Department of Health and Welfare (KDHW)
- Karenni Mobile Health Committee (KnMHC)
- Mae Tao Clinic (MTC)
- Mon National Health Committee (MNHC)
- National Health and Education Committee (NHEC)
- Shan State Development Foundation (SSDF)

The aim of the HCCG is to prepare existing ethnic community-based health networks, both inside Burma and those managed from the Burma border areas, for future possibilities to work together with Union and state/region government health agencies, ethnic authorities, international donors, international non-governmental organizations (INGOs), and civil society organizations. The purpose of the HCCG is to explore policy options for achieving the convergence of ethnic health networks with the health system of the Burma Government through political dialogue. Potential outcomes of convergence:

- Increased access to health care for populations in need
- Ethnic and community-based health programs are supported and strengthened
- Positive impact on peace building
- Basic needs and human rights are addressed
- Recognition and accreditation of ethnic health workers
- Increased decision-making and power sharing at the state/region and local levels
- International partnerships and networking are promoted

In looking at both the health system of the Burma Government and that of the Burma border-based managed EHOs, it is seen that the Burma Government health system is highly centralized while those of the border-based managed EHOs/HCBOs are decentralized. Within this context, the HCCG has been looking at various global health system models:

- **Centralized/deconcentrated health systems:** The government is responsible for the health care of the people - curative, promotive, preventative, and rehabilitative.
- **Devolved health systems:** The government and the people are both responsible, to varying degrees depending on structure, for the health care of the people – curative, promotive, preventative, and rehabilitative.

From these health system studies, devolved health systems, especially primary health care, seem most compatible with the situation in Burma as they are more community-based, more responsive, and more in line with the aspirations of the ethnic people. Also devolved health systems appear to be the accepted global model.

The BPHWT has been moving forward with convergence activities at the program level; convergence at the policy, system and structural level will develop in conjunction with the ceasefire/peace process and as a durable, meaningful political change occurs in Burma. These ongoing initiatives with both Union and state/region health officials in Burma include:

- Expanding immunization programs
- Addressing the emergence of drug-resistant malaria
- Expanding the reproductive and child health workforce
- Information sharing on health indicators
- Health worker recognition and accreditation
- Procurement strategies
- Overlaps and gaps in programs, protocols, and target areas
- Pilot convergence activities (e.g., Auxiliary Midwife Program)
- Mutual recognition of health infrastructures
- Meetings and workshops
- Concept of health convergence

AMW Training in Pa An

As an aspect of health convergence, the BPHWT has supported the Auxiliary Midwife (AMW) training that began in 2013. The BPHWT with Phlon Education Development Unit (PEDU) and the Karen State Department of Health (KSDoH) have, to date, organized five trainings for 107 AMWs. The AWM training consisted of three months of classroom theory and three months of clinical internships/training in the Reproductive Health Department at the Mae Tao Clinic in Mae Sot, Thailand. The key course topics of the AMW Training Course are:

- Basic anatomy and physiology
- Basic nursing care
- Basic first aid
- Universal precaution
- Basic history taking and physical examination
- Common diseases - diarrhea, acute respiratory infection (ARI) RI, malaria, worm infestation, measles, anemia, vitamin deficiency
- Anatomy and physiology of reproductive systems
- ANC, delivery, PNC, abortion, < 5 year care, IMCI, and PHC concept and approach

Following the clinical internships/training, the new AMWs are sent back to their respective communities to implement a Maternal and Child Healthcare Pilot Program planned by the BPHWT. The AMW trainers were from the BPHWT, KSDoH, and IRC/PLE as well as retired Burma Government medical personnel. At the end of the training, the AMWs typically receive AMW kits and medical supplies. Also they were given accreditation certificates signed by the Directors of the KSDoH, PEDU, and BPHWT.

Moreover, the BPHWT has hosted and participated in a number of other HCCG activities:

- **HCCG Policy Meetings**
  Exploring policy options for a federal decentralized health system
- **Health System Development Seminars**
  Health as a "*Bridge for Peace"*
  Health equity during political transformation period
  Health Policy Option paper
  Development of the health system and policy for future Burma/Myanmar
- **Health Convergence Presentations**
  Villages within the BPHWT field areas
  Ethnic and international conferences
  INGOs, international development agencies, and foreign government officials
  Media
- **Health Services Mapping**

The health convergence activities of the BPHWT and the other EHOs/HCBOs can be greatly enhanced by INGOs and international donors through:

- Exploring funding opportunities that support health convergence and the peace process (e.g., joint funding for programs in Burma Government- and EAO-controlled areas, cross-border funding, etc.)
- Ensuring that healthcare services and development aid are delivered in alignment with ethnic groups' needs and in a way that supports the peace process
- Considering how planned projects may support program, system, or policy convergence
- Recognizing the EHOs/HCBOs and their experience, skill sets, workers, and capacity built up over past 25 years and supporting them as the primary service providers in their respective ethnic areas
- Encouraging the participation of EHO/HCBO leaders in coordination meetings, workshops, and related activities in respect to health care in Burma
- Promoting and directly supporting ethnic and community-based health programs through financial support, capacity building, technical assistance, and supplies

Such action by INGOs and international donors would greatly enhance the successful convergence of ethnic and Burma Government health systems for the benefit of all the people of Burma and serve as another "*Bridge for Peace*" in the ongoing peace negotiations.

As mentioned, the health convergence initiative works in concert and supports the ceasefire and peace negotiations between the Burma Government and the EAOs. However, while supporting these negotiations, the movement and timing of health convergence entails certain real risks to ethnic health workers and infrastructures should the negotiations breakdown and fighting resume. The BPHWT remains vigilant during these transitional times so as to be able to respond quickly and appropriately to any such risks.

V. Coordination and Cooperation

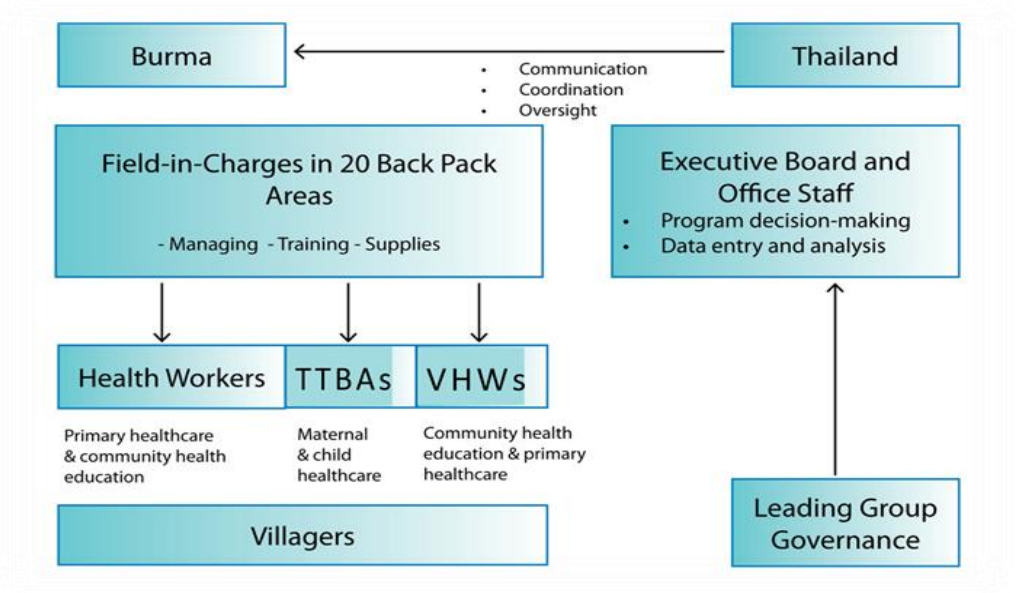
The Back Pack Health Worker Team coordinates with other health organizations, health professionals and health institutions that have the same community health vision. To review the effectiveness of the program, the BPHWT organizes coordination meetings every six months, in conjunction with the regular BPHWT general meetings, field workshops, field operational meetings and village workshops. The BPHWT coordinates with other health organizations which work in areas related to the programs or issues, such as: Mae Tao Clinic (MTC); Burma Medical Association (BMA); local ethnic health organizations, such as the Karen Department of Health and Welfare (KDHW), Shan Health Committee (SHC), Mon National Health Committee (MNHC), and Karenni Health Department (KnHD); and other CBOs, NGOs and INGOs based inside Burma. The technical assistance of BPHWT is supported by the Global Health Access Program (GHAP), in terms of designing public health, data instrument, preparation and monitoring of health indicators; and by the International Rescue Committee (IRC) for medical technical support and organizational capacity building.
The field in-charges from 20 field areas organize field meetings every six months, which include coordinated activities with local health organizations. The BPHWT mainly cooperates with ethnic local health departments, local community based organizations, school teachers and village leaders.

VI. Management, Monitoring and Evaluation

(i) Organizational Management and Development: There are a range of documents that guide the management of the BPHWT and the table below gives a summary of the internal reporting framework. BPHWT receives technical assistance from external consultants and organizations to develop and improve programs, such as reviewing field log books; reviewing and rationalizing drug treatment; improving data management and analysis; improving reporting documentation; and the development of presentations in the international arena.

The Back Pack Health Worker Team organizes program activities meetings twice a year and a general meeting once a year. The meetings include a section on monitoring and evaluation. BPHWT utilizes an Internal Program Monitoring Team (IPMT) in order to evaluate the improvement of the activities and is particularly focused on Quality Control (Drug and Health workers' skills), Logistic Management, Office/Program Administration and the improvement of women participation.

Organizational structure and governance:



Internal Reporting Framework

Human Resources	Guiding Documents	Avenue	Frequency	Evidence
Field workers report to fields-in-charges	- Duty statements - Treatment handbook	Field Meeting	Monthly	- Team activity reports
Fields-in-charges report to program coordinators	- Duty statements - Policies & Procedures	Program Meeting	6 Monthly	- Field activity reports
Coordination staff report to director	- Duty statements - Policies & Procedures	Coordination Staff Meeting	Monthly	- Coordination staff meeting reports
Program coordinators report to director	- Duty statements - Policies & Procedures	Executive Board Meeting	Monthly	- Program reports - Executive Board meeting reports
Director reports to Leading Committee members	- Duty statement - Policies & Procedures - Constitution - Funding contracts	Leading Group Meeting	Twice a year	- Combined program reports - Leading Group meeting reports
Chairperson & Director report to BPHWT members	- Constitution - Funding contracts	Annual General Meeting	Annually	- Annual general meeting report - Annual report & Audited Financial Statements

(ii) Program Monitoring and Evaluation:

The BPHWT undertakes a range of monitoring and evaluation activities, some of which are conducted by external consultants or organizations, to constantly assess the effectiveness and impact of our programs. Internally, our monitoring and evaluation covers three areas: program management, program development and program effectiveness. Data collection and analysis is a vital part of BPHWT's monitoring systems for each of these three areas. Every six months, field in-charges submit caseload data from the filed logbooks to the program coordinators and HID staff in

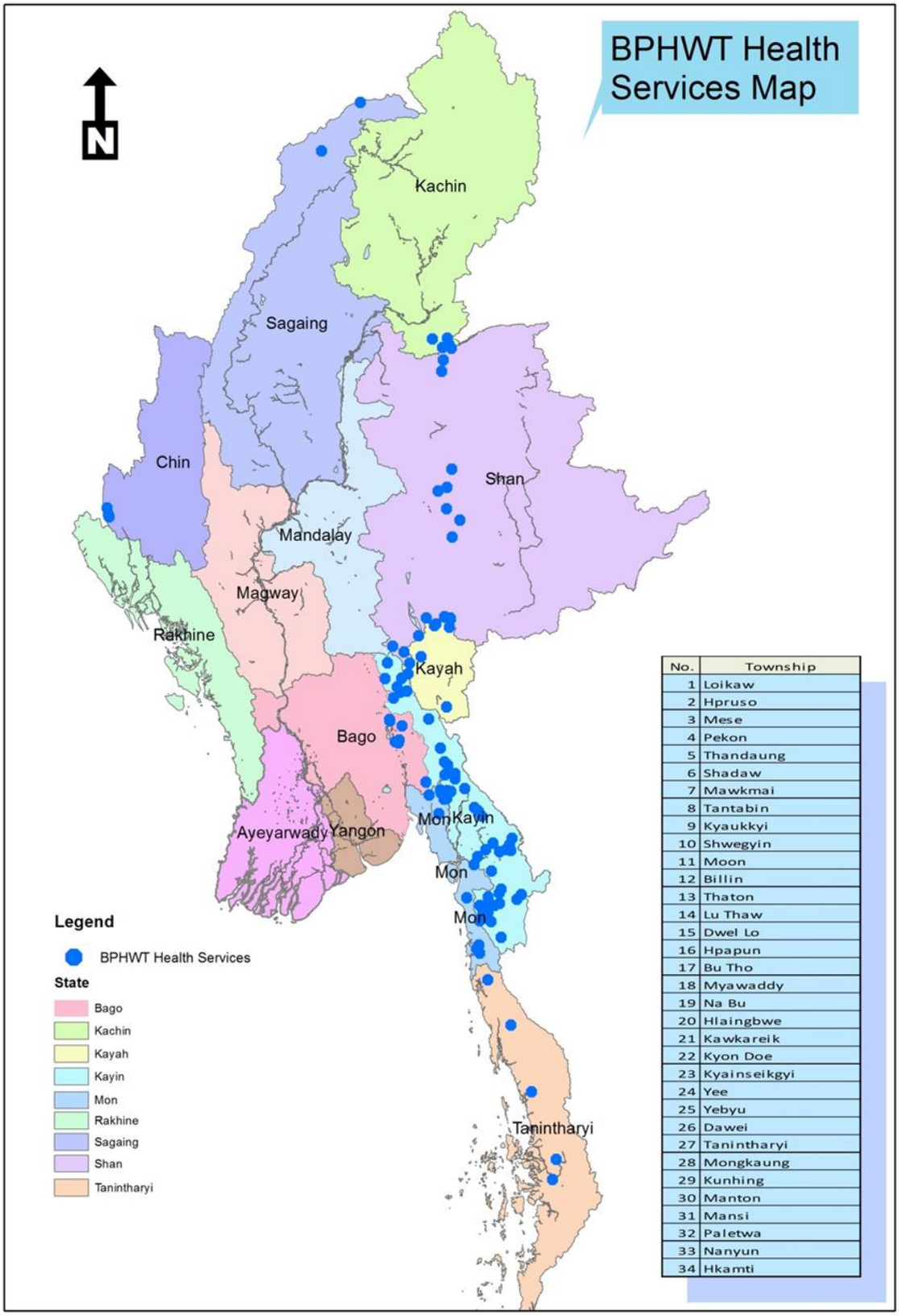
the central office, which is later analyzed and presented in the general meeting that is held every six months.

In addition to reviewing caseload information, the participants also discuss challenges, discuss treatment protocol updates and make decisions and changes to programs. In order to monitor program management, the health workers' performance is regularly reviewed. Additionally, field in-charges regularly meet with village leaders and community members to get feedback on programs and to monitor their local health needs. Lastly, the BPHWT carries out an Impact Assessment Survey every two years using clusters of randomly selected households in most field areas. This survey assists the BPHWT in reviewing program activities, evaluating program effectiveness and planning for future activities. In addition to our internal monitoring, the BPHWT is also regularly evaluated by donors and sometimes independent external consultants. In 2011, the Border Consortium (TBC) and the IRC carried out a monitoring visit to BPHWT target areas and found that the monitoring and evaluation systems in Eastern Burma are among the most reliable in conflict zones in the world. In addition, the Leading Committee members often visit to the targeted field areas and talk to village leaders and communities to see how effective of the programs. The table below summarizes the current Monitoring and Evaluation framework:

Monitoring and Evaluation Framework

Activities	Method	Participants	Frequency	Evidence & Reporting
Quality of field health workers' medical skills	Logbook reviews	- External Physician - Fields-in-Charge - Program Coordinator	6 monthly	Logbook review and analysis included in the Annual Report
Program implementation	Comparison of planned and actual activities	- Leading Committee - Fields in-Charge	Annually	Comparison and reasons for variance included in the annual report
Effectiveness of VHW & TTBA Training	Pre-and post-testing of participants	- Executive Board - Program coordinators	Annually	Results of training evaluation included in the annual report
Effectiveness of programs	Calculating morbidity rates of common diseases	- Director - HIS staff - Program Coordinators	Annually	Morbidity rates over time included in the annual report
Improving health outcomes	Impact assessment	- Survey team	Biennially	Impact assessment included in the corresponding annual report
Financial management	Comparison of budget & actual income & expenditure financial audit	- Leading Committee - Fields in-Charge	6 monthly	Comparison and explanation of variances included in the 6 month and annual reports
Satisfaction with organizational management	Election of Leading Group	- External Auditing Firm - Director - Finance Manager - Accountant - All BPHWT members	Annually Triennially	Audited Financial Report included in the Annual Report Outcome of elections included in corresponding Annual Report

VII. Map of Operational Areas



No.	Township
1	Loikaw
2	Hpruso
3	Mese
4	Pekon
5	Thandaung
6	Shadaw
7	Mawkmai
8	Tantabin
9	Kyaukkyi
10	Shwegyin
11	Moon
12	Billin
13	Thaton
14	Lu Thaw
15	Dwel Lo
16	Hpapun
17	Bu Tho
18	Myawaddy
19	Na Bu
20	Hlaingbwe
21	Kawkareik
22	Kyon Doe
23	Kyainseikgyi
24	Yee
25	Yebyu
26	Dawei
27	Tanintharyi
28	Mongkaung
29	Kunhing
30	Manton
31	Mansi
32	Paletwa
33	Nanyun
34	Hkamti

VIII. Logical Framework of BPHWT Programs in 2016

The BPHWT programs and descriptions of the activities, indicators of achievements, verification sources, expected outcomes and the assumption or risks involved in the delivery of the programs.

Overall goal	***To reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare***						
OBJECTIVES	***ACTIVITIES***	***INDICATORS OF ACHIEVEMENT***	***VERIFICATION SOURCES***	***2016 EXPECTED RESULTS***	***2016 ACTUAL RESULTS***	***VARIANCES OR DIFFERENCES***	***ASSUMPTION OR RISKS***
Medical Care Program							
1. Provide essential drugs and treat the common diseases	*1.1 Maintain the existing BPHWT teams*	*No. of teams existing*		*114 BP teams*			*14 teams from BHM support will be integrated*
	1.2 Provide medicines and medical supplies	*No. of target population and total case-load (w/m), under/over 5)*	*Procurement delivery documents; logbooks; analysis of data collected; and field reports*	*228,000 targeted population (no. of families & HH, no. of w/m and under/over 5)*			*It can be more targeted population because the BPHWT integrates the 14 teams that have been supported by BHM to overall targets.*
	1.3 Treat common diseases and minor injuries	*No. of cases treated (w/m, under/over 5)*		*114,000 cases being treated (w/m, under/over 5)*			
	1.4 Provide ITNs, malaria rapid diagnosis tests (RDTs) and malaria medicine	*No. of ITNs provided and no. of HHs and people receiving ITNs*	*ITNs distributing lists & annual report*	*15,000 ITNs will benefit 18,000 HHs*			*It seems high targeted because BPHWT will collaborate with URC for this activity.*
		Percentage of people in	*2016 Impact Assessment*	*65% of people in households sleeping*			*These impact indicators are*

		households sleeping under ITNs (Baseline-53%)	*Survey*	*under ITNs*			*measured in every two years by IAS.*
		Malaria mortality rates per 1,000 population (baseline-3.5 malaria case deaths per 1000 population)	*2016 Impact Assessment Survey*	*2.2 malaria mortality rates per 1,000 population*			
		Mortality rates among children under 5 years old per 1,000 live births in target population (baseline-138)	*2016 Impact Assessment Survey*	*130 mortality rates among children under 5 year old per 1,000 live births in target population*			
		Percentage of under 5 children with malnutrition (according to accepted guidelines for MUAC cutoffs) (Baseline – 16.5%)	*2016 Impact Assessment Survey*	*14% of under 5 children with malnutrition*			
2. Respond to disease outbreaks and emergency situations	*2.1 Purchase emergency medical supplies and immediately take action*	*Prompt reporting Population affected No of cases treated (w/m, under & over 5)*	*Delivery document; field reports; exception reports; annual report*	*-Effective response and treatment for disease outbreaks or emergency situations (w/m & under/over 5*			*It depends on the political and environmental factors.*
3. Improve	*3.1 Refer patients*	*No of referrals*	*Mid-year*	*30 patients referred*			*- Health workers*

patient referral systems	*to the nearest hospitals or clinics.*	*patients(w/m) List of referral sites*	*and annual reports; patient's referral for*	*to clinics or hospitals (w/m) including EMoC cases*			*work closely with community. -Because of the distance the patients might refuse to be referred*
4. Promotion awareness of mental health in communities	*4.1 Conduct mental health workshop to the health workers*	*No. of workshops No. of participants*	*Mid-year & annual report*	*1 workshop 20 participants*			*This project is on process of planning and Technical support from AAPP*
	4.2 Providing counseling to the patients	*No. of targeted areas and population*		*2 areas (Pa An & Papun)*			
Community Health Education and Prevention Program							
1. Reduce the incidence of malnutrition and worm infestation	*1.1 Distribute de-worming medicine to children between 1 to 12 years*	*No. of children receiving de-worming medicine*	*Worker data form; mid-year & annual reports*	*40,000 children*			
	1.2 Distribute Vitamin A to children between the ages of 6 months to 12 years	*No. of children receiving Vitamin A*		*40,000 children*			
2. Improve health knowledge of students and communities	*2.1 Provide school health education*	*No. of school health sessions and no. of students (w/m)*	*Field reports; mid-year & annual report*	*90 sessions attended by 13,500 students (w/m)*			*1 session for 150 students*
	2.2 Organize Village Health Workshops for communities	*No. & category of people in Village Health Workshops (w/m)*		*9,500 people participate in 95 Village Health Workshops*			

	2.3 Provide health campaign	*No. of participants (w/m)*	*Mid & annual reports*	*100 World AIDS events 15,000 participants (w/m)*			*1 event for 150 participants*
3. Improve community level knowledge and participation in health	*3.1 Organize village health worker trainings and workshops*	*No. training and VHW attended (w/m)*	*mid-year & annual report*	*10 VHW trainings for 100 new VHWs (w/m)*			*1 VHW training for 20 participants*
	3.2 Establish Village Health Committee	*No. of VHC organized*	*Mid-year & annual report*	*12 VHCs*			*8 VHC currently under the SDC project.*
	3.3 Organize Village Health Committee meeting quarterly	*No. of VHC meeting and participants*	*Mid-year & annual report*	*48 VHC meeting 144 participants (F/M)*			*9 members in each VHC Four meetings per VHC per year*
4. Improve water and sanitation systems in the community to reduce water-borne diseases	*4.1 Build community latrines*	*No. of latrines built No. of HHs*	*mid - year & annual report*	*2,400 community latrines for 2,400 HHs*			*1 latrine per household.*
	4.2 Install gravity water systems	*No. gravity flows installed No. of HHs and people (W/M)*	*mid - year & annual report*	*30 gravity flow water systems 1,800 house-holds (9,000 pop)*			*1 gravity flow for 60 HHs & 300 Pop.*
	4.3 Install shallow well water systems	*No. shallow wells installed No. of HHs and people (W/M)*	*mid - year & annual report*	*50 shallow wells for 500 HHs & 2,500 Pop*			*1 shallow well for 10 HHs & 50 pop.*
	4.4 Install school water filters	*No. of water filters installed*	*mid - year & annual report*	*30 water filters for 3,000 students*			*1 water filter for 100 students*
		% of people who own a latrine using latrines (always and sometimes) (Baseline -98%)	*2016 Impact Assessment Survey*	*99% of people who own a latrine using latrines (always and sometimes)*			

		% of people who own a latrine (Baseline - 70% in 2010)	*2016 Impact Assessment Survey*	*85% of people who will own a latrine*			
Maternal and Child Healthcare Program							
1. Increase maternal and child healthcare	*1.1 Distribute de-worming medicine to pregnant women*	*No. of pregnant women receiving de-worming medicine*	*TBA's form, mid -year & annual report*	*4,000 pregnant women*			
	1.2 Distribute folic acid and ferrous sulphate tablets to pregnant women and women	*No. of pregnant women and women receiving iron*	*TBA's form, mid -year & annual report*	*4,000 pregnant women and women*			*There is assumption that women will take all the iron provided*
	1.3 Train Emergency Obstetric care (EmOC) workers	*No. of EmOC trainees*	*Mid & annual report*	*8 EmOC trainnes*			*BPHWT will coordinate with MTC.*
	1.4 Provide EmOC supplies	*No. of EmOC supplies provided*	*Mid & annual report*	*8 EmOC supplies*			*Depend on the # of EmOC workers trained*
	1.5 Provide nutrition food for pregnant women	*No. of pregnant women receive nutrition foods*	*Mid & annual report*	*700 pregnant women (35 per team x 20 teams)*			*(Oil, yellow bean, eggs, fish cans and dry fish in 2015 under SDC project)*
	1.6 Provide ANC to pregnant women	*% of pregnant women in target population with at least four ANC (Baseline – 44.7% in 2010)*	*2016 Impact Assessment Survey*	*55% of pregnant women in target population with at least four ANC*			*These indicators are measured in every two years.*

		% of children 0-5 months who are fed exclusively with breastfeeding in target population (Baseline -23%)	*2016 Impact Assessment Survey*	*35% of children 0-5 months who are fed exclusively with breast milk in target population*			
		No. and % of Trained Traditional Birth Attendants who can identify at least 5 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines(Baseline -45% -2010)	*2016 Impact Assessment Survey & TBA assessment*	*55% of TBAs/TTBAs who can Identify at least 5 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines*			*3 signs have been changed to 5 signs since 2013. So, the % is still low.*
	1.7 Provide obstetric gynecology (OG) instruments to skilled MCH workers	*No. of OG instruments*	*Mid - year and annual reports*	*30 OG instruments*			
	1.8 Refer serious obstetric cases	*No. of serious obstetric cases*	*Patient's referral form; mid & annual report*	*15 obstetric cases referred*			
2. Raise awareness among villagers on family planning and	*2.1 Provide family planning supplies*	*No. of clients using the family planning (w/m)*	*Mid - year and annual reports*	*4,500 (w/m)*			*short term family planning services (Depo,Pill, Condom)*

provide them with family planning supplies	*2.2 Provide family planning education*	*% of people using family planning methods*	*2016 Impact Assessment Survey*	*35%*			*There is still traditional cultural barriers*
	2.3 Organize Reproductive Health awareness workshop	*No. of workshop No. of participants (M/F)*	*Mid - year and annual reports*	*60 RH workshops for 3,000 participants (M/F)*			*50 participants per workshop*
	2.4 Providing joint IEC materials	*No. of IEC materials (Antenatal care, Antenatal services Hand washing & Danger sign of pregnancy) distributed*	*Mid & annual report*	*No. of IEC materials distributed*			*With CHEB inside partners*
3. Improve the knowledge and skills of TBAs/TTBAs and MCH Supervisors	*3.1 Conduct TTBA training*	*No. of new TTBAs complete the training*	*mid-year & annual report*	*6 TTBA training for 120 people (w/m)*			
	3.2 Conduct TBA/TTBA workshops	*No. of TBA/TTBA Follow-up Workshops held & no. of TTBAs attending (w/m)*	*mid-year & annual report*	*150 follow-up TBA/TTBA Workshops for 750 TBAs/TTBAs (w/m)*			
	3.3 Provide TBA/TTBA kits	*No. of TBA/TTBA kits provided*	*Kits distributing list; midyear & annual report*	*1,500 TBAs/TTBAs kits*			*It depends on the numbers of deliveries.*
	3.4 Provide maternity kits	*No. of maternity kits provided*		*4,500 maternity kits*			
		No. of births attended by trained TBAs/TTBAs and	*TBA's/TTBA's form; mid-year & annual*	*4,000 babies delivered by trained TBAs/TTBAs and health workers*			

		health workers, among total target population	*report*				
		% of births attended by trained TBAs/TTBAS *% of births attended by health workers (Baseline – TBA -67%, health worker – 27%)*	*2016 Impact Assessment survey*	*60% of births will be attended by TBAs/TTBAs* *35% of birth will be attended by health workers*			*- Currently, more TTBAs are trained*
		Appropriate sterile instrument (new razor blade, sterile scissors, etc) = 326 (79%)-2010, povidine/Iodine or other antiseptic = 354 (85%) -2010	*2016 TBA assessment survey*	*- 85% of new razor blade, sterile scissors, and etc were used* *- 90% of povidine/Iodine or other antiseptic were used*			
		At the last pregnancy that you delivered provide at least 3 information = 353 (85%) -2010	*TBA Assessment Survey*	*- 90% of postpartum women were given at least 3 information*			
4. Every newborn baby attended by TBAs/TTBAs, MCH workers, & health workers will have birth record.	*Provide delivery records*	*No. of newborn baby received delivery records*	*Mid-year and annual report*	*2,000 delivery records*			*Some communities can access to government services.*

5. Promote awareness of gender based-violence in the communities	*5.1 Conduct training for post-rape care to MCH workers*	*No. of training* *No. of MCH workers*	*Mid-year and annual report*	*1 training for 20 participants*			*This is a new pilot project; it might start the second six month of 2016 in Palaung, Pa O & Kler Lwee Htoo) Supported by WRC and CDC*
	5.2 Organize community awareness raising workshops	*No. of meetings* *No. of participants (M/F)*	*Mid-year and annual report*	*12 workshop for 480 participants (M/F), (40 participants per workshop)*			
	5.3 Provide primary care to survivors of SV	*No. of cases treated*	*Mid-year and annual report*	*No. of cases treated*			
Capacity Building							
1. Improve health worker and staff knowledge and skills	*1.1 Community Health Worker training*	*No. of trainees completed CHW training (w/m)*	*CHW training report & attendance list*	*3 CHW trainings for 90 CHW (w/m)*			
		% of trainees show improved knowledge from pre and post test	*Training report*	*80 % of trainees show improved knowledge from pre and post tests. (disaggregate by gender)*			
	1.2 Medic refresher training course	*No. of trainees complete training (w/m)*	*Mid-year & annual report*	*1 training* *30 participants*			
		-% of Improving diagnosis & treatment (baseline – 96.3% in 2014)	*- Logbook review & analysis*	*- 98% of improving diagnosis & treatment*			
	1.3 Conduct organizational	*No. of training* *No. of participants*	*Mid- year & annual*	*1 training* *30 participants*			

	development training		*report*				
	1.4 Organize Field workshops	*No. of field workshops and participants*	*Annual report*	*38 workshops 300 participants*			*Twice a year for 19 areas (15-20 participants in each workshop or meeting)*
	1.5 Organize Field meetings	*No. of field meeting and participants*	*Annual report*	*38 meetings 300 participants*			
	1.6 Organized six month workshops and meeting	*No. of field health workers*	*mid-year and annual report; workshop attendance list*	*100 health workers (w/m)*			*This happens in Mae Sot every six monthly. The security for the HWs is important while they travel.*
	1.7 Attend local and international conferences and meetings	*No. of meeting times and participants*	*Mid - year & annual report*	*6 conferences or meeting 8 staff members*			
	1.8 Attend local and international short course	*No. of participants attend short course training*	*Mid - year & annual report Attendance list*	*4 participants*			
	1.9 Conduct computer training for field interns	*No. of training No. of participants*	*Mid - year & annual report Attendance list*	*1 training 20 participants (F/M)*			
	1.10 Organize internship program	*No. of participants*		*40 interns*			
2. Promote gender equality	*2.1 Review adopting policies*	*% of women leading health*	*Field report & staff list*	*At least 30%*			

in leading positions		*programs*					
		% of women field in-charges	*Field report & staff list*	*At least 30%*			
		% of women in leading committee	*Annual report & staff list*	*At least 30%*			
	2.2 Hold the BPHWT general selection triennially	*% of women was elected*	*Annual report & staff list*	*At least 30%*			*It will be held in 2016*
Health Information and Documentation							
1. Assess and document community health situation and needs	*1.1 Produce Health Information and Documentation (HID) materials*	*No. of digital cameras and no. of video cameras provided*	*HID staff report*	*40 digital cameras and 2 video cameras*			
	1.2 Conduct services mapping training	*No. of training* *No. of participants*		*1 training for 10 participants*			
2. Standardize health data collection processes	*2.1 Analyze data collected by health workers*	*Frequency of analysis*	*Six months workshop report*	*2 times*			*-HIS teams* *-10 participants each time.*
		No. of participants		*20 participants*			
3. Make evidenced based health status comparisons with the target community	*3.1 Organize field meetings and workshops*	*No. of field meetings or workshops provided*	*Field meeting and workshop report*	*38 meetings* *38 workshops*			
		No. of participants		*300 participants in workshop and 300 in meeting*			
4. Raise awareness of the community health problem	*4.1 Produce health information, education and communication*	*No. of health information and communication (IEC) materials*	*Mid-year and annual report*	*No. of IEC materials distributed*			

	materials	*provided*					
5. Advocate local and international organizations about the health situation in Burma	*5.1 Organize health program coordination and development seminars*	*No. of seminar*	*Annual report*	*1 time*			
		No. of participants	*Annual report*	*30 participants*			
Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	*1.1 Conduct impact assessment survey*	*Frequency of impact assessment survey conducted*	*2016 Impact Assessment survey report*	*1 every 2 year*			*This survey will be conducted in 2016*
	1.2 Conduct monitoring trip	*No. monitoring trips and no of staff*	*Mid-year & annual report*	*4 trips*			*This can be according to the strategy for organizing the regular meeting*
	1.3 Conduct six months meeting	*No. of health workers attend the six months meeting*	*Mid-year & annual report*	*100 health workers*			
	1.4 Provide Leading Committee meetings	*No. of Leading Committee meetings provided*	*Office records*	*2 times*			
	1.5 Provide Executive Board meetings once in a month	*No. of Executive Board meetings provided*	*Office records*	*12 times*			
	1.6 Provide staff meetings	*No. of staff meetings provided*	*Office records*	*24 times*			

Health Convergence							
1. Converge and coordinate with the Burma government's state administered Reproductive healthcare program in Karen State and public health institution	*1.1 Conduct AMW training*	*No. of trainees complete the training (w/m)*	*Mid & annual report*	*1 AMW training 30 participants*			
	1.2 Conduct AMW follow-up workshop	*No. of trainees complete the training (w/m)*	*Training attendance list & report*	*1 AMW follow-up workshop for 45 participants*			
	1.3 Provide AMW kits	*No. of AMW kits provided*	*AMW training report & attendance list*	*81 kits*			
	1.3 Certificate in Public Health Training	*No. of trainees complete training (w/m)*	*Training attendance list & report*	*1 training for 30 health worker (w/m)*			
		% increase in field skilled health workers who have certificate which is recognized by the state/union government	*Annual training reports*	*Increase from 6.9 % to 12.5 % of field skilled health workers who have certificate which is recognized by the state/union government*			*Currently 25 health worker were trained in public health and there are currently 360 health workers are working with BPHWT. (25/360=6.9%)*
		% of trainees show improved knowledge from pre and post test	*Training report*	*80 % of trainees show improved knowledge from pre and post tests. (disaggregate by gender)*			*This will focus on CHW and Certificate in Public Health training.*

	1.4 Organize meetings between midwives from Ministry of Health and BPHWT trained Auxiliary midwives	*No. of meeting* *No. of MW* *No. AMW*	*Meeting report*	*2 meetings* *60 participants (AMWs & MWs)*			
	1.5 Providing joint IEC materials	*No. of IEC materials (Anti-natal care* *Anti-natal services* *Hand-washing* *Danger sign of pregnancy) distributed*	*Mid & annual report*	*No. of IEC materials distributed*			*Under the SDC project*

IX. Program Activity Time Lines

ACTIVITIES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Medical Care Program												
1. Maintaining the existing BP teams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Provide medicine and medical supplies			✓	✓				✓	✓			
3. Treat common diseases and minor injuries	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Provide ITNs					✓				✓			
5. Provide malaria rapid tests & medicines					✓				✓			
6. Collect caseload information, population information	✓						✓					
7. Purchase emergency medical supplies	**As necessary**											
8.Refer patients to the near hospitals or clinics	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9.Conduct mental health workshop			✓									
10. Provide mental health counseling to communities				✓	✓	✓	✓	✓	✓	✓	✓	✓
Community Health Education and Prevention Program												
1. Distribute de-worming medicine and Vitamin A to children			✓	✓					✓	✓		
2. Provide school health education						✓					✓	
3. Village Health Workshops				✓	✓					✓	✓	
4. Village health worker training				✓	✓	✓				✓	✓	✓
5. Build community latrines			✓	✓					✓	✓		
6. Install gravity flows, water filters & shallow wells			✓	✓					✓	✓		
7. Organize Village Health Committee			✓	✓					✓	✓		
8. Organize VHC meetings			✓			✓			✓			✓
Maternal and Child Healthcare Program												
1. Distribute de-worming medicine			✓	✓					✓	✓		
2. Distribute folic acid and ferrous sulphate			✓	✓	✓	✓			✓	✓	✓	✓
3. Train EmOC				✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Provide EmOC kits			✓	✓					✓	✓		
5. Provide nutrition food to pregnant women			✓	✓					✓	✓		
6. Provide ANC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

7. Provide obstetrics gynecology instruments		✓						✓				
8. Referral of serious obstetric cases	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. Provide family planning supplies			✓	✓	✓	✓			✓	✓	✓	✓
10. Provide family planning education				✓	✓	✓	✓				✓	✓
11. Organize RH Awareness workshop			✓	✓					✓	✓		
12. Provide joint (IEC) materials			✓	✓					✓	✓		
8. Conduct TTBA training			✓	✓					✓	✓		
9. Conduct TBA/TTBA workshop			✓	✓					✓	✓		
10. Provide TBA / TTBA Kits and Maternity Kits			✓	✓					✓	✓		
11. Document and issue delivery records	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
12. Conduct post-rape care training			✓									
13.Organize GBV awareness raising workshop							✓	✓	✓	✓	✓	✓
14. Provide primary care to survivors of SV							✓	✓	✓	✓	✓	✓
Capacity Building												
1. Organize community health worker training				✓	✓	✓	✓	✓	✓	✓	✓	✓
1. Organize Medic Refresher Training				✓	✓	✓						
3. Organize OD training		✓	✓				✓	✓				
4. Field Meetings	✓						✓					
5. Field workshops			✓						✓			
6. Organize 6 month workshops and meeting			✓					✓				
7. Attend local and international conferences and trainings					✓	✓			✓	✓		
8. Attend local and international short course training					✓	✓			✓	✓		
9.Conduct computer training for field interns									✓	✓	✓	
10. Organize internship program	✓	✓	✓	✓	✓	✓						
Health Information and Documentation												
1. Provide HID materials	✓	✓				✓	✓					
2. Conduct services mapping training			✓									
3. Analyze data collected by health workers	✓	✓				✓	✓					

4. Provide IEC materials	✓	✓				✓	✓					
5. Organize health program coordination and development seminars	✓	✓				✓	✓					
Program Management and Evaluation												
1. Conduct impact assessment survey									✓			
2. Conduct monitoring trips			✓	✓					✓	✓		
3. Conduct six monthly regional meetings		✓						✓				
4. Organize Leading Committee meetings	✓						✓					
5. Organize Executive Board meetings	✓		✓		✓		✓		✓		✓	
6. Organize staff meetings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Convergence												
1. Conduct Auxiliary Midwife (AMW) training												
2. Organize AMW follow-up workshop			✓						✓			
3. Provide AMW kits			✓						✓			
4. Conduct certificate in public health				✓	✓	✓	✓	✓	✓			
5. Distribute joint IEC materials (MCH)			✓						✓			

X. BUDGETING

A. BUDGET Summary

Budget Category	Total THAI	Total USD	%
1. Medical Care Program (MCP)	14,839,800	436,465	34%
2. Community Health Education and Prevention Program	8,847,000	260,206	20%
3. Maternal and Child Health Program (MCHP)	5,930,200	174,418	13%
4. Capacity Building Program (CBP)	4,896,000	144,000	11%
5. Health Information and Documentation (HID)	685,000	20,147	2%
6. Program Management and Evaluation	4,544,000	133,647	10%
7. General Administration	4,258,000	125,235	10%
TOTAL	**44,000,000**	**1,294,118**	**100%**

B. DETAILS BUDGET

1st January 2016 to 31st December 2016 Budget			
Items	**Total (THB)**	**Total (USD)**	%
I. Medical Care Program (MCP)			
A) MCP program operation cost			
1. Program coordinator operation cost (9000 B x 2 person 6+6 mths)	216,000	6,353	
2. Program staff operation cost (6000 B x 1 person 6+6 mths)	72,000	2,118	
MCP program operation cost sub total	**288,000**	8,471	1%
B) MCP Activities and supplies			
1. General Medicine & Medical supplies (30,000B x114 BPsx1+1term)	6,840,000	201,176	
2. Malaria Medicine & supplies (5,000Bx100 BPsx1+1term)	1,000,000	29,412	
3. Malaria rapid test (40B x150 x 100 BP x1+1term)	1,200,000	35,294	
4. Mosquito net - ITN(150B x 7,500+7,500 ITN)	2,250,000	66,176	
5. Medicine transportation (3,500 B x 100 BPs x 1+1 term)	700,000	20,588	
6. MCP worker's operation cost (1,200 B x 128 persons 6+6 mths)	1,843,200	54,212	
7. Field-coordinator operation cost (1500 B x 20 persons 6+6 mths)	360,000	10,588	
8. Emergency medical supplies	200,000	5,882	
9. Treatment Hand Book (200 B x 500 Books)	100,000	2,941	
10. Report form	28,600	841	
11. Log book	30,000	882	
MCP Activities and supplies cost sub total	**14,551,800**	427,994	33%
MCP Sub Total	**14,839,800**	436,465	34%
II. Community Health Education and Prevention Program (CHEPP)			
A) Program Operation Cost			
1. Program coordinator operation cost (9,000B x 2 ps x 6+6 mths)	216,000	6,353	
2. Program staff operation cost (6000 B x 1 person x 6+6 mths)	72,000	2,118	
3. CHEPP Worker's operation cost (1,200 B x 100 persons x 6+6 mths)	1,440,000	42,353	
4. Field coordinator operation cost (1,500 B x 20 fields x 6+6 mths)	360,000	10,588	
Program operation cost sub total	**2,088,000**	61,412	5%
B) 1. Village Health Worker Training and Workshop			
1. Organize Village Health Committee (1500baht x 8+4 VHC)	18,000	529	
2. Village Health Committee meeting (1000 Baht x 16+32VHC)	48,000	1,412	
3. Village Health Worker handbooks (200B x 40 + 60 books)	20,000	588	
4. Village Health Worker Training (100,000 B x 2 + 3 session)	500,000	14,706	
5. VHW compensation (1000B x 300 x 1+1 time)	600,000	17,647	
VHW Training/workshop sub total	**1,186,000**	34,882	3%
C) School Health Promotion			
1. Personal hygiene (50 B x 150 students x 100 BPs)		22,059	
2. Health Camping event (2,000 B x 100 BPs)		5,882	
3.School Health Assessment		1,471	
School Health Promotion sub total		29,412	2%
D) Village Health Workshop (3,000 B x 95 workshop)	**285,000**	8,382	1%
E) Water & Sanitation			
1. Gravity flow water system (45,000 B x15+15sessions)	1,350,000	39,706	

2. Shallow well water system (10,000 B x 30 +20 sessions)	500,000	14,706	
3. Community Latrine (750B x 1000 +1400 Latrins)	1,800,000	52,941	
4. Water Filter (5000 Baht x 30 filter)	150,000	4,412	
Water & Sanitation sub total	**3,800,000**	111,765	9%
F) Nutrition Promotion			
1. Vitamin A distribution (3 B x 40,000 + 40,000)	240,000	7,059	
2.De-worming for mebendazole (1.5 B x 40,000 + 40,000)	120,000	3,529	
Nutrition promotion sub total	**360,000**	10,588	1%
G)Communicable disease Control (Filiariasis)			
1. End line Assessment (50,000 B x 1 term)	50,000	1,471	
2. Awareness workshop 2,000 B x 3 sessions)	6,000	176	
3. Personal Operation cost (1,200 B x 5 staffs x 6+6 mths)	72,000	2,118	
Communicable disease Control (Filariasis Pilot Program)sub total	**128,000**	3,765	0%
CHEPP Sub total	**8,847,000**	260,206	20%
III. Maternal and Child Health Program (MCHP)			
A) Program Operation Cost			
1. Program coordinator operation cost (9,000B x 2 ps x 6+6 mths)	216,000	6,353	
2. Program staff operation cost (6000 B x 1 ps x 6+6 mths)	72,000	2,118	
3. MCH worker's operation cost (1,200 B x 100 ps x 6+6 mths)	1,440,000	42,353	
4. Field coordinator operation cost (1,500 B x 20 ps x 6+6 mths)	360,000	10,588	
5. TTBA Curriculum (hand book) 120 books x 70 B	8,400	247	
6. AMW Stipend (1,200 B x 35 person x 1+1 term)	84,000	2,471	
MCHP program operation cost sub total	**2,180,400**	64,129	5%
B) TTBA Training (50,000B x 3+ 3 training)	**300,000**	8,824	1%
TTBA Training	**300,000**	8,824	1%
C) TBA / TTBA Workshop			
1. TBA / TTBA Workshop (9,000 B x 75+ 75 sessions)	1,350,000	39,706	
2. TBA Kit (400 B x 10 TBAs x 75+75 sessions)	600,000	17,647	
3. Maternity Kit (150 B x 3 mothers x 10 TBAs x 75+75 sessions)	675,000	19,853	
4. AMW kits (800B x 35+ 46 kits)	64,800	1,906	
MCHP Follow-up workshop sub total	**2,689,800**	79,112	**6%**
D) Obstetrics Gynecologe (OG Instrument) (7000B x 30 sets)	**210,000**	6,176	**0%**
F)Family Planning			
1.Family Planning Supplies	*500,000*	14,706	
2. Information Education Communication (IEC) materials	*50,000*	1,471	
Family Planning sub total	**550,000**	16,176	1%
MCHP Sub Total	**5,930,200**	174,418	13%
IV. Capacity Building Program (CBP)			
A. Capacity Building			
1. CHW training (400,000 B x 2+1 training)	1,200,000	35,294	
2. Medic Refresher Training Course(350,000B x 1 course)	350,000	10,294	
3. Certificate in Public Health training (450,000B x 1 course)	450,000	13,235	
4. Auxiliary midwife training (300,000 B x 1session)	300,000	8,824	
5. AMW follow up workshops & meeting (90,000B x 1 workshop)	90,000	2,647	

6. International Conference and meetings	200,000	5,882	
7.Trainner stipend (9,000B x 2 person x 6+6 mths)	216,000	6,353	
8.Technical Consultant (35,000B x 1person x 6+6 mths)	420,000	12,353	
9.Computer Training for field interns (20,000B x 1 training)	20,000	588	
10.Organizational Development Training (50,000B x 1 term)	50,000	1,471	
11.Local and international health institution (40,000B x 5ps x 2 times)	200,000	5,882	
12.Internship Program (1,200B x 20+20 ps x 6+6 mths)	288,000	8,471	
13.Training center construction	1,000,000	29,412	
14.AMW meeting with MOH at Pa An (1700B x 30 Ps x 2 times)	102,000	3,000	
15.Services Mapping training (10 trainees x 10000 B x 1 training)	10,000	294	
Capacity Building Program sub total	**4,896,000**	144,000	11%
V. Health Information and Documentation (HID)			
A. Health Information & Documentation			
1. Program coordinator operation cost (9,000 B x1psx 6+6mths)	108,000	3,176	
2. Program staff operation cost (6000B x 1 p x 6+6mths)	72,000	2,118	
3. Still digital camera (4,000 B x 20+20 digital cameras)	160,000	4,706	
4.Video Camera (30,000B x 1 + 1 camera)	60,000	1,765	
5. Publication (T-Shirt 200 x 500)	100,000	2,941	
6. Communication Equipment	60,000	1,765	
7. Publication (Posters)	50,000	1,471	
8.Video Documentation	50,000	1,471	
9.Services Mapping	25,000	735	
HID Sub total	**685,000**	**20,147**	**2%**
VI. Program Management and Evaluation			
A) Program managing cost			
1. Leading members Stipend (9,000 B x 5 persons x 6+6 mths)	540,000	15,882	
2. Director stipend (9,000 B x 1 person x 6+6 mths)	108,000	3,176	
3. Deputy director stipend (9,000 B x 1 person x 6+6 mths)	108,000	3,176	
4. Treasurer stipend (9,000 B x 1person x 6+6 mths)	108,000	3,176	
5. Finance manager stipend (9,000 B x 1 person x 6+6 mths)	108,000	3,176	
6. Accountant stipend (7,000 B x 2 person x 6+6 mths)	168,000	4,941	
Program managing cost sub total	**1,140,000**	33,529	3%
B. Annual and six monthly regional meeting and workshop	**2,000,000**	58,824	5%
C) Field Meeting and Workshop			
a. Field Meeting	**400,000**	11,765	
b. Field Workshop	**400,000**	11,765	
D) Program Monitoring and Evaluation			
1. Monitoring trip (30,000 B x 2+2 trips)	120,000	3,529	
2. Impact Assessment Survey	100,000	2,941	
Program monitoring and evaluation sub total	**220,000**	6,471	1%
E) Management Meeting			
1. Leading group meeting (5,000 B x 1+1 time)	10,000	294	
2. Executive Board meeting (1,000 B x 6+6 times)	12,000	353	
3. Staffs meeting (500 B x 12+12 times)	12,000	353	
Management Meeting sub total	**34,000**	1,000	0%

F) Health Convergence Activities			
a .Health Convergence Meeting	**100,000**	2,941	
b. Health Program Coordination and Development Seminar	**250,000**	7,353	
Program Management and Evaluation sub total	**4,544,000**	**133,647**	**10%**
VII. General Administration			
A. Office running cost			
1. Office running cost (80,000 B x 6+6 mths)	**960,000**	28,235	
B. Office supplies			
1. Office furniture and Equipments	170,000	5,000	
2. Computer maintenance	50,000	1,471	
3. Money Transfer Fees	40,000	1,176	
4. Car warranty and maintenance	300,000	8,824	
5. Basic Food for staff members (20,000 B x 6+6 mths)	240,000	7,059	
Office supplies total	**800,000**	23,529	2%
C. Staff stipend			
1. Office staff's stipend (6000 B x 5 persons x 6+6 mths)	360,000	10,588	
2. Office manager stipend (9,000 x 1person x 6+6 mths)	108,000	3,176	
3. Driver stipend (6,000B x 2persons x 6+6mths)	144,000	4,235	
4. Social support	300,000	8,824	
5. Registration (5,000 B x 20 Persons)	100,000	2,941	
6. Intern stipend (1500 B x 10 persons x 6+6 mths)	180,000	5,294	
Staff stipend total	**1,192,000**	35,059	3%
D. Other Administration		0	
1. Auditor fee	50,000	1,471	
2. Visa Extension Fees (30,000 B x 2+2 persons)	120,000	3,529	
3. Computer (Desktop/Laptop)(25,000 B x 2+2Sets)	100,000	2,941	
4. Dealing with border committee (8,000 B x 6+6 mths)	96,000	2,824	
5. Distance transportation 20,000 B x 6 + 6 mths)	240,000	7,059	
6. Emergency Health care	400,000	11,765	
7. Security cost (5,000 B x 6 + 6 mths)	60,000	1,765	
8.Local transportation (15,000B x 6+6 mths)	180,000	5,294	
9. Pa An training center & Coordination office (5000Baht x 12 mth)	60,000	1,765	
Other administration cost total	**1,306,000**	38,412	3%
Total Administration	**4,258,000**	**125,235**	**10%**
Grand total for all program in year 2016	**44,000,000**	**1,294,118**	**100%**