



# **Activity Report**

**January – December 2012**

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# 1 About Medical Action Myanmar

## 1.1 Introduction

Stichting Medical Action – Myanmar (MAM) started medical activities on the 1<sup>st</sup> of June 2009. It was officially registered on 27 June 2009 with the Chamber of Commerce in Amsterdam under number 34345953. The legal office address is in Amsterdam. The office of the general director and management team of the organization is located in Yangon, Myanmar.

## 1.2 Management & Board

The operational management of MAM is based in Yangon, Myanmar and consists of:

- Dr. Frank Smithuis – General Director
- Dr. Ni Ni Tun – Medical Coordinator
- Mr. René Mous – Resource Coordinator

The board of the organization consists of:

- Dr. Alex Winkler, chairman of the board, (*General director Stichting Artsen voor Kinderen, Amsterdam*)
- Prof. Nick White (*Chairman of the Oxford University based Wellcome Trust Southeast Asian Tropical Medicine Research Programmes*)
- Drs. Jikke Wigmans (*Stichting Artsen voor Kinderen, Amsterdam*)
- Dr. Constant Mostart, (*general practitioner, Amsterdam*)
- Dr. Job van Woensel, (*paediatrician/intensive care specialist, Amsterdam*)

## 1.3 Goals

MAM wants to achieve:

- increased access to prevention, diagnosis, treatment and
- decreased mortality and morbidity,

MAM will focus on the following diseases and conditions:

- HIV/AIDS and sexually transmitted diseases (STI)
- Malaria
- Tuberculosis, and
- Common severe childhood diseases and acute malnutrition.

MAM also wants to achieve increased access to family planning.

In addition MAM will try to treat all patients with severe acute diseases who can realistically be treated by MAM.

## 1.4 Values

Above all else, Medical Action Myanmar values:

- Accessibility for the poor
- Non-discrimination
- Patient dignity
- Proven effectiveness
- Accountability to patients and donors
- Cost-effectiveness and replication to large scale.

## 1.5 Strategy

The aim of Medical Action Myanmar is to set up a network of clinics that take on a large number of patients to reach the goals mentioned above. The size of the activities and of the number of clinics depends on the amount of donations secured. AIDS treatment is long term and needs an additional carefulness with regards to future planning. Due to the unsure financial future, the growth will have to be undertaken step by step, in line with new commitments of donors. Whenever additional funds are found MAM will set up new activities and clinics quickly.

## 1.6 Finance

MAM is a relatively young organisation and is gradually increasing its network of donors. Due to delayed registration with the Burmese authorities, it was not possible to approach certain institutional donors, who required in-country registration. MAM has focused on fundraising among private donors. At this moment all activities are funded by private donors except for one malaria project in Mon & Kayin state which is funded by an institutional multi-country donor. From the funds of this institutional donor most of the coordination costs are financed.

Due to the fact that many patients need long term treatment, MAM needs to build up a reserve. In case donors suddenly decrease, patient's care and treatment needs to continue. To secure this MAM wants to build up a minimal reserve that covers 6 months of operational costs plus 2 years of medical supply for patients with chronic diseases.

## 2 Activity report January to December 2012

### 2.1 Introduction

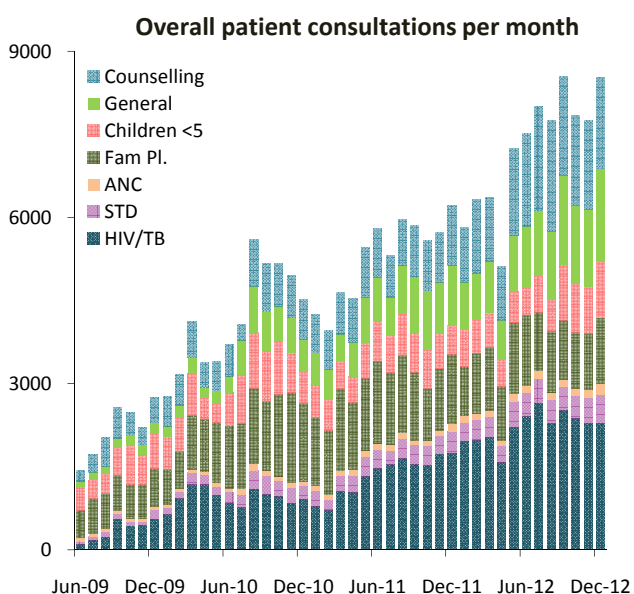
Medical Action Myanmar started operations in June 2009 with the opening of one clinic in Hlaingthayar township. From that moment we aimed to expand activities in this clinic, add more clinics with similar activities in other poor townships of Yangon and start additional projects in other areas. The speed of the growth mainly depended on the acquirement of funds from donors and authorization of government to implement the activities.

The year 2012 saw a significant growth of activities, due to an increase in patients in Hlaingthayar, the start of a 2<sup>nd</sup> clinic in Yangon (in Shwepyithar township), support of clinics in the far north of the country (Putao in Kachin state) and a considerable increase in malaria and primary health care activities in East Myanmar (Mon and Karen states).

### 2.2 Yangon clinics; General health and AIDS services

**Rationale:** Hlaingthayar and Shwepyithar are the poorest Township in Yangon. Most people cannot afford to pay for their basic health needs. MAM supports 2 clinics; The 'Thazin' clinic (Thazin is the name of a flower) in Hlaingthayar Township and the Tun clinic (named after Dr Ni Ni Tun, as this clinic is registered as a private clinic and not an NGO clinic) in Shwepyithar Township. These clinics provide a mix of activities including mother and child care, treatment of malnourished children, reproductive health including family planning and treatment of sexually transmitted infections and testing, counselling, treatment and care for people with HIV/AIDS and Tuberculosis.

#### 2.2.1 Hlaingthayar Township clinic



#### Overall consultations

**Activities:** The number of consultations increased to 275 on average per day in December. The total number of consultations in 2012 was 86,809 varying from a simple out-patient visit to intensive treatment of severe diseases.

In addition 5,392 home visits were performed by out-reach workers (not included in the graph). Mostly for patients with TB, HIV, acute malnutrition and for HIV (+) pregnant mothers who receive treatment to prevent HIV transmission to their unborn babies.

The clinic staff increased from 9 staff in 2009 to 35 staff in 2012 (6 doctors, 2 receptionists, 6 nurses, 4 counsellors, 6 laboratory technicians, 5 outreach workers, 1 peer educator, 3 guards and 2 cleaners).

#### Treatment of children under 5 years of age

**Rationale:** The most common pathology in children under-5 years are respiratory tract infections, diarrhoea and skin infections. All children are also screened for malnutrition. Children with severe acute malnutrition (who have a mortality of 50% if untreated) are admitted and treatment reduces mortality to <10%. This includes rehydration, feeding 6 meals a day in a step up schedule and treatment of underlying diseases (mostly TB or HIV). We also look into the socio-economic situation of the family, in particular for orphans and children with a single parent.

**Activities:** 8,418 consultations were performed for children under 5 years in 2012. Most consultations were for respiratory tract infections (4,526), tuberculosis (504), diarrhoea (579) and malnutrition (1,425). Some severely sick children were referred by other NGO's to MAM for the management of complicated diseases. After treatment and stabilization, these children are sent back to the respective NGOs.





Children at the feeding centre. Pictures from Olivia Mann

### ○ **Reproductive Health**

**Rationale:** Reproductive health activities include screening and treatment for reproductive tract infections and sexually transmitted infections (STI), including a physical exam and laboratory screening for the most common pathology and testing and consultations for pregnancies. Female sex workers and men who have sex with men are important target groups for STI management because they are involved with high risk behaviour and their positivity rates are usually high. Screening and treatment for RTI reduce the chance to get, or spread HIV. Syphilis prevalence is very high in this township and a potential danger for patients and unborn babies and it is an important factor for the spread of HIV. Pregnant women are therefore an important target because of the danger for themselves and for their unborn babies.

**Activities:** From January to December, 1,411 patients were examined for reproductive tract infections (RTI). 4,916 persons were screened for syphilis as this is common in Hlaingthayar. 464 patients (9.4%) tested positive and received treatment for syphilis.

### ○ **Family planning**

**Rationale:** Many women have more children than they want and/or can care for adequately. This leads to poor health of both mothers and children. In addition, it leads to illegal abortion, which is usually performed in a non sterile way, leading to infection and death of the mother. This is mainly due to a lack of access to (affordable) family planning methods.

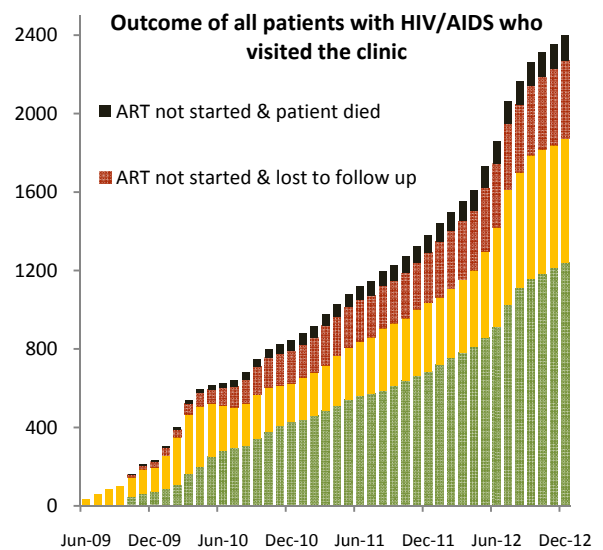
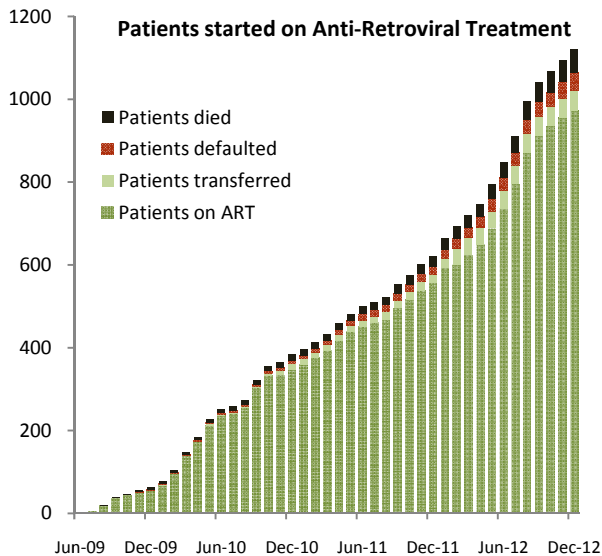
**Activities:** 13,077 consultations were made for family planning in 2012. Most women are treated with a *depot* injection which prevents pregnancy for  $\geq 3$  months and is very popular in Myanmar. Others take the combination pill.

### ○ **AIDS prevention and treatment**

**Rationale:** In the Thazin clinic we give comprehensive HIV care which includes all aspects of HIV care, from testing and counselling to diagnosis and treatment of opportunistic infections, treatment with antiretroviral treatment and support for food and transport fees in case the patient has to visit regularly and cannot afford the charges. The aim is to have a one-stop service where all services are provided together in order to improve compliance and make it able for the patient to live a normal life and return to their job and get income as soon as possible (opposed to many clinics where only a certain part of the services are provided and patients have to be referred to other clinics for specific services).

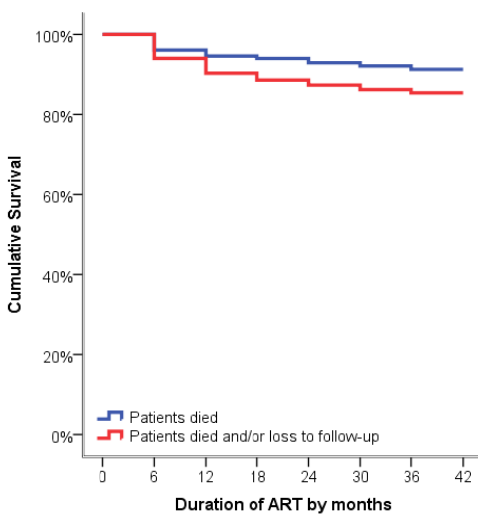
**Activities:** 3,621 persons were tested for HIV and 600 persons tested positive (16.5%). Patients who tested positive were informed about the possibility of treat HIV with *Anti-Retroviral Treatment* (ART). 555 new patients with AIDS were started on treatment in 2012 and the total number of patients enrolled to receive ART is 1119.

Of the 1119 patients enrolled, 56 patients died during follow up; 53 adults and 3 children. They presented with an advanced stage of AIDS and treatment did not prevent a further deterioration. All of them had a baseline CD4 below 100, and most (68%) of them had a CD4 below 50. In addition, 45patients, 43 adults and 2 children were lost to follow up. Consequently 1018 patients (91%) were still on treatment at the end of 2012. Of them 939 patients (96 %) were already fit enough to do daily activities or return to work. 49 patients were transferred to other projects where ART is available, because they live very far from the clinic (Mandalay, Shan and Kachin).



	Interval start time (months)	Number entering interval	Number of deaths and lost to follow up	Proportion terminating	Proportion surviving	Proportion surviving at end of interval
	0-6	1153	38 + 21	6%	94%	94%
	6-12	760	10 + 16	4%	96%	90%
death + lost-to-follow-up	12-18	530	3 + 6	2%	98%	89%
	18-24	405	4 + 1	1%	99%	87%
	24-30	296	2 + 1	1%	99%	86%
	30-36	174	1 + 0	1%	99%	85%
	36-42	37	0	0%	100%	85%

**Table 1:** Details of the HIV treatment outcome analysis (Kaplan Meyer survival analysis) of patients who started ART between June 2009 and December 2012 in Hlaingthayar and Shwepyithar (graph of the same data below).



These data show that we have very low proportions of patients who died or were lost to follow up during treatment. These indicators compare very well to other projects in 3<sup>rd</sup> world countries. We believe that the high survival is a reflection of the comprehensive package of care Dr NiNi Tun and her team provide. Next to good clinical management, laboratory facilities and intensive counselling, the project provides travel expenses and food for the initial 6 months when patients cannot yet return to work. Patients who are very sick or who live far away can stay in the MAM guesthouse, which we built nearby the clinic until they can return home. In addition the



team tries to help with social issues for the entire family, which can have a detrimental effect on treatment compliance of the patient (like patients selling their medicines to solve an urgent financial problem).

Another 972 HIV+ patients have been visiting the clinic regularly but did not receive ART yet. Among them, 130 have died so far. Another 400 patients have been lost to follow up. They might have found ART elsewhere (a rare event) or - more likely - died as well. 632 are still waiting to get admitted into the ART program.



HIV + children, feeding centre children, their parents and MAM staff went with a rented bus to “Happy World Playground “.

○ **HIV+ pregnant women and prevention of HIV transmission from mother to child**

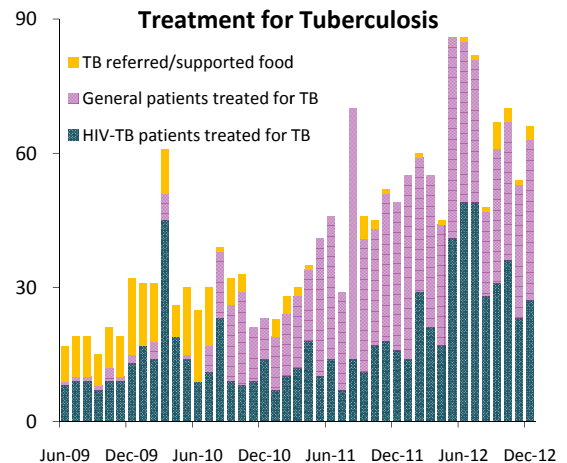


**Rationale:** HIV pregnant women have been visiting the clinic and get preferential treatment. They are offered ART immediately to treat their HIV infection. This treatment not only saves their lives, which enables them to take care for their children, but it is also highly effective to prevent HIV transmission to their unborn/born baby. The mothers are in the program up to 1 ½ year after the birth of the baby.

**Activities:** 28 new HIV+ mothers entered the program in 2012 and 553 follow up consultations were conducted with HIV+ mothers who were already in the project.

○ **Tuberculosis Treatment**

**Activities:** 3,734 patients were tested for TB and 393 tested positive in this period. (Note; Many HIV+ patients who have TB test negative for TB with the routine sputum test and the diagnosis has to be made in another way). 693 patients started treatment in the clinic while 14 patients were referred. All patients, including the referred patients, received food support to improve their nutritional status.



○ **'Intensive care' and over-night stay**

**Rationale:** Critically ill patients need intensive treatment for a number of days (mostly patients with severe dehydration, severe malnutrition, meningitis, sepsis or patients who needed 14 days consecutive treatment with IV amphotericin for cryptococcal meningitis). MAM provides them with "intensive day care" in the clinic. These patients are not allowed to stay overnight in the clinic (government rules). That is problematic, especially for patients who come from far. For these patients we have built a house with 6 rooms nearby the clinic, where they can stay overnight.

**Activities:** 902 patients needed intensive treatment in the clinic for a total of 2,636 days. Several severely sick patients were referred to us by other NGOs for further management.

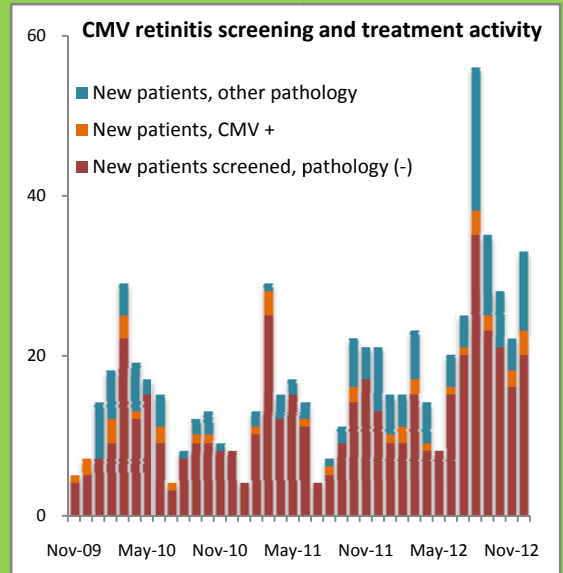
○ **Eye screening for CMV retinitis and other pathology to prevent blindness**

**Rationale:** People with severe HIV infection have a high risk of developing blindness due to an infection of the retina by *cytomegalovirus* (CMV retinitis) and sometimes by other pathology. This is an important source of blindness among young people. If CMV retinitis is diagnosed early, the process - to develop blindness - can be stopped by injecting a medicine (*ganciclovir*) inside the eye ball. Dr Ni Ni Tun received training from an American ophthalmologist, Dr David Heiden, and she is now specialized in this procedure (according to Dr Heiden, her skills have overtaken his).

**Activities:** In this period 294 patients were screened for eye pathology. 197 follow up consultations were done for patients with CMV retinitis and/or other eye pathology.



CMV diagnosis and treatment training course in Hlaingtharyat the MAM clinic for 10 doctors under supervision of ophthalmologist Dr David Heidenj and Dr Ni Ni Tun.



Dr. Ni Ni Tun doing the eye screening



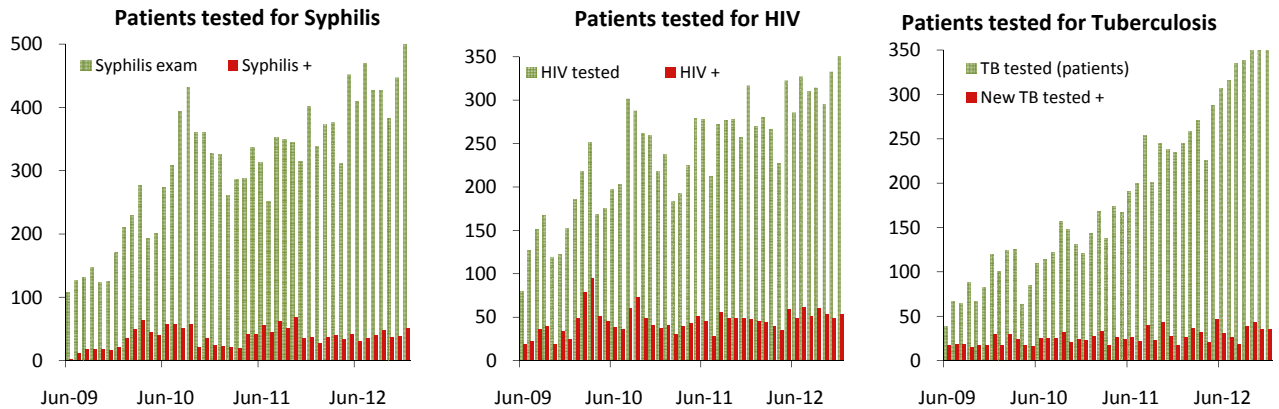
Medical doctors practicing the eye screening





○ **Laboratory testing**

In total 12,050 laboratory tests were performed in this period. 4,916 patients were tested for *syphilis* (464+), 1,411 patients were tested for *gonorrhoea*, *trichomonas vag.*, *candida* and other reproductive tract disorders, 3,734 patients were tested for TB (393+), and 3,621 patients were tested for HIV (600+). Another 3,284 laboratory tests were performed to investigate blood, stool, urine, spinal fluid, lymph node aspiration (for TB), and skin smears (for penicilliosis, cryptococcosis & TB). Trends of numbers of tests performed are reported below.



○ **Food and travel support**

**Rationale:** Patients with serious chronic infections are more vulnerable as they cannot work. At times patients are forced to sell their medicines, which leads to treatment failure and resistance. MAM provides food for a few months until the patient is able to work again. MAM also provides bus fees to regularly visit the clinic. This has most likely been an important contributing factor to the high cure rates and low defaulter rates we have seen in the clinic. In the long run we expect to see less treatment failures and less need to switch to expensive second line treatment for HIV.

**Activities:** 3,040 food rations (rice, beans, oil, fish and salt) were supplied for extra vulnerable patients with chronic diseases, handicapped patients, orphans, single-women households, and households lead by grandparents.

○ **Home visits for patients with chronic diseases**

**Rationale:** For patients who need to take treatment for a long period, adherence is essential. This is particularly important for patients with tuberculosis or AIDS, pregnant mothers who are HIV+ and who need to take drugs to prevent spread of HIV infection to their unborn child and malnourished children who need therapeutic feeding for several months. Home visits are done to discuss and strengthen treatment adherence.

**Activities:** 5,392 home visits were made for children with malnutrition and for patients with HIV and TB.

○ **Other support activities**

**Rationale:** Some people have been unfortunate. If possible we try to do something extra for them.



The operation fees were provided for this child with a fractured elbow joint.

An 8 months old child with a cleft palate. MAM provided operation costs and transport fees for this child.

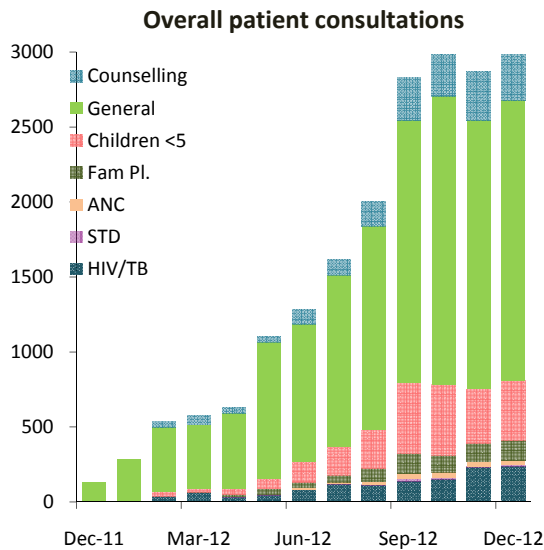
### 2.2.2 Shwepyithar clinic; General health and AIDS services

**Rationale:** Hlaingthayar and Shwepyithar Townships are the poorest Townships in Yangon. The rationale of the activities in Shwepyithar are the same as in Hlaingthayar (see above).

#### ○ Introduction

This clinic was started in December 2011. Over time the number of consultations are picking up. Construction of the 1<sup>st</sup> building with 10 rooms finished in October 2012. A second building will be built in 2013.

#### ○ Overall consultations



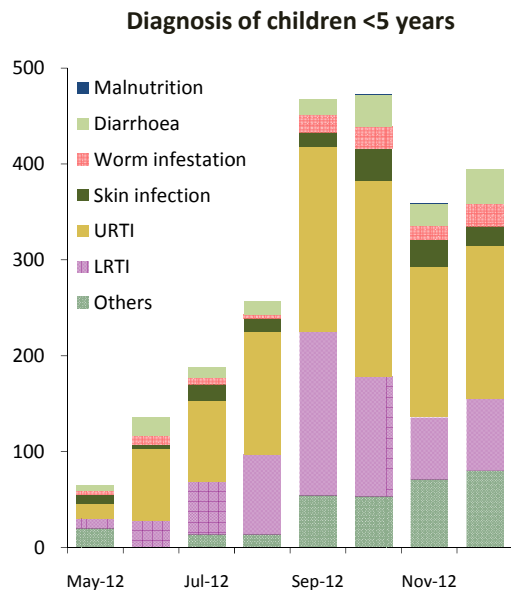
**Activities:** Over the initial 12 months the total number of consultations was 19,835. Consultations vary from a simple out-patient visit with an uncomplicated disease to intensive treatment of severe diseases.

In addition we started home visits in May. Home visits are done to follow up patients with chronic diseases (malnutrition, HIV, Tuberculosis) and for HIV (+) pregnant mothers who receive treatment to prevent HIV transmission to their unborn babies.

The clinic staff increased from 2 staff in December 2011 to 9 staff at the end of December 2012 (2 doctors, 1 nurse, 2 registration clerks, 1 counsellor, 1 OAS, 1 cleaner and 1 guard). In addition a number of staff are working part-time from Hlaingthayar clinic; an outreach worker, a data analyst, and the medical coordinator. The clinic is open 7 days per week.

Forty-three patients were referred to a hospital for severe and complicated diseases. The costs for the transport and the hospital management were paid by the project.

#### ○ Treatment of children under 5 years of age



**Activities:** 2,461 children under 5 years of age came for a consultation since the start of the project. Initially very few young children attended, but after a few months the number of children started to rise.



Patient registration



Prevention HIV transmission mother to child



Blood taking for laboratory tests



○ **Family planning**

**Activities:** 726 women came for family planning in 2012. Most women receive a *depot* injection which prevents pregnancy for ≥3 months and is very popular in Myanmar. Others take the combination pill.

○ **AIDS prevention and treatment**

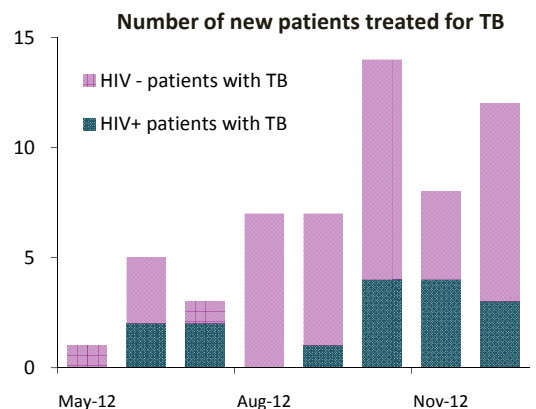
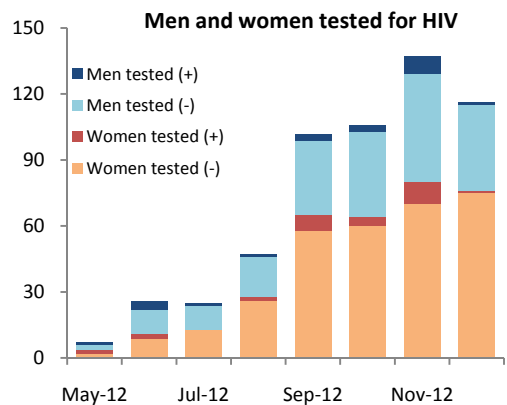
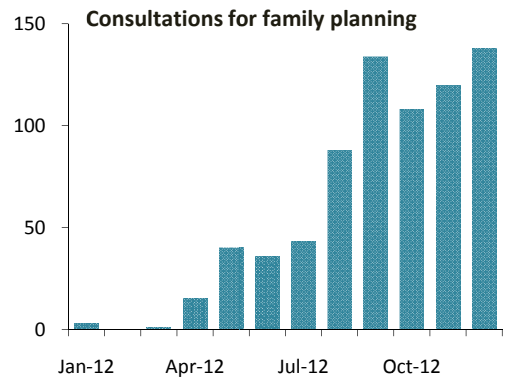
**Activities:** HIV testing in Shwepyithar clinic started only in May (in order to avoid attention by the local authorities). Since then 566 persons were tested for HIV and 50 tested positive (9%). Patients who tested positive were informed about the possibility of treat HIV with *Anti-Retroviral Treatment* (ART). Patients with severe disease or whose immune system was compromised (CD4 count <350) are offered ART. In total 32 patients were enrolled to receive ART in this period. In addition there are a number of patients who tested positive for HIV but were not enrolled to receive ART yet (graph below right). Part of these patients are in the preparation phase to start ART soon and some still have a decent immune system (high CD4). 2 patients died and nobody got lost to follow up.

○ **HIV+ pregnant women and prevention of HIV transmission from mother to child**

**Activities:** 3 mothers tested HIV+ in 2012. All received ART prophylaxis treatment.

○ **Tuberculosis treatment**

**Activities:** 57 patients started treatment for Tuberculosis in the clinic in 2012. All patients received food support to improve their nutritional status.



○ *Eye screening for CMV retinitis and other pathology to prevent blindness*

Initially this service was not yet available in Shwepyithar clinic and patients with low immunity were referred to the MAM clinic in Hlaingthayar for screening of CMV retinitis in particular. For 2013 this service will also be available in Shwepyithar clinic.

○ *Laboratory testing*

**Activities:** Except for HIV tests, which started in Shwepyithar in May, all other laboratory tests were performed in Hlaingthayar clinic because Shwepyithar did not have a licence to operate a laboratory. Only at the end of the year we could open a laboratory in Shwepyithar. 566 patients tested for HIV and 50 patients tested positive (9%). 285 patients tested for sputum AFB test and 29 patients tested positive (10%). And 64 patients were tested for syphilis and 5 patients were found to be new positive cases.

○ *Home visits for patients with chronic diseases*

**Activities:** 652 home visits were made for patients with chronic diseases and for HIV+ mothers (to prevent transmission of HIV to their babies).



← Microscopic examination to identify tuberculosis.



Blood taking from the patient by the counsellor for HIV testing →



← Nurse giving drugs and explanation to the patient.



Dr. Ni Ni Tun giving eye training to new medical doctors for CMV screening →

## 2.3 Kachin State (Putao); general health care and HIV treatment

### 2.3.1 Introduction

**General situation;** Putao district is a restricted zon' in northern Kachin state, the most northern State of Myanmar. Poverty is high and commodities are expensive due to high transport costs. This situation dramatically worsened after fighting erupted in Kachin state between the KIA and the Myanmar government and access to Putao by land route has been impossible for over a year.

**Health situation;** Health services are inadequate and relatively expensive (due to high transport costs). Poverty generates poor health. And poor health on itself is an important cause of poverty. Lack of access to affordable family planning exacerbates this situation. Many women have more children than they want or can afford. This leads to poor health of both mothers and children and poverty. In addition, HIV is a major killer. Initially driven by high-risk behaviour, now more and more women and children are also getting infected. AIDS is treatable with anti-retroviral treatment (ART). And ART is also highly effective to prevent HIV transmission from HIV+ mothers to their unborn baby. But ART is not available in Putao and AIDS patients in Putao who need ART consequently die. HIV + mothers also have no access to ART and therefore have a high chance to spread HIV to their unborn babies.

There are no national or international medical organizations present in Putao district which deliver medical services.

### 2.3.2 Putao clinics; general health and AIDS treatment services

In Putao people usually cannot afford to pay for their basic health needs. MAM is supporting 2 clinics in Putao (1 main clinic and a small out-patient clinic 15km away) which provide a mix of activities including general health, tuberculosis, malaria and reproductive health including family planning and treatment of sexually transmitted infections. In addition it provides HIV testing and counselling and treatment and care for people with HIV/AIDS.

### 2.3.3 MAM training activities

MAM staff have visited the Putao project 3 times so far. The first visit was in 2011 by Dr Ni Ni Tun (medical coordinator) and Frank (general director). This visit was to explore the situation and the possibilities to work together and improve the level of services provided. After this visit MAM started to supply a limited package of medicines and started to look for a donor. Community Friendship Foundation approved a grant to support the health services in Putao and a more comprehensive package of support could be offered. In March and May/June 2012 MAM visited Putao with 6 staff, including Dr Ni Ni Tun, a nurse, a counsellor, a laboratory technician, a data clerk and a financial officer. During these visits the various aspects of clinic management, patient management and book keeping were discussed and on the job training was provided. For 2013 another 3 visits are planned.

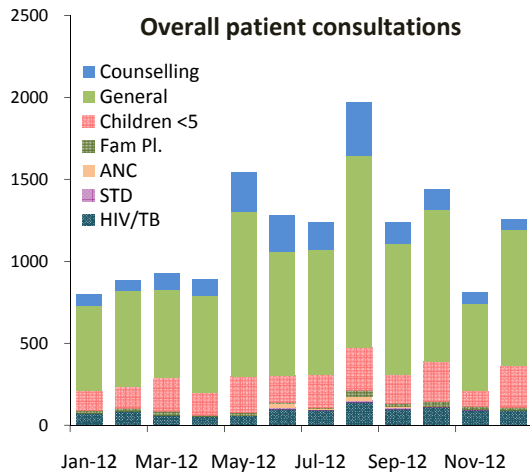


MAM training team and Clinic staff in front of the clinic



Patients waiting for the doctor at the mobile clinic

### 2.3.4 Overall consultations



**Activities:** Over the whole year the total number of consultations was 14,283. Consultations vary from a simple out-patient visit with an uncomplicated disease to intensive treatment of severe diseases. The number of clinic consultations is approximately 1,200 per month. The total consultations for the project was planned to be 10,000 and the project has reached this goal. However, the number of consultations has not increased over the past couple of months. We will have to see in the coming months if this is a seasonal trend or if there is another reason.

The main clinic has 6 staff (2 doctors, 1 dentist/ counsellor, 1 lab technician, 1 registration clerk and 1 finance/logistic staff) and the out-patient clinic has 3 staff (1 nurse, 1 lab technician and 1 registration clerk).

### 2.3.5 Family planning

**Activities:** 217 women came for family planning. Most women are treated with a *depot* injection which prevents pregnancy for  $\geq 3$  months and is popular in Myanmar. Others take the combination pill.

The number of women visiting the clinic for family planning services is relatively low (compared to other clinics in communities of a similar size), due to pressure of religious leaders in the community who are against family planning.

Consultations for family planning



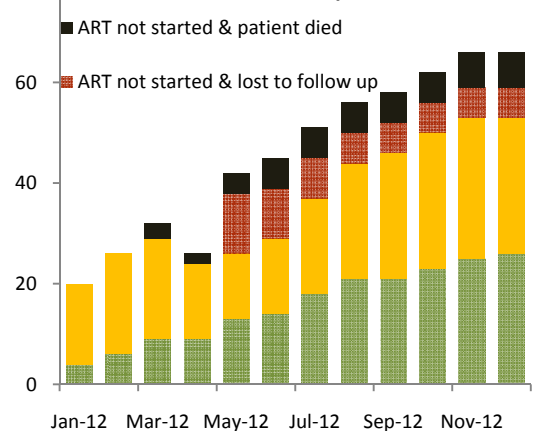
### 2.3.6 AIDS prevention and treatment

**Activities:** 455 patients were tested for HIV and 56 tested positive (12%); 223 women of whom 24 (11 %) tested positive and 232 men of whom 32 (14 %) tested positive. Patients who tested positive were informed about the possibility of treat HIV with *Anti-Retroviral Treatment* (ART). Patients with severe disease or whose immune system is compromised are offered ART. In total 27 patients were enrolled to receive ART in 2012.

Due to the fact that ART was not available in this region before, many people with HIV are not aware of the services and either never arrived at the clinic or arrive very late and have a very poor prognosis. Some patients died within days after arrival in the clinic and treatment could not be started. Others live far away and cannot visit the clinic regularly. Many patients come from remote areas and transport is very difficult, which is very worrisome with regards to access to the clinic and a serious concern for regular adherence, which is essential for treatment success.

We started to refurbish a house nearby the clinic where sick patients can stay for a number of days until their medical condition has stabilized.

Overall outcome of patients with HIV



### HIV+ pregnant women and prevention of HIV transmission from mother to child (PMTCT)

**Activities;** Two pregnant women tested HIV + and started PMTCT to prevent spreading HIV to their unborn babies.



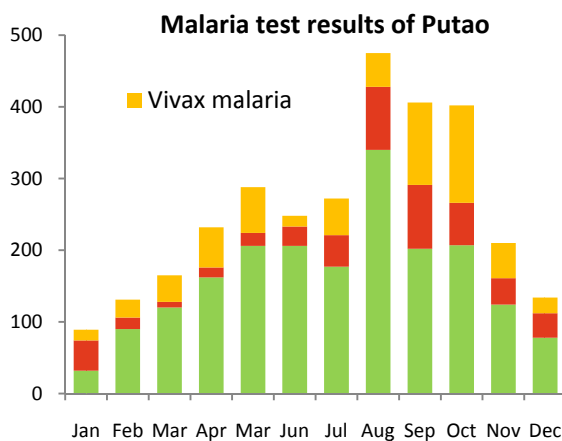
Counselling activity of HIV positive patient at the clinic



Home visit treatment of the HIV positive patient

### 2.3.7 Malaria testing and treatment

**Rationale;** Malaria is the leading cause of morbidity and mortality in Myanmar and most likely also in Putao district. Malaria management in Putao (and the rest of the country!) is inadequate. Lack of good diagnostics and consequent empirical clinical diagnosis based on non-specific symptoms is still common practice. Cheap, ineffective and/or incomplete anti-malaria treatments are still commonly prescribed. Fake medicines are sold widely.



**Activities:** The first time MAM visited the Putao clinic we did an assessment of the laboratory skills and found that the accuracy of malaria diagnosis was approximately 25% .. ! Therefore we started with laboratory training of the laboratory technician and we subsequently introduced quality testing and treatment in these clinics. This has significantly improved patient management and it will also reduce the spread of artemisinin resistant malaria and contribute to artemisinin resistance containment. The total number of patients tested for malaria is 3,043. And 1,108 (36%) tested positive for malaria. Among them 476 patients tested positive for *Plasmodium Falciparum* malaria and 632 patients tested positive for *Plasmodium vivax* malaria.



← A blood sample is taken from a patient to test for malaria.

Testing rapid diagnosis test for malaria disease. →



### 2.3.8 Tuberculosis treatment

**Activities:** 233 patients were tested for TB and 26 of them tested positive for TB in 2012. Overall 106 patients started treatment for TB in the clinic in 2012. All TB patients were also tested for HIV and 16 of them tested positive for HIV. They were informed about the possibility to start ART treatment as well.

2.3.9 Laboratory testing

Activities: 3,731 laboratory tests were performed for HIV, TB and Malaria in Putao clinic in 2012.

2.3.10 Home visits for patients with chronic diseases

Activities: In June out-reach activities were started for patients with HIV, TB and for HIV+ mothers. 167 home visits were made, 165 for patients with Tuberculosis and 2 for mothers who are in the PMTCT program.



A child with conjunctivitis



A patient with large foot ulcer



Family planning counseling session



The Out-Reach Worker provides a dry ration to the patient.



MAM staff training the laboratory technician in Putao.



MAM staff training the receptionist at Putao Clinic



Dr. Ni Ni Tun and MAM staff training the nurse at Putao Clinic



## Malaria activities in Myanmar

### *Rationale for malaria activities in Myanmar:*

Malaria is the leading cause of morbidity and mortality in Myanmar. Malaria cases are estimated at 4-8 million per year (although it is believed that the incidence has decreased over the past years), and malaria deaths are estimated at 9,097 while others believe that it can be as high as 40,000 to 80,000 per year. Malaria management in Myanmar is inadequate. Lack of good diagnostics and consequent empirical clinical diagnosis based on non-specific symptoms is still common practice. Cheap, ineffective and/or incomplete anti-malaria treatments are still commonly prescribed. Fake medicines are sold widely.

Artemisinin derivatives are a 'new' (+/- 30 years) class of highly effective anti-malarials and artemisinin-based combination therapy (ACT) [artemisinin + another antimalarial drug] is now considered as the best treatment for *falciparum* malaria and recommended throughout the world. Replacing ineffective regimen with ACT has significantly reduced morbidity and mortality. In 2008 *artemisinin resistance* was identified in Western Cambodia. Exposure to incomplete treatment for many years has probably been the driving force in the selection of resistant parasites. Subsequent monitoring in the region discovered that artemisinin resistance is also present on the Chinese-Myanmar (Kachin) border and on the Myanmar-Thai border (Kayin, Mon and Tanintharyi provinces).



*Child gets a finger prick to examine blood for malaria*

The spread of artemisinin resistance is a very serious threat to malaria all over the world and measures for containment are needed urgently to limit the spread of these parasites and to prevent a major disaster. There are currently no drugs that can replace artemisinins and the costs of wide-spread artemisinin resistance in terms of lives lost and resources used, in Asia and above all in Africa, would be immense. The increase in malaria deaths could be 200,000 per year (mainly children) if artemisinin resistance spreads.

Good diagnosis and treatment are difficult to get / afford. Therefore people resort to services with poor diagnostics and incomplete treatments, worsening the situation. Immediate action is needed to make quality diagnosis available and treat people adequately in order to prevent the spread of this resistant parasite.

## The place to head off malaria

**MYANMAR II**  
Lying between the Andaman Sea and the Himalayas, Myanmar is in a unique position to halt the spread of resistance to India and Africa.

**Frank Smithuis  
Nick White**

**YANGON, MYANMAR** Throughout history malaria has been a major killer, particularly in tropical countries. Over the past half century several highly effective anti-malarial drugs have been introduced and these have contributed to substantial reductions in mortality. The best of these was chloroquine, which was affordable, simple to take and well tolerated. But widespread use, and abuse, of chloroquine allowed malaria parasites to develop resistance and mortality rose as a consequence.

In the 1970s a remarkably effective plant-derived medicine — qinghaosu, or artemisinin — was developed in China. Artemisinin combination treatments, or ACTs, have now become accepted as the most rapidly and reliably effective anti-malarial drugs.

Supported by international funds (notably the Global Fund to Fight AIDS, Tuberculosis and Malaria), widespread deployment of ACTs in tropical countries has contributed to a significant global reduction in malaria.

The World Health Organization estimates that there are approximately 2,000 deaths a day from malaria (most of these preventable deaths are in African children), whereas before the ACTs were deployed there were well over 3,000. There is even renewed hope that malaria could be eradicated from the world.

All this is now threatened by the emergence of malaria parasites that are resistant to artemisinin on the Cambodia-Thailand border. This is the same place where chloroquine resistance emerged 50 years ago and spread across Asia and Africa to claim millions of lives.

The spread of artemisinin resistance is a very serious threat to health in the tropics. There are currently no drugs that can satisfactorily replace artemisinins. The costs of widespread

artemisinin resistance in terms of lives lost and resources used, in Asia and Africa, would be immense.

Myanmar, which has the largest malaria burden in the region, is the next frontier in the spread of artemisinin resistance, and the likely conduit for its spread west. Lying between the Andaman Sea and the Himalayas, it is in a unique position to halt the spread of resistance to India and Africa.

The Myanmar government, in cooperation with WHO and other partners, has developed a plan to contain artemisinin resistance. But there is little external financial support for this.

Myanmar is undergoing dramatic change. A chorus of international approval has yet to translate into aid, which is still a small fraction of that received by other countries in the region with comparable levels of development. Over the past two decades, Myanmar has been left out of large-scale humanitarian and development aid for political reasons. Aid to contain this emergency

is needed, and it is needed urgently.

Delayed intervention risks extension of the epidemic across the tropical world and the threat that even more serious levels of resistance could develop. At that point, the epidemic will be much more difficult and much more expensive to contain.

It is estimated that spread of artemisinin resistance to Africa could cost 100,000 to 200,000 children's lives per year.

The world cannot afford to lose this battle. Immediate and large scale action in Myanmar is needed to prevent further spread of these artemisinin-resistant malaria parasites. Myanmar needs substantial financial support to prevent a looming malaria catastrophe. The tropical world will be the beneficiary.

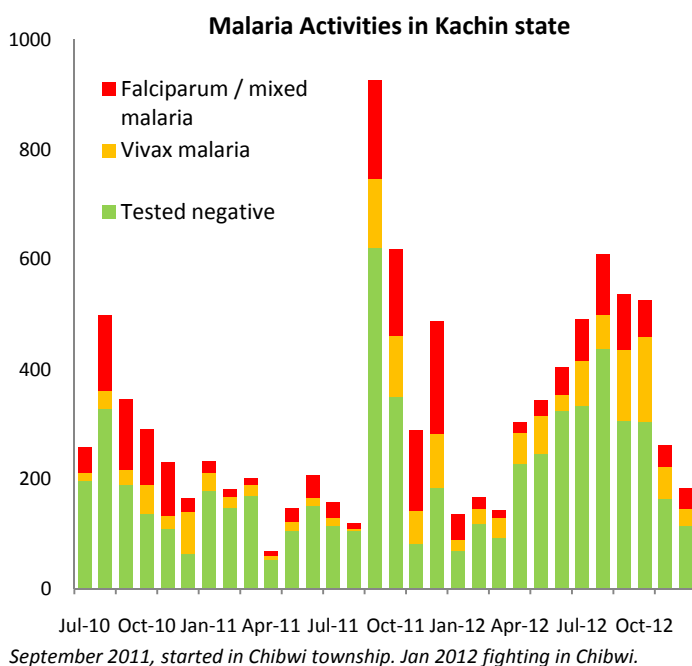
**FRANK SMITHUIS** is director of Medical Action Myanmar, in Yangon. **NICK WHITE** is professor of tropical medicine at the Mahidol Oxford Tropical Medicine Research Unit, in Bangkok.

Medical Action Myanmar

An article in the New York Times written by Frank and Professor Nick White (Oxford University)

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## 2.4 Kachin state; Malaria control and family planning



**Activities:** Ten villagers were trained to make a correct diagnosis and provide effective treatment. After the training these 'malaria field site staff' were provided with diagnostics (microscopes and rapid diagnostic tests) and treatment for malaria and supplies to set up 'malaria field sites'. The malaria activities have been quite low because of the fighting between Kachin and the Burmese army in Kachin state in June 2011 which deteriorated the security situation. At the end of the year 2012, 9,541 patients have been tested for malaria and 3,502 patients (36 %) tested positive and were treated for falciparum malaria (1,993) and vivax malaria (1,509).

Together with the malaria supply, family planning was offered to these clinics. All sites requested family planning but some sites did not use it at all while other sites used only small amounts. The low numbers of consultations are

due to pressure from the religious leaders in the villages.

The project activities, both malaria and family planning, need more support including a promotion campaign with health education and advertisement to make it happen. However that is difficult to realize under the current circumstances. Cease fire talks have failed so far. For the time being we will continue the activities with a low profile, a small output and a small amount of expenses.

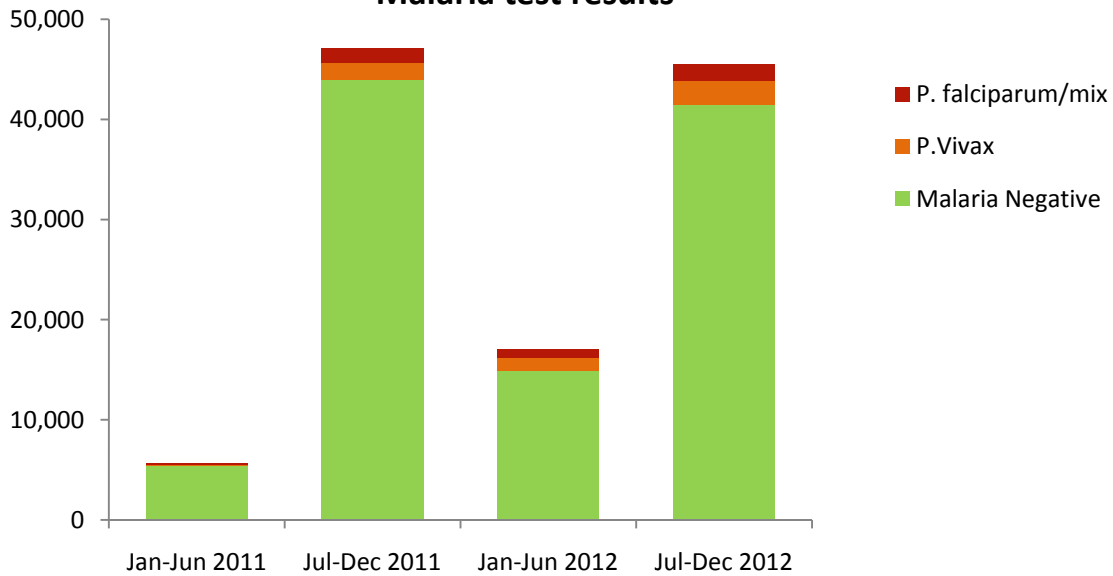
## 2.5 Mon & South Kayin state: Malaria control programme

**Activities:** In April 2011, 61 villages were selected to set up as *Malaria Field Sites* in villages of Mudon, Paung townships in Mon State followed by expansion of field sites in Kyaikmaraw and Yae Townships. In Kayin State 40 villages in Kyainseikgyi townships are opened as field sites in March 2012. In these villages local volunteers who are interested in working as malaria field site staffs (MFSS) were identified and trained to make a correct diagnosis and provide effective treatment. MFSS are supported with a package containing rapid diagnostic tests (RDT), artemisinin combination treatment (ACT) and supplies to set up the malaria field site clinics. Since April 2011 we have gradually increase the number of Malaria clinics in this region from 61 to 164. The area chosen as field sites are remote and roads conditions are poor. These areas have been identified by the DoH and WHO as the highest priority state in Myanmar to contain malaria because of the very serious threat of artemisinin resistance (*Rationale for malaria activities in Myanmar*). The main stay of artemisinin resistance containment strategy is to make quality diagnosis and treatment widely accessible in these areas (WHO/DoH).

Health educators were recruited locally to advise all fever patients to get tested for malaria and to disseminate health education on malaria prevention and control. In addition mobile teams, each with a medical doctor and paramedical staff, travel among the project field sites to diagnose diseases, treat patients and to promote the Malaria Field Sites. The team also supervise and monitor the MFS regularly to make sure the sites are functioning well with optimum access for malaria diagnosis and treatment by villagers.



### Malaria test results



Relatively few patients with malaria are seen in Mudon, Paung, Kyaikmaraw and Yae townships in Mon State and more patients with malaria are seen in Kyainseikgyi and Kyaik Don Townships in Kayin State. Despite the very hard work of the staff, we have difficulties in getting timely report during rainy season in Kyaik Don, Kayin State. Since the malaria prevalence and transmission is high in Kyainseikgyi township, we will work on 100 more field sites in 2013 to try at best for whole population coverage in order to contain the potential spread of artemisinin resistant parasites.

## Results for May 2011 – Dec 2012

	Jan - June 2011	Jun-Dec 2011	Jan-Jul 2012	July -Dec 2012	Total
<b>Diagnosis (RDT) and treatment of malaria</b>					
New 1-person 'clinics' trained and set up for diagnosis and treatment of malaria	61	122	164	164	164
Total patients tested	5,610	47,125	16,956	45,543	115,234
Total patients tested Negative	5,379	43,976	14,927	41,460	105,742
Total patients tested Positive for malaria	231	3,149	2,029	4,083	9,492
<i>P. falciparum</i> (+) and mixed infections	141	1,442	843	1,691	4,117
<i>P. vivax</i> / <i>P. malariae</i> (+)	90	1,707	1,258	2,392	5,447
<b>Non malaria consultations</b> (Patients provided diagnosis and treatment)	-	15,639	1,468	408	17,515
<b>Health education</b> , (Persons provided with malaria health education)	38,805	25,209	57,928	133,909	255,851
<b>Insecticide treated bed-nets</b>					
Long Lasting Impregnated Nets (LLIN) distributed	15,000	38,692	67,525	30,752	151,969
Re-impregnation with insecticide of existing nets	-	11,484	3,369	9,494	24,347

**Patients with other diseases:** The 3 Disease Fund grant only allowed us to prevent, diagnose and treat malaria. However, many patients with fever have other pathology. The 3MDG does not provide for funds or medicines to treat them. The Planet Wheeler Foundation was willing to provide MAM with funds to purchase medicines for the treatment of patients who tested negative for malaria and who had diseases other than malaria.

**Prevention activities:** Although diagnosis and treatment of malaria is the most effective method to control *and* to prevent malaria (by decreasing transmission of malaria from patient to mosquito), insecticide treated bed nets can add to decrease the transmission of malaria. Health education sessions, door-to-door health education were provided locally to advise all fever patients to get tested for malaria and to disseminate health education knowledge, to convince and facilitate villagers in changing attitude and behaviour on prevention and control of malaria. To enable the villagers to take up behaviour on prevention, Long Lasting Insecticide-treated Net (LLIN) are distributed to have a maximum effect in malaria control. Furthermore, all pregnant women who visited the project clinics and every villager with a positive RDT, not only from field site village but also from catchment areas, received an LLIN because they have a high risk of malaria complications and transmission.



Demonstration of new bed nets



Re-impregnation of bed nets with insecticide



Insecticide treated bed nets distribution



Training for malaria diagnosis and treatment



Health education to the public



Health education to the school children

## 2.6 North Kayin state; Malaria and Basic Health Care

### 2.6.1 Background

Myanmar's health system is under-funded. People have to pay for most health services and many cannot afford to do so. In many remote areas, particularly in areas with ethnic tensions, quality health care is practically not available. The situation is worst in East Myanmar (around Kayin and Kayah), where ethnic minority groups and the central government have fought for decades for control. Due to the poor security situation, these areas are not included in the malaria control activities or in any other health care projects. Access for NGO's is restricted. But recently the situation has improved due to a different government policy.

### 2.6.2 How will this project address the problem

Malaria and the problem of spreading artemisinin resistance are best addressed by large scale access to good diagnosis, effective and complete treatment and reduced transmission. MAM has made contact with a number of local groups in East Myanmar (mainly in Kayin state). These groups have access in both government and insurgent controlled areas. They are interested in health care and some already have small clinics and/or a network of 'health volunteers', but they are poorly trained and equipped.

MAM has trained a number of these health volunteers and built a network to improve the management of patients with fever and the use of early diagnosis and quality treatment of malaria. These malaria activities will decrease morbidity and mortality of malaria in the project areas and will stop or reduce the spread of artemisinin resistance. For patients with fever but who test negative for malaria treatment will be made available for the most common diseases (pneumonia, typhus, diarrhoea e.g.) and family planning.

For the people in these areas this will be the first access to quality basic health care.

### 2.6.3 Activities

The project operates currently 88 one-person basic health clinics (*"Field Sites"*) that have been trained and started health



activities in three different batches (July, September and December). The trained villagers (*"Field Site Staff"* or FSS) are focusing on the diagnoses and treatment of malaria and on a few other most common and important diseases, like upper respiratory tract infections, pneumonia, diarrhea, wound infections and family planning.

Recently screening for malnutrition has been added. These one-person clinics are in 88 mostly very remote and small villages. The estimated population of the 88 villages is 35,000. However, the real coverage is bigger as some villages have one or two

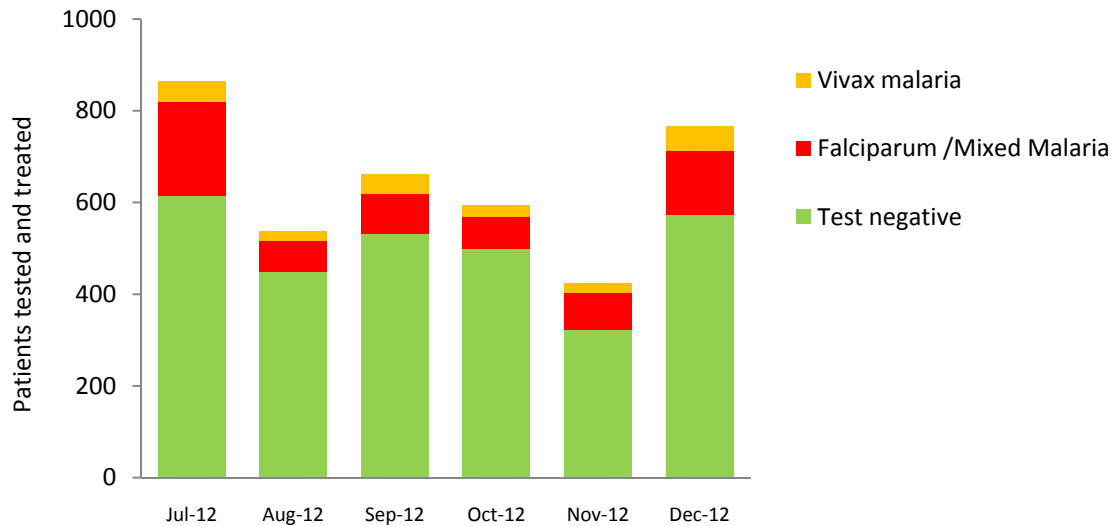
neighboring villages from which people do have access to these project field sites as well. In 2013 we plan to further increase the number of field sites.

All field sites are monitored on a regular basis by our field teams. These teams are lead by a team leader (medical doctor) and consist of several local support staff who do speak the local language. This is essential since many of the patients do only speak Karen language. Monitoring reports and data analysis are the bases for action plans to enhance support and output of the field sites.

A total of 9,179 consultations were performed during the initial 6 months period of this project.

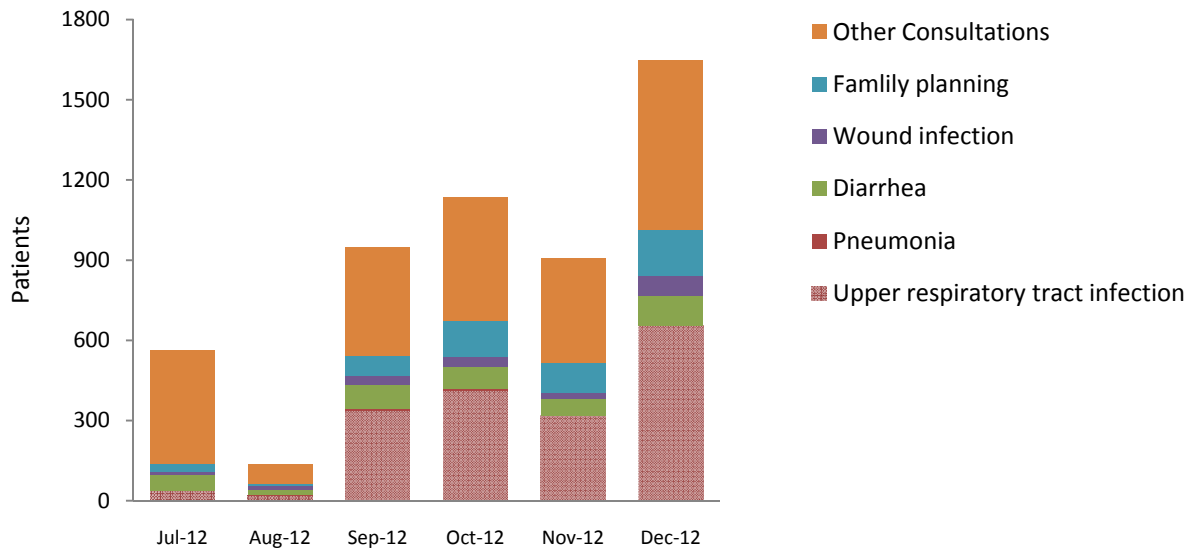
### 2.6.4 Malaria

A total of 3,851 patients received a Rapid Diagnostic Tests (RDT) to find out if they had malaria. 862 patients (22%) tested positive for malaria, among them 652 patients (76 %) tested positive for Falciparum malaria (and mixed) and 209 patients (24%) tested positive for Vivax malaria. All received quality treatment. The chart below shows the figures in detail.



### 2.6.5 Other common diseases

5,331 patients received treatment for other diseases. There were 1,770 patients with upper respiratory tract infection, 427 patients with diarrhoea, 196 patients with wound infection, 23 patients with pneumonia and 2,389 consultations for other diseases. Besides, 526 patients were consulted for family planning.



### 2.6.6 Malnutrition screening

At the end of 2012 screening for malnutrition was started in the project. Middle Upper Arm Circumference (MUAC) has been introduced to detect malnutrition in children between 1 and 5 years of age. (See picture below). When children are found to have acute severe malnutrition they will be treated with special high quality ready-to-use-paste.

### 2.6.7 Health education

Health education is carried out to promote the malaria and basic health activities of the Field Site Staff.



#### 2.6.8 Constrains

- The accessibility to most of the project villages is extremely difficult, particularly in the rainy season. Travel by motorbike is particularly hard on the wet slippery and very narrow paths along very steep gorges in the mountains. And transport by boat has to be followed by several hours of walking. Communication by phone to the project field sites is usually not available.
- The villages are very small, which makes delivery of health services per person very time consuming and the number of patients reached lower than expected.
- The villagers have sometimes extraordinary beliefs about diseases and treatments, which makes it sometimes difficult for the Field Site Staff to follow the guidelines.
- The background education of the Field Site Staff is sometimes low, which limits the training possibilities.

#### 2.6.9 Opportunities

- Due to the remoteness of the villages the health activities are very much appreciated by the villagers. There is no alternative source of health services.
- The Field site staff are active and enthusiastic.

#### 2.6.10 Future planning

- Extension of the number of villages covered.
- Refresher training for all field site staff.
- Long Lasting Impregnated Bed nets (LLIN) distribution in the most remote areas.
- Increase the number or targeted diseases, such as skin infections, worm infections and wound infections.



Mobile clinic activities



Training of the malaria field side staff



Tough Roads



Tough Roads



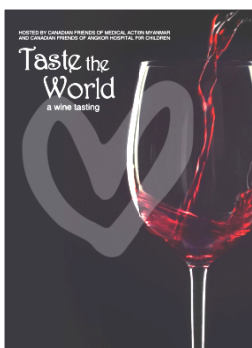
Dr. Ni Ni Tun monitoring the progress of the project



Malaria training of health volunteers by medical doctor



### 3 Private fundraising initiatives



#### 3.1 Taste the World wine event

Canadian Friends of Medical Action Myanmar, organized their yearly special fundraising evenings in Vancouver and Calgary. Nina and John Cassils, the initiators of these events have been hugely successful in fundraising through these events. Many enthusiastic people volunteered to make these events a success. Many many thanks indeed! (also on the website)

#### 3.2 A special fundraising event

Harry Barker and Miles Morris rowed a 2-man Kayak in the 2012 Devizes to Westminster International Canoe Marathon (6-9 April). This involved rowing 125 miles. It is considered 'the Mount Everest' of canoeing! Among the challenges are the many locks and weirs where they had to get out of the boat, lift the boat onto their shoulders and run (77 times!). Harry and Miles raised 3,000 pounds. Many thanks!



#### 3.3 The launch of UK friends of Medical Action Myanmar.

On the 3<sup>rd</sup> of May UK Friends of MAM was launched in London. UK Friends of MAM is an initiative of Lizzie Slinger, Jane Frazer and Tony and Thiri Dickenson. They plan to get attention for the needs of the people of Myanmar and do fundraising to support the activities of Medical Action Myanmar. Approximately 200 people attended the launch. A fantastic initiative!



#### 3.4 Dr Rebecca White swimming event

Becky White, from the (in) famous White family, took part in an open water swimming event on 22nd September. She swam 10kms (that is 400 laps in a regular swimming pool!) down the River Dart in Devon, England, with 700 others and completed the course in 3hrs and 16mins. With this event she raised £860 for MAM. Thank you 400 times and more!



#### 3.5 Donation of a professional photographer

Olivia Mann, a professional photographer from the UK visited Myanmar and gave her time and skills to Medical Action Myanmar. She made some beautiful pictures. Clearly a different level than the snapshots we are usually producing. Thank you very much for this fantastic and very kind initiative!

*And in case you don't want to row or swim but just want to know the bank account of Medical Action Myanmar .....*

Bank details Medical Action (in Thailand): US\$		Bank details Medical Action (in the Netherlands): EURO	
Bank name:	UOB (United Overseas Bank [Thai])	Bank name:	ABN AMRO Bank
Bank address :	Sathorn 2 Branch, 179/3 Bangkok City Tower, Sathorn Road, Khet Sathorn, Bangkok 10120, Thailand	Bank address :	Apollo laan 171, 1077 AS Amsterdam, The Netherlands
Account name:	Mr. Rene Mous or Mr. Frank Smithuis	Account name:	Medical Action
Account number	817-900-080-6	Account number (EURO)	54.12.25.693
Swift code:	UOVBTBKK	IBAN number	NL24ABNA0541225693
Branch:	Trade Fin. Sathorn 2 Branch	BIC	ABNANL2A



*Picture by Olivia Mann*

## 4 Financial Statement 2012

### 4.1 Balance Sheet 31st December 2012

	31-12-2012 USD	31-12-2011 USD
<b>ASSETS</b>		
<b>Non Current Assets</b>		
Land	16,918	16,918
Long term deposit	9,636	8,000
	<u>26,554</u>	<u>24,918</u>
<b>Current Assets</b>		
Grants receivable	1,644,232	1,463,850
Outstanding orders	0	0
	<u>1,644,232</u>	<u>1,463,850</u>
<b>Liquid Assets</b>		
Bank	672,752	828,117
Cash	66,664	125,032
	<u>739,416</u>	<u>953,149</u>
<b>TOTAL ASSETS</b>	<u><u>2,410,202</u></u>	<u><u>2,441,918</u></u>
<b>EQUITY</b>		
Reserves	<u>693,925</u>	<u>458,287</u>
<b>LIABILITIES</b>		
<b>Current liabilities</b>		
Project obligations	1,577,298	1,941,076
Outstanding order payable	0	0
Amounts payable	138,978	42,556
	<u>1,716,277</u>	<u>1,983,631</u>
<b>TOTAL EQUITY &amp; LIABILITIES</b>	<u><u>2,410,202</u></u>	<u><u>2,441,918</u></u>

*For additional clarification see chapter 'Explanation Financial Statements'*

## 4.2 Income & Expense Statement 2012

	Actual 2012 USD	Budget 2012 USD	Actual 2011 USD
<b>INCOME</b>			
Donor Grants Turnover	1,927,562	2,076,076	1,313,465
Donations Received	134,177	100,000	89,801
Donated materials received	3,722	20,000	120,757
Other Income	7,018	4,000	9,096
<b>TOTAL INCOME</b>	<u>2,072,480</u>	<u>2,200,076</u>	<u>1,533,119</u>
<b>EXPENSES</b>			
Personnel cost	702,981	727,809	509,133
Operating running cost	77,314	124,981	89,364
Medical / nutrition cost	776,728	652,317	543,875
Logistic & watsan expenses	47,315	102,750	28,514
Training & support	55,408	54,850	44,719
Transport / freight / storage	166,352	112,560	139,512
External consultants / field support	755	94,430	956
Miscellaneous expenses	9,989		-20,096
<b>TOTAL EXPENSES</b>	<u>1,836,842</u>	<u>1,869,697</u>	<u>1,335,978</u>
<b>Result</b>	<u><u>235,639</u></u>	<u><u>330,379</u></u>	<u><u>197,141</u></u>

*For additional clarification see chapter 'Explanation Financial Statements'*

### 4.3 Cash Flow Statement

	<b>31-12-2012</b>	<b>31-12-2011</b>
	<b>USD</b>	<b>USD</b>
Cash & Bank balance at 1st January	<u>953,149</u>	<u>660,527</u>
<b>Total Income</b>	2,072,480	1,533,119
<b>Total Expenses</b>	<u>-1,836,842</u>	<u>-1,335,978</u>
	<u>235,639</u>	<u>197,141</u>
	1,188,788	857,668
increase / (decrease):		
Cash flow operational activities		
- Land purchase	0	-16,918
- Long term deposit	-1,636	-2,000
- Grants received (for next year)	-544,159	477,225
- Outstanding orders payable	0	-288,471
- Amounts payable	<u>96,423</u>	<u>-74,355</u>
	<u>-449,372</u>	<u>95,481</u>
Cash & bank balance at 31st December	<u><u>739,416</u></u>	<u><u>953,149</u></u>

#### 4.4 Budget forecast 2013

The budget forecast for 2013 is as follows:

	2013 USD	2012 USD
<b>FUNDS</b>		
<b>Estimated Income this year</b>		
- Donor Grants	2,400,000	2,076,076
- Donation	200,000	100,000
- Donated materials	3,000	20,000
- Other income	10,000	4,000
<b>TOTAL ESTIMATED FUNDS</b>	<b>2,613,000</b>	<b>2,200,076</b>
<b>Estimated Expenses</b>		
- Personnel cost	1,005,767	727,809
- Operating running cost	137,707	124,981
- Medical / running cost	859,091	652,317
- Logistic & watsan expenses	114,255	102,750
- Training & support	129,876	54,850
- Transport / freight / storage	246,987	112,560
- Consultants / external support	2,576	94,430
<b>TOTAL ESTIMATED EXPENSES</b>	<b>2,496,259</b>	<b>1,869,697</b>
<b>ESTIMATED RESULT</b>	<b>116,741</b>	<b>330,379</b>

#### Budget per project activity 2013

The budget per project activity can be specified as follows:

	Hlaing thayar Clinic USD	Shwe pyithar Clinic USD	Malaria Mon State USD	Malaria & BHC Kayin State USD	Putao Clinic support USD	Kachin health support USD	Total USD
<b>EXPENSES</b>							
Personnel cost	200,571	102,107	531,539	121,440	12,360	37,749	1,005,767
Operating running cost	9,362	3,850	97,005	13,360	2,264	11,866	137,707
Medical / running cost	306,020	93,750	288,061	130,410	32,000	8,850	859,091
Logistic & watsan expenses	63,880	44,475	0	2,700	2,100	1,100	114,255
Training & support	5,000	820	90,670	14,980	9,821	8,585	129,876
Transport / freight / storage	50,038	17,084	141,223	18,200	12,305	8,137	246,987
Consultants / external support	140	640	1,000	761	21	14	2,576
<b>TOTAL EXPENSES</b>	<b>635,011</b>	<b>262,726</b>	<b>1,149,498</b>	<b>301,851</b>	<b>70,871</b>	<b>76,301</b>	<b>2,496,259</b>

## 5 Explanation Financial Statements

### 5.1 Introduction

The Annual Accounts are made based on the recommendations of Guideline 650 (Reporting Fundraising Organizations) of the Council for Annual Reporting in the Netherlands.<sup>1</sup>

Assets and liabilities are recorded at nominal value, unless stated otherwise.

### 5.2 Explanation

#### 5.2.1 Foreign currency

Due to the fact that most donor fund contracts are in US dollars and the Local Kyat currency's exchange rate is linked to the US dollar, it was decided to change the accounting currency from EURO to USD as per 1<sup>st</sup> January 2011. All transactions in foreign currency are converted to US dollar at the average monthly exchange for the Foreign Exchange rate applicable at the month of transaction. At the end of the financial year all assets and liabilities are converted to US dollars at the year-end Foreign Exchange rate. Exchange results are included in the Income & Expense statement.

#### 5.2.2 Fixed Assets

The organization has purchased a few plots of land in Hlaingthayar and Shwepyithar townships. On these plots of land a patient house and a clinic were built. The purpose of the purchase of land is to ensure MAM is able to continue health services to the vulnerable people without the risk that land or house owner decides to sell the property or increases the rent to unaffordable levels.

The plots of land are included on the balance sheet at historical cost price.

*Specified as follows:*

	31-12-2012	31-12-2011
	USD	USD
<b>Land</b>		
Plot #1 - Hlaingthayar	1,387	1,387
Plot #2 - Hlaingthayar	4,156	4,156
Plot #3 - Hlaingthayar	1,312	1,312
Plot #4 - Shwepyithar	10,063	10,063
	<u>16,918</u>	<u>16,918</u>

The organization does not keep any fixed assets on the balance sheet. Durable assets such as vehicles and computers are directly expensed and recorded as such in the Income & Expense Statement of the year of acquisition. An inventory list of equipment such as vehicles, office and medical equipment is recorded in a separate equipment register.

#### 5.2.3 Stocks

The organization does not keep any stock on the balance sheet. Stocks such as medical drugs and consumable materials are directly expensed and recorded as such in the Income & Expense Statement

<sup>1</sup> Richtlijn 650 (Verslaggeving Fondsenwervende Instellingen) van de Raad voor de Jaarverslaggeving.

of the year of procurement. A stock inventory list of pharmaceuticals and other medical consumables are recorded in a separate stock overview.

#### 5.2.4 Non-Current Assets

	<b>31-12-2012</b>	<b>31-12-2011</b>
	<b>USD</b>	<b>USD</b>
<b>Long term deposit</b>		
USD 6,000 deposit at AFXB account	8,000	6,000
3DF Funds r'ble from AFXB	<u>1,636</u>	<u>2,000</u>
	<u><u>9,636</u></u>	<u><u>8,000</u></u>

MAM has a deposit of USD 8,000 in the AFXB account to open a bank account on MAM's behalf in order to facilitate the money transfers from 3DF for the Mon State Malaria project. This deposit should be paid back to MAM at the end of the project period.

#### 5.2.5 Current Assets

*Specified as follows:*

<b>Grants receivable</b>	<b>31-12-2012</b>	<b>31-12-2011</b>
	<b>USD</b>	<b>USD</b>
3DF - FXB Malaria (closed in 2011)	0	79,254
3DF - PSI - MARC	452,136	761,321
Community Friendship Foundation - HTY	0	57,600
Community Friendship Foundation - Putao	50,000	100,000
Kadoorie Charitable Foundation - Malaria & BHC	676,421	0
Kadoorie Charitable Foundation - SPT Clinic	465,675	465,675
	<u><u>1,644,232</u></u>	<u><u>1,463,850</u></u>

Grants receivable represents the amounts to be received by the organization according to the current donor contracts.



## 5.2.6 Liquid Assets

*Specified as follows:*

	<b>31-12-2012</b>	<b>31-12-2011</b>
	<b>USD</b>	<b>USD</b>
Cash – Kyat	44,244	17,587
Cash – USD	4,825	16,164
Cash – FEC	864	49,245
Cash – EUR	16,731	42,037
Cash – GBP	4,878	0
CB Bank a/c - Kyat	72,423	66,696
UOB Bank – USD	469,070	595,337
ABN AMRO Bank - USD	52,851	34,412
ABN AMRO Bank - EURO	66,360	124,502
UOB Bank a/c - Baht	<u>7,170</u>	<u>7,170</u>
<b>TOTAL LIQUID ASSETS</b>	<b><u>739,416</u></b>	<b><u>953,149</u></b>

## 5.2.7 Reserves

*Specified as follows:*

	<b>31-12-2012</b>	<b>31-12-2011</b>
	<b>USD</b>	<b>USD</b>
As per 31st December previous year	458,287	93,549
Added / (withdraw) this year	<u>235,639</u>	<u>364,738</u>
As per 31st December this year	<b><u>693,925</u></b>	<b><u>458,287</u></b>

In order to safeguard the continuity of the project activities, the board aims to create a reserve of 6 months operational costs plus 2 years of medical supply for chronic disease patients which amount to approximately USD 500,000. Due to the long term commitment of certain activities (ARV treatment) and difficulties securing the necessary funds, the management team is of the opinion that such a reserve is minimally required to ensure the continuity of the project activities in the future.

## 5.2.8 Current Liabilities

Specified as follows:

### Project Obligations

	31-12-2012	31-12-2011
	USD	USD
3DF - FXB Malaria	0	62,954
3DF - PSI - MARC	121,894	926,337
ART AIDS	0	35,361
Community Friendship Foundation - Putao	66,850	100,000
Kadoorie Charitable Foundation - HTY Clinic	0	57,600
Kadoorie Charitable Foundation - Malaria & BHC	743,323	0
Kadoorie Charitable Foundation - SPT Clinic	518,864	712,157
Planet Wheeler Foundation	40,337	0
Radcliff Foundation	86,031	0
Stichting W.M. de Hoop	0	46,667
	<u>1,577,298</u>	<u>1,941,076</u>

Project Obligations represents the project reporting obligations of the organization according to the current donor contracts.

### Accounts payable

	31-12-2012	31-12-2011
	USD	USD
Payable staff expenses	<u>138,978</u>	<u>42,556</u>

## 5.2.9 Specification Income

Specified as follows:

### Donor Grant Turnover

	31-12-2012	31-12-2011
	USD	USD
3DF/FXB - Malaria	-14,665	726,356
3DF/PSI - MARC	1,119,925	149,870
Aids Ark Foundation	28,673	26,080
Art Aids	66,417	
Community Friendship Foundation	90,750	
Planet Wheeler Foundation	160,803	198,004
Radcliff Foundation	92,603	105,000
Stichting De Hoop	46,667	
The Kadoorie Charitable Foundation	336,391	3,518
AHRN		1,568
DKR Foundation		100,000
Dutch Embassy Bangkok		3,068
Total	<u>1,927,562</u>	<u>1,313,465</u>

### Donations received

	31-12-2012	31-12-2011
	USD	USD
D. Hartz	12,987	13,643
Greenshoots Foundation	15,254	
Netherlands - Thai Chamber of Commerce	5,000	
The Radiology Assistant (website)	26,212	14,114
UK Friends of MAM	4,976	
Various donations	69,748	18,680
J. Gessner		30,223
Lotte-Ehrhardt-Stiftung		13,141
Total	<u>134,177</u>	<u>89,801</u>

### Donations in-kind received

(Donations in kind of pharmaceuticals and medical material are valued based on the MSF-H pricelist)

	31-12-2012	31-12-2011
	USD	USD
ACF	811	1,549
PSI	2,520	0
Save the Children	391	0
MSF-Holland	0	105,902
MSF-Switzerland	0	2,427
Cassils	0	7,980
Other	0	2,899
Total	<u>3,722</u>	<u>120,757</u>



## 5.2.10 Specification Expenditure

### Expenses per project activity

The expenses per project activity can be specified as follows:

	Hlaing thayar Clinic USD	Shwe pyithar Clinic USD	Malaria Mon State USD	Malaria & BHC Kayin State	Putao Clinic support USD	Kachin health support USD	Total 2012 USD
Personnel cost	153,301	46,936	446,177	45,793	7,728	3,047	702,981
Operating running costs	4,150	3,332	61,926	7,073	392	441	77,314
Medical / nutrition costs	212,273	45,338	458,852	47,498	11,223	1,544	776,728
Logistic & watsan expenses	8,329	38,456	379	0	152	0	47,315
Training & support	3,206	40	43,285	8,462	0	414	55,408
Transport / freight / storage	16,940	30,905	82,349	25,979	6,612	3,567	166,352
Consultants / external support	216	330	0	166	31	13	755
Miscellaneous expenses	9,005	0	-1	29	481	475	9,989
<b>TOTAL EXPENSES</b>	<b>407,418</b>	<b>165,338</b>	<b>1,092,968</b>	<b>134,999</b>	<b>26,618</b>	<b>9,501</b>	<b>1,836,842</b>

### Expenses per destination

The expenses per destination can be specified as follows:

	Project activities USD	Fundraising activities USD	Operational activities USD	Total 2012 USD	Budget 2012 USD
Personnel cost	659,865	19,542	23,574	702,981	727,809
Operating running costs	70,190	2,000	5,124	77,314	124,981
Medical / nutrition costs	776,728	0	0	776,728	652,317
Logistic & watsan expenses	47,315	0	0	47,315	102,750
Training & support	55,408	0	0	55,408	54,850
Transport / freight / storage	163,347	1,153	1,852	166,352	112,560
Consultants / external support	229	125	401	755	94,430
Miscellaneous expenses	0	0	9,989	9,989	0
<b>TOTAL EXPENSES</b>	<b>1,773,082</b>	<b>22,820</b>	<b>40,940</b>	<b>1,836,842</b>	<b>1,869,697</b>

The allocation of staff expenses to the project -, fundraising – and operational activities is based on the approximate time spent on each of those activities. The other expenses are either directly related to an activity or allocated pro rata where necessary.



### 5.2.11 Key Indicators

#### *Percentage Project Expenses / Total Expenses*

	<b>2012</b>	<b>2011</b>
	<b>USD</b>	<b>USD</b>
Project expenses	1,773,082	1,314,977
Total expenses	1,836,842	1,335,978
Percentage	96.5%	98.4%

#### *Percentage Fundraising expenses / Total donations and grants received*

	<b>2012</b>	<b>2011</b>
	<b>USD</b>	<b>USD</b>
Fundraising expenses	22,820	12,214
Total Income	2,072,480	1,533,119
Percentage	1.1%	0.8%

### 5.2.12 Other Explanation

#### *Employees*

*The number of employees is as follows:*

	<b>31-12-2012</b>	<b>31-12-2011</b>
Expatriate Staff	3	2
National Staff	139	98
Total	<u>142</u>	<u>100</u>

#### *Salary payment to board members and director*

None of the board members received any salary or other benefits from the organization.

## 5.3 Other Information

### 5.3.1 Allocation of Result

The result of the year subtracted with not yet spent allocated project funds will be added to the reserves.

### 5.3.2 Approval Annual Report by the Board

The annual account have been acknowledged and approved by the board on .....

### 5.3.3 Auditors Statement

An independent auditor has reviewed the financial statements and procedures, validation of documents and the annual report. A copy of the official statement of the auditor is attached below.

## ***JF Group- Certified Public Accountants & Auditors***

*Room No. 503, (5<sup>th</sup> Floor) , No.33-49, Strand Condo, Mahabandoola Garden Street, Corner of Bank Street & Mahabandoola Garden Street, Kyauktada Township, Yangon Region, The Republic of the Union of Myanmar*

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***Audit Report of Auditor for "Management Team" of  
"Medical Action Myanmar (MAM)"  
For the operational year from 1 January to 31 December 2012***

Our group has audited the accompanying annual report-financial statements of "Medical Action Myanmar - MAM" which is related activities (stated in page no 4 to 13) and cash flow statement have been implemented by Management Team of "MAM" for the operational year from 1 January to 31 December 2012.

### ***Responsibilities of Management Team of "MAM"***

"MAM" is responsible for the maintenance of proper financial records and the preparation of the financial statements relating to the activities of "MAM".

### ***Responsible of External Audit Team***

External Auditor / Independent Auditor is responsible to give the professional opinion upon the observations for annual financial statements.

### ***Opinion of Independent Auditor***

Our group has audited the attached annual report of "MAM" in accordance with "Myanmar Standards on Auditing" in compliance with "General Accepted Auditing Standards" and "International Standards on Auditing" where necessary. An audit includes examination, test basis, supporting evidence for such other amounts and necessary disclosure in the annual report-financial statements. An audit also includes an assessment of whether the accounting policies, procedures and guidelines used are appropriate, consistently applied and disclosed necessary.

Our group has conducted our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the annual report- financial statements are free from material misstatement, misuse, any fraud and irregularity or error.

Overall opinion on annual report – financial statements have been show fairly presented of its financial position.



## ***JF Group- Certified Public Accountants & Auditors***

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### ***Internal Control***

Internal control procedures has been set up adequately and sufficient control procedures and control frameworks for making the payments and uses of expenses during the course of audit.

### ***Financial Risk Assessment***

During the course of audit, there is no material financial risk upon implementing of activities of "MAM".

***Best regards,***



*(Wan Tin)*

***B.Com, Q, C.P.A, ACCA (Affiliate-UK)***

***Certified Public Accountants, Auditors & Financial Consultants***

***JF Group***

**WAN TIN**

**B.Com, Q, C.P.A, ACCA (Affiliate-UK)**

**Certified Public Accountant and Auditor**