နယ်လှည့်ကျောင်းအိတ်ကပ်နီးမာရေးလုပ်သားအဖွဲ့
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Provision of Primary Health Care among Internally displaced people of Burma

Annual Report 2006

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1. Executive Summary

In 2006, the BPHWT extended health care into the Shan and Lahu areas, which increased the number of BPHWT teams from 70 to 76. Currently, there are over 300 people working for the BPHWT, including 284 health workers in Burma, the Leading Group and Executive Board members and office staff . The BPHWT also has trained and provided supplies for 530 traditional Birth Attendants and trained 700 Village Health Volunteers who provide assistance to BPHWT activities.

The BPHWT continues to provide three main programs, Medical Care, Community Health Education and Prevention, and Maternal and Child Health Care, to people who are internally displaced in Burma. The BPHWT also improves capacity at the field level through workshops and training. The BPHWT collects heath data and reports on the health status of internally displaced people in Burma.

2. Current Situation by Area

a. Kayah and Kayan Area

Though there is a current ceasefire in the Kayah and Kyan areas, between the SPDC and the Karenni National People Liberation Front (KNPLF), fighting is still occurring between the pro-democracy Karenni National Progress Party (KNPP) and SPDC . There is resultant tension which often leads to armed conflict between the cease-fire groups and the KNPP. During the six months, the BPHWT have negotiated with the ten mobile health teams in the KNPP area, to have consistent case definitions and data collection within the maternal and child health program, and agreement for a health assessment survey to be implemented in the future.

b. Northern Karen Area

i. Toungoo

As a result of increased fighting within the Toungoo area, more villagers have become internally displaced or fled to refugee camps on the Thai Burma border. There has also been an increase in the number of landmines laid, resulting in three villagers being killed and nine injured. Of those injured, three received all their treatment from the BPHWT and six needed to be referred to nearby health clinics for further treatment. Delivering health care in the Toungoo area continues to be difficult and dangerous. The delay in the delivery of medical supplies to the northern region also impacted on the delivery of all programs in the Toungoo area.

The family from Taungoo area
– in termporary camp 2006

ii. Kler Lwee Htoo

There has been an increase in the number of SPDC posts built in Kler Lwee Htoo, resulting in more villagers becoming internally displaced and fleeing to the refugee camps on the Thai Burma border. During this six months, the SPDC ordered people from the towns to move into the abandoned homes of the villagers who fled. The BPHWT teams treated three villagers injured by landmines. The medical care program was only able to be delivered during the months of January and February.

The family from Klerlweetu area – in temporary camp 2006

iii. Thaton

There was increased fighting between the allied SPDC and Democratic Karen Buddhist Army (SKBA) armies and the Karen National Liberation Army (KNLA) in Thaton. During the six months the SPDC ordered the villagers to remain within the immediate village boundaries, which prevented them from planting rice and working their fields. As a result, the food supplies of villagers have been destroyed and they are at high risk of malnutrition in the near future.

iv. Papun

Two issues have contributed to poor harvests in some regions of Papun. Firstly, the SPDC made three attacks on the Yel Mu Plaw area which prevented the villagers from working their fields. The second is the high rainfall in some areas provided ideal breeding conditions for insects, and they have destroyed some paddy fields. These two factors will lead to poor harvests and increase the risk of the villagers and suffering from malnutrition.

Emergency situations have impacted on the ability of the BPHWT to deliver the targeted programs. There were also delays in transporting medical supplies, which has prevented the BPHWT teams from delivering care to all the areas. As a result less data has been collected. The Field-in-Charge requires further training on using the reporting format.

c. Southern Karen Area

i. Paan

Though this area was more stable than other areas, the BPHWT teams are still required to travel discreetly within the areas. The Field-in-Charge reported there were insufficient medical supplies to treat all the cases in the target area. They also reported that some health workers need further training.

ii. Dooplaya-includes Win Yee and Kawkareik

The SPDC, DKBA and the Karen Peace Force (KPF) are operating in this area and have increased the number of military posts in the last six months. There was fighting between the Mon area, these forces and the KNLA. This made it difficult for the BPHWT to travel and to transport medical supplies, especially along the car roads. The SPDC attacked one village during BPHWT TBA Training. The Training was completed in another village. The weather provided ideal breeding conditions for insects and they have destroyed many of the crops in this region.

In Win Yee, located close to the Mon area, the SPDC, DKBA and the New Mon State Party (NMSP) operate. Transportation of the medical supplies was delayed due to high level of security and military activity along the route. In one of the BPHWT field areas, the people are facing a shortage of food as high level military activity disrupted the villagers' ability to farm. Villagers moved to other places in search of food. Due to these movements the BPHWT provides health care in schools, monasteries and in the jungle. The medical care program data has only been collected for the months of May and June due to the late arrival of medical supplies.


Another village destroyed by the SPDC

In Kawkareik there was fighting between the KNLA and the allied SPDC and DKBA forces. Villagers were forced to porter and provide labour for the SPDC. The Field –in Charge reports some health workers need capacity building to improve their diagnosis and treatment skills.

iii. Mergue / Tavoy

Villagers in this area have been forced to porter for the SPDC and forced to relocate. SPDC soldiers also stole cooking utensils and rice from some villagers. Fear forced some villagers to flee to the jungle to hide. Many villagers also face food shortages. In this area the price of goods has increased.

Though some patients required further treatment through referral to health clinics, the BPHWT were unable to refer patients, as they had no money to purchase patients' treatment. The Field-in-Charge reported quinine resistant malaria in some areas and would prefer to use artesunate or other similar drugs to treat quinine resistant malaria in some areas. Some patients have chronic diseases such as Tuberculosis but the BPHWT do not have medicine to treat these conditions, so they can only provide advice. Referral to SPDC hospitals is not appropriate as the staff have not had training for the treatment of these chronic conditions.

Sometimes the BPHWT health workers are depressed because of the security problems and the shortage of money to treat patients effectively. The current circumstances make it very difficult to improve the health situation amongst the internally displaced population.

The field –In charge reported that many Traditional Birth Attendants (TBAs) are getting older and reporting poor eyesight. The Field –In Charge said the TBAs are asking BPHWT to provide glasses to improve their eyesight. Three village health volunteers were arrested by the SPDC and have been jailed for 4 years. The SPDC fined the villagers 650,000 kyat.

d. Mon Area

There is a cease-fire agreement between the SPDC and the New Mon State Party (NMSP). In Mon State, the BPHWT members are required to be extremely cautious when they are delivering health care, as they are at risk of SPDC questioning about their activities. Being expected to provide information on BPHWT activities has become a heavy burden for many team members, especially in areas where many military groups and information groups are active.

The Mon area delivers health care through two different strategies – the establishment of health care centres and traveling through the villages. Currently the BPHWT teams have enough human resources to deliver all programs, all of the time. However the shortage of medical supplies prevents them from treating all of the patients. In some areas, villagers would have access to midwives posted by the SPDC, if they did not have to pay for their service.

The field-In charge reported an improvement in the BPHWT activities in the 6 months due to improved community participation. However, the Field-in-charge believes community participation can be further improved.

e. Shan and Lahu Areas

In the six months, the BPHWT extended the delivery of health care programs into the Shan and Lahu area. There are now six BPHWT teams operating in this area.

In this area, the Lahu region is under the direct control of the SPDC which has a ceasefire with the Shan state Army- Northern (SSA-N) In this area the Shan State Army-Southern (SSA-S) is involved in active resistance with the SPDC. The Field-In-Charge reports that this makes the area complicated politically and administratively.

In the rainy season it is very difficult to transport the medical supplies to the distant Lahu region. In the Shan region, the two BPHWT team's data was delayed because of the fighting between the SPDC and the SSA. SPDC activity in the region includes the confiscation of land, forced labour, killing of villagers and the destruction of some village. As a result, some villagers were forced to flee in to the jungle. The SPDC has also raised compulsory rice and food taxes. Villagers are getting poorer and so is their health status. The Field in charge report that curative care is more important than primary health care, in the current situation.

The Field-In-Charge reported that it is very dangerous for the BPHWT workers to be caught carrying health documentation with the BPHWT name and logo, or other health posters or books with other organizations' logos, such as WEAVE . The workers would be safer if they carried health documentation or posters with no logos, as they are at risk of intensive questioning from the SPDC. The Field-In-Charge also reports there is a need for community education about the dangers of drugs and a need to find a solution to drug abuse. The Field-in-Charge requested capacity building for health workers to improve their health knowledge and skills.

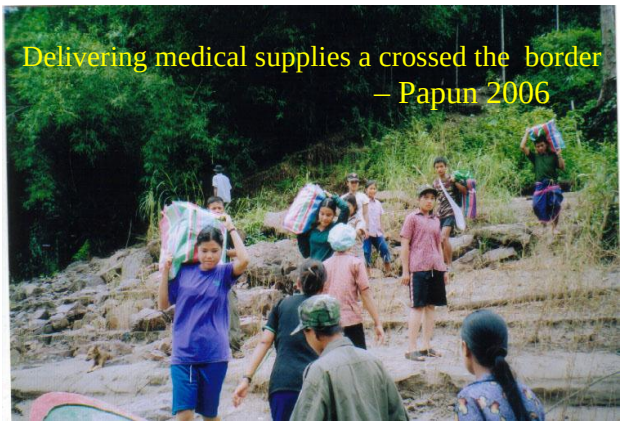
3. Obstacles, Threats and Constraints

a. Purchasing Medical Supplies

During the six months, the leading Group made a decision to purchase medial supplies from a new company. The negotiation for the supply and delivery of medial supplies was a long process which created delays in supplies reaching the field, especially in the northern area. To minimize the impact the BPHWT purchased emergency supplies locally to meet the needs of the Toungoo area and the maternal and child health programs in northern areas. Some medical supplies, such as vitamin A are not able to be purchased in Thailand. The BPHWT relies upon individuals and international organizations to purchase and donate the medicines for some health prevention programs. Insufficient supplies were donated to meet the needs of the target population.

b. Transportation of Medical Supplies

The cost of transporting medical supplies increased during the period due to the high cost of petrol and the delays caused by high-level military activity of SPDC and DKBA troops in some areas. Usually military activity is limited in the rainy season, but the SPDC is building roads around the border areas of Burma and the military Presence has been maintained at a high level.



Delivering medical supplies a crossed the border – Papun 2006

c. Delivering Health care and Collecting Health Data

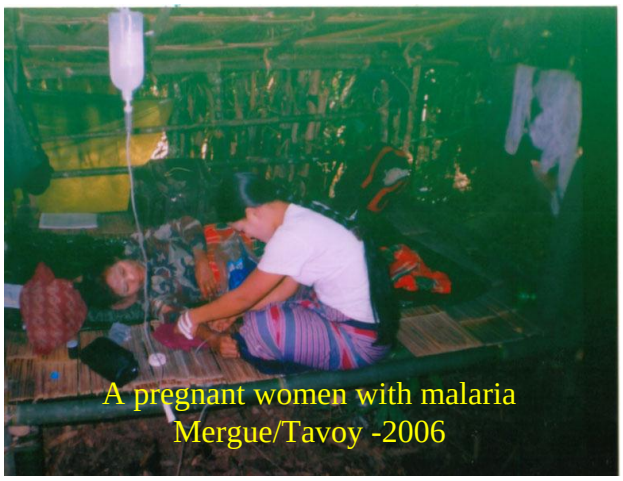
Delivering health care and collecting health data in BPHWT field areas is constrained by the military activity of the SPDC and other supporting armies. BPHWT Workers can not move openly through their field areas, as they risk being captured and imprisoned, or shot by these armies. Villagers are also under many constraints and threats which force them to flee and hide in jungles, making the delivery of health care more difficult. Three village Health Volunteers have been jailed and others forced to sign documents that prevent them from working with BPHWT. As a result of these conditions, some BPHWT staffs feel depressed.

Delivering medical supplies into the Jungle Mergue/Tavoy 2006

4. BPHWT's Implementation Programs in 2006

In 2006, the 76 backpack teams provided health care to about 150,000 displaced people in Burma. The Back Pack Health Worker Team's have been implementing primary health care consisting of three main programs; medical care, community health education and prevention, and maternal and child health care. They have also focused on two other issues; Health Information and Documentation and Capacity Building which were implemented through the main programs. The BPHWT aims to improve and enable public health promotion among internally displaced people in Brumes.


A woman with malaria –Klerlweetu - 2006


A pregnant women with malaria Mergue/Tavoy -2006


Village workshop Thaton- 2006


Antenatal Care – Thaton - 2006


Constructed gravity water flow system Papun - 2006

5. General BPHWT activities in 2006

No.	Area	Name of Field In charge	Number Back Packs	Total Workers			Number of Families	Population	Total Cases Treated
				M	F	Total			
1	Kayah	1st Joeseph 2nd Aung Ning Oo	6	13	8	21	2767	12549	6856
2	Kayarn	1st Lay Layn 2nd U Myar Note	3	14	7	21	1003	6556	554
4	Taungoo	1st Saw David Yell 2nd Saw Hel Kler	5	14	6	20	1909	12411	2302
5	Kler Lwee Htu (Nyang Lay Bin)	1st Naw Hser Mu Ler Htoo 2nd Saw That Ning	5	12	0	12	1369	9668	3671
6	Tha Ton Area	1st Saw Ohn Myint 2nd Saw Soe Myint	7	17	4	21	3199	20011	3188
7	Mutraw (Pa Pun)	1st Saw Win Kyaw 2nd Saw Who Plar	7	22	2	24	3005	15918	3792
8	Pa an Area	1st Saw Charlie 2nd Saw Eh Mwee	6	15	12	27	2967	20629	8022
3	Special Area	1st Saw Than Htite 2nd Aung Ngeh	3	12	2	14	1573	8443	N/A
9	Doo Pla Ya Area	1st Saw Thar Dee 2nd Saw Say K'Paw Htoo	5	18	4	22	1581	14087	6198
10	Kawkarate - East	1st Saw Poe Lay 2nd Saw Win Shwe	3	10	0	10	1167	9208	4353
11	Winyee	1st Saw Than Shwe 2nd Saw Lar Taw Thaw	3	6	5	11	1382	7996	2381
12	Mon Area(1) Da wai	1st Nai Nyain Chan 2nd Nai Kon Site	3	7	2	9	979	5942	4322
13	Mon Area(2) Ye / Da wai	1st Nai Sar Da 2nd Nai Nyan Chaing	3	7	2	9	1171	5570	4490
14	Mon Area(3) Mawlamyaing/ Tha Ton	1st Nai Win Aye 2nd Mi Mon Aye	6	4	17	21	2452	11494	8700
15	Mergue/Davoy	1st Saw William 2nd Saw Living Stone	5	13	7	20	1455	12135	6519
16	Shan Area	1st Sai Lonng 2nd Sai Noi	4	9	4	13	1456	8000	5950
17	Luhu Area	1st Kyar Shell 2nd Kyar Down Long	2	7	2	9	641	4559	491
Total			76	200	84	284	30076	185176	71789

6. Medical Care Program

The Back Pack Health Worker Team has provided 76 backpack teams to work among internally displaced people in the Karen, Karenni, Kayah, Kayan Mon, Shan and Lahu areas inside Burma. Two hundred and sixty one health workers serve a population of 150,000. Under the medical care program there are six major conditions treated, including Malaria, Diarrhea, ARI, Anemia, Worm infestation and war injury. The most commonly seen disease in BPHWT areas is malaria, followed by ARI, worm infestation, anemia, diarrhea and dysentery.

BPHWT treating patient in hidden site (jungle) - Mergue /Davoy -2006

a. Caseload of BPHWT in 2006

All Back Pack cases load 2006

Month	Jan-Jun		July-Dec		2006 Jan-Dec		Total
Condition	< 5	> 5	< 5	> 5	< 5	> 5	
Anemia	675	1754	774	2678	**1471**	**4479**	**5950**
ARI, Mild	1329	2536	2431	4402	**3783**	**6985**	**10768**
ARI, Severe (Pneumonia)	346	776	720	1397	**1087**	**2213**	**3300**
Beri Beri	125	643	357	1008	**485**	**1660**	**2145**
Diarrhea	527	1019	859	1445	**1402**	**2469**	**3871**
Dysentery	476	1119	631	1535	**1110**	**2659**	**3769**
Injury, Acute - Gunshot	0	13	4	133	**4**	**147**	**151**
Injury, Acute - Landmine	0	17	1	10	**1**	**27**	**28**
Injury, Acute - Other	90	374	149	547	**239**	**924**	**1163**
Injury, Old	38	204	32	317	**72**	**528**	**600**
Malaria (Presumptive)	875	2410	1786	4196	**2722**	**6658**	**9380**
Malaria (with Para check)	75	299	572	1363	**676**	**1718**	**2394**
Measles	40	84	118	57	**158**	**141**	**299**
Meningitis	12	20	10	61	**22**	**81**	**103**
Suspected AIDS	0	52	0	1	**0**	**53**	**53**
Suspected TB	14	124	10	242	**30**	**383**	**413**
Worms/Infestation	1087	1751	1727	2753	**2848**	**4518**	**7366**
Other	968	6772	1519	10746	**2497**	**17539**	**20036**
Total	**6677**	**19967**	**11700**	**32891**	**18607**	**53182**	**71789**
	26644		**44591**		**71789**		

b. General Overview of Morbidity Rates

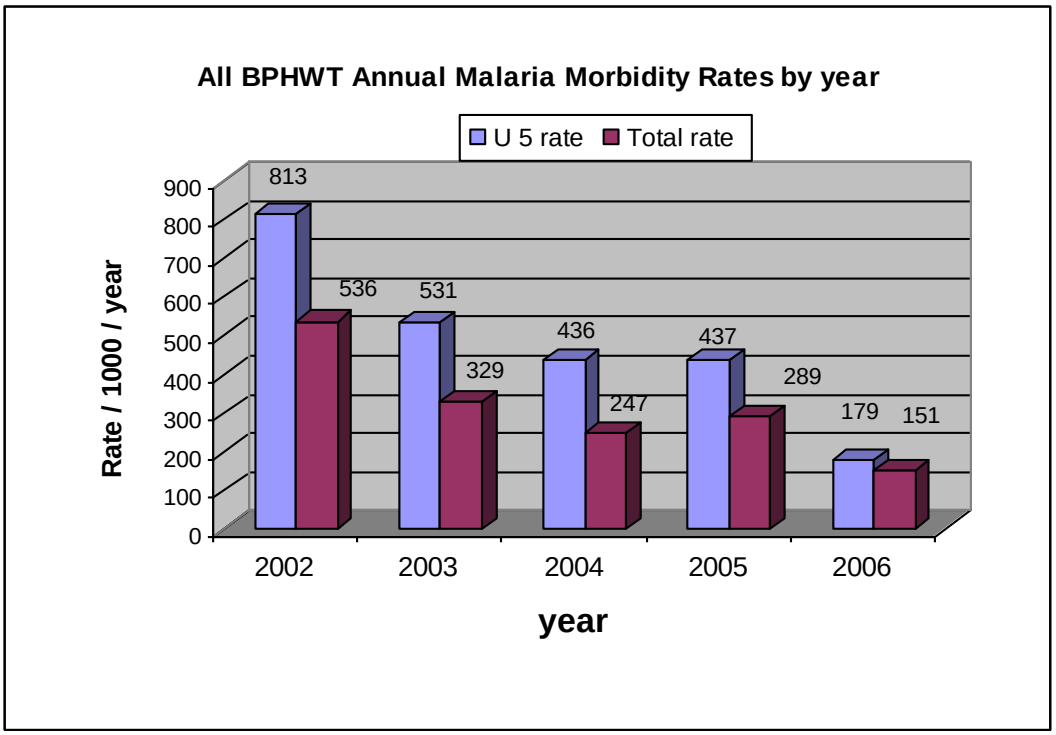
In general, all morbidity rates have decreased each year. From 2002 to 2006 within five years, malaria morbidity rates decreased by 70%; ARI (mild) by 62%; ARI (severe) by 56; diarrhea by 73%; dysentery by 63 %.

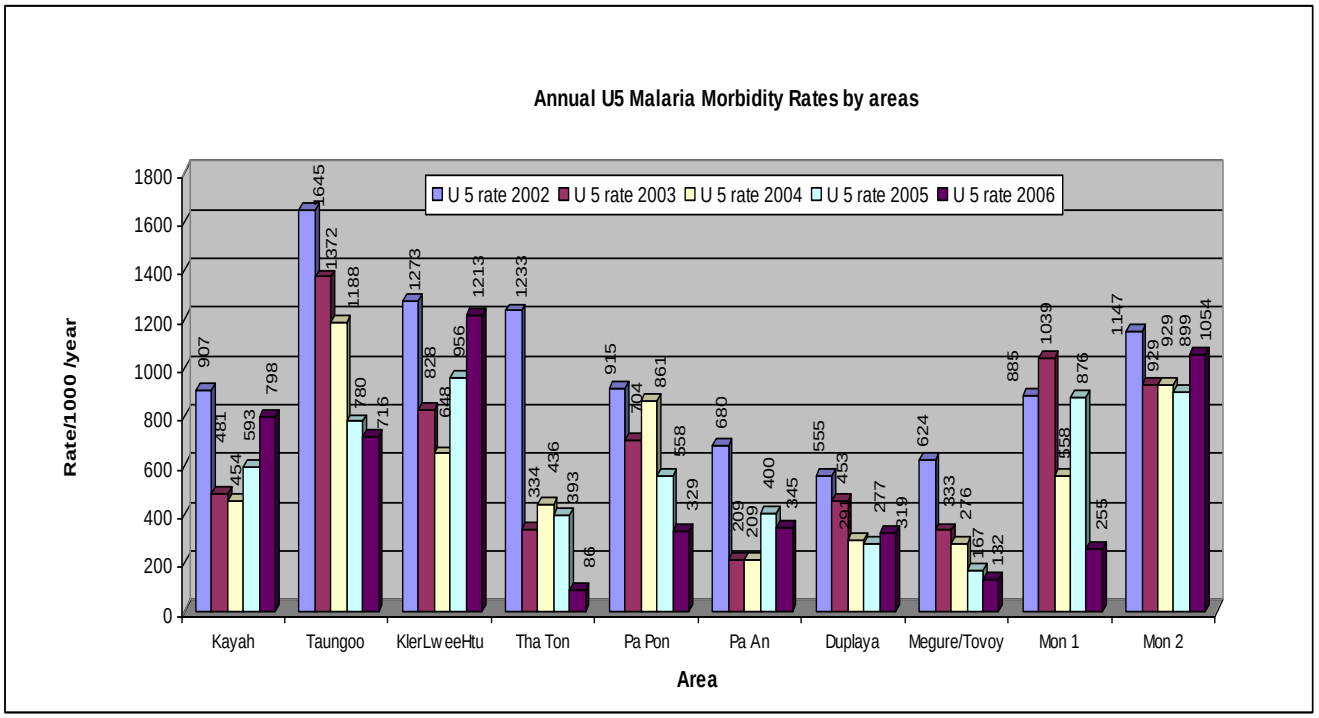
i. Malaria

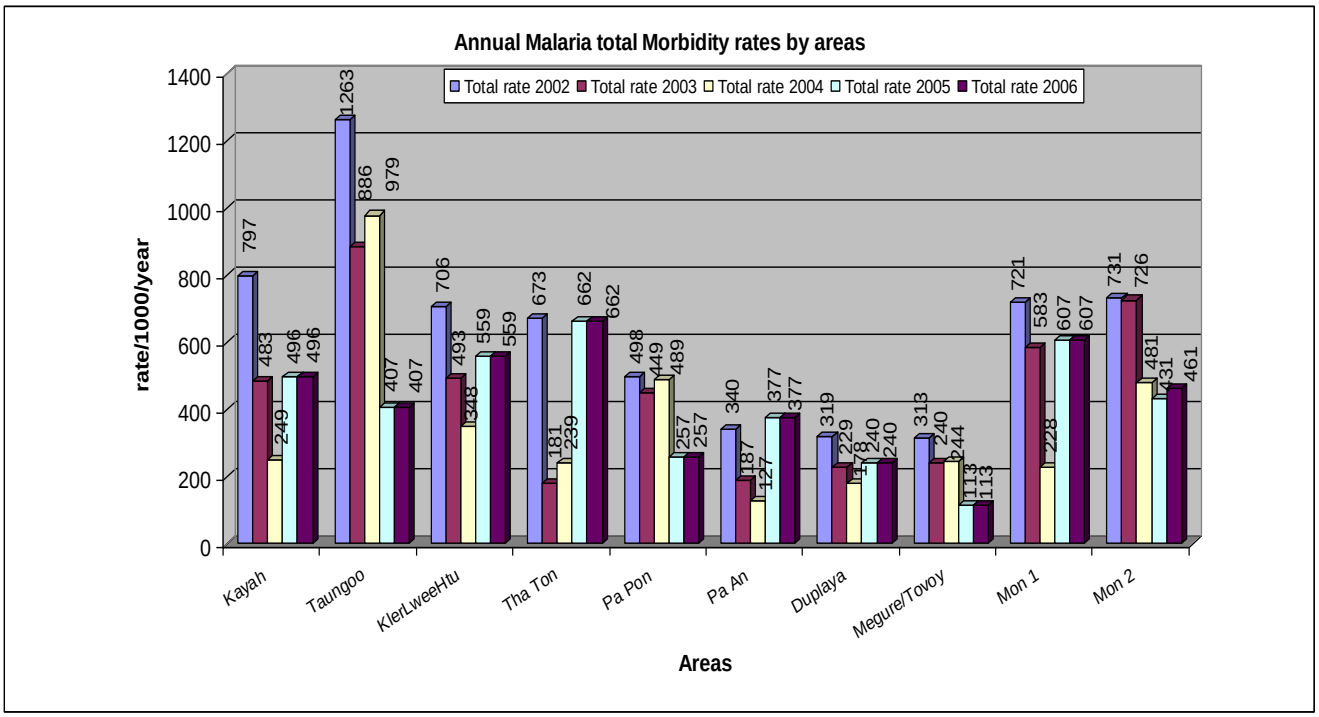
The BPHWT provided a limited number of rapid malaria tests (para-check) to Back Pack teams. The para-check process is used to confirm suspected malaria cases that may not present with clearly defined symptoms. In some BPHWT operating areas a malaria control program has been introduced with three control strategies by local ethnic health departments, this has led to some decrease in malaria morbidity. Next year, the BPHWT planed to provide an increased number of Para-Check rapid tests to each back pack team in order to confirm malaria diagnosis and provide effective treatment. As the graph shows, the malaria morbidity rate hugely decreased from 2002 to 2006. In addition, under five malaria morbidity rate decreased by 55% and total rate was decreased by 59% whilst compared with last year. But, there was an increase in the rate of malaria morbidity in Mon 2, and Kler Lwee Tu areas. The Taungoo area still has highest rate of malaria morbidity compared with other areas in Karen state, with the exception of Kler Lwee Tu area. The Mon area 2 has the second highest malaria morbidity rate, despite experiencing less fighting than in the cease-fire zones. The people still faced forced labor, land confiscation and high taxation by the SPDC. Consequently the people have poor health access, food shortages and lack of sanitation. As result, there was increased disease transmission and increased rate of malaria morbidity.


All family got malaria after back from hidden site - Toungoo area - 2006


VHV workshop in Papun - area - 2006

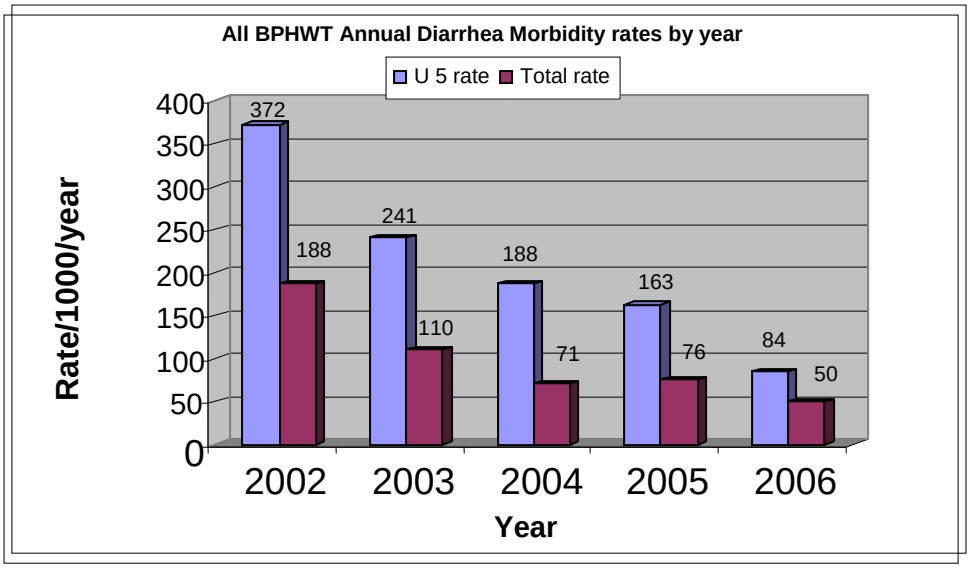

All BPHWT Annual Malaria Morbidity Rates by year
U 5 rate
Total rate
Rate / 1000 / year
900
800
700
600
500
400
300
200
100
0
813
536
531
329
436
247
437
289
179
151
2002
2003
2004
2005
2006
year

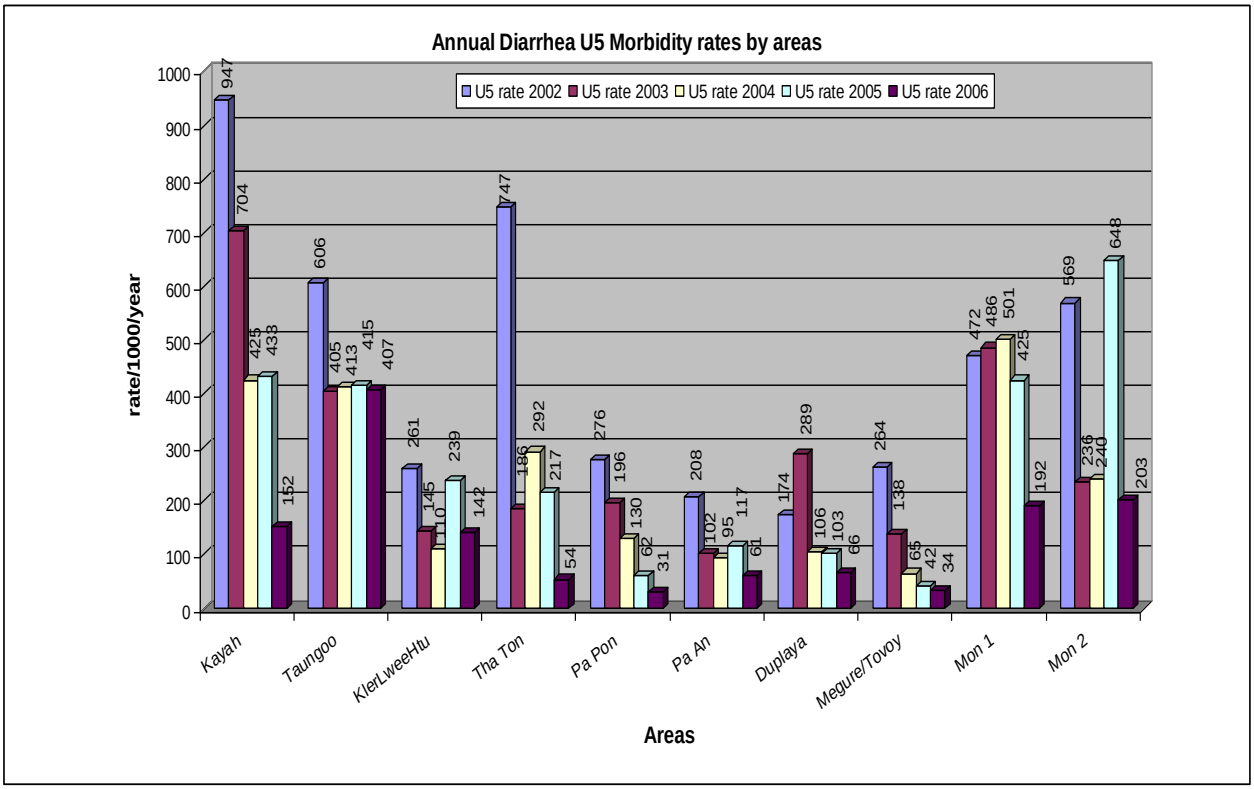

Annual U5 Malaria Morbidity Rates by areas
U 5 rate 2002
U 5 rate 2003
U 5 rate 2004
U 5 rate 2005
U 5 rate 2006
Rate/1000 /year
1800
1600
1400
1200
1000
800
600
400
200
0
907
481
454
593
798
1645
1372
1188
780
716
1273
828
648
956
1213
1233
334
436
393
86
915
704
861
558
329
680
209
209
400
345
555
453
291
277
319
624
333
276
167
182
885
1039
558
876
255
1147
929
929
899
1054
Kayah
Taungoo
KlerLweeHtu
Tha Ton
Pa Pon
Pa An
Duplaya
Megure/Tovoy
Mon 1
Mon 2
Area

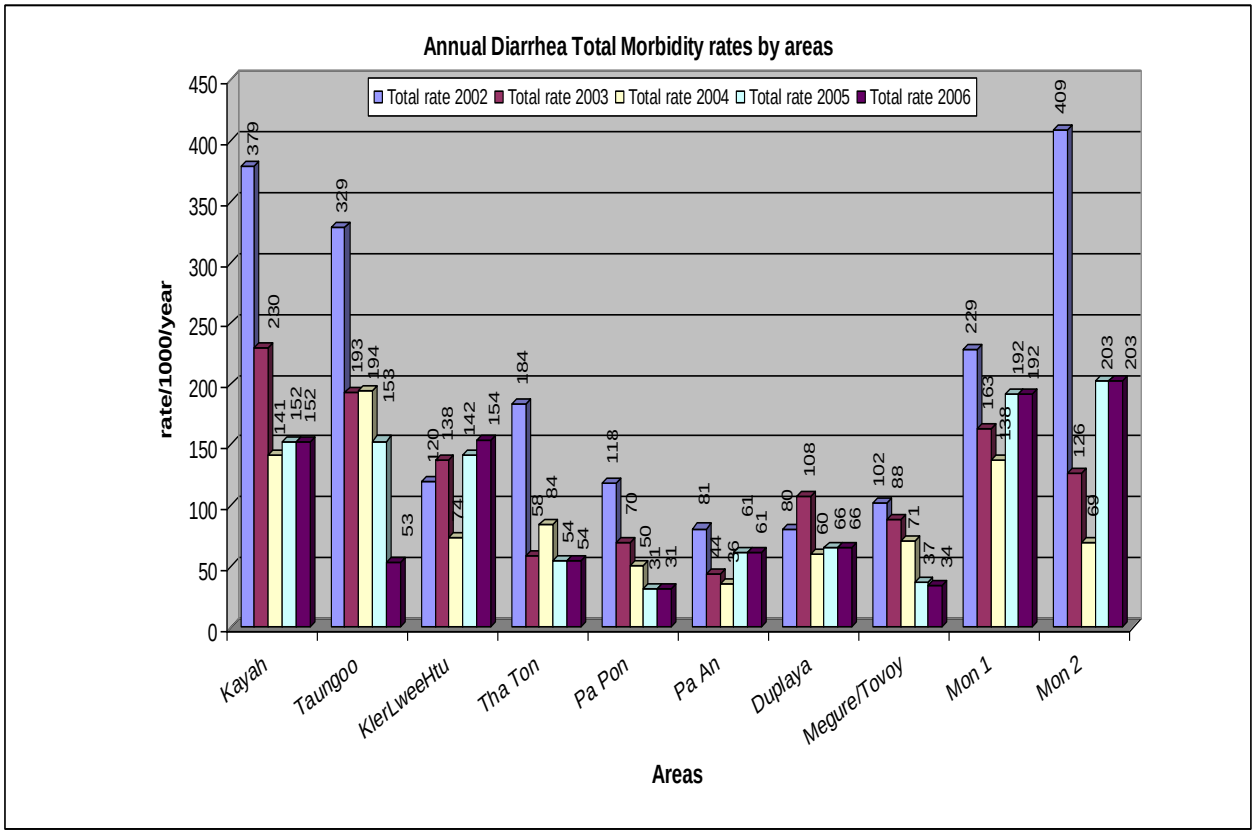


ii. Diarrhea

As the graph shows, in the entire BPHWT area, both U5 and total diarrhea morbidity rates decreased by 48% and 34% form 2005 to 2006. This could be due to improvement of knowledge about hygiene and sanitation among the community. The diarrhea morbidity rate largely decreased in 2006 compared to last year. The reason is that there was a diarrhea out-break last year in the Mon area. However, it can be seen that the diarrhea morbidity rate increased in Taungoo and Kler Lwee Tu areas in 2006, because the people have faced increased human rights violation by SPDC such as forced displacement and forced relocation. This resulted in poor sanitation and hygiene which led to an increase of diarrhea transmission among that community. As the BPHWT mentioned in their report "***Chronic Emergency***" human rights violation increases morbidity and mortality rates. Therefore the increasing diarrhea morbidity rate in Taungoo and Klerlweetu areas were caused by human rights violation.

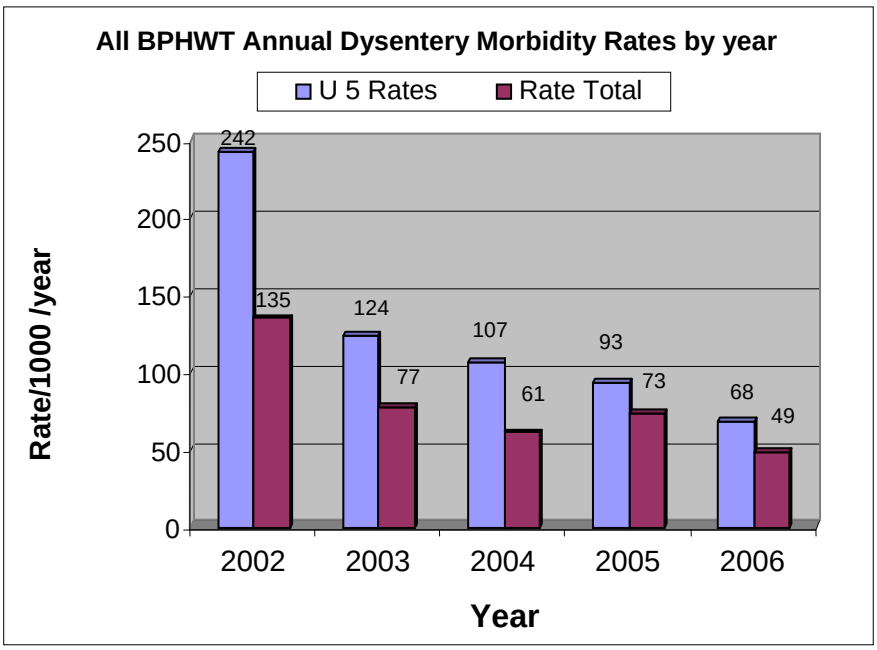

All BPHWT Annual Diarrhea Morbidity rates by year
U 5 rate
Total rate
Rate/1000/year
Year
2002
2003
2004
2005
2006
372
188
241
110
188
71
163
76
84
50

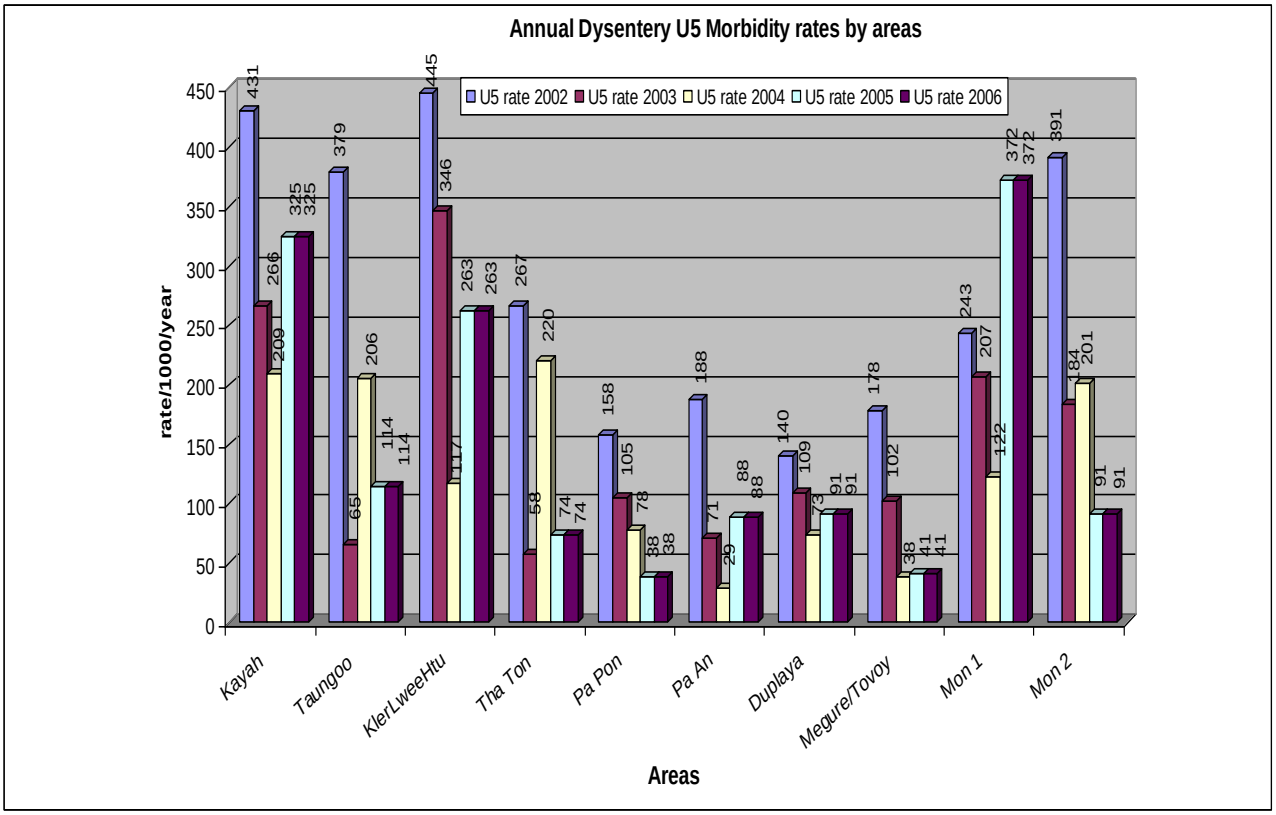

Annual Diarrhea U5 Morbidity rates by areas
U5 rate 2002
U5 rate 2003
U5 rate 2004
U5 rate 2005
U5 rate 2006
rate/1000/year
Areas
Kayah
Taungoo
KlerLweeHtu
Tha Ton
Pa Pon
Pa An
Duplaya
Megure/Tovoy
Mon 1
Mon 2

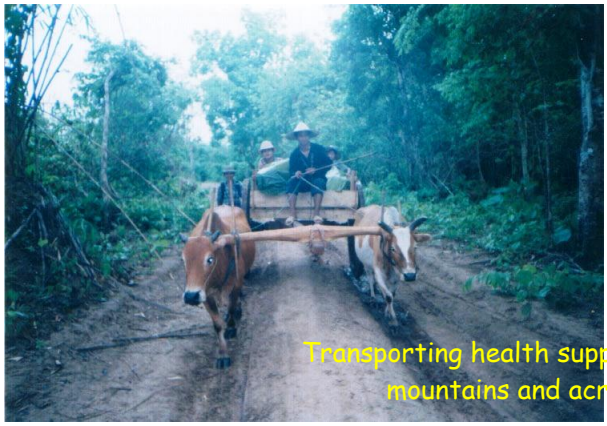


iii. Dysentery

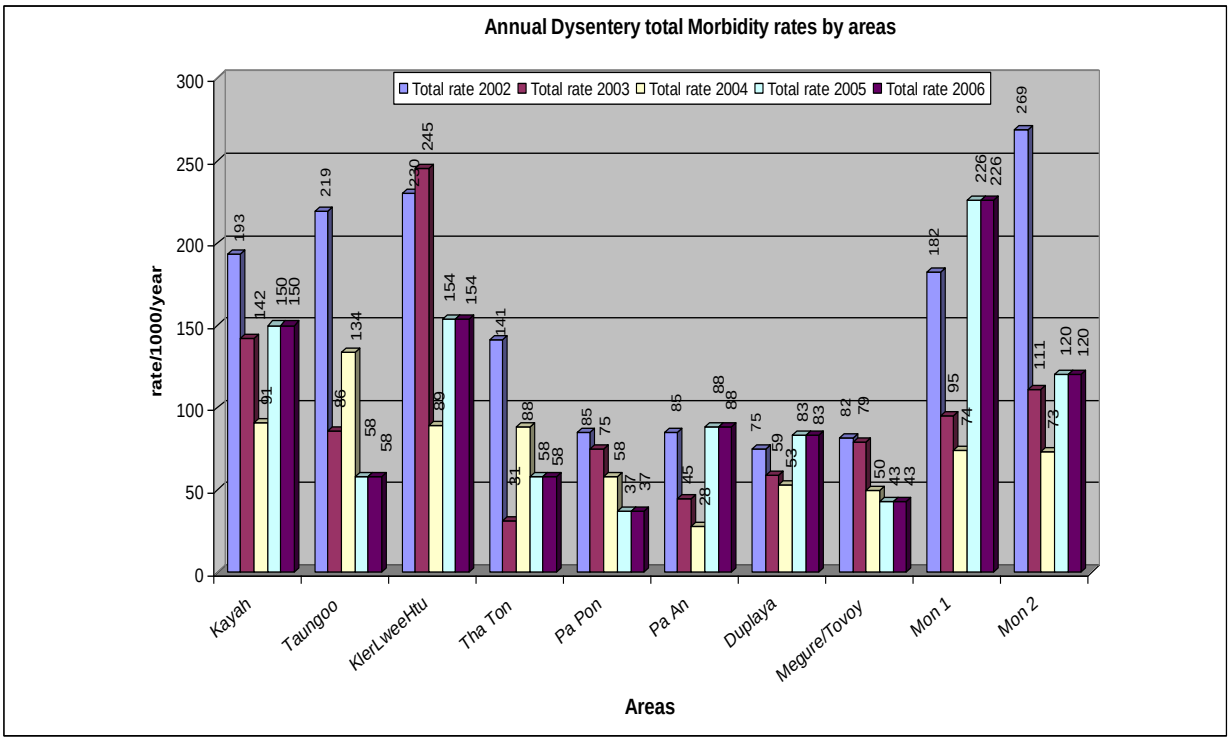
For dysentery, the morbidity rate trends were similar to those for diarrhea.





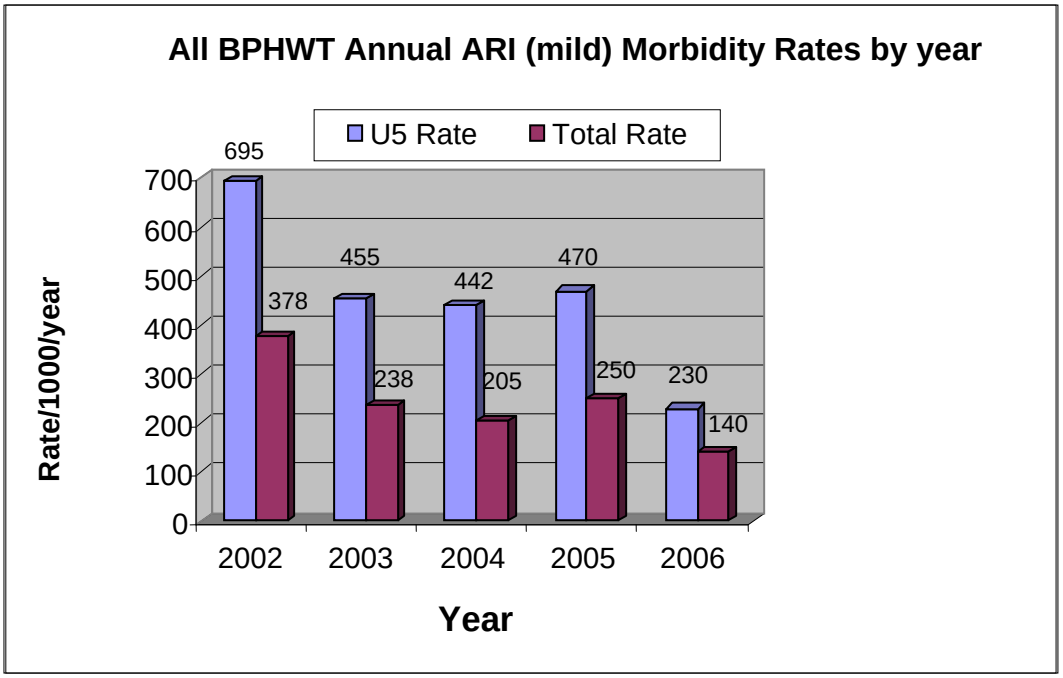


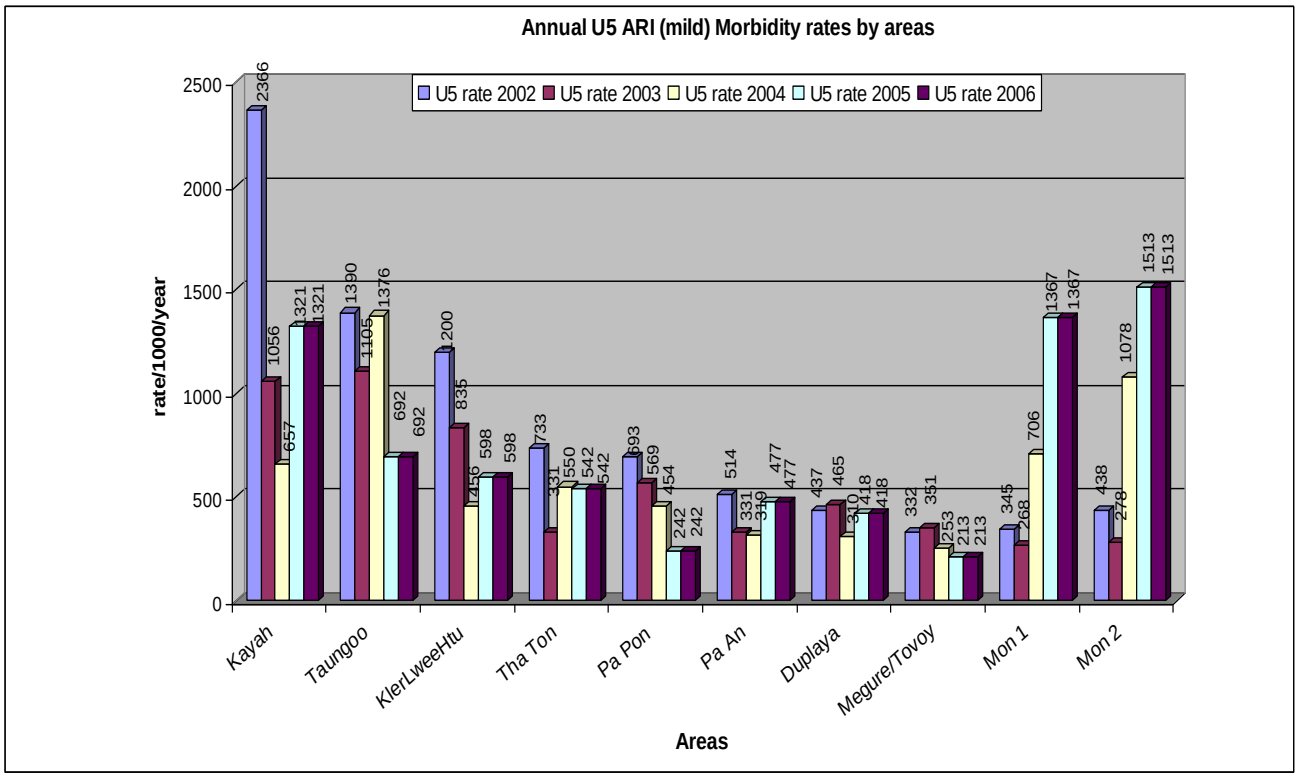
Transporting health supplies along the roads, over the mountains and across the rivers - 20006

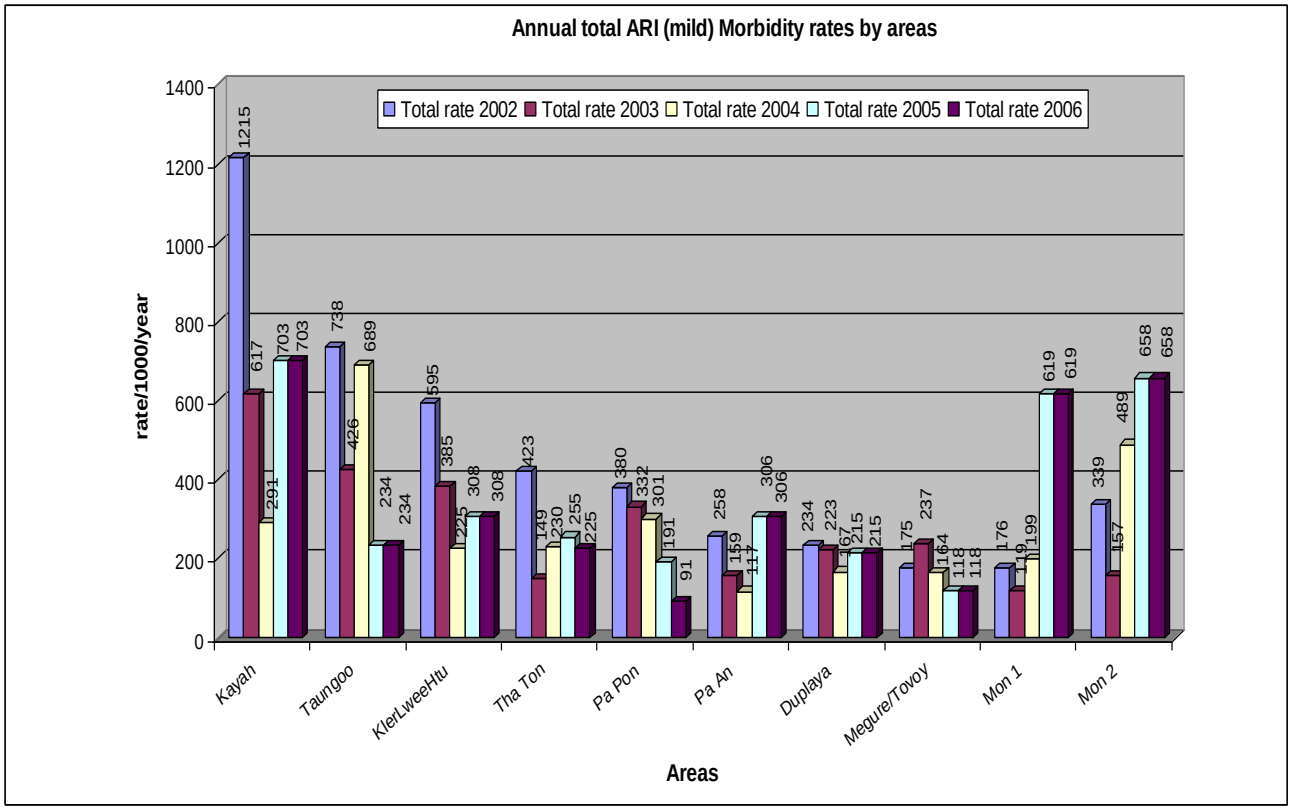


iv. ARI Mild

In Mon 1, Mon 2 and Kayah, Thaton, and Dooplaya areas, the rates of ARI (mild) decreased, however in Taungoo and Klerlweetu areas rates of ARI (mild) increased, this is also related to human rights violations. Overall the total ARI (mild) morbidity rates were decreased by 44% between 2005 and 2006. The BPHWT is not convinced that the ARI (mild) morbidity rate hugely decreased in the Mon area, because the collection and calculation of data was compounded with mobile health and center based health care information. For this reason, the data analysis system will be done separately between mobile health care areas and center based health care areas in the future.



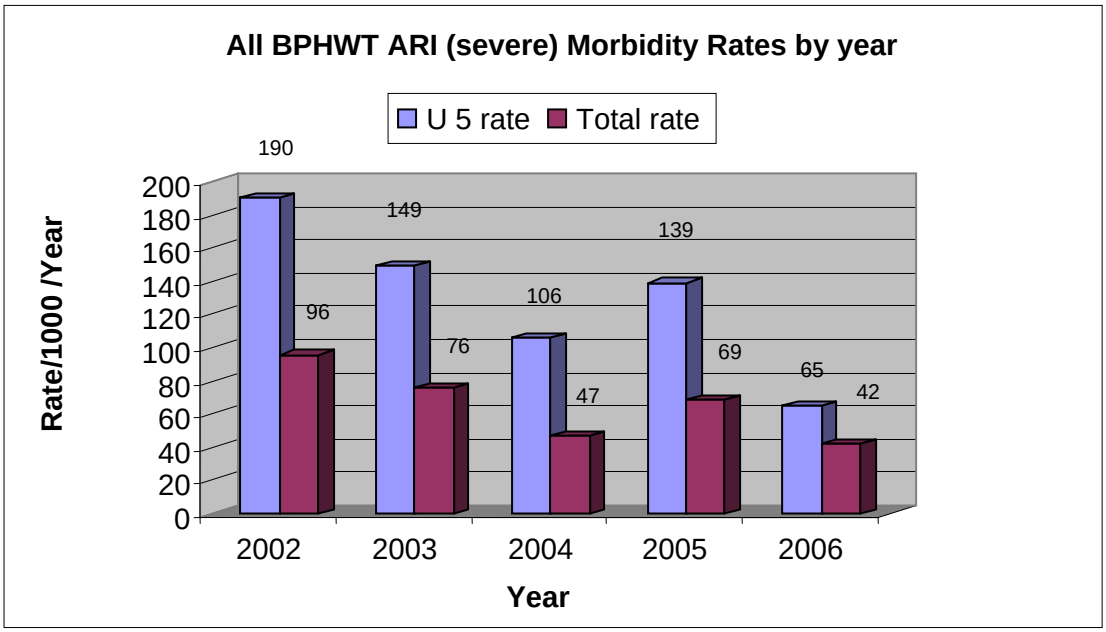

Annual U5 ARI (mild) Morbidity rates by areas
U5 rate 2002
U5 rate 2003
U5 rate 2004
U5 rate 2005
U5 rate 2006
rate/1000/year
Areas
Kayah
Taungoo
KlerLweeHtu
Tha Ton
Pa Pon
Pa An
Duplaya
Megure/Tovoy
Mon 1
Mon 2

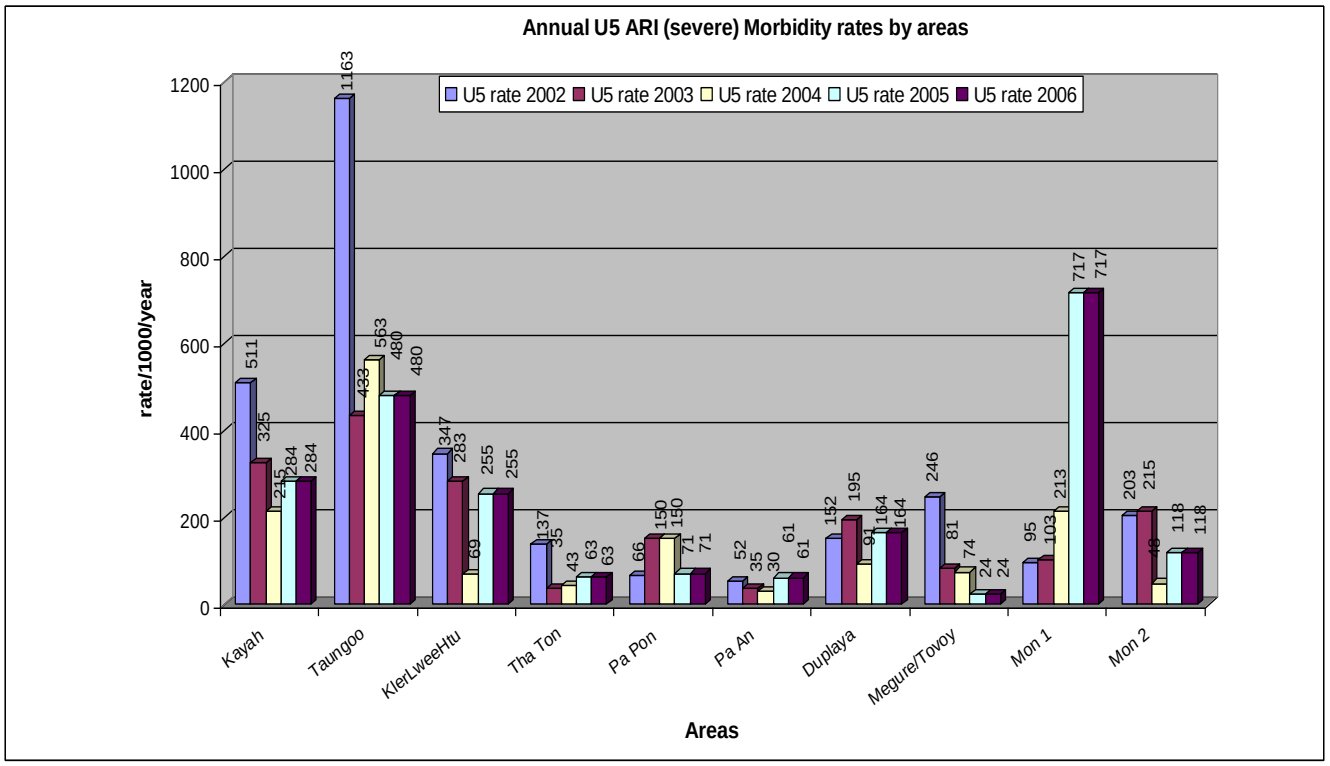

Annual total ARI (mild) Morbidity rates by areas
Total rate 2002
Total rate 2003
Total rate 2004
Total rate 2005
Total rate 2006
rate/1000/year
Areas
Kayah
Taungoo
KlerLweeHtu
Tha Ton
Pa Pon
Pa An
Duplaya
Megure/Tovoy
Mon 1
Mon 2

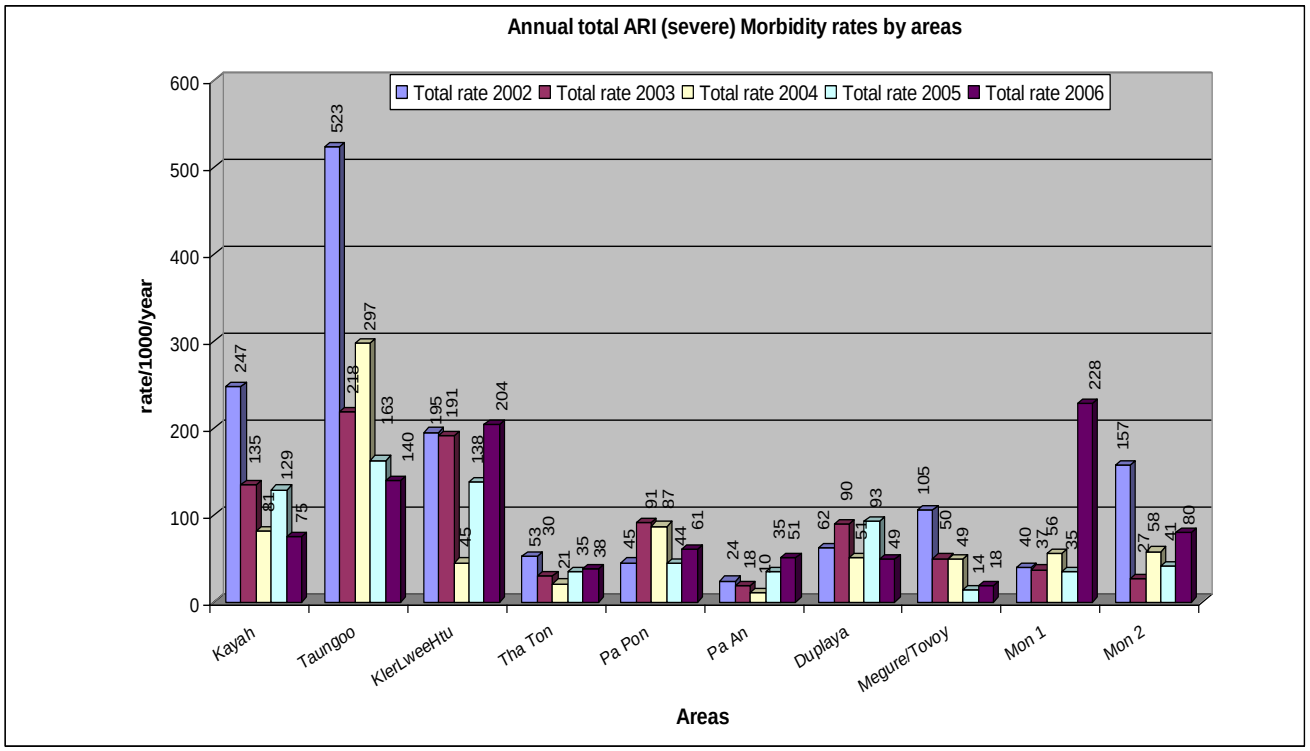
v. ARI Severe

In 2006, generally ARI (severe) under five morbidity rates decreased by 53% and the total rate decreased by 39% when compared with last year. There was a slight increase in Kler Lwee Tu, Papun, Pa-an and Mon 2 areas. In particular there was a significant increase in under five morbidity rate last year and the total rate in 2006.

All contributing factors to the increase are being considered; the BPHWT will discuss more about the case of ARI severe or pneumonia, because the signs and systems are very similar with Bird flu. The BPHWT intends to introduce a program for prevention and preparedness from the transmission of Bird flu among internally displaced people of Burma.

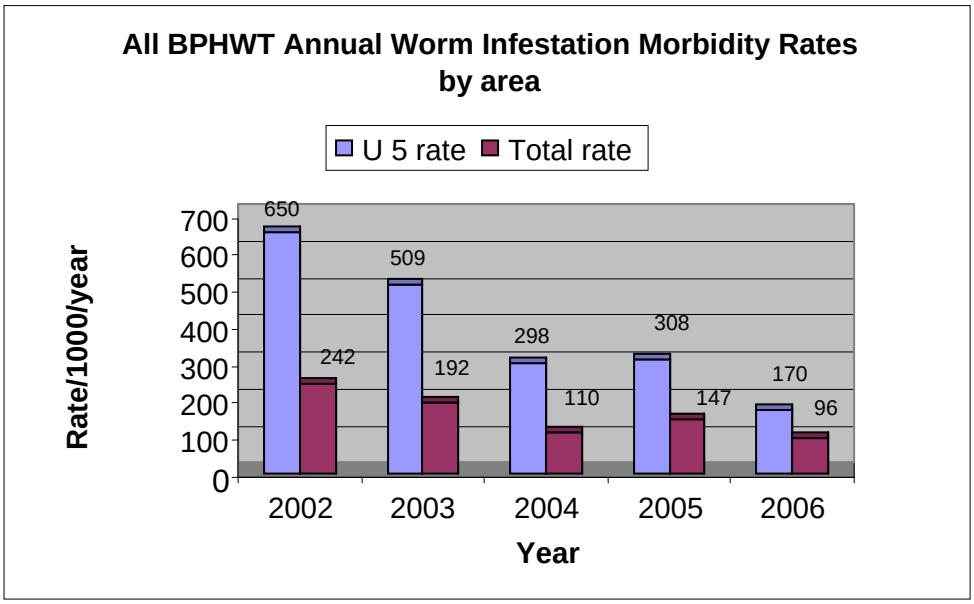


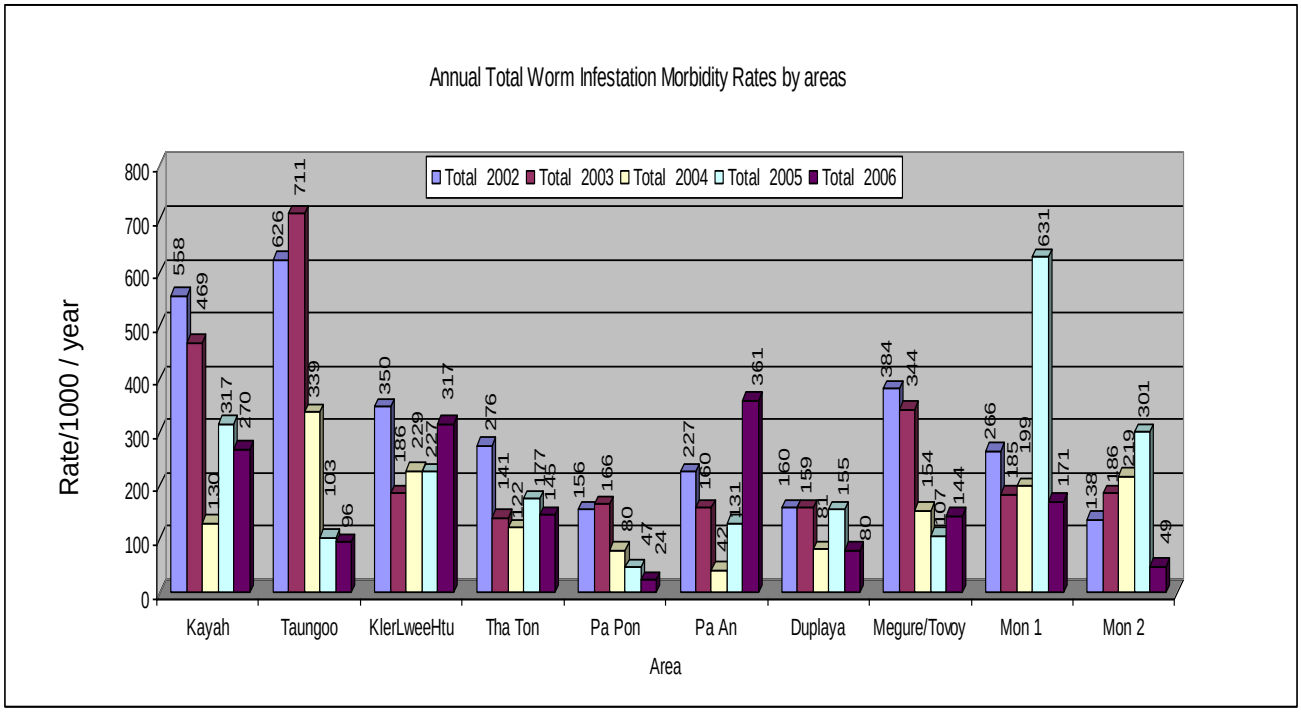

Annual U5 ARI (severe) Morbidity rates by areas
U5 rate 2002
U5 rate 2003
U5 rate 2004
U5 rate 2005
U5 rate 2006
rate/1000/year
Areas
Kayah
Taungoo
KlerLweeHtu
Tha Ton
Pa Pon
Pa An
Duplaya
Megure/Tovoy
Mon 1
Mon 2


Annual total ARI (severe) Morbidity rates by areas
Total rate 2002
Total rate 2003
Total rate 2004
Total rate 2005
Total rate 2006
rate/1000/year
Areas
Kayah
Taungoo
KlerLweeHtu
Tha Ton
Pa Pon
Pa An
Duplaya
Megure/Tovoy
Mon 1
Mon 2

vi. Worm

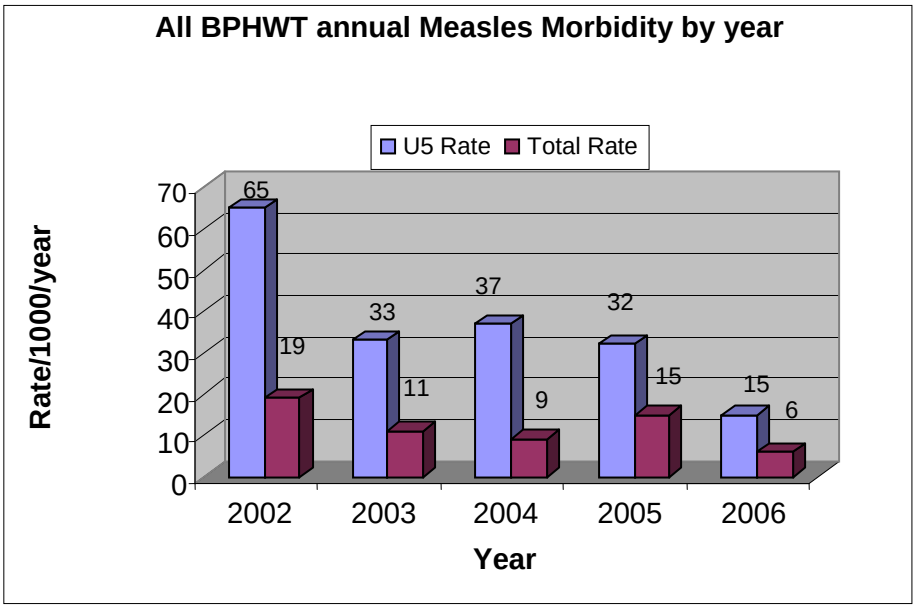
Since 2003, the BPHWT established a deworming program and distributed mebendazole among children's age 2 to 12. The aim of the program is to reduce malnutrition among children. The graph provided below only takes into account cases of worm infestation morbidity, not preventative deworming. The BPHWT also provides health education, focusing on hygiene, sanitation and water and sanitation activities among the villages. As the graph shows, the morbidity rate has hugely increased in Klerlweetu area, because of instability and perhaps the data of the preventive program has been included.





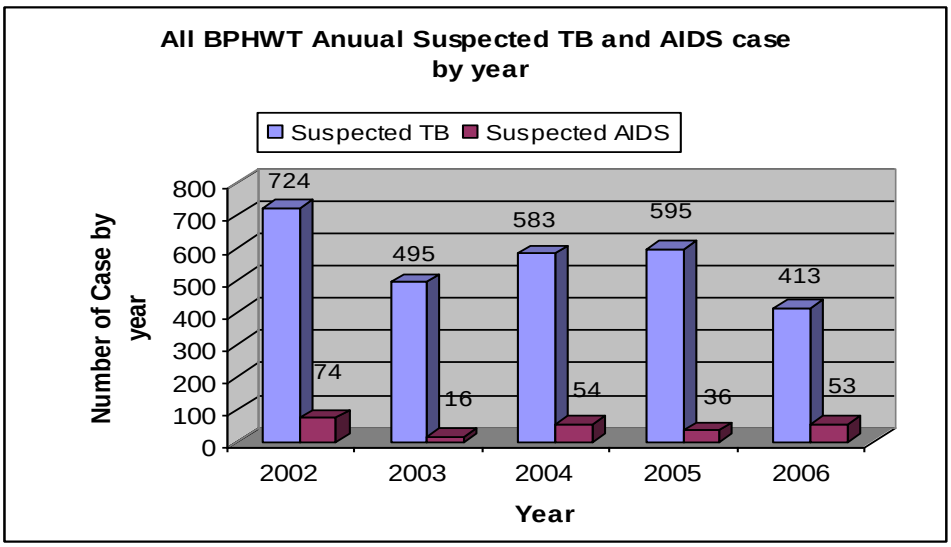
vii. Measles

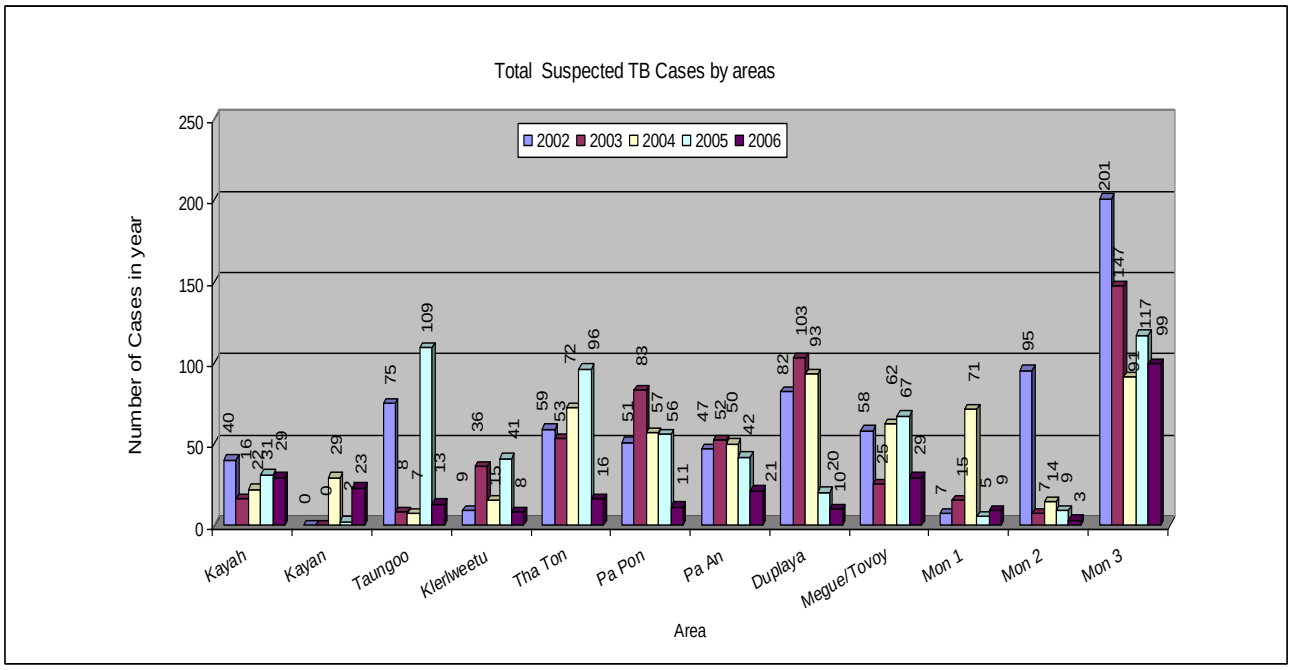
In 2006, the total rate of measles morbidity decreased when compared to the last four years. The BPHWT is attempting to address this problem by either establishing their own vaccination programme or by coordinating with other groups to administer vaccinations.

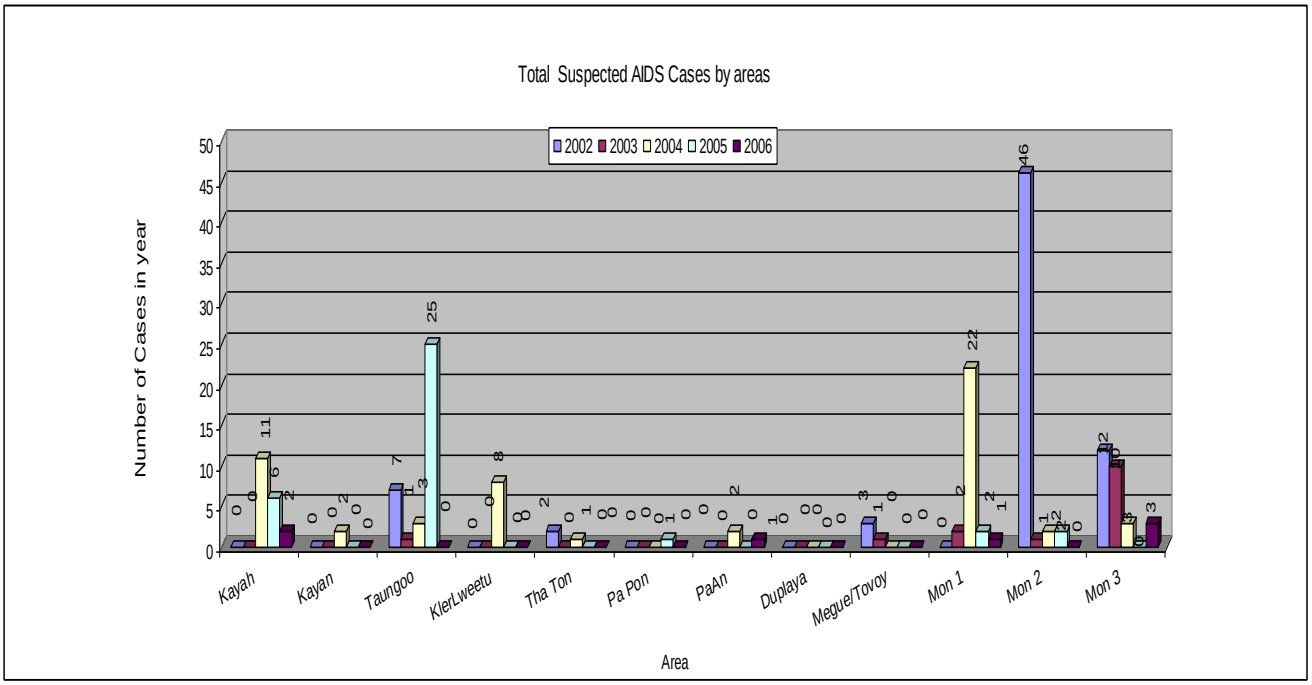


viii. Suspected Cases AIDS and Pulmonary TB

The total number of TB suspected cases seen in 2006 were 413 patients. However the back packs health workers could not give treatment for TB cases. BPHWT is only able to provide health education and advice for referrals, to get appropriated treatment and services. It should be noted that TB is also considered a main health problem among the IDP community. In the future BPHWT aims to expand the TB program to include treatment by coordinating with other health organizations. Secondly, the graph shows the suspected AIDS cases that have been seen in the IDP areas. The BPHWT is considering expanding activities regarding TB and HIV/ AIDS issues.




Total Suspected TB Cases by areas
2002 2003 2004 2005 2006
Number of Cases in year
Area
Kayah
Kayan
Taungoo
Klerlweetu
Tha Ton
Pa Pon
Pa An
Duplaya
Megue/Tovoy
Mon 1
Mon 2
Mon 3

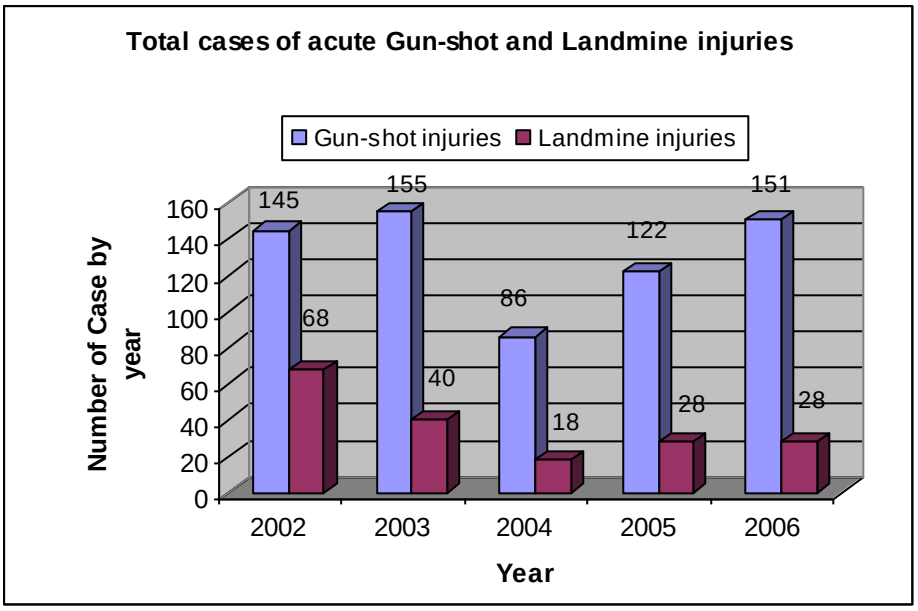

Total Suspected AIDS Cases by areas
2002 2003 2004 2005 2006
Number of Cases in year
Area
Kayah
Kayan
Taungoo
KlerLweetu
Tha Ton
Pa Pon
PaAn
Duplaya
Megue/Tovoy
Mon 1
Mon 2
Mon 3

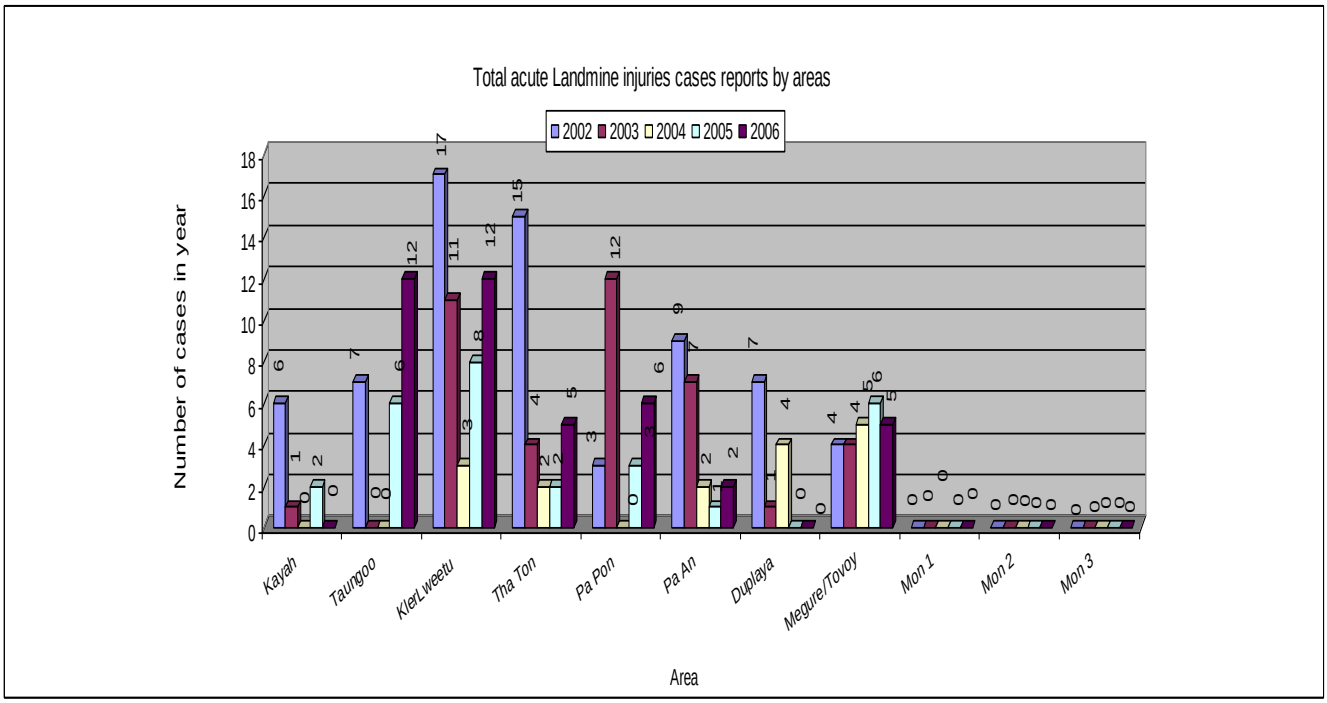
ix. Acute Gun-shot and Landmine injuries

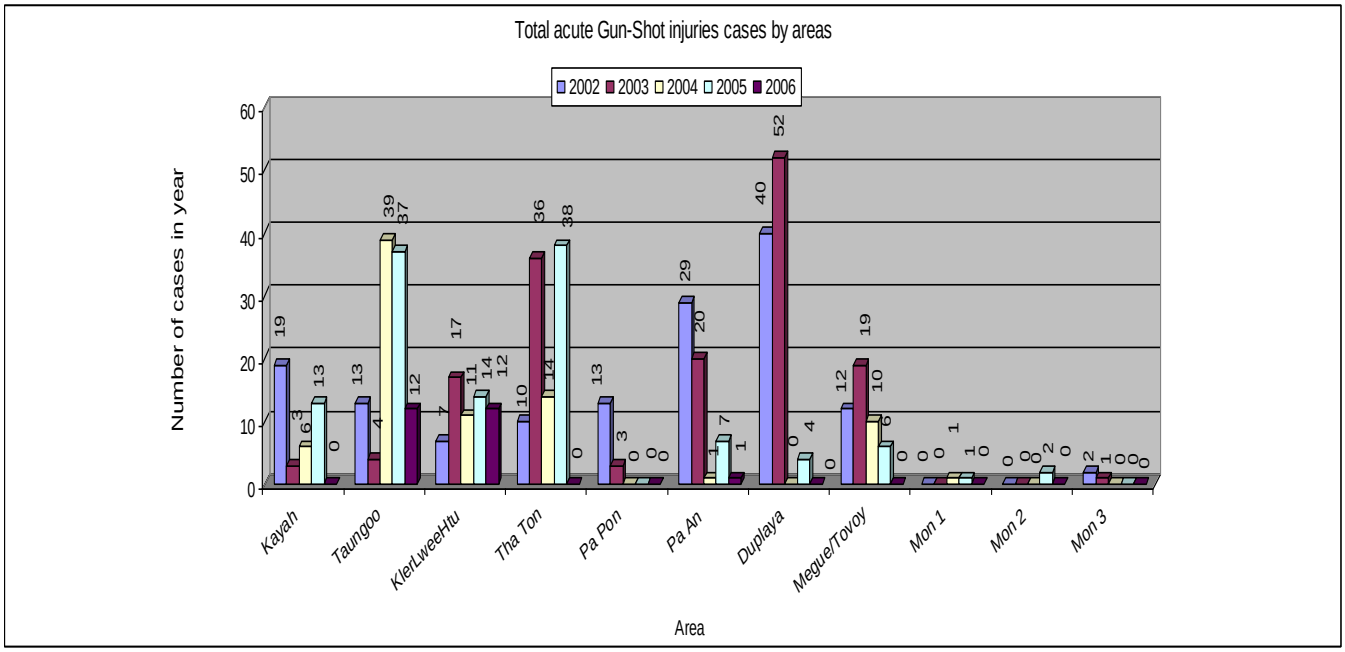
From the years 2002/2003 to 2004 the number of gun-shot injuries decreased by about one fourth, however in 2005 the number almost doubled and also increased in 2006. This is because; the cease-fire agreement between State Peace and Development Council (SPDC) and Karen National Union (KNU) on January 2004 decreased fighting during the first six months of the year. However, since the mid-year of 2004, SPDC increased attacks against the KNU. During this time many villagers were forced to move by SPDC troops and lost their homes. Therefore, in 2005 and 2006, there was an increase in the number of reported cases of gun-shot and landmine injuries when compared with the year before. There continues to be high rates of internal displacement and SPDC activity in BPHWT areas. Some back pack teams, have experienced difficulties in referring land mine injuries.

Treating mine –injured- Klerlwetu - 2006

Land- mine –injured- Klerlwetu - 2006


Total cases of acute Gun-shot and Landmine injuries
Gun-shot injuries
Landmine injuries
Number of Case by year
Year
2002
2003
2004
2005
2006
145
68
155
40
86
18
122
28
151
28


Total acute Landmine injuries cases reports by areas
2002
2003
2004
2005
2006
Number of cases in year
Area
Kayah
Taungoo
KlerLweetu
Tha Ton
Pa Pon
Pa An
Duplaya
Megure/Tovoy
Mon 1
Mon 2
Mon 3



7. Community Health Education and Prevention Programs

The community health education and prevention program aims to enable and empower the communities of the internally displaced population in Burma, with skills and knowledge related to basic health care and primary health care concepts to improve hygiene, water and sanitation systems, nutrition and other health promotion related issues. The main topics are;

- Prevention of malaria
- Hygiene and sanitation
- Prevention of diarrhea
- Malnutrition
- High risk pregnancy
- Breast feeding practice
- Landmine risk education
- HIV/AIDS education
- Prevention and Awareness of Bird Flu


Community Health Workshop - Dooplaya,2006

The main projects currently being conducted are education in schools, training peer educator and organizing village health workshops. In terms of preventative activity, the BPHWT provides Vitamin A distribution, and deworming.

On December 31st 2006, the BPHWT organized World AIDS Day awareness raising activities for each back pack team and about 10,000 people participated in the activities.

a. School health activities

In 2006, the BPHWT provided school health program for 441 schools comprising 1155 teachers and 22880 students. The program distributes de-worming medicine and Vitamin A prevention and treatment, personal hygiene supplies and latrine construction. The students are given information about water and sanitation.

b. Nutritional program

The BPHWT distributed Vitamin A and De-worming medicine among the children and pregnant women in order to prevent malnutrition. In 2006, 23,774 children and 2478 women (Prenatal and Postpartum) received vitamin A. An additional 1430 women (Prenatal and Postpartum) received vitamin A through Mother and Child Health Care Program and 24,373 of children received de-worming medicine.

Providing Vitamin A - Kayah - 2006

Number of children and women (Prenatal and Postpartum) who receiving Vitamin A 2006

Age	0-6 month		6-12 month		1-6 year		6-12 year		Postpartum		Total
Term	Jan-June 1st term	July-Dec 2nd term	Jan-June 1st term	July-Dec 2nd term	Jan-June 1st term	July-Dec 2nd term	Jan-June 1st term	July-Dec 2nd term	Jan-June 1st term	July-Dec 2nd term	
Kayah	5	66	3	119	77	606	66	474	0	11	1427
Kayan	26	122		153		243		488	8	149	1189
Taungoo	139	133	144	297	186	246	162	300	631	976	3214
Klerlwitu	0	111	130	204	145	254	140	420	0	111	1515
Tha Ton	0	199	0	316	0	0	0	622	0	107	1244
Mutraw	0	76	179	93	150	157	273	549	0	76	1553
Pa An	0	72	0	131		568		605	0	78	1454
Du Pla Ya	0	0	4	89	53	169	187	205	0	150	857
Win Yee	0	0	0	50	0	0	184	0	603		837
KawKarake	0	0	106	164	86	274	45	705	0	0	1380
Mon (1)	23	303	26	52	353	270	328	384	10		1749
Mon (2)	26	0	54	78	490	378	589	600	3		2218
Mon (3)	0	0		147	0	1554	0	2180	0		3881
M/Tavoy	0	132		167	0	319	0	470	0	140	1228
Special	0	0	640	145	280	174	360	397	0		1996
Shan	0	17		47	0	41	0	42	0	28	175
Lah Hu	0	31		31	0	153		120			335
Total	219	1262	1286	2283	1820	5590	2150	9164	652	1826	26252
	1481		*3569*		*7410*		*11314*		*2478*		*26252*
	23774										

De-worming (January to December 2006)

Area	First Term	Second Term	Total
Kayah	483	1438	1921
Kayan	748	748	1496
Taungoo	567	816	1383
Kler Lwee Tu	400	1125	1525
Tha Ton	0	1897	1897
Pa Pun	740	2242	2982
Pa An	0	1383	1383
Duplaya	296	1052	1348
KawKaKeik	792	747	1539
Win Yee	0	900	900
Mergue/Tavoy	0	790	790
Mon (1)	317	0	317
Mon (2)	559	567	1126
Mon (3)	0	3786	3786
Special Area	640	927	1567
Shan	0	175	175
La Hu	0	238	238
Total	**5542**	**18831**	**24373**

c. Village Health Volunteer Training and Workshop


Village Health Volunteer Training and Workshop in-Pa An 2006

The objective of BPHWT is to train and provide for 10 village health volunteers for each back pack team, targeting a 2,000 population. The BPHWT have already trained 700 Village Health Volunteers (VHV). BPHWT organizes village health workshops every six months. These workshops covered topics such as water sanitation and disease prevention. The focus was typically on the discussion of water borne diseases. Strategies for preventing the spread of infection of malaria, diarrhea, respiratory infections, worm infestations, measles and typhoid were also addressed. Also, discussions addressed other topics such as high risk pregnancies.

Field Workshop Mon area 2006

The occurrence of workshops depend on community security and available time, but generally last about three sessions for each backpack team. Workshops usually involve small group discussions then topics are bought back to the main group for general discussion. Communities are invited to send representatives from

different sectors such as religious leaders, traditional birth attendants and school teachers to attend discussions. These representatives then go back to their respective fields and teach other to further spread the knowledge on these health practices. The focus of the sessions is on primary health care concepts. Currently villagers rely on curative treatments, instead of preparing and preventing the spread of infection. Also a part of these sessions is a discussion period. Discussions are issues of relevance to the community. The health priorities of the community are decided, and how the BPHWT can help with these projects. In 200, the BPHWT organized World AIDS day activities, in which 76 sessions were held where over 22, 000 people participated in the events. The health workers organized and coordinated with school teachers and community leaders. The sessions aimed to bring awareness to the communities in order to gain knowledge about AIDS and prevention.

Village Workshop (January to December 2006)

Area	Teachers	Students	TBAs	CHWs	VHVs	Shop Kepers	Religion leaders	Women Org.	Youth Org.	Village leaders	Villagers	Authorities	Total
Kayah	99	306	42	49	23	75	79	39	211	146	291	52	**1412**
Kayan	120	174	15	19	18	3	9	14	72	8	432	10	**894**
Taungoo	33	312	31	43	27	6	17	22	38	50	229	33	**841**
Klerlwehtu	37	250	38	39	40	12	21	42	51	30	301	30	**891**
Tha Ton	89	989	91	82	80	85	51	43	71	138	1552	95	**3366**
Pa Pun	57	499	94	78	87	41	39	41	24	66	988	78	**2092**
Duple	70	275	104	88	79	59	32	35	54	98	672	102	**1668**
Kawkareik	46	141	80	66	68	47	34	22	34	57	235	58	**888**
Win Yee	30	10	32	28	17	21	5	3	9	39	260	27	**481**
Mergue/Tavoy	31	326	34	50	36	35	15	17	16	52	288	4	**904**
Mon 1	30	90	48	36	39	14	69	11	15	81	312	69	**814**
Mon 2	27	176	15	25	0	27	33	0	61	50	355	0	**769**
Mon 3	19	0	16	941	215	284	87	0	182	77	569	17	**2407**
Special	0	0	11	18	14	18	16	0	0	17	280	0	**374**
Shan	35	57	53	41	44	17	23	16	39	41	110	60	**536**
Lahu	8	78	1	11	0	2	9	0	37	16	124	7	**293**
	2	15	0	0	0	1	4	6	10	3	35	3	**79**
	725	**3620**	**704**	**1603**	**787**	**745**	**534**	**311**	**887**	**953**	**6909**	**638**	**18709**

c. Water and Sanitation project

The Back Pack Health Worker Team established water and sanitation projects that included 20 sessions of gravity flow and 20 shallow well systems.

The beneficiary population that has received water from this project is 1924 households comprising of 11,160 people. BPHWT provides 380 school latrines and 2,000 village latrines in the year 2006. The BPHWT aims to provide 1 latrine to every 5 people in all areas.

Constructed the gravity Flow and shallow well water system 2006

8. Maternal and Child Health Care Program

The Back Pack Health Worker Team began the Maternal Child Health Care Program in 2000. The BPHWT have trained Traditional Birth Attendants every year in order to reach their goals that for every 2000 people there will be 10 TBAs. In 2006, 289 Traditional Birth Attendants were trained. Currently there are 720 TBAs trained and working with Back Pack Health Worker Team in the MCH program. In 2006, the BPHWT assisted with 2693 births by Traditional Birth Attendants, of these 2594 (4 mothers twins) were live births, 103 still births or abortions, 94 were neo-natal death and there were 15 maternal deaths.

TBAs Training in Klerlweetu- 2006

a. TBA training

In 2006, the BPHWT organized TBA trainings that comprised of 28 training sessions; as a result 289 TBAs have been trained. And now there are 720 TBAs trained and working with Back Pack Health Worker Team which is related to the MCH program.

b. TBA workshops

The BPHWT organized TBA workshops every six months in order to improve their knowledge and skills, to share their experiences and to participate in ongoing learning opportunities. Delivery kits and maternity kit supplies were also restocked. These workshops provided a supportive environment for the discussion of issues faced in the field, which are documented and reported at the Reproductive Health workshop or at BPHWT six months general meeting. The TBA workshops consisted of 42 sessions of 361 TBAs in the first term, and 51 sessions consisting of 507 TBAs in the second term in 2006.

TBA's workshop –Papun area -2006

Total Deliveries by TBA in 2006

No	Area	Delivery	Live Birth	Still Birth / abortion	Neonatal death	Maternal death
1	Taungoo	88	81	7	1	0
2	Kler lwe Htu	166	157	9	13	0
3	Mutraw	296	282	14	10	3
4	Thaton	329	323	6	13	3
5	Paan	482	458	26	25	5
6	Megue/Tavoy	289	285	4	7	0
7	Doplaya	247	229	20	10	2
8	Win Yaw	194	185	9	5	1
9	Kawkaraik	29	29	0	1	0
10	Kayah	161	159	2	2	0
11	Kayan	47	47	0	1	0
12	Mon 3	249	245	4	0	0
13	Special areas	116	114	2	6	1
	Total	**2693**	**2594**	**103**	**94**	**15**

c. Family planning activities

The BPHWT introduced family planning activities in 2003 in order to improve maternal and child health status among internally displaced people. The BPHWT provides family planning education and supplies to communities who would like to access these services. The aim of the BPHWT Family Planning activities is to address urgent health concerns among the displaced communities.

The BPHWT provided family planning services to 1262 people, of this 1160 were women and only 102 were men. This shows that only a small number of men participate in family

planning. In the future BPHWT aims to encourage greater male participation in family planning, as methods are simpler and have less complication.

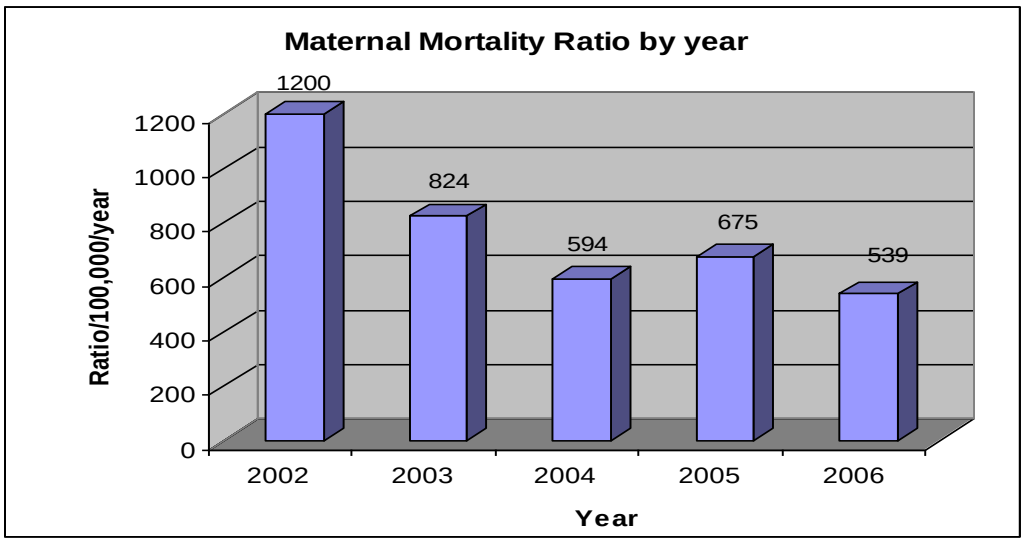
Family planning activities January to December 2006

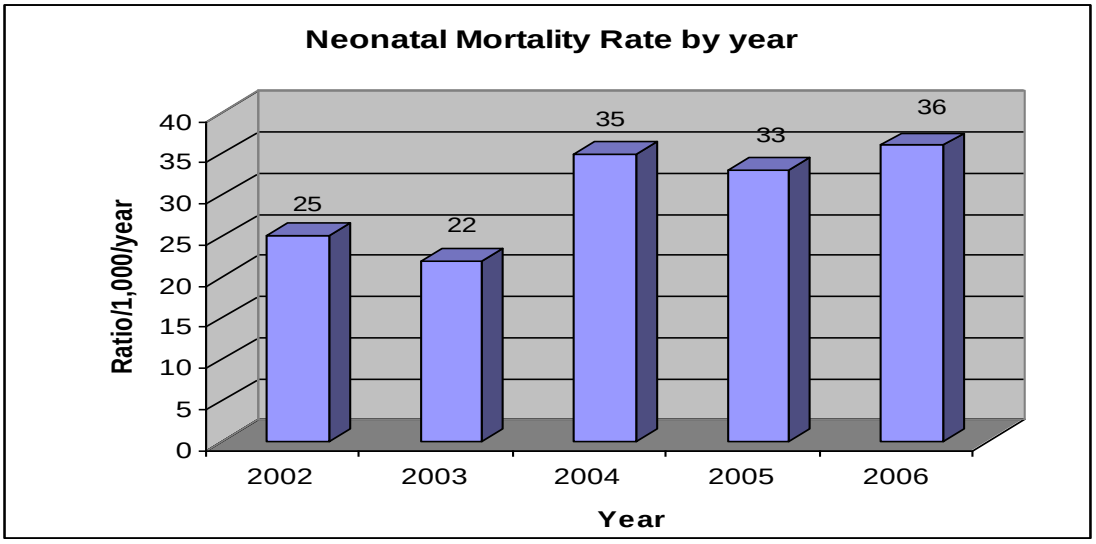
No	Area	Age			G/P			Visit		Clients			Quantity		
		total	<20	>20	0	1-4	>4	New	F/U	Depo	Pill	Cond	Depo (Inj)	Pill -Pack	Condon (Piece)
1	Taungoo	29	1	28	1	25	3	29	0	11	13	3	11	84	540
2	Klerlweetu	18	1	17	0	4	14	10	8	1	12	6	2	140	220
3	Mutraw	64	0	64	0	32	32	52	12	21	42	0	47	235	24
4	Thaton	32	0	32	0	19	13	22	10	29	6	7	49	26	108
5	Paan	225	24	201	4	139	82	88	137	92	109	21	142	288	449
6	Megui/ Tavoy	307	3	304	1	221	85	163	144	180	97	2	380	718	288
7	Dooplaya	48	1	47	0	34	14	19	29	40	8	0	62	51	0
8	Win Yee	44	0	44	0	32	12	39	5	25	5	13	30	28	263
9	Kaw Karaik	44	4	40	3	30	11	32	12	28	20	0	46	56	0
10	Kayah	91	0	91	1	53	37	82	9	40	33	15	68	139	154
11	Kayan	30	0	30	0	14	16	16	14	13	7	10	64	84	348
12	Lahu	151	3	148	1	79	71	133	18	110	36	17	172	102	318
13	Special area	111	0	111	0	93	18	40	71	76	34	16	155	216	1766
14	Mon 3	476	0	476	51	401	24	258	218	293	183	0	295	295	0
Total		**1670**	**37**	**1633**	**62**	**1176**	**432**	**983**	**687**	**959**	**605**	**110**	**1523**	**2462**	**4478**

d. Summary Fact Sheet of MCH Program's Activities (2000-2006)

Generally the maternal mortality ratio has decreased from 2002, but the ratio remains very high when compared to international standards being similar to Afghanistan and Angola. The ratio is also twice as high as the official maternal mortality ratio released by SPDC for Burma. Neonatal mortality rates have increased slightly; therefore, the BPHWT need to increase TBA training and provision of birthing kits to increase coverage, so that there will be one TBA for every 200 people. This will enable the implementation of safe birthing practices and improve the maternal mortality ratio.

	2000	2001	2002	2003	2004	2005	2006
Total Deliveries	115	324	2201	1517	1432	2297	2693
Live- birth	101	296	2066	1457	1347	2222	2594
Still-birth/abortion	14	28	135	60	84	81	103
Neonatal Death	N/A	N/A	52	32	47	73	94
Mother Death	N/A	N/A	21	12	8	15	15





9. Capacity Building Program

The BPWHT Members attended many conferences, seminars and training workshop in 2006. These include:

- Proposal Writing Training organized by IRC
- Project Management Training by IRC
- Monitoring and Evaluation Training organized by IRC
- Peace Building organized by MTC
- Gender based Violence training organized by MAP
- Health and Human Rights
- Office Management training- organized by BPHWT
- Gender based Violence - organized by BRC
- Leadership training - organized by MTC
- Financial Management – organized by NCA
- Financial Planning - organized by IRC
- Environment training – organized by MTC
- Basic Computer Training – organized by Border Media
- Network for Human Rights Documentation on Burma- organized by BI\
- Video training – organized by BI
- Transitional Justice Workshop- organized by HREI-B
- Women Political Exchange – organized by MTC

10. Comments and Suggestions

The field in-charge commented that the Backpack team should expand into new areas. It is also recommended that BPHWT extend the water and sanitation projects. They asked for more posters to use during educational activities, more copies of the Burma border guidelines and surgical supplies. The field in-charge noted that there has been improved community participation in their health program activities. Two more ethnic (Arakan and Pa-O) areas requested back pack programs.

11. 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 organized coordination meetings every six months, in conjunction with the regular BPHWT general meetings, field workshops, field operational meetings and village workshops.

Coordination meeting with NHEC and BMA

The executive committee of BPHWT coordinates with other health organizations which work in areas related to the programs or issues, such as: Mae Tao Clinic, Burma Medical Association (BMA), local ethnic health departments, National Health and Education Committee (NHEC), and Global Health Access Program (GHAP).

The field in-charge from fifteen field areas organized field meetings every six months, which included coordinated activities with local health organizations. The BPHWT mainly cooperates with ethnic local health departments, local community based organizations, school teachers and village leaders.

12. Monitoring and Evaluation

The Back Pack Health Worker Team organizes program's activities meetings twice a year and a general meeting once a year. The meetings include a section on monitoring and evaluation. In 2006, the BPHWT established Internal Programming Improvement Project (IPIP) in order to evaluate the improvement of activities and particularly focused on communication, rational drug use and performance review of clinical log-book.

a. Framework of M & E

Key Indicators	Methods	Period
Health worker performance	**Logbooks reviews**	**Every six months**
Program development	**Annual report comparing of planning and actual activities**	**Once a year**
Program management	**Leading group election and Executive Board**	**Every 3 years**
Out-come and Impact Assessment	**Conducting Annual Survey**	**Every year**
Training effectiveness	**Pre-test, post-test and examination**	**Every year**
Financial management	**Comparing of Planning and Actual budget**	**Every six months**
	External audit	**Once a year**

a. Monitoring and Evaluation Processes

The BPHWT organizes program meeting every six months and annual meeting once a year in order to review the activities. During this term, the BPHWT have reviewed the patient record book, in terms of quality of care, treatment protocol and case definition

Summary Findings of BPHWT Patient Record book review:

	Feb-06	Aug-06	Feb-07
MALARIA IN ADULT: 240 patients	YES	YES	YES
S/S -> Dx	**95%**	**97%**	**96%**
Dx -> Rx	**93%**	**97%**	**96%**
Rx: CORRECT DRUG	**95%**	**96%**	**95%**
CORRECT DOSE	**N/A**	**N/A**	**77%**
DOSE RECORDED	**80%**	**97%**	**85%**
ANAEMIA TREATMENT GIVEN	**N/A**	**24%**	**35%**
VITAL SIGNS RECORDED	**N/A**	**N/A**	**85%**

	Feb-06	Aug-06	Feb-07
MALARIA IN CHILDREN: 186 patients	YES	YES	YES
S/S -> Dx	**98%**	**99%**	**96%**
Dx -> Rx	**95%**	**100%**	**89%**
Rx: CORRECT DRUG	**92%**	**100%**	**95%**
CORRECT DOSE	**N/A**	**N/A**	**71%**
DOSE RECORDED	**74%**	**96%**	**81%**
ANAEMIA TREATMENT GIVEN	**N/A**	**26%**	**16%**
VITAL SIGNS RECORDED	**N/A**	**N/A**	**90%**

	Feb-06	Aug-06	Feb-07
ARIs: 229 patients	YES	YES	YES
SPECIFIC DIAGNOSIS			**68%**
S/S -> Dx	**75%**	**88%**	**69%**
Dx -> Rx	**75%**	**88%**	**74%**
Rx: CORRECT DRUG	**74%**	**82%**	**69%**
CORRECT DOSE	**67%**	**75%**	**66%**
DOSE RECORDED	**83%**	**99%**	**93%**
VITAL SIGNS RECORDED	**N/A**	**N/A**	**68%**

	Feb-06	Aug-06	Feb-07
DIARRHOEA: 144 patients	YES	YES	YES
S/S -> Dx	**88%**	**100%**	**75%**
Dx -> Rx	**70%**	**88%**	**61%**
Rx: ORS RECORDED	**17%**	**82%**	**57%**
ANTIBIOTIC GIVEN	**92%**	**15%**	**41%**
VITAL SIGNS RECORDED	**N/A**	**N/A**	**76%**

	Feb-06	Aug-06	Feb-07
DYSENTERY: 180 patients	YES	YES	YES
S/S -> Dx	**60%**	**58%**	**83%**
Dx -> Rx	**97%**	**93%**	**90%**
Rx: CORRECT DRUG	**85%**	**90%**	**91%**
CORRECT DOSE	**43%**	**35%**	**38%**
VITAL SIGNS RECORDED	**N/A**	**N/A**	**94%**

	Feb-06	Aug-06	Feb-07
ANAEMIA: 228 patients	YES	YES	YES
S/S -> Dx	**91%**	**97%**	**93%**
Dx -> Rx	**98%**	**95%**	**97%**
Rx: CORRECT DRUG	**98%**	**96%**	**98%**
CORRECT DOSE	**53%**	**80%**	**77%**
DOSE RECORDED	**78%**	**100%**	**97%**
MEBENDAZOLE GIVEN	**N/A**	**8%**	**16%**
VITAL SIGNS RECORDED	**N/A**	**N/A**	**81%**

Recommendation

Malaria

Common Problems	***Improvement***	***Plan for Next Steps in Feb,2007***
• Often Quinine and Amoxicillin given in children: Amoxicillin is not active in malaria • Often Quinine and Amoxicillin given in children: Amoxicillin is not active in malaria • Some medics forget to give Doxycyline and give only Quinine • Often, no Doxycyline is given in severe malaria (when patient improves) • A few medics still make mistakes on Doxycyline (1OD for adults) and Chloroquine (1BD x 3 days or 2 OD for 3 days) doses • Majority of medics does not give F/S, but better than in August (35% vs 24%) • Some medics give F/S in PF, but not in PV malaria (but PV malaria makes people very anemic)	• Choice of drug is mostly correct • Doses are mostly correct • Some Health workers have started to give anaemia treatment • Generally very good	• To give correct dose in 95 % of patients (now 77%) • To give F/S in 85% of patients (now 35%)

ARI

Common Problems	*Improvement*	*Plan for Next Steps in Feb,2007*
• Several medics still use "ARI" as diagnosis for all respiratory infections • Many medics use: common cold / tonsillitis / pneumonia and ARI • Usually they give Cotrimoxazole for "ARI" and Amoxicillin for pneumonia. • Maybe ARI is instead of bronchitis or non complicated pneumonia? • Amoxicillin more used than Cotrimoxazole • Always antibiotic in acute bronchitis	• Some medics make specific diagnosis and do not use any more ARI (68%) • Many medics do not give antibiotics in common cold • Some medics use Cotrimoxazole as first line treatment for non complicated pneumonia • Doses of antibiotics are correct • Few medics give 10 days antibiotics for tonsillitis	

Diarrhea

Common Problems	*Improvement*	*Plan for Next Steps in Feb,2007*
• Use of Cotrimoxazole increased (41% vs 15%) • ORS often not recorded (57% vs 82%)	• Got worse from August 06	• To stop using antibiotics: 10% (now 41%) • To write ORS use: 85% (now 57%) • To give Vit A to children With diarrhea (80%)

Dysentery

Common Problems	*Improvement*	*Plan for Next Steps in Feb,2007*
• No improvement in Metronidazole dose (38 % vs 35%)	• Most medics now make correct diagnosis (83% vs 58%)	• Improve correct diagnosis: 95% (now 83%) • Improve dose of Metronidazole 65% (now 38%)

Anemia

Common Problems	*Improvement*	*Plan for Next Steps in Feb,2007*
• Most medics do not deworm anemia patients, but better than August (16.5% vs 8%)	• Most medics give correct treatment (but we did not improve from August: 77% vs 80%)	• Improve correct diagnosis: 95% (now 83%) • Improve dose of Metronidazole 65% (now 38%)

Summary Findings and Recommendations of I-PIP

Problems	*Solution*	*Action Plans*
Rational Drug Used		
- Drug supplies run out early, often arrive late and at times include faulty or incorrect items.	• Drug supplies arrive on time, are enough to last and contain correct, good quality items as ordered.	-Team members from north area to review recent problems in detail for lessons learned and consider possible ways to avoid these problems in the future. -Mae Sot team members to work with Jerry and outside experts to consider appropriate budget amounts/percentages considering disease profile, population size, etc. Number of rx's given per patient to be reviewed, etc. - Survey of all field checkers to determine extent and rate of faulty medical supplies/drug orders by past shipment dates and by locations

Communication		
-Systematic communications system is weak and communications equipment are lacking for many field locations.	-Communications protocols are in place and working, including feedback mechanism, all field sites equipped for better communications as feasible.	-Team will generate a chart to define what should be considered routine communications and what should be considered emergency or non-routine communications. Routine communications items will include frequency (monthly, six-monthly, etc.) and who (what person in Mae Sot office to FIC, FIC to whom, etc.). -Consider ways to encourage FEEDBACK in the communications loop – Mae Sot should be aware what sites have received messages and what sites have not been able to receive messages. -Mae Sot team members to research purchase of radios (and telephones) for field use (costs, quality, durability, battery life, etc.). -Survey of all field sites – what locations have access to radios now, what sites to not have access to radios, what restrictions are on radio use at each site, what sites may possibly use telephones, etc.
Performance Review of Clinic Log Books		
-Review system is working and the process has lead to improvements, however, review shows that compliance with treatment protocols could be improved, particularly for new or younger health workers and particularly for treatment of Malaria.	Drug supplies arrive on time, are enough to last and contain correct, good quality items as ordered.	-FIC to conduct focus group discussions with health workers (with emphasis on new and younger health workers) to gather information on what may be issues regarding weak points identified in clinic log book review (protocols are not always followed – particularly for malaria treatment). -Focus group to be conducted before the conclusion of this meeting to get feedback from health workers (not field in charges) that are here from the field. -Look at data carefully from current round of logbook reviews for further insight.

b. Program development and program's activity reviews in 2006

Comparing of planned activities and actual activities

Planned Activities	Actual Activities	Out-comes/ Results
A. Medical Care program		
1. providing medical supplies for 85 BP teams	provided medical supplies for 76 BP teams	71789 case- treated
2. 36 sessions of field workshop	36 sessions of field workshop	~ 20 health workers each sessions
3. 36 sessions field meeting	36 sessions field meeting	~ 20 health workers each sessions
4.Reviewing treatment protocol and case definition twice a year	Reviewed treatment protocol and case definition twice a year	90 health workers each time
B. Community Health Education and Prevention program		
1. 85 sessions of School health	76 sessions of school health	441 schools, 22880 students have received
a. 850 latrines for schools	380 latrines in schools	380 latrines in schools
b. 2,000 community latrines	2,000 community latrines	2000 house-holds, beneficiary population of approximately 12,600
2. a. 20 sessions of Gravity flow water system	20 sessions of Gravity flow water system	Beneficiary for 735 house-holds comprising of 4454 population
b. 20 sessions of shallow well	20 sessions of shallow well	Beneficiary of 3,800 population
3. 85 sessions for world AIDS day	74 sessions for world AIDS day	22177 people involving in the events
4. Village workshop (280 sessions)	Village workshop (280 sessions)	9686 people participated
5. VHV training (23 sessions)	VHV training (21 sessions)	293 VHVs were trained

Planned Activities	Actual Activities	Out-comes
6. Vitamin A 76 Back pack teams	Vitamin A 70 Back pack teams	41354 Children and 1228 mothers received Vit A
7.Deworming 85 Back pack teams	76 Back Pack Teams	24373 children received mebendazolde
C. Mother and Child Health Care Program		
1. 28 sessions of TBA training	28 sessions of TBA training	318 TBAs had been trained
2. 97 sessions of TBAs workshop	93 sessions of TBAs workshop	480 TBAs participated
3. 1300 TBAs kits	1180 TBAs kits	590 TBAs received kits
4. 6500 maternity kits	5900 maternity kits	2693 deliveries
5. family planning (birth spacing) according to the requests	11 areas	1670 clients (11560 women + 110 men)
6. 3000 delivery records	3000 delivery records	677 child received delivery record
D. Capacity building		
1. Office management training	2 Times	8 staffs
2. Accounting training	N/A	
4. 2 sessions of CHW training	One sessions	30 trainees (CHWs)
E. Health information and Documentation		
1.Photo document	Photo document	76 back pack teams
2.Publication (calendar)	Publication (calendar)	100 copies
4. Annual survey	25000 copies –questionnaires	2109 returned
E. Program management		
1. Meeting and seminar (2 times)	Meeting and seminar (2times)	90 workers participated
2. Leading group meeting (2 times)	Leading group meeting (2 times)	11people participated each time
3. Executive Board meeting (6times)	Executive Board meeting (2 times)	7 people participated each time
4. Office staffs meeting (24 times)	Office staffs meeting (6 times)	9 people participated

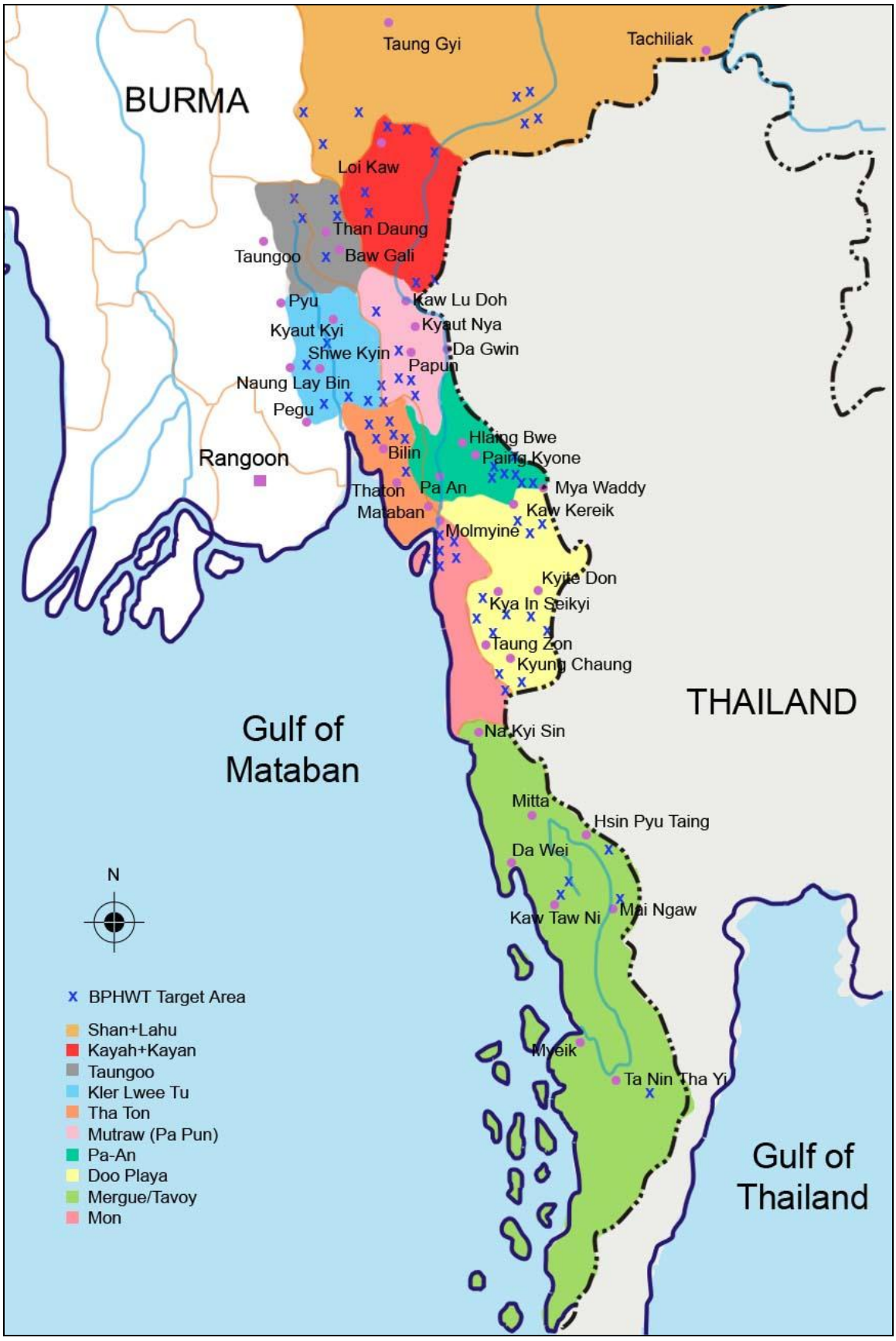
13. Financial Reports

The total income in 2006 budget year and balance from 2005 is totally 19,410,435 Thai baths. The main source of funding is CIDA (BRC) and the second largest source is the DCA and SV foundations and others. It is noted that the remaining budget from 2005 provided by the SV foundation, is included in the income for 2006.

BPHWT Income and Expenditure report in 2006

Description	Cash In Thai Baths	Cash Out Thai Baths	%
Remaining from 2005	3,232,270		
Total imcome in 2006	16,178,165		
			100%
Back Pack Medicine and Medical Equipment		4,587,260	26 %
Back Pack Field Operation Supplies and Services		2,958,816	17 %
Capacity Building Program		570,536	3 %
Community Health Education and prevention		2,586,400	14 %
Mother and Child Health Program		2,304,749	13 %
Health Information and Documentation		731,853	4 %
Program Monitoring and Evaluation		1,968,008	11 %
Administration		1,830,782	10 %
Community Health Development Program		360,947	2 %
General Expenses		21,200	0 %
	19,410,435	**17,920,551**	**100%**
Balance From 2006	***1,489,884***		

14.Map


BURMA
THAILAND
Taung Gyi
Tachiliak
Loi Kaw
Than Daung
Taungoo
Baw Gali
Pyu
Kaw Lu Doh
Kyaut Kyi
Kyaut Nya
Shwe Kyin
Da Gwin
Papun
Naung Lay Bin
Pegu
Rangoon
Hlaing Bwe
Bilin
Paing Kyone
Thaton
Pa An
Mya Waddy
Mataban
Kaw Kereik
Molmyine
Kyite Don
Kya In Seikyi
Taung Zon
Kyunt Chaung
Gulf of Mataban
Na Kyi Sin
Mitta
Hsin Pyu Taing
Da Wei
Kaw Taw Ni
Mai Ngaw
N
BPHWT Target Area
Shan+Lahu
Kayah+Kayan
Taungoo
Kler Lwee Tu
Tha Ton
Mutraw (Pa Pun)
Pa-An
Doo Playa
Mergue/Tavoy
Mon
Myeik
Ta Nin Tha Yi
Gulf of Thailand

Temporary shelter for refer the patient

15. Conclusion

BPHWT has implemented a primary healthcare delivery system to address the most pressing health needs of communities along the border and in the remote interior regions of Burma. In 2006, the 76 backpack teams provided primary health care to approximately 150,000 displaced people inside Burma. The Back Pack Health Worker Team's have implemented a primary health care service consisting of three main programs; medical care, community health education and prevention, and maternal and child health care. They have also focused on improving Health Information and Documentation, and Capacity Building through the three main programs.

This report provides information about the time period from January to December 2006. The morbidity rates of various diseases seen in the population are analyzed and the figures illustrated in tables and graphs. The data shows that in general morbidity rates in BPHWT areas have decreased from 2002 to 2006. The data illustrates and informs about which health problems are the most important in the communities in which BPHWT works. From this information community health education and prevention activities can be targeted to areas of most need. This is important as BPHWT's ultimate aim is enabling the communities to be self-reliant.

In 2006 BPWHT have expanded the comprehensive three programs to more areas. Next year BPWHT plan to implement all three programs in all areas, and to expand the program into other ethnic areas.

BPHWT continues to work towards its aim of equipping people with the skills and knowledge necessary to manage and address their own health problems, while working towards long-term sustainable development for the community of Burma.

Back Pack Health Worker Team