

This Report is dedicated to the memory of those who lost their lives in the service of Back Pack Health Worker Team. We offer our gratitude to these 10 brave and committed individuals and send our prayers to their loved ones. On a daily basis, BPHWTs traverse areas of active conflict and territories where the landscape is littered with land mines. Traveling from village to village, BPHWT members must trek, climb, negotiate river waters and determine if there is a safe means to evade a conflict situation and reach the villages that await their skilled care. These health workers consistently put the welfare of their communities above their own personal safety. As a result of their selfless service, countless villagers have enjoyed improved health and enhanced understanding. May their memories live on in our hearts and be a blessing to every BPHWT member and to all those we serve everyday.

**Maran Seng Ra**  
2018

**Saw San Thein**  
2015

**Khaing Soe Paing**  
2015

**Zi Wah Ni**  
2009

**Saw Eh Keh**  
2004

**Saw Ta Pi**  
2003

**Saw Maung Myint**  
2002

**Ka Haw Moo**  
2001

**Tu Naing**  
2000

**Saw Nay Say**  
2000

The Back Pack Health Worker Team extends our heartfelt appreciation to the generous donors and partners which have sustained our work for 20 years. In addition to these organizations, countless individual contributors have supported us. Thank you, without you this life-saving work would not be possible!

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Burma Refugee Care Project  
Burma Relief Centre  
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Christian Aid  
Committee for Protection and Promotion of Child Rights  
Community Partners International  
Crossroads Charity  
Danish Church Aid  
Department for International Development (UK)  
Global Affairs Canada  
Global Health Access Program  
Help without Frontiers  
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Swiss Agency for Development and Cooperation  
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The Border Consortium  
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University Research Co., LLC  
Voluntary Service Overseas  
Women's Education for Advancement and Empowerment  
World Children's Prize

~ Our sincere apologies for any omissions ~

# Table of Contents

Dedication .....	i
Donor Appreciation .....	ii
Forward by Dr. Cynthia Maung .....	2
Introduction by Saw Win Kyaw .....	3
Brief History of Burma .....	5
Health Care in Burma .....	13
Back Pack Health Worker Team's Founders, Vision, Mission & Goal .....	17
Health Care for IDPs and Vulnerable People in Burma .....	19
Understanding the Population Data .....	22
Map of BPHWT Service Areas .....	23
Birth of the Back Pack Health Worker Team .....	25
New & Noteworthy: 1998-2017 Program Highlights, Lessons Learned, New Challenges to Address .....	29
Testimonials From BPHWT's Field Areas .....	49
Three Sustaining Programs, Three Major Illnesses .....	53
Human Resources and Capacity Building Program .....	59
Building Coalitions for Lasting Change .....	63
Fulfilling Our Promise: BPHWT Looks Toward the Future .....	69
Notes .....	77
Source Materials .....	78

*All pictures throughout this Report are of BPHWT health workers  
except where noted*

# FORWARD

## Dr. Cynthia Maung

### Chairperson, Leading Committee, Back Pack Health Worker Team

My awareness of the stark disparity in access to health care in Burma began during medical school. An internship at two general hospitals plunged me into a system that was under-resourced and under-staffed. Attention was necessarily devoted to addressing serious problems; there was neither time nor resources to offer preventative or basic primary health care. After the uprising of August 8, 1988, as I made my way across the country toward Thailand, I met many people in rural and remote areas of Burma. These people were in desperate need of health care; they had never had access to even rudimentary medical services. In Thailand, students and doctors who had fled the country began pooling resources and discussing how we could best bring primary and conflict-related health care to Burma's remote communities. We began sending small teams of medics into Burma; each person outfitted with a backpack of medicines and supplies and each team traveling to a circuit of villages for several months at a time. In 1997 – 1998 pervasive and hard-hitting attacks by the Burma military on many ethnic communities in Eastern Burma caused internal displacement, increased numbers of refugees and the destruction of ethnic health and education infrastructures. Health workers from various groups met to discuss how to rebuild and support vulnerable people and communities. From this came the Back Pack Health Worker Team (BPHWT) in 1998.

Burma as a nation has undergone much change since that time. The Nationwide Ceasefire Agreement, has been met with varying degrees of sincerity and insult, instilling the minority ethnic population alternately with hope, suspicion and caution. With the National Health Plan, and its concomitant goal of Universal Health Care by 2030, the Ministry of Health and Sports has at last acknowledged the serious fissure in healthcare access within the nation. Through it all, the BPHWT has remained both responsive to and active in shaping policy and practice that effects health care for Burma's ethnic minorities.

The BPHWT not only brings health care to the communities we serve, but empowers communities and individuals to better care for themselves. The BPHWT has created a network of Community Health Workers (456 workers in 2017) and Village Health Committees (44 committees, with 455 leaders in 2017) that provide consistent on-going care and participatory guidance in their villages. The BPHWT provides training to hundreds of Traditional Birth Attendants / Trained Traditional Birth Attendants (799 in 2017) who play a vital role in promoting maternal and child health while creating a critical link between villagers and the larger ethnic health system.

The BPHWT is forging relationships with other organizations, societies and governments; the BPHWT is an important member of the Ethnic Health Systems Strengthening Group, the Health Information Systems Working Group, and the Health Convergence Core Group. Together we are working to lead systemwide change in health care, develop robust and systemwide demonstrable data that can be shared and used to determine programs and policy going forward, and assure that ethnic health workers receive accreditation and acknowledgment so that their roles are enshrined in Burma's future.

This document celebrates the BPHWT's 20 years of growth and change. Our experience has made us stronger. Our partner organizations have broadened our horizons. Our funders have made it possible to deepen knowledge with training, deliver context-appropriate care, and provide needed medicines and supplies to hundreds of thousands of people. We offer our heartfelt thanks to all who have played a part in this life-saving work.

# INTRODUCTION

## Saw Win Kyaw

### Director, Executive Board, Back Pack Health Worker Team

Over 20 years, the Back Pack Health Worker Team (BPHWT) has grown to embrace a wide range of health workers and reached ever further to address the healthcare needs of remote ethnic populations. We have increased and changed program offerings, remaining responsive to emergent and shifting in needs in the communities we support as well as keeping abreast of international standards, protocols, testing and treatment within our areas of care.

The BPHWT has significantly improved wellness and brought knowledge and the tools of self-care to hundreds of thousands. With an initial target population of 45,000 in 1998, we now serve nearly 300,000 (2017). We began with 32 teams and 120 health workers in 2018; our teams now number 114, with 456 health workers. We currently reach every state and 3 regions in Burma. Due to relative stability in some areas, 48 of our teams are “stationary teams” where a dedicated building enables storage of medicines and basic supplies, and a space for examination and consultation areas. Villagers come to the building when in need of care; workers still travel to villagers’ homes as needed. We also train Village Health Workers and Trained Traditional Birth Attendants who live full-time in their communities and offer on-going care and immediate medical response. This supports our mission of empowering communities with the skills and knowledge that will enable greater self-care.

The BPHWT has 3 main programs: Medical Care Program (MCP), Maternal and Child Healthcare Program (MCHP) and Community Health, Education and Prevention Program (CHEPP). All MCP’s frequently-seen major illnesses have been markedly reduced in the past two decades. In the past 10 years, cases of malaria have decreased by 89% in our target population — a result not only of more accurate testing, early intervention and medicines, but also significant attitude change regarding use of mosquito nets and water/sanitation practices. We learned early on that primary health care cannot be divorced from clean water, sanitation and hygiene and developed a multi-faceted program to bring workshops and educational offerings to the communities we visit (CHEPP). The MCHP is a vital component of our work: in 2017, 4144 babies were born in our target areas — more than ever before! Well-trained health workers, prepared mothers, and attention to sanitary environments have borne real results: while 135 stillbirths were recorded in 2002 (6% of all births), in 2017 there were only 29 (0.007% of all births).

Some things are beyond our ability to control —injuries due to landmines, gunshot, and other casualties of war are an on-going legacy for too many living in Burma. The risks of malnutrition, exposure, and disease are infinitely greater to displaced populations than stable communities. The risks to health due to unscrupulous development, resource extraction and natural- and human-made disasters will persist. The BPHWT will continue to provide care and emergency assistance to those who are affected.

For 20 years, we have faced repeated challenges to the delivery of health care. Even as obstacles and threats continue, we will persevere. Our role remains as vital as ever: We will continue to strive for quality accessible, low- or no-cost health care to all ethnic people in a Federal Union of Burma. Not only do we provide care, we are the recipients of care, and we are driving the policy and network that will support health care in Burma for decades to come. We extend our appreciation to all health workers, staff, partner organizations, donors, volunteers and anyone who has ever contributed to the BPHWT. We look forward to the next 20 years of change and improved health!



# Brief History of Burma

## **Economic Displacement and Human Rights Abuses of Burma's Ethnic Peoples**

In 2012 President Thein Sein lifted economic sanctions and opened the door to foreign investors and development. As the military government prioritized business interests over inclusion of and meaningful dialogue with all Burma's people, foreign and state-sanctioned companies poured into Burma seeking to exploit resource-rich lands for development. Some villages were to forced to relocate, others were forced into service, most without compensation. Natural resource extractive projects have not only led to the taking of ethnic minority lands, but the polluting of critical resources leading to a range of illnesses.

*In the Ta'ang/Palaung ethnic area of Northern Shan State, the community has been devastated by the effects of the Shwe Gas and Oil Pipeline, a joint venture of the China National Petroleum Company (CNPC) and the Myanmar Oil and Gas Enterprise (MOGE). This project will bring crude oil and natural gas from Arakan State, through Central Burma and Northern Shan State to China's Yunnan Province. As a result of this large-scale energy project, the pipeline running through the Ta'ang/Palaung area has led to increased deployment of Burma Army troops in each village on the route. The Burma Army has been confiscating land, posting armed guards at pipeline sites, and providing a military security detail to Chinese workers. Back Pack health workers reported that increased militarization in this area has led to neardaily fighting between the Burma Army and ethnic armies, displacement of villagers, escalation of human rights abuses, increased drug trade and abuse, increased prostitution and violence against women, restricted access to health care, land confiscation, and environmental degradation. The Burma Army soldiers are not the only perpetrators of human rights violations – Chinese men working on the pipeline are guilty of crimes against the local population. In October 2012, a thirteen year-old girl walking home from school in Namkham Township died after being abducted and gang-raped by ten Chinese workers from the CNPC.*

- *Adapted from the BPHWT 2012 Annual Report*

A country's history is fundamental to the creation of its identity; a national history forges a national identity. Yet Burma's "national identity" has omitted the lives of many of its people. Burma's history is complex and often confusing: allegiances have changed and terms of agreement and ceasefire have repeatedly been brokered and broken. Reported

data, both from official internal sources and reputable international actors, has been skewed toward the majority group and excluded large segments of Burma's ethnic population. This has resulted in an unbalanced national identity story with an implicit lack of a simultaneous, conflicting narrative. Perceptions beyond Burma's borders have been biased by an absence



A village in Burma's hills

the central plains. Many ethnic minorities live in the borderlands of Burma and large numbers, due to military incursions and state-supported development, have become Internally Displaced Persons (IDPs) within their own country or refugees in neighboring countries having fled violence and human rights violations at home. These ethnic groups include Shan, 9% of Burma's population; Karen 7%; Arakanese 4%; and Mon 2%; other groups include Karenni, Chin, Kachin; and a multitude of ethnic groups

of questioning the dominant ethnocentric paradigm. For these reasons it is important to devote some space here to Burma's tumultuous history.

Burma has been living with extreme unrest for decades. Before and since independence from Britain in 1948, the country of approximately 54 million people has been under the constant yolk of armed violence and human rights abuses and corresponding resistance and struggle. The CIA World Factbook (2014) helps draw the picture of a nation of ethnic groups. The largest of these groups, the Bamar or Burmans (for which the country was named) constitute 68% of the population and lives largely in



Back Pack health worker delivers health care to all, irrespective of religion, ethnic group or political beliefs

that are smaller in overall population. The Burmese Nationality Law, 1982, recognizes 135 distinct ethnic minorities within Burma — although this is both contested and controversial.

Before the British colony was established in 1886, Burma was a united yet separate group of territories within one border. Under British rule, a system of segregation and hierarchy was established where none previously existed. British administration divided the territories into Burma Proper and the Frontier Lands. Burma Proper, in the central plains area, was home to the Burman ethnic majority; the Frontier Lands



A knee wound receives medical care from a Back Pack health worker



It can take hours or days to reach a village to bring medical care and education

defined the border areas where other ethnic groups lived. These two areas were governed separately: while the new leaders provided administration and support for Burma Proper, the ethnic groups were accorded self-rule in their regions. This approach of dividing the country into regions with separate policies and treatment for different areas was to have far-reaching consequences in both attitude and in policy for decades to come.

With a fought-for and negotiated independence, the country set its hopes upon General Aung San in negotiating a way forward in the new “united” country. However, the mechanisms for unification of the new Union were not negotiated with full participation of or buy-in by all



Back Pack health workers stitch up a hand wound

ethnic groups. Notably absent from the historic Panglong Conference convened in February 1947 to draft the country’s new Constitution were Karenni, Arakanese, Mon and numerous other ethnic group leaders. Among the ethnic groups present, many did not have the right to participate on a par with the Burmans. As a result, even in its infancy, the rights accorded to minority ethnic people in the new Union of Burma were at best ambiguous and at worst completely absent.

The assassination of General Aung San (and the majority of his cabinet ministers) five months after Panglong, prior to further negotiations on unification and before the country’s independence was official, left many issues between the former Burma Proper and the Frontier Lands unresolved. A colleague of Aung San, U Nu assumed the reins as prime minister and ushered in an “independent” Burma. However, unresolved issues and consistently violated rights led to an on-going climate of mistrust and violence between the national Burma Military and the ethnic opposition armies that persists to this day.

In 1962 a military coup ended the Parliamentary Democracy and established a one-party system with General Ne Win as leader. For the next 14 years, ethnic voices were suppressed and Burma was ruled brutally as a matter of course. One spoke out against the regime at risk of harm or death. Still, students braved protest repeatedly (in 1965, 1969, 1970 and 1974). On August 8, 1988 in a demonstration led by students and joined by monks, children, and citizens, hundreds of thousands of protestors took to the streets in Rangoon demanding change: an end to the military regime and a democratically-elected government. This became known as the 8888 nationwide popular pro-democracy



Family members look on as blood pressure is checked

uprising. The military responded by gassing, killing, and imprisoning protestors; others fled Burma to further organize from a place where their lives were not under constant threat.

The protest forced Ne Win to step down. After a replacement who held but a month-long tenure, a military coup seated a new government: the State Law and Order Restoration Council (SLORC). In the midst of this political upheaval, the daughter of slain General Aung San, Daw Aung San Suu Kyi, returned to Burma. Her leading voice for a democratically-elected government led to the founding of the National League for Democracy (NLD). People hung their hopes

on the possibility of the NLD overthrowing the oppressive regime and leading the country to the freedoms it had long sought. Due in part to her growing popularity, the SLORC placed Suu Kyi under house arrest some 10 months later.

At the same time, the SLORC initiated a brutal crackdown, arresting and killing thousands including students, civilians and leaders of the newly-established NLD. Still, elections in 1990 saw the NLD winning 392 seats in the Union Parliament to SLORC's 10 seats. The military regime refused to acknowledge the results of the election as legitimate and maintained power. Many of those who had been elected were arrested



An infected wound causes swelling and pain to this little girl



Burma is a beautiful country with vast natural resources

while others fled into areas controlled by Ethnic Armed Organizations (EAOs).

Heavy fighting continued for the next four years. During this time SLORC offered ceasefire agreements to certain EAOs — often such agreements were padded with favors, business/financial opportunities or other privileges to encourage members of an EAO to break with their army and join the Burma military. Another tactic the SLORC employed was to approach



Back Pack health worker treating patient with burns

one faction of an ethnic army and seek to recruit its members, thus weakening the mother organization. Contrary to its intent, this factionalization often led to increased fighting and the need for multiple additional ceasefire agreements.

The SLORC refashioned its image along with its name in 1997 and became the State Peace and Development Council (SPDC). An economically repressive environment exacerbated by a sudden and excessive hike in fuel, food and other commodity prices led to massive protests again in 2007. Countrywide, thousands of monks protested in the streets and were joined



Back Pack health worker carefully administers an injection

by activists, students and local citizens. The peaceful “Saffron Revolution” (so named for the monk’s saffron robes) demanded political representation and economic justice. The SPDC response was immediate and brutal; many were killed and arrested.

In the wake of massively destructive Cyclone Nargis the following year, the military barred international aid from reaching hundreds of thousands who desperately needed it. And, though much of the country was in disaster recovery mode, a constitutional referendum vote scheduled for only days after the cyclone hit, went ahead. Under threat of harm, citizens voted overwhelmingly for the oppressive 2008 Constitution. The role of Burma’s military as



It takes several people to safely refer a patient

stated in the 2008 Constitution cannot be overstated; it is central in all affairs of state. The Constitution simultaneously assures the role of the military and a centralized government.

The 2015 election saw 70% of Burma’s 34.5 million eligible voters casting ballots for the House of Nationalities and the House of Representatives. Aung San Suu Kyi was seated as the State Counsellor, a title and position fashioned specifically for her. Notwithstanding the election of a close colleague, U Htin Kyaw, as President



Taking vital signs includes a blood pressure check

in March 2016 (resigned and replaced in March 2018), Aung San Suu Kyi remains the defacto leader of the country.

With the election of Aung San Suu Kyi and her party, the NLD, hopes were high and new efforts afoot for a Nationwide Ceasefire Agreement (NCA). The NCA initially received 8 and now has 10 signatories; it has been repeatedly violated by the Burma military in order to achieve tactical or strategic objectives or to expand or strengthen its positions.

Although long beloved by many of her country people, revered by the

international community and “the face of Burma “ the world over, Aung San Suu Kyi’s role and that of the NLD is both complex and difficult. The might of the military arm of the government and its ability to veto any efforts for genuine democratic change cannot be ignored. Military attacks, land seizures and human rights abuses have continued unabated. With the NCA, ethnic equality and autonomy remain unresolved issues and although the ceasefire and peace process has progressed, its lack of inclusivity and specificity, its lack of any statement concerning the code of military conduct or provisions for independent



Auscultation for lung sounds

monitoring and the military’s blatant and consistent disregard for honoring the territorial imperative of current signatories are troubling.

At the close of 2016 the Internal Displacement Monitoring Center (IDMC) indicated there were 1,153,000 internally displaced persons in Burma due to conflict, violence and disasters; 544,000 added in 2016 alone. Additionally, the IDMC documented 490,000 refugees in 2016. 2017 fared no better, the first six months of the year having 23,600 people displaced due to conflict, violence and disasters; and the later half of the year inviting worldwide



A growth in the eye will need care from specialist



A pregnant women is examined as she rests with her two children



Elderly man discusses his care while his daughter and grandson listen

horror as the crisis in Arakan State unfolded and worsened. This time roughly 700,000 Rohingya were exiled as refugees in Bangladesh with thousands more internally displaced.

The road forward is one of great challenge. Burma is a land of great riches — from its ethnic diversity to its natural resources. Yet

its painful history is one of marginalization and human rights violations. The path towards peace, democracy and a truly inclusive Burma will require massive change and genuine commitment. Efforts are afoot on multiple fronts in this many-year long process. This complex environment is the framework for BPHWT's bold and life-saving work.



# Health Care in Burma

Burma is ailing. It suffers from decades of neglect — a lack of investment in the health of its people and a systemic caste system where availability of state-sponsored health care is largely limited to the populace and majority-culture areas, by-passing the rural, remote and displaced ethnic minorities. Burma's people are literally being kept hungry, sick and tired.

Ranking 188 on a list of 192 countries in terms of national GDP spent on healthcare, Burma dedicates only 2.3% of its GDP to the health of its people (a change of only +.1% in 20 years). By comparison, the United States of America dedicates 17.1%, Germany 11.2%, and Serbia 10.4%; only Qatar, Turkmenistan, Laos and Timor-Leste dedicate fewer funds.<sup>(1)</sup> From a rate of just below \$3 per capita for health care in 2000, Burma now allocates \$59 per capita for health care, while its neighbor Thailand allots \$217 per capita, China \$426, and the USA \$9,536<sup>(2)</sup>.

This lack of investment in the health of Burma's people is reflected in large out-of-pocket costs borne by those who access

health care in Burma. According to the World Bank, in 2012 more than 93% of healthcare costs in Burma were paid for privately — including basic primary and preventative health care. While there has been improvement, this rate lowered to 81% in 2014, and to 54% in 2015, citizens in Burma carry a far greater payment burden than the global average of 32% of costs paid privately, and the NLD's own goal of 25% (by 2020). The delivery of care is so deficient that even among those who have the means to pay, many seek medical care elsewhere. Medical tourism out of Burma is on the rise. In Malaysia alone there was a 23% increase from 2011 to 2012 in Burmese seeking health care<sup>(3,4)</sup>. Amongst the poor and persecuted ethnic minorities, this problem is compounded — there is both a lack of resources locally and an inability to pay for services at an urban center. Burma has yet to address the striking disparity of care available in urban and rural populations, and between the ethnic minorities and the majority Burmans.

A further challenge to effective and appropriate disbursement of allocated funds remains the absence of a credible administrative body to oversee fund expenditure, thus rendering the advantage of an increase in available funds questionable. Nor is there any prioritized, publicly available record of fund recipients or regions. It is impossible to follow allocated funds to ensure they reach the intended target: for a government that has been plagued with corruption, these are serious accountability concerns.

Investment in the training and deployment of medical professionals has been similarly lacking. According to a 2014 Ministry of



Debriding the skin

### Life-saving Referral and the Challenges of Rainy Season

*We had one case with a pregnant woman. She had pre-eclampsia and was a high-risk pregnancy. We noticed a change in her blood pressure, a lot of edema and she became hypertensive. We needed to refer her to hospital. But it was rainy season and we are in a very mountainous area. Transfer was very difficult, it took three days. She got to the hospital and they did a cesarean section. The baby died but the woman was okay. If we had not referred her to hospital when we did, the mother might have died, too.*

*-Lway Poe Khaung, Palaung Field in-Charge*

Health report, there were at that time 15 universities offering medical courses to nearly 1,200 students in medical, dental, pharmacy, medical technology, and community health areas of specialization. There is no private medical university in Burma; the Ministry of Health and Sports, the Ministry of Education, and the Ministry of Defense are responsible for the training of the health workforce. Although the availability doctors, 61 per 100,000 population, is inadequate to meet the need, in 2012 the government reduced those accepted for medical training by half and extended the study period from six to seven years, stating that this was needed to ensure

quality education. Under separate budgets, the Ministries of Defense, Railways, Mines, Industry, Energy, Home and Transport each provide health care for employees and their families within their own facilities. A countrywide survey in 2013-2014 revealed a total of 13,099 doctors in the country, an 11.7% increase from 2011-2012 <sup>(5)</sup>.

Who are these future doctors and medical professionals? Burma's medical students are predominantly drawn from the country's wealthier families and live in major urban areas. Once doctors, many prefer working in cities where transportation and the most current communication technology is



Navigating the road in rainy season



Getting supplies to the next BPHWT location is a group effort!



Patient referral can be perilous for patient and Back Pack health worker

readily accessible. Urban centers are also home to the country's private hospitals that serve wealthy citizens and offer top salaries, favorable working conditions and more modern facilities. Some doctors choose to work outside the country in lieu of serving in the capacity of a rural doctor. In fact, current medical workers describe pay for doctors sent to rural areas of Burma as "not respectable" and "discouraging."<sup>(6)</sup>

As a response to the acute need for doctors, the Ministry of Health in 2013 removed 1,010 sanctioned doctors from a "blacklist." The doctors had been stripped of their medical licenses and, if residing in Burma, not permitted to travel outside the country; those doctors who were outside the country were not permitted to return.



Dental care is an important aspect of primary health care

A variety of reasons were cited for the original sanction from refusal to accept a rural posting, to hospital mismanagement and corruption, to those who fled Burma due to the oppressive military regime.

While doctors generally prefer an urban posting, roughly 70% of the country's nearly 54 million people live in rural areas of Burma. Still, most health services continue to be concentrated in larger towns and cities. Rural health centers, a third-tier health delivery service under the government's health structure, saw a 17% increase over 24 years<sup>(7)</sup>; during this time,



Delivering supplies to the next village

the population increased by 12 million. Many of these centers are noted for lack of medicines and supplies. Staff serve on a part-time basis and frequently workers are assigned to communities where they do not speak the ethnic language, thus hampering effectiveness and compromising trust. Patients with more complex medical needs are required to seek care in a larger city, Rangoon and Mandalay having two predominant specialist hospitals. However since the average Burmese household spends 70% of their income on food alone<sup>(8)</sup>, travel to and the burden of paying exorbitant out-of-pocket costs for health care is a luxury few can afford.

What are these out-of-pocket costs? Patients are customarily expected to pay



Novice receives care for an arm injury

There are only two dedicated psychiatric hospitals that provide pharmaceutical-focused treatment for patients with major disorders. No counseling services are offered on an outpatient basis<sup>(11)</sup>. Since 2013, counseling services have been available through the Thai-based Assistance Association for Political Prisoners' (AAPP) Mental Health Assistance Project. Currently the AAPP offers services in Rangoon, Mandalay and in Mae Sot, Thailand. In line with their mission, these services, developed in collaboration with Johns Hopkins University, are available solely to political prisoners and their families.

for medicines, the use of equipment, extra blankets, even in some locations, for the use of the toilet. And, incidental to the actual delivery of care, costs may include expected “favours,” the greasing of a palm to ensure quality care. In fact, as much as 82% of healthcare spending is out-of-pocket, the 2nd highest rate in the world<sup>(9)</sup>. Patients who are unwilling or unable to pay such bribes report longer wait times, substandard care and, sometimes, refusal to treat.



Teaching how to check for the heartbeat and movement of the fetus

Mental health care is in even more dire circumstances. In 2016, the head of psychiatry at Yangon University reported that there was one psychiatrist per 260,000 population<sup>(10)</sup>.

A hoped for commitment to and improved funding for health care in Burma is showing glimmers of hope, yet actual change has thus far been nominal. At the close of 2016, the health sector was flooded with possibility and anticipation at the recently released, National Health Plan (NHP). The NHP was drafted in an effort to meet the WHO’s mandate for universal health coverage by 2030. Although much remains to be sorted out, the NHP outlines a future where health services are widely available both in urban and rural settings, on a fee-appropriate basis, and offered to minority ethnic communities on a par with Burma’s ethnic majority.



Treating a child in IPD at a BPHWT clinic

## Back Pack Health Worker Team's Founders



### **Vision ~**

The vision of the Back Pack Health Worker Team is that of a healthy society in which accessible and primary health care is provided to all ethnic people in a Federal Union of Burma.

### **Mission ~**

The Back Pack Health Worker Team is a community-based organization established by health workers from their respective ethnic areas. The BPHWT equips ethnic people, living in rural and remote areas, with the knowledge and skills necessary to manage and address their own health care problems, while working toward the long-term sustainable development of a primary healthcare infrastructure in Burma.

### **Goal ~**

The goal of the BPHWT is to reduce morbidity and mortality and minimize disability by enabling and empowering the community through primary healthcare.



BPHWT's Leading Committee and Back Pack workers from different ethnic areas



BPHWT's 7<sup>th</sup> Conference and Annual General meeting

# Health Care for IDPs and Vulnerable People in Burma

## Healthcare Delivery within the Conflict Zone

*Violent conflict and human rights violations both increase the need for health services and create barriers to delivering health care. In addition to the obvious and significant dangers of working in conflict areas, Back Pack team experience challenges in reaching target populations. Frequent displacement of communities due to violence and development projects disrupt the continuity of BPHWT programs and worsen community members' ability to access health care and medicines. Even in ceasefire areas, obstructions to healthcare delivery persist due increased checkpoints, forced taxation and bribery. All this is added to already difficult access due to natural physical barriers, particularly during rainy season.*

*- Adapted from the BPHWT 2012 Annual Report*

The United Nations High Commission on Refugees (UNHCR) says this of Internally Displaced Persons (IDPs): *while IDPs may have fled their homes for similar reasons [as refugees], IDPs stay within their own country and remain under the protection of its government, even if that government is the reason for their displacement. As a result, these people are among the most vulnerable in the world* <sup>(12)</sup>

While the health situation in Burma is poor, the situation for Burma's vulnerable ethnic and IDP population is on even more precarious footing. Some IDPs are forcibly displaced from their land to make way for industrial or business interests, resource extraction or construction of military quarters or supply areas; others are fleeing physical harm and other human rights abuses. All IDPs and minority ethnic



Displaced families and neighbors hiding together in the jungle



Back Pack health workers use available resources to make a bed for a sick IDP



Back Pack health worker at an IDP camp

Burmese have had their lives radically compromised in the course of 50+ years of conflict.

In 2016, the Internal Displacement Monitoring Centre's global database cited a total of 1,153,000 people displaced in Burma due to conflict, violence and disasters; and an additional 490,000 refugees who left the country seeking a new life in one of Burma's border countries (UNHCR). 2017 promises to see a radical spike in these numbers as over 700,000 of Arakan State's Rohingya people have fled the country in the final four months of year alone.

There is a unique and dangerous health profile for the IDP. Political, environmental, economic and socio-cultural determinants of health are adversely influenced by conditions of conflict and displacement. Harsh living conditions and the struggle for survival present daily challenges. Exposure to on-going violent conflict and forced displacement impacts every aspect of physical and mental well-being:

#### Malnutrition/poor nutrition

- due to destruction of crops, food store or looting of food
- inadequate food to support all members of family/community

#### Exposure to/spread of preventable disease

- increased risk of TB, vector-borne diseases, STIs (including HIV/AIDS)
- illnesses such as diarrhea can easily progress to dehydration and serious risk to life
- diseases resulting from insufficient sanitation and disposal of human excrement
- increased acute respiratory infections due to unsanitary conditions, open fires, exposure to extreme temperatures, inadequate shelter
- serious illnesses swiftly become fatal illnesses

#### Disease/Illness due to insufficient supply of clean drinking water

- water-borne illness due to unsanitary water supply
- dehydration due to insufficient clean water

#### Complications in pregnancy/childbirth and lack of basic and obstetric care

#### Increased propensity to contract malaria and dengue fever due to increased exposure and inadequate shelter



IDPs set up camp

Denial of or severely restricted access to health services due to:

- damage or destruction of health facilities
- attacks on or obstruction to healthcare transports (referrals for more comprehensive care)
- intimidation of health providers and/or patients
- attacks of health workers and the subsequent looting or destruction of medicines and supplies

Greater risk of injuries specifically related to armed conflict:

- increased incidence of landmine injuries/deaths
- increased incidence of gunshot injuries/deaths

Mental health complications:

- due to physical and emotional stress, trauma and exertion
- due to lack of stability

Children under five, pregnant women and those whose health is already compromised are especially vulnerable to disease and illness under these circumstances. Currently only Ethnic Health Organizations (EHOs) and Community-Based Ethnic

Health Organizations (CBEHOs) are in a position to effectively offer support to these populations. Due to the tentative nature of the Nationwide Ceasefire Agreement (NCA), it's many brokered and broken agreements and the lack of trust between parties, the BPHWT remains a vital player in the on-going health needs of Burma's IDPs, rural and vulnerable ethnic populations. As the details of both the NCA and the National Health Plan are worked through, the possibility exists that health care on the village, tract and community level may be enhanced and supported by the Burma government. EHOs and CBEHOs serve a vital role both currently and in the future; the need for the BPHWT is as indispensable as ever.



Under attack, villagers leave home to hide in the jungle

# Understanding the Population Data

From 30 March to 10 April 2014, 100,000 census takers in Burma undertook the first census in 30 years. The theme of the census, “A Nationwide Census – Let us all Participate,” was sadly and predictably unrealized. Contrary to enhancing understanding of the population profile of the country, the rush to complete the census prior to 2015 elections resulted in a census that has promulgated profound inaccuracies and caused additional “strain on the peace process at a critical time.”<sup>(13)</sup>

The UN Population Fund (UNFPA) was the leading organization involved with creation and execution of the census, which was estimated to cost approximately USD 74 million to conduct. Although problems inherent in taking a census in Burma were known far in advance, identified concerns were not addressed nor were specific political and conflict-related risks acknowledged; ethnic organizations were never a part of the consultation, drafting and planning process.

The Census resulted in massive undercounts of the population in minority ethnic areas. Themes of inclusion, identification and access plagued the 2014 census: In Kachin, Northern Shan and Karen States in areas of active fighting between ethnic armies and the Burma army or in areas under the protection of ethnic armies, no data was collected. In Arakan State, those who asked to be recorded as “Rohingya” were instructed to identify as “Bengali.” If individuals insisted on being listed as Rohingya, the census taker collected no data whatsoever. Throughout the country, multiple discrepancies occurred including: listing of non-existent ethnic groups, ethnic groups listed under different names in different regions, pairs of ethnic groups

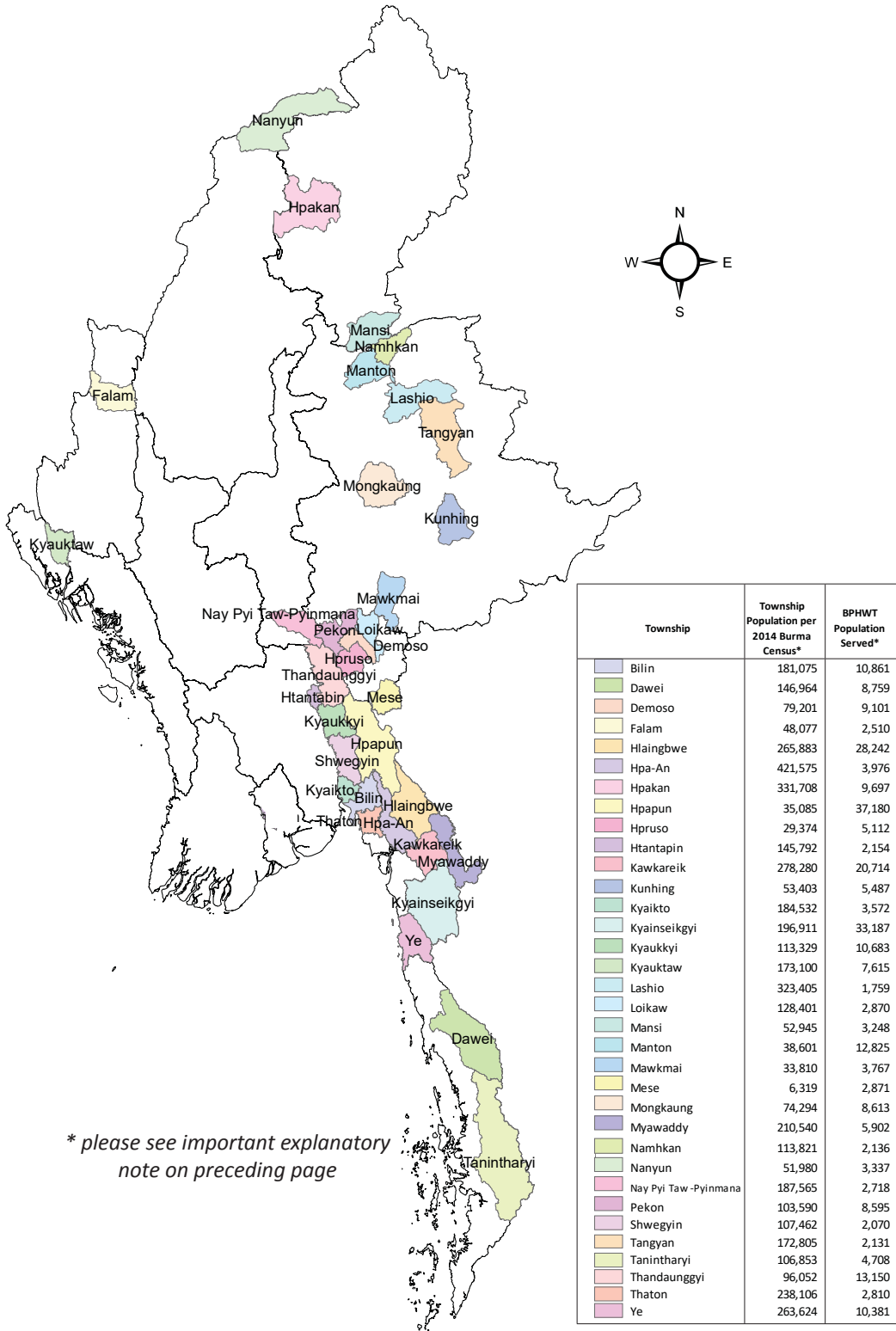
listed as one group, and confusion around naming of groups and sub-groups.

Census findings were first published in May 2015 with a subsequent update in December 2015. Although some townships noted a three-fold population increase in the update, the December data sported a caveat that numbers were “subject to change.” Although results failed to meet international standards, the 2014 Census remains the universally-cited population data for Burma. The census data on the BPHWT Service Areas map are from the December 2015 update.

Back Pack teams collect population data by house-to-house counts. The BPHWT-served population for Papun township is 37,180 persons. BPHWTs serve a portion of individuals within Hpapun township, not the entire population. The Karen Department of Health and Welfare (KDHW) also provides healthcare services for a portion of the population within Hpapun township not covered by the BPHWT. KDHW serves 51,193 persons <sup>(14)</sup>. The Burma census indicates a total township population of 35,085. Individuals served by the BPHWT and KDHW (still not the entire township population) total 88,373 minority ethnic people, *more than double that reported by the census*. This is but one illustration of the inaccuracy of the Burma 2014 Census.

*Since the intention of the 2014 Census was to support the development of policy and programs and to guide resource allocation for the people of Burma, the 2014 Census is not a reliable mechanism to do so. Minority ethnic people — especially those living in remote and vulnerable areas and conflict zones — have been widely under counted.*

# Map of BPHWT Service Areas



\* please see important explanatory note on preceding page



# Birth of the Back Pack Health Worker Team

## Traditional Beliefs, Modern Medicine

*A monk living at a monastery in the village became very sick. Everyone thought witches were visiting him. Parents and family all refused to touch him. When Back Pack health workers met him we did a blood test and found he had malaria. We treated the malaria and he became strong again. Then the community realized there was not a witch, it was just malaria.*

*-Sai Lao, Shan Field in-Charge*

The 1988 nationwide pro-democracy uprising in Burma, organized primarily by students, drew hundreds of thousands of students, monks, children and other

citizens to march and speak out against the repressive regime. The protests culminated in thousands dead and renewed crackdowns on the citizenry. It was amidst



Back Pack health worker providing Vitamin A to children



Patient referral requires several people and much care!



Patient referral through the jungle



Keeping a record of patient visits



Data collection is logged in a BPHWT field area

this environment that the future founding members of Back Pack Health Worker Team were emboldened to better the situation for Burma’s ethnic minorities.

One individual who fled Burma during this time was Dr. Cynthia Maung, Dr. Cynthia as she is fondly known. During her journey of seven days to the Thai border town of Mae Sot, Dr. Cynthia and others walked through countless villages where, upon hearing that she was a doctor, villagers rallied asking for care and treatment. Many of these villagers were struggling for basic survival; they had never enjoyed medical care of any kind. No entity was providing services to this vulnerable population. Dr. Cynthia was no stranger to the need for health care amongst Burma’s marginalized and rural



Back Pack health worker treating patient with boils

communities. Of her work at Moulmein Hospital where patients had to travel three to five hours by cart or boat to reach the facility, Dr. Cynthia states, “It became clear to me that for rural populations, preventive care was non existent and emergency services were not accessible. Government services were simply not accessible to all.”

(15)

Soon after arrival in Thailand, Dr. Cynthia established the Mae Tao Clinic (MTC). In 1991, responding to the massive need, MTC and partner organizations supported Mobile Medical Teams (MMTs), groups of ethnic health workers who journeyed into eastern Burma for six to eight weeks



Just born by Traditional Birth Attendant

to deliver health care and health care education. The MMTs carried all medicines, equipment and supplies in backpacks as they trekked through the jungle to reach remote villages. MMTs were joined by members of the local community who were familiar with the terrain and able to navigate safe passage, and who could also assist in building trust between villagers and traveling medics.

MMTs had diverse duties and were deeply engaged with the communities they served. Since MMTs could stay in one location for only a few days, it was essential that the health workers teach skills and



Delivering supplies through the river to the next Back Pack location

best practices to community members; practices that sometimes ran counter to traditional approaches to health care. When a patient needed to be transported elsewhere to facilitate more advanced care, the MMTs were tasked with explaining to local authorities why such a transport was necessary. After traveling for three to six months, MMTs returned to the MTC where they received additional medical training.

Over time, MMTs included health workers from ABSDF and other ethnic health organizations in Karen, Mon and Karenni



Back Pack health workers enjoy supporting their community!

States. In this way, access to healthcare services in remote and vulnerable areas near Burma's border grew. The MMTs operated from 1991 to 1997. As the Burma military increased attacks in the borderlands from 1997 through 1998, the challenges to providing safe and effective health care increased. Some workers were unable to safely reach villages that had grown to depend upon their visits; field clinics had been destroyed or could no



Weighing the baby

longer operate. In 1998, following a series of meetings amongst interested ethnic organizations, the Back Pack Health Worker Team was formally established: Working together would allow greater collaboration and standardization of services and health care delivery. The Back Pack Health Worker Team, a community-based, stable and sustainable organization, was prepared to take on the mantle of this work.



# New & Noteworthy: 1998-2018 Program Highlights, Lessons Learned, New Challenges to Address

## Introduction

The Back Pack Health Worker Team (BPHWT) was founded in 1998 with 32 teams, 120 health workers and serving a population of approximately 45,000 minority ethnic people. These dedicated health workers traveled three ethnic areas such as Karen, Karenni and Mon. Since that time, the BPHWT has steadily grown to encompass 113 teams, comprised of 456 medics, 799 Traditional Birth Attendants / Trained Traditional Birth Attendants (TBAs/TTBAs) and 281 Village Health Volunteers / Village Health Workers (VHVs/VHWs). We now support nearly 300,000 minority ethnic Burmese. Our efforts reach and contribute to the health and well-being of people in all seven states and three regions, encompassing 21 field areas.

The founders of the BPHWT were health workers from Karen, Karenni and Mon areas. Created to provide quality free or low-cost primary and conflict-specific

healthcare where it was not otherwise attainable, the BPHWTs provides a range of medical care, community health education and prevention, and maternal and child healthcare services to internally displaced persons (IDPs) and other vulnerable people in Burma.

Since the practice of medicine in Burma requires specific government-approved training, degrees and accreditation, it should be noted that merely working as a medic in Burma (and without such accreditation), is a revolutionary act; those who digress from this proscribed system are in violation of the law. There also may be a perception that anyone empowering the rural ethnic population with education and health care must be working for the ethnic army. Over the years, encounters between the BPHWT health workers and the Burma military have not always been cordial. the BPHWT health workers have at



Back Pack health worker cleans a wound



Villagers receiving healthcare by Back Pack health worker



A malnourished child with complications of measles receives care



EPI delivery by a Back Pack health worker



A large gash in the heel — before and after receiving care

various times been dealt with harshly: the movements of health workers have been impeded, workers have been harassed, questioned, medicines and other materials have been taken and destroyed, people have been arrested without cause, been assaulted, and killed. the BPHWT medics put their lives on the line daily in order to care for and educate their communities.

The BPHWTs now include 48 stationary teams or Public Health Centers. These teams staff “permanent” clinics, built where conditions are sufficiently stable and secure. Stationary clinics provide on-going care to more than twice the population than a mobile team is able to support.

Clinics include examination rooms, storage for medicines and some have additional equipment available such as an ultrasound machine. Notably, much like the villages they support, these clinics do not have electricity or running water. Equipment that requires electricity is powered by generator, which is used judiciously and on a strictly as-needed basis. Clinics are staffed by local BPHWT-trained community members; including an active network of VHV/VHWs and TBAs/TTBAs. The clinic network is helping to create an enduring infrastructure that empowers the community and ensures that adequate health care and education are endemic to the way of life.

### 1998-2003

The BPHWT's early years were characterized by a growth in staff, scope and methodology. From 1998 through 2001, all care was covered under the BPHWT's overarching Medical Care Program. Team medics responded to a variety of primary healthcare needs, chief amongst these being malaria, diarrhea and acute respiratory infection.

As early as **2000** medics reported evidence of increased interest in health-related issues and greater self-care amongst those they served. Villagers were asking more questions; they had greater understanding



It is a group effort to carry the concrete cylinders used in constructing water storage!

of the factors and healthy habits influencing better medical outcomes. Still, most had not yet fully incorporated these changes into daily routines. The challenges of a life of displacement shaped the willingness to do what was necessary for positive health outcomes.

Mid-year **2000** marked a change in data collection methodology and data points observed. In the first two years of the BPHWT's history, data collection was not standardized and there is little enduring and comparable morbidity and mortality data from this time. In 2000, the BPHWT partnered with Johns Hopkins University and a collection tool was devised that was used in all field areas. Teams of health workers mapped village tracts according to demography, geography and human resources. Although this particular method of data collection was not carried forward in subsequent years, this cemented the BPHWT's commitment to standardized, thorough data collection.

In **2000**, the BPHWT officially included Traditional Birth Attendants (TBAs) among its ranks, a critical role within the village. There were 55 TBAs in the BPHWT service areas at that time. Vitamin A and iodized salt was added to pregnancy care kits used by the TBAs. Although TBAs were added to the roster in **2000**, systematic training of this important group did not begin until four years later.

In **2001**, the BPHWT responded to its first documented emergency, a cholera outbreak outside the BPHWT area. A team of nearby medics launched an immediate response to Dooplaya, Karen State where 110 patients were treated, with 76 deaths. Unfortunately three other areas experiencing an outbreak were unreachable.



A child's hair is trimmed to allow head wound to be treated

The School Health Education Program (SHEP) was piloted in January **2001**. The program was established to address issues that came to light in the Water & Sanitation Survey: building latrines and hand washing facilities in schools, teaching about latrine use, brushing teeth, hand washing and distribution of iodized salt (for brushing teeth) and soap to schools.

In addition to teaching school kids about hygiene and clean/safe water, efforts were afoot for health education to the broader community. Toward this effort, the Women Employment Advance Education (WEAVE) supplied educational materials and posters. It soon became obvious that health

education in conflict zones required a very particular attention to safety. Under the assumption that they were working with ethnic armies to educate others, a villager caught with an education poster could be interrogated or harmed by the Burma military. Although the BPHWT workers knowingly assumed the risk of carrying educational materials, documentation and data, they had contingency plans for discarding this information if a risky situation arose. The villagers needed no further exposure to risk. It was decided that after workshops or teachings, posters would be left in public places – schools, monasteries, even on trees, so danger to individual villagers would be reduced.

In **2001**, reproductive data was collected for the first time with the intended use for a future Maternal and Child Healthcare Program. At this time, data points were not yet clearly defined and the integrity of documentation was variable. An important lesson was learned, those collecting data needed to be thoroughly trained to ensure consistent and usable data.

By the close of **2001**, the BPHWT counted among its ranks 60 teams comprised of 182 medics and 200 TBAs. The BPHWT became aware that many TBAs were illiterate and recording of data was both challenging and,



First an injection is made, then Back Pack health workers operate on this woman's large abscess

when it did occur, rife with inaccuracies. The Global Health Access Program (GHAP) and Dr. Cynthia Maung began work to develop a usable data collection system for TBAs.

Also in **2001**, five Back Pack teams were intercepted by the Burma military. All medicine and supplies were taken and one medic was arrested.

In **2002**, the BPHWT began the year with three distinct and targeted programs: Medical Care Program (MCP), School Health and Education Program (SHEP) and Maternal and Child Healthcare Program (MCH). In **2002**, the BPHWT was able to support, educate and heal 140,000 people!



BPHWT birth records include baby's footprint

was introduced. Also in **2003**, the home office in Mae Sot began a formal Capacity Building Program for staff training. *\*since the BPHWT was established in mid-1998, 2003 marks five complete years*

## 2004-2008

### 2004

In keeping with the mission to work towards a long-term sustainable development of a primary healthcare infrastructure and empower local communities, in **2004**, the BPHWT established the Village Health Volunteer training. These volunteers, trained at a more rudimentary level than the BPHWT's medics, provide on-going and locally-based support and care to their



BPHWT workers give hygiene education and distribute a toothbrush and toothpaste in school

In **2002**, the BPHWT began an extensive deworming effort. Higher incidences of worms are recorded as medication administration and closer monitoring identifies previously overlooked cases.

After five years\* in **2003**, the BPHWT had more than doubled the number of teams to 70, increased the number of medics to 250 and, for the first year, counted amongst its number 20 Maternal and Child Healthcare in-charges. A family planning program including education and distribution of reproductive health supplies



Concrete cylinders are placed to build the base of a latrine



Back injury is cleaned and drained

communities, in addition to assisting the BPHWT's medics whenever possible. By the close of **2004**, 204 Village Health Volunteers had received training. Although the BPHWT began training of TBAs in 2000, a need for more consistent and structured training had become apparent in the ensuing four years. This systematic training of Traditional Birth Attendants began in **2004**.

In addition, in the first center of its kind established by the BPHWT, a "Public Health Center" in Kayah and Kayan areas was established for outpatient care; it was staffed by two BPHWT medics and open five days each week.



Back Pack health worker administered to patient with allergic problem

Also in **2004** the School Health Education Program (SHEP; sometimes referred to as the Public Health Promotion Program) formally became Community Health Education and Prevention Program (CHEPP), a name that continues to this day. Thus, all three of the BPHWT's enduring Programs were firmly established: Medical Care Program, Community Health Education and Prevention Program, and Maternal and Child Healthcare Program.



Eye care is a routine component of primary health care

## 2005

An escalation of Burma military attacks on the Karen National Union (KNU) in the second half of **2005** led to widespread displacement and a doubling of gunshot and landmine injuries. One medic was arrested and imprisoned.

Extensive trainings were held in **2005**: 21 Village Health Volunteer trainings were offered with hundreds more volunteers joining the VHV ranks; 138 schools received educational sessions on water and nutrition with 381 teachers and 9409 students attending; and, 318 TBAs were trained. In December the BPHWT offered World AIDS Day activities for the first time, an effort that has continued yearly.



Back Pack health worker helps to clean this child's skin infection

### 2006

In **2006**, the BPHWT extended their service area with 6 teams serving Shan and Lahu areas. The BPHWT also received requests for support from Arakan and Pa Oh ethnic areas.

The use of para-check malaria test kit was introduced as a pilot program in **2006**.

The de-worming program, an important countermeasure against malnutrition, was extended to treat children as young as 1 year old.

A typical logistical challenge was encountered in **2006** with Vitamin A. Since Vitamin A cannot be purchased in

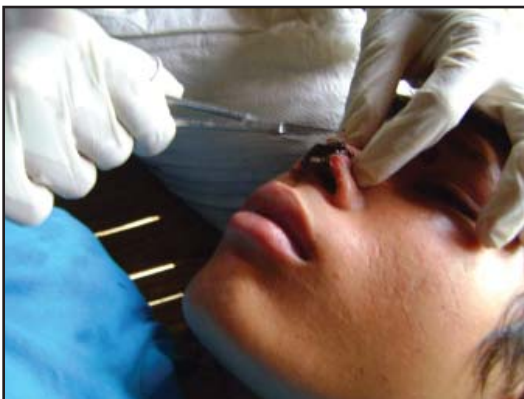
Thailand BPHWT relies upon international organizations and individuals to donate this (and other) important medicine. In **2006** an insufficient quantity was donated to meet the needs of the BPHWT's target population.

Repeated attacks by the Burma military had a profound effect on all areas of the BPHWT activities in **2006** — from health worker travel, to transportation of supplies, to health care data and documentation. In yet another related by-product of work within the conflict zone, three village health volunteers were arrested and jailed by the Burma military; other village health volunteers were forced to sign documents indicating they would no longer work with the BPHWT.

In four years, from 2002 to 2006, the BPHWT documented a 70% decrease in malaria morbidity; a marked 59% decrease in acute respiratory infections (average of mild and severe ARI); a marked 73% decrease in diarrhea and a 63% decrease in dysentery.

### 2007

**2007** saw greater growth and expansion as pilot programs were introduced in Arakan and Pa Oh areas and four teams were added to Shan and Lahu areas.



Necrotic skin is removed and nose is stitched up

Increased consciousness of gender inequity prompts the addition of the BPHWT gender policy and analysis and gender equity goals, recorded in **2007** and subsequent Annual Reports.

Although the para-check malaria rapid test was widely available, in **2007** malaria morbidity doubled in Dooplaya area due to forced displacement, food insecurity and lack of sanitation. An upsurge in violence led to further displacement and a doubling in landmine injuries in Karen State. Four teams had their medical supplies confiscated by the Burma military. Three medics were arrested.

**2008**

In **2008**, the BPHWT began detailing human rights abuses that the BPHWT communities experienced. These included the taking of residences for use by the military; enforced curfew and “lights-out” policy with military orders to shoot anyone breaking curfew; forced use as guides, porters, sentry duty, fence building and clearing roads for military; being forced to carry/deliver letters; forced to cut and carry bamboo trees; build camps and plant crops for troops; cook for troops. Regularly money was extorted from villagers; chicken or other food taken or

villagers were required to provide livestock and rations to the military on a regular basis. Burma military troops also freely took livestock without reimbursement and prohibited villagers from leaving the village under threat of death. If people refused to participate, they were fined or tortured. Human rights abuses are summarized in the BPHWT’s Annual Reports.

During **2008**, two villagers being used as guides stepped on landmines; one was killed, one lost his legs. Four villagers forced to carry food for Burma military troops stepped on landmines, two were killed, two lost their legs. One medic was arrested and released upon payment by family. One Maternal and Child Healthcare worker was arrested.

In **2008**, a lymphatic filariasis (LF) problem was identified in Mutraw, Kler Lwee Htoo and Thaton areas. In response, a pilot program was initiated in the Papun area of Mutraw where 71% of those tested were positive for LF. Half of the affected population was given medicine with the goal of providing medication for the other half and also those in Kler Lwee Htoo and Thaton areas in 2009.



Health workers take/record mom’s vital signs while curious on-lookers watch



A new group of Trained Traditional Birth Attendants graduates!



Multiple lacerations on this man's leg are cleaned and sutured

Aspotlight on eye care prompted a workshop attended by 24 medics on eye anatomy, vision checking, refraction and pinhole making. The BPHWT began providing eyeglasses for TBAs, many of whom were elderly and with failing eyesight.

As the BPHWT hit the 10-year mark in **2008**, the BPHWT had grown to 78 teams comprised of 290 medics; in addition, the BPHWT was now working with 570 TBAs, and 413 VHV's. The service area had expanded to include Karen, Karenni, Kayah, Kayan, Mon, Shan, Lahu, Arakan and Chin areas for a total of 160,000 served annually.

### **2009-2013**

#### **2009**

In advance of the 2010 elections, **2009** saw increased militarization and attempts by Burma military forces to convert ethnic organizations into emissaries under Burma military control. Increased conflict caused instability, forced displacements and increases in human rights violations — a challenging environment for the BPHWT's communities and health workers alike.

Still, need for the services that BPHWT provided could not be curbed, and a pilot program was established in the Pa Oh area.

A flu outbreak in Lu Thaw township, Papun District was all the more devastating due to a Burma military lock down and "shoot-on-sight" policy. Between September and October **2009**, the flu spread to 35 villages. The BPHWT worked in collaboration with the Karen Department of Health and Welfare and the Pa Hite Clinic to mount a response to the epidemic. A Thai hospital also contributed to the effort with the donation of influenza test kits and diagnostics.

#### **2010**

In **2010**, three new teams were deployed to Kachin, Shan-Kayah and Palaung areas. In July, a medic was killed by an Burma military attack in Karen State.

The BPHWT worked in collaboration with the Burma Medical Association, National Health and Education Committee and health organizations serving Karen, Karenni, Mon, Shan and Palaung communities to plan, design and implement a health and human rights survey in Eastern Burma. The results of the study were published in October **2010** as *Diagnosis: Critical — Health and Human Rights in Eastern Burma*.

Following November elections, armed conflict and human rights violations soared. Many rural ethnic communities were



As part of her routine care, a woman with a large goiter has her blood pressure taken

displaced and a mass exodus in Eastern Burma surged toward the Thai-Burma border. Working with the Mae Tao Clinic and Burma Medical Association, mobile “outpatient department clinics” (OPDs) were established near the border to offer health care and assistance to displaced people; each OPD was stocked with medicine and supplies and staffed with 3-5 experienced medics.

### 2011

In **2011**, four new Back Pack teams were created to serve in Palaung, Arakan, Kayan and Shan-Kayan areas; 2 teams in Lahu area were discontinued. Two medics were arrested and detained for nearly three months.

Malaria treatment changed to use of first line drugs: artemisinin combination therapy led to an 18% decrease in malaria morbidity since the previous year; under 5 years old morbidity decreased by 35%. Screening for malaria became a routine aspect of preventative care for all pregnant women; when possible, women were screened twice during pregnancy.

Also in **2011**, the BPHWT offered its first trauma management training course focused on emergency and conflict-related health care.

### 2012

Twelve new teams were added to BPHWT in **2012**, in Palaung, Kachin, Pa Oh, Shan, Win Yee, Papun, Kler Lwee Htoo, Kayah and Dooplaya areas.

The BPHWT mounted emergency responses to three health and natural disasters in **2012**:

Flooding in Kyauk Kyi Township in Kler Lwee Htoo area caused food shortages, tainted water and poor sanitation. The BPHWT responded with provisions of rice, chlorine, soap and a workshop on hygiene, sanitation, clean water and disease prevention.

A measles outbreak in Pa An District effected about 500 people in three villages. Six BPHWT health workers offered a coordinated response with the Karen Department of Health and Welfare and the Karen National Union; about 20% of the effected population was treated.

In Tae Bo Hta and 10 nearby villages in the Papun area, an influenza outbreak affected



Infected wound is cleaned and drained



Stones of multiple sizes are gathered and prepared for use in a water filter

4,107 people. Seven health workers and one VHV responded to provide treatment.

In a 2010-2011 review and evaluation of the BPHWT's work, the Burma Relief Centre (BRC) noted that medics are limited to a stay of one to three days in any one village due to the need to travel to other villages on their route. In the effort to create more continuous health care, the BRC recommended that the VHVs receive additional training in tasks involving greater expertise and responsibility (thus extending training to three months, rather than one month) and be called Village Health Workers (VHWs). This would empower the VHW to treat common diseases, provide follow-up treatment and determine within 24-hours of an individual with fever tested positive for malaria and begin immediate treatment. Training for VHWs began in **2012**.

The BRC review also suggested that TBAs receive additional training and be called Trained Traditional Birth Attendants (TTBAs); 57 TBAs received this follow-up training in 2012.

In the light of ongoing peace negotiations in many ethnic areas of Burma, several health-related organizations came together in **2012** to form the Health Convergence Core

Group (HCCG). The HCCG seeks to develop a plan to converge the extensive network of community-based organizations, ethnic health organizations and border-managed health systems with the Burmese national health system and to form an inclusive and thorough delivery of healthcare. For more information on the work of this important group, see "Building Coalitions for Lasting Change."

### 2013

On-going stability and security supported the growth of the BPHWT's stationary teams in **2013** with 24 new Public Health Centers established in Shan, Karenni, Karen and Mon States and Tenasserim region. Five new mobile Back Pack teams were formed to support Papun, Pa Oh, Kayan and Kler Lwee Htoo areas.

In response to an assessment on maternal health and malaria management, the BPHWT collaborated with Pa An-based Phalon Education and Development Unit (PEDU) and the retired Government Township Medical Office Nursing Matrons to offer an extensive Auxiliary Midwife (AMW) Training as a pilot project. The training consisted of four months of classroom instruction followed by a clinical training of three



Laying pipes through the jungle to bring clean water to the village



BPHWT supplies are piled high and ready for transport

At the close of **2013**, the BPHWT had 100 teams comprised of 351 medics. They were joined by 696 TBAs/TTBAs, 417 VHV/VHWs for 225,000 people served.

**2014-2017**

**2014**

On-going clashes in Kachin State and Northern Shan State presented challenges to the BPHWT and the villages they served in **2014**. Especially in the Palaung areas of Northern Shan State, the increased needs of displaced villagers added to the challenges of service delivery.

months at the Mae Tao Clinic. Following the training, new AMWs returned to their communities to implement a Maternal and Child Healthcare Program as outlined by the BPHWT. Both the survey and the pilot project were conducted under the aegis of the HCCG. Under government's Rural Health Center structure, AMWs are not permitted to perform deliveries unassisted, they must work with a midwife. However, since there is only one midwife for every 20,000 people, this arrangement is unsustainable; AMW do in practice perform deliveries solo. Increasing the number of well-trained AMWs is one means of providing readily accessible and much needed care.



Regular antenatal visits can help prevent problems



RH awareness raising by MCH supervisor

In areas of temporary ceasefire, medics were able to travel more freely but encountered frequent checkpoints and interrogation by Burma military. Acting with caution due to military presence, some medics altered planned activities. In the final quarter of **2014**, health workers in the Arakan Field Area were stopped and questioned by the Burma military; they were told they needed to obtain permission from local authorities before engaging in their activities.

In the Pa Oh field area, armed conflict between two Ethnic Armed Organizations



Tubing is placed throughout the village to bring clean water to all

and the presence of land mines restricted access to a local village; medical services could not be provided.

In **2014**, the BPHWT began use of the SD Bioline test. This comprehensive malaria test checked for both plasmodium falciparum and plasmodium vivax malaria, thus supporting immediate treatment.

Also in **2014**, both the presumptive and tested malaria caseload decreased dramatically to 2,308 (1%) and 1,614 (<1%) cases respectively.



Providing humanitarian assistance to Cyclone Nargis victims

Also in **2014**, Maternal and Child Healthcare Program recorded the fewest maternal deaths since the program's inception (2004) and the fewest number of still births/abortions/neonatal deaths.

### 2015

In **2015**, the Emergency Assistance and Relief Team (EART) was repeatedly pressed into service. The EART is the emergency response unit of the Forum for Community-based Organizations of Burma (FCOB). FCOB functions as a collaborative group offering assistance to the ethnic community along the Thai-Burma border who have experienced natural or man-made disasters.



Thumbprint sign-in to receive foods offered through the BPHWT's antenatal nutrition support program

- In June, land confiscation and the destruction of homes, food stores and personal effects in Upper Kawt Yin in Pa An township prompted the EART to supply rice, oil, mats, blankets, and mosquito nets to 83 households/393 people. The BPHWT provided support in collaboration with the 88 Karen Generation Student of Development Social Association. Local villagers offered guidance on geography and security concerns.



Villagers listen to health worker at a BPHWT Family Planning Workshop

- In July, fighting between the Burma military and the Democratic Karen Buddhist Army (DKBA) along the Asia Highway near Kaung Mu Village led to displacement of 61 households/359 people. The BPHWT delivered emergency rations.
- In late July, heavy rains caused massive flooding. The BPHWT and partner organizations provided rations, clothing, chlorine, personal hygiene

items, protective sheeting, mosquito netting, water containers and other needed supplies.

- In October, the Burma military attacked Shan State Progress Party (SSPP)/Shan State Army-North near Wanhai Village, Monghsu Township after the later refused to withdraw soldiers from that area. Approximately 6000 people were displaced. The BPHWT provided medicine and hygiene kits through a local partner, the Tai Youth Network.



Expectant moms and kids receive yellow bean, eggs and oil to support a healthy pregnancy

- Further rains in October caused a landslide in Mawchi Taung Paw village, Hpa Saung township in which 17 people died, 48 were injured, 30 were missing and 4,000 were forced to relocate. The BPHWT worked with youth community service organizations to deliver tinned fish, cooking oil, rice and blankets. The EART also delivered emergency medicine and hygiene kits.



Informational posters cover the walls of a BPHWT clinic

In February **2015**, the Health Information System Working Group (HISWG), a consortium of organizations that provide



Baby with a fever receives a sponging

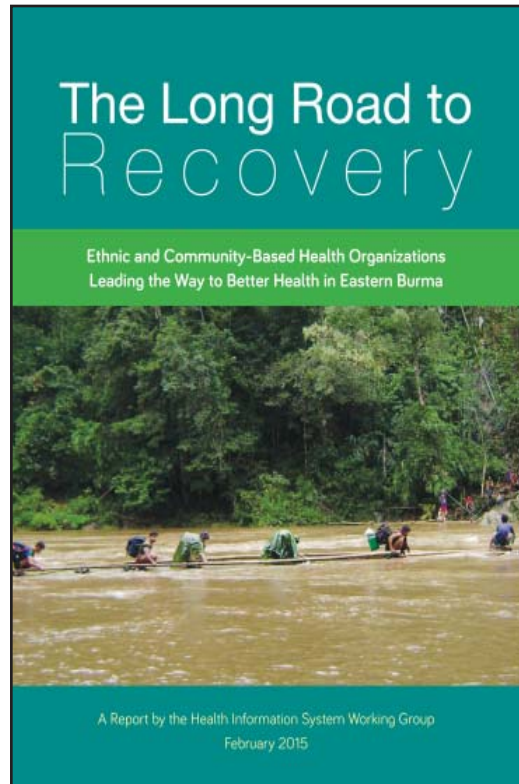
Eastern Burma Retrospective Mortality Survey (EBRMS) in Eastern Burma, published the results of a study entitled, *Long Road to Recovery: Ethnic and Community-based Health Organizations Leading the Way to Better Health in Eastern Burma*. Due to their finding that in 2013, 11.3% of women of reproductive age were moderately to severely malnourished, BPHWT's Maternal and Child Healthcare Program began providing oil, yellow bean, eggs, canned fish, dried fish, iodized salt and sugar to pregnant women. The Program offered support to pregnant women in 4 field areas to combat malnutrition and improve pregnancy outcomes.

In **2015**, the NLD's Election Manifesto outlined several healthcare priorities that would lead toward the creation of a universal healthcare system in Burma. The role of ethnic and community-based health organizations was noticeably absent, as was any mention of a movement toward a decentralized, inclusive system of health care. (This document has since been replaced by the NLD's National Health Plan, published in December 2016.)

## 2016

Responding to critical and unmet need in the target population, the BPHWT offered two mental health workshops to health workers in **2016**.

In **2016**, the Back Pack health workers reported being stopped at checkpoints with increased frequency. Often they were required to present official documents and pay fees in order to proceed with supplies. This occurred in several field areas. In some areas the fee was dependent on the discretion of the officer on duty, in other locations, health workers were also required to obtain permissions from immigration, police and township General Administration Department prior to conducting a training. This is adding to mission costs and health worker delays.



Health and Human Rights survey report



Many modes of transportation are used by Back Pack health workers to reach to communities

As widespread drug use, especially with yaba and heroin, has been reported in the BPHWT tracts, the BHPWT is considering the best response to the growing drug addiction problem and the resultant difficulties it creates. Increased drug use and addiction has been accompanied by a spike in the violent crimes of rape and homicide. The Back Pack team often encounter drug-addicted villagers when they become ill with diarrhea or other addiction-related side effects; health workers provide treatment of these side-effects when possible.

In **2016**, a measles outbreak occurred in the Nanyun and Lahe Townships in the Naga Field Area.



Skin is thoroughly cleaned prior to treatment

A medic from the Lahe Hospital administered treatment to the children. In addition, a medic was dispatched from the Burma military who unfortunately arrived with insufficient medicine to address the affected population. The BPHWT's field in-charge and second field in-charge were able to offer treatment to an additional 100 households in Kel San village, Nanyun Township. The outbreak was finally contained.

Also in **2016**, the BPHWT established the first Village Health Committees (VHCs) in Win Yee, Kawkareik, and Pa An field areas. The VHC serves to empower the local



Burns on this baby will be closely monitored to ensure they stay clean and uninfected

community by embodying participation and the on-going, sustained development of primary health care and positive health outcomes. The VHCs are responsible for patient referral, encouraging community empowerment and participation, providing health education and oversight of clinic management, ensuring community sanitation needs are met, and coordination with CBOs and NGOs. VHCs are also tasked with organizing quarterly regional meetings to communicate their activities to the local community and seek input. Twenty VHCs have been established thus far with 198 participants.



In order to treat skin infection, dead skin is gently cleaned away

In **2016**, the BPHWT had grown to 113 Back Pack teams (including 48 stationary Public Health Centers), comprised of 359 health workers; also on the team were 741 TBA/TTBAs, 215 VHV/VHWs, and a total of 244,410 people served. Primary and conflict-specific healthcare was provided in Karen, Kachin, Kayah, Kayan, Mon, Shan, Lahu, Arakan, Naga, Pa Oh, Palaung and Chin areas; Tenasserim Division and, portions of Bago and Sagaing Division.

### 2017

In **2017**, the BPHWT recorded a record 4,144 deliveries. Of these, there were only two maternal deaths and eight neonatal deaths. While any deaths are too many, these numbers indicate vast improvements in antenatal care, nutrition, and well-trained birth attendants.



A broken arm is stabilized with a bamboo cast

The BPHWT added three additional field areas to the MCH Program for nutritional support to pregnant women. The BPHWT now offers nutritional support to Taungoo, Thaton and Papun areas in addition to Pa An, Kawkareik, Win Yee, Dooplaya field areas. In its height, in August **2017**, the BPHWT offered food supplementation to 1,144 women; 33% more women than the BPHWT was able to support in its busiest month in 2016.

In **2017**, the BPHWT offered gender-based violence workshops to community



For BPHWT's CHEPP, latrines, tubing and other supplies are stacked and ready for transport on the river

members; a subject that had been introduced in previous reproductive health workshops, but never given its own platform.

In May and June **2017**, the EART responded to a dengue hemorrhagic fever outbreak in the Kayah Field Area. Three villages and 849 people were affected. Health workers provided treatment to 231 villagers, performed demographic analysis and offered health education.

Multiple efforts are afoot in the BPHWT areas to provide a shared delivery

### **Government-Instituted Health Care to the Rural Ethnic Population: not a formula for health**

*The Burma Government opened a health clinic in the Palaung Field Area at Tar Nay Village with two government health workers. However, the government health workers do not staff the clinic full-time nor do they speak the local language. The clinic poses some obstacles to the continued delivery of the BPHWT health services as requested by the local community. Also in the Palaung Field Area, there is a concern about the safety of Back Pack health workers delivering needed medical treatment and conducting health workshops due to the encroaching presence of the Burma Army.*

*- Adapted from the BPHWT 2014 Annual Report*

of healthcare, with varying levels of cooperation and success. (To read more about how the BPHWT envisions collaboration and partners as we move forward please see sections: Building Coalitions for Lasting Change and Fulfilling Our Promise: the BPHWT look toward the future.) What follows are a few examples:

- In the Mon Field Area, the BPHWT delivers babies while a Burma government midwife provides birth records (at fee of 1,500 - 3,000 Kyat). Also working in this area are two INGOs: The American Refugee Committee (ARC) and Community Partners International (CPI). ARC and CPI provide malaria testing and cover

costs of transportation and travel for their volunteers; serious malaria cases receive hospital referrals. For all other cases, ARC, CPI and the BPHWT work together in patient treatment.

- In the Kayan Field Area, the Back Pack team perform deliveries and Burma government midwives provide free birth records as well as immunizations for women and children. The Karen Baptist Church runs a malaria program.
- In the Pa An Field Area, near the Noh Kwee Back Pack clinic, a local monk has set up a sub-township health



Gloved medic stitches up a back injury



An intake interview is a first step in every medical consultation



A new and exhausted mother receives a blood pressure check

kyat). The Burma government has established a clinic near the Kwin Ka Lay Back Pack clinic. The government clinic provides immunizations, maternal and child healthcare and treatment. Government health workers receive pay of 100,000 - 200,000 kyat per month.

- In the Thaton Field Area, the Back Pack team deliver babies and provide birth records. The Burma government also provides birth records (for a fee of 3,000 kyat). The BPHWT's birth records are not recognized by the

center in Pa Khoh village. To help fund the health center, each household in the village is required to pay 6,000 kyat.

- In the Ta Naw Hta Back Pack team in Kawkareik Field Area, the Democratic Karen Benevolent Army has set up a clinic with five health workers; one worker is a trained community health worker, and the others have not completed basic medical training.
- In the Dooplaya Field Area, Burma government health workers provide birth records for a fee (3,000 – 5,000



A healthy lifestyle includes a healthy weight

Burma government. This has led to some individuals having two birth records. There is no communication between government health workers and the BPHWT health workers. When in the same village, government workers communicate only with the head of the village. In this same field area, the UNICEF has established a clinic near the Kyat Kart Chaung Back Pack clinic. The UNICEF provides maternal and child health care, immunizations and general treatment. The UNICEF operates independently and with no communication with



An accurate inventory requires counting all received medicine and supplies



Baby with complications from chickenpox



Villagers wait to see the Back Pack health worker

either the government workers or BPHWT.

though not exclusively, held by women.

In **2017**, 59% of all positions in the BPHWT were held by women, exceeding the BPHWT goal (stated in the BPHWT's by-laws) by 9%. This does not include Traditional Birth Attendants, a role that is traditionally,

At the close of **2017**, the BPHWT had teams dispatched to 21 field areas. These 113 teams are comprised of 456 health workers, 799 TBA/TTBAs, and 281 VHV/VHWs. A total of 292,741 people were served in BPHWT's targeted areas.



BPHWT works with Dr. Saw Nay Hser from the KNLA medical branch to provide eye surgery.



Back Pack health workers travel to next village for medical care

# Testimonials From BPHWT's Field Areas

## Testimonials from the Kachin Back Pack Teams

In 2017 a villager in the Wa Ra Zap village, Hpa Kant district, suffered for more than one month from hand pain caused by infection of an insect bite. He treated his hand pain with traditional medicine at his home. However, he experienced extreme hand pain so he went to the government's clinic at Wa Ra Zup village. There the clinic staff told him he needed surgery for his hand and to go to Myint Kyi Nar Hospital. Upon hearing this the patient experienced stress and became depressed that he would lose his hand; he also did not have enough money to get the suggested treatment. It

was at this time that he came to the BPHWT clinic. The BPHWT's medic consulted with the patient; the patient trusted the BPHWT medic. Through this process the patient understood and accepted the medic's treatment. The medic performed the hand surgery and the patient's hand healed. Currently his hand function is normal and he is happy to be back to his life as before. The community accepts and relies on the BPHWT because BPHWT health care services are efficient and achieve the desired results



Kachin Field In-charge is providing surgical treatment to a patient in Kachin Field Area

# Testimonials from the Pa An (Karen) Back Pack Teams

NAME: Saw Myint Htwe

ETHNICITY: Karen

JOINED BPHWT IN: 2012

POSITION: Pa An Field In-Charge

## Meaning of Time

Time is a value of people which has been recognized by philosophers. But I don't know how time has meaning for me because I don't have a timetable like other people to go, to come, and to eat. Everyone has time. As for me, I would like to get free time like other people, but I can't seem to get it. Time is very difficult for health workers like me. In morning, I must spend my time such as for cooking, preparing food for my child, and taking them to school. After that, it's time to go to my work which is my pleasure.

At a time one day in the morning, I heard the telephone ring while I was preparing food for my child. I thought it was maybe a patient telephoning me. It was as I had thought. This call to me was by one of my pregnant women to deliver a baby. It was an emergency case. So I had to go immediately

to my patient's house.

Because of raining season, it's very difficult to travel to my patient's house since she lives in other village. But she needs my help to save her life; so I keep going. When I arrived at the patient's house, I did an examination and took other history. Then when I got the results from that, I saw that the patient needed to be referred to the hospital. I asked the patient's family to find a car and bring the patient to the hospital. We needed a lot of people to follow us because transportation is not easy - if the car stops and faces any problem on road, we need people to push the car. Also when we arrive at hospital and if the patient needs a blood transfusion, we may get blood from them.

When we arrived at the hospital, we hoped that the patient would be safe in delivery there. We needed the doctor to exam and operate on the patient quickly. We were very worried about the patient when she went into the operating room. Then the patient came out from the operating room and we saw that both the baby and mother were healthy – there were no problems with them. So we became very happy. After we saw that the patient and baby were in good condition, we returned to our village. Thus, it is difficult for health worker who want to give good health care to their community to have a personal timetable like other people. Because of this, it is also not easy for health workers to have free time.



## Testimonials from the Thaton (Karen) Back Pack Teams

Saw Thein Tan and Naw Tha Dar, who live in Thaton District, Tha Gay Laung village tract, Min Saw village, delivered Naw Tha Yu Paw in Thaton Public Hospital on 28 November 2016. After the delivery, a tumor was found growing inside of the baby's nose as a result of congenital disease. Therefore, we had to refer the baby to Yankin Children Hospital. The doctor there said the situation was very

worrisome for the baby. I had planned to go back as soon as I made sure the mother and the baby had safely arrived to the hospital. However, I decided to accompany them because the mother was sick and did not understand or speak Burmese. The baby did not sleep the whole night and always started crying if I was not holding her. When she cried, I looked at the fluid dripping from her tumor and started crying too. I stayed with the baby for ten days in the hospital without sleeping. After doing a physical examination, we had to refer the baby to a better hospital. The doctor at that hospital said "the baby is too young to do a surgery on her, but come back once every week for examination". The family's income was mainly from farming so they could not make it to this appointment schedule because of financial issues. I suggested that they go to Mae Tao Clinic instead. On 16 January 2017, the family decided to go to MTC. After examining the baby, MTC referred the baby to Chiang Mai Hospital on 17 January 2017. Presently, the mother and the baby are being cured at Chiang Mai Hospital. The family later thanked me for the medication given to their child. I could not donate any money for the baby, but I feel good for myself that I was able to help the family by the referral to Mae Tao Clinic.



A mother with her child who is suffering from congenital disease



# Three Sustaining Programs, Three Major Illnesses

## Back Pack Health Worker Teams Sustaining Programs:

**Medical Care Program**

**Maternal and Child Healthcare Program**

**Community Health Education and Prevention Program**

### Health is Wealth

*The community needs to know that health is important! If you have a health problem, you can lose everything. Health literacy means how to implement good health for the people. Prevention and education is what we want to teach.*

*- Khaing Myo San, Arakan Field in-Charge*

The BPHWT employs a variety of measures and practices that enable prevention and treatment of disease and illness, a system of referral for cases beyond the capability of its workers and other programs to support sustained health and sanitation in the community. This work is embodied in three main programs: Medical Care Program, Maternal and Child Healthcare

Program, and Community Health Education and Prevention Program.

The BPHWT's pillar and original program is the **Medical Care Program (MCP)**. Workers are trained to care for and actively track 32 categories of illness and injury. In addition to provision of care and necessary medicines, the MCP includes facilitating



Assembling pipes to bring clean water to the village



Working at night without electricity is an additional challenge for Back Pack health workers.

Electricity is essential to strengthen the health care system.



In dry season, risk of acute respiratory infections increases

referrals when a situation is outside the scope of the BPHWT health workers and responding to disease outbreaks and other emergency situations. The **Maternal Child and Healthcare Program (MCHP)** was established in 2000 and provides care and nutrition to pregnant woman during the course of their pregnancies, post-natal support and care to infants and children up to age 5. This program includes training for locally-based Traditional Birth Attendants. Also included in the MCHP, are family planning activities, reproductive awareness programs and gender-based violence education to address these urgent concerns amongst its target population.

The **Community Health Education and Prevention Program (CHEPP)**; an expansion of the School Health Education Program pioneered in 2002) offers workshops and education-related activities both within schools and to entire communities. Workshops are offered on a variety of topics, including: malaria and diarrhea prevention, hygiene and sanitation, malnutrition education and reduction, high-risk pregnancy, breast feeding best-practices, HIV/AIDS education, nutrition awareness, WASH (water, sanitation and hygiene) awareness, and prevention and awareness of communicable diseases. As an adjunct to educational offerings within schools, the BPHWT has instituted a Nutrition Sub-Program which provides de-worming medicine and Vitamin A to school children. Also included in the CHEPP is the Water and Sanitation Sub-Program, established in 2005. The Water and Sanitation Sub-Program assists villagers in building gravity flow water systems, shallow wells and latrines. Village Health Committees (VHCs), a newer component to the CHEPP, meet quarterly with the community and enhance participation, ownership, and sustained support for primary health care on the village level.

## Tracking morbidity across three prevalent illnesses



Testing for malaria

The Back Pack workers are trained to respond to a variety of illness, disease and conflict-related injury. In addition, when a patient is in need of more intensive care, equipment, or medicine than the BPHWTs can provide, team members will endeavor to arrange a transfer to a facility better equipped to deliver care. This is no simple matter as jungle, mountains and torrential rains create environmental challenges, while active combat and roadblocks create barriers of a different kind. Under

the best of circumstances the portering of a sick and injured patient, carried in a sling that is borne on the shoulders for a potentially days-long walk, is difficult and dangerous for both patient and porters. For the patient who needs immediate and emergent care, time in transport and the conditions of travel can worsen illness or even hasten death. The job of the porter can be demanding and relentless.

The health issues contributing most significantly to morbidity and mortality in BPHWT field areas are malaria, diarrhea, acute respiratory infection, anemia, worm infestation and conflict-related injury. Three types of illnesses, and trends toward wellness are traced here over our 20-year history: malaria, diarrhea and acute respiratory infections (ARI).

## Malaria

In 2015, of the six countries in USAID’s Greater Mekong Sub-region (Burma, Cambodia, China/Yunan Province, Lao People’s Democratic Republic, Thailand and Viet Nam), 75% of all recorded cases of malaria were in Burma <sup>(16)</sup>. In addition, the Thai-Burma border has the distinction of being the area with the most drug-resistant falciparum malaria in the world. During rainy season malaria rates typically skyrocket, raising the incidence of malaria as much as 30% <sup>(17)</sup>. In an effort to frame its commitment to addressing this problem, Burma has signed on to a National Malaria Elimination Project, seeking to eradicate malaria in Burma by 2030 — a tall order considering the prevalence of disease in

many border areas.

In the early years, the BPHWT provided the only opportunity for malaria testing and treatment for its target population. The BPHWT documents a promising trend of improvement in disease transmission, detection and management. Over 300 townships are still considered “high risk” (defined as greater than 1 case per 1000 people) — especially in Kachin and Rakhine States and Sagaing Region <sup>(18)</sup>. However, those in the BPHWT field areas have noted a steady and striking improvement in malaria rates. These figures point to more than a promising trend, they indicate a spectacular improvement in the BPHWT



Villagers gather to receive Long Lasting Insecticide Treated Nets (LLITNs)



LLITNs for youngest members of the family is a BPHWT prioritization

field areas: from 2003 to 2017 a 93% improvement was documented in number of cases per 1000. (It should be noted that in data in 2003 and 2004 reflects numbers for presumptive malaria only; testing began in 2005.) For the 10 years from 2007-2017, a 89% improvement was documented, from 76 cases per 1000, to fewer than 9 cases per 1000. This improvement embodies change on multiple levels: incorporated shifts in habit and attitude with respect to preventative practices as well as increased access to testing and medicine. It also reflects communities that have greater stability and thus conditions that support

comprehensive and on-going attention to malaria prevention.

Multiple actors from a variety of countries, NGOs, INGOs and the Burma government are currently involved in malaria prevention, treatment and eradication efforts in Burma. The Back Pack team serve in some areas where other malaria services are offered; in these locations coordination of efforts is handled with varying degrees of success. Some examples are mentioned in the section entitled: “New & Noteworthy: 1998-2017 Program Highlights, Lessons Learned, New Challenges to Address.”

## Diarrhea



Good hygiene, including trimming nails, helps avoid the spread of disease



Sick child is examined

Like many of the most prevalent diseases amongst the BPHWT communities, diarrhea is easily preventable given the proper conditions. However when water may be contaminated, sanitation poor and education lacking on how to swiftly replenish depleted bodily fluids, diarrhea can become a medical emergency. Worldwide 2,195 children under 5 years of age die each day from diarrhea-related problems — more than deaths from AIDS, malaria and measles combined <sup>(19)</sup>. Persistent or frequent episodes of diarrhea can effect childhood growth and development <sup>(20)</sup>. Of these deaths, 88% of the cases of diarrhea are attributable to tainted water or poor sanitation <sup>(21)</sup>.

While these reports focus on children, the dangers to adults of contaminated water and poor sanitation are just as deadly. And, adults without adequate sanitation practices further risk impacting the health of countless others, as they prepare food and handle objects at home and in the community. The BPHWT's Breastfeeding Workshops contribute to a lowering of



Villagers pitch in to build a concrete water storage

diarrhea because as mothers move away from water-based sources for infant feeding, the risk of contamination lowers dramatically.

For vulnerable communities living in conflict zones, lack of stability may compromise the efforts necessary to ensure thorough sanitation, clean water and sustained beneficial hygiene habits. Individuals forced to flee on a regular basis may not have the opportunity or the will to build permanent structures that support good health. Others

may not be able to afford the necessary materials for such construction. This is exacerbated by encroaching development interests that are introducing pollutants into groundwater and toxins to the air.

Under adverse conditions, diarrhea management and treatment becomes vitally important as effects can soon create a critical and life-threatening situation. The BPHWT treat diarrhea and also provide education to communities, especially to those living within challenging circumstances, to create the best possible environment for health to flourish. Toward this end, the Community Health Education and Prevention Program (CHEPP) teaches about personal hygiene and how and where to build wells and latrines. Over the years the BPHWT has lowered the rate of diarrhea by 57%; still, in 2017, 18 of every 1000 people experienced diarrhea. This number has fluctuated quite a bit over the years as conditions (both environmental and human-made) have changed. There is still much work to be done. Without sustainable peace and sovereignty over one's land and community, the struggle to manage diarrhea will continue.

## Acute Respiratory Infection (ARI)

Respiratory infections are those infections of the upper airways (ear, nose, throat, trachea and bronchi), and the lower respiratory tract (lungs and smaller airways). These infections can be viral, bacterial, parasitic or fungal in origin and, depending upon location and origin, will have different treatment protocols.

While upper respiratory infections spread quickly and their effect may be widespread in any given community, their burden is relatively minor and rarely life threatening.



Back Pack health worker examines a child



School health receive Vitamin A

The majority of ARI deaths and severe illnesses are acute infections of the lower respiratory tract, especially pneumonia. This disproportionately affects the under 5-year-old population, the elderly and those with compromised immune systems. However, amongst populations where there is a high degree of malnutrition, inadequate shelter due to displacement and/or destruction of one's home, low rates of immunization or delays in immunizations, diagnosis of

critical disease, exhaustion/fatigue and the physical and psychological stresses of life in a conflict zone — all of these create a pre-disposition to pneumonia and other ARIs. The same factors that affect ARI infection also increase the risk of ARI transmission and progression and severity of disease. In short, amongst the vulnerable populations BPHWTs serve, ARIs are a pervasive concern.

Many of the conditions driving ARI are outside of the control of the BPHWT. From 2003 to 2017 the BPHWT improved upon nearly 98 mild ARI cases per 1000 people, to 63 mild ARI cases per 1000 – an improvement of nearly 36%. Severe ARI, much more challenging to mitigate and more virulent when present, improved by a more modest, yet still significant 27% over this same time period. Notably, the rate of severe ARI has fluctuated markedly as a result of natural disaster (Cyclone Nargis, for example) and during periods of renewed fighting and displacement.



Framing is placed for a latrine



WASH awareness raising in the community

# Human Resources and Capacity Building Program (HRCBP)

The BPHWT's Human Resources and Capacity Building Program facilitates, coordinates, and provides essential training in support of the organization's three health programs as well as its Health Information and Documentation Program, and organization development.

The following are a listing of many of the key trainings supported over the past twenty years in Thailand and Burma:

## Type of Health Workforce Trainings

No	Training Titles	Duration	
		Theory	Practical
1.	Health Assistant Training (HA)	22 - months	6 - months
2	Medic Training	6 months	4 months
3	Basic Emergency Obstetric and Neonatal Care Training (BEmNOC)	4 months	6 months
4	Maternal and Child Healthcare Worker Training (MCHW)	3 months	7 months
5	Community Health Worker Training (CHW)	6 months	4 months
6	Auxiliary Midwife Training (AMW)	3 months	6 months
7	Trained Traditional Birth Attendant Training (TTBA)	10 days	6 months
8	Pharmacy Management Training (PMT)	10 weeks	
9	Village Health Worker Training (VHW)	1 months	
10	Certificate in Public Health Training (CPH)	6 months	
11	Certificate in Health Facility Management Training (CHFM)	5 weeks	
12	Integrated Management of Childhood Illness Training (IMCI)	1 month	
13	Master of Public Health (MPH)	1 year	
14	Trauma Management Training (TM)	1 month	

### **Medical Care Program**

- Community Health Worker Training
- Community Mental Health Training
- Continued Medical Education (Training of Trainer)
- Medic Training (Training of Trainer)
- Medical Refresher Training
- Pharmacy Management Training
- Trauma Management Training
- Basic Lives Support/First Aid Training (BLS)
- Forensic Medicine / Medico-Legal Training

### **Health Information and Documentation Program**

- Data Collection and Health Information Training
- Video Editing and Documentation Training
- Photography Training
- SPSS and Microsoft Access Training
- Global Information System Training
- Services Mapping Training
- Health and Human Rights Survey Training

### **Maternal & Child Healthcare Program**

- Auxiliary Midwife Training
- Maternal & Child Healthcare Training
- Basic Emergency Obstetrics and Neonatal Care Training (BEmNOC)
- Traditional Birth Attendant Training
- Integrated Management of Childhood Illness (Training of Trainer)
- Gender-Based Violence / Gender Mainstreaming Training

### **Organization Development Training**

- Basic Computer & Office Management Training
- Financial Management Training
- Business Administration Training Course
- Community Organizing Training Course
- Non-profit Organization Development Training Course
- Leadership and Facilitation Skill Training
- Health as Human Rights Training
- Project Cycle Management Training
- Disaster Preparedness and Management Training
- Basic and Intermediate English Language Training
- Graphic and Layout Design Training

### **Community Health Education and Prevention Program**

- Certificate in Public Health Training Course (Thammasat University and Magway University)
- Master of Public Health (Khon Kaen University, Thailand)
- Village Health Volunteer Training
- Village Health Worker Training
- Nutrition Training



Certificate in Public Health Graduation Ceremony



Health Facility Management Course



BPHWT's Medic Refresher Training



AMW Refresher Workshop



# Building Coalitions for Lasting Change

## Health Information System Working Group (HISWG), established 2002

### Empowering Villagers

*People in the village are comfortable with Back Pack health workers. If there is a problem, they want to see the Back Pack health worker and not be referred to another location. The Village Health Workers (VHWs) have our cell phone numbers. If there is a problem when we are traveling to another village, they will call us and we will go there. One time they called us because someone in the village was in a coma from meningitis. We could not get back in time for emergency, so the Back Pack health worker instructed the Village Health Worker over the phone how to care for the person and what medications to give. The person recovered.*

*- Mr. Z, Kachin Field in-Charge*

The HISWG is a collaborative venture of eight ethnic health organizations and multi-ethnic community-based health organizations\* working to assess and strengthen the health system for ethnic minorities in Burma. The HISWG seeks to establish health workforce strategies, develop training curricula, identify service gaps and needs, design and implement projects and programs, and conduct health surveys.

Beginning in 2004, the HISWG began collecting broad, population-based, retrospective mortality and morbidity data as well as assessments of basic health indicators for internally displaced persons (IDPs) and remote communities in Eastern Burma. The HISWG also documented human rights violations and the health consequences of these abuses for their target population. This composite data is especially important as it represents health information on IDPs and vulnerable people that is unavailable elsewhere.

Collected data was initially published in a 2006 document entitled, *Chronic Emergency: Health and Human Rights in Eastern Burma*. A subsequent research effort led to the publication of *Diagnosis: Critical – Health and Human Rights in Eastern Burma* in 2010. In 2015, the HISWG published its most recent report, *Long Road to Recovery: Ethnic and Community-Based Health Organizations Leading the Way to Better Health in Eastern Burma*.



Data collection and reporting training

*Chronic Emergency*, the results of a population survey in Back Pack target areas and designed with the collaboration of the Johns Hopkins University Center for Public Health and Human Rights and CPI/GHAP, was cited by a public health expert as “a scientific breakthrough” by clearly establishing significant correlations between human rights violations and adverse health outcomes. The report was also notable as the surveyed population remained inaccessible to NGOs and INGOs, thus undeniably establishing the critical need for the BPHWT.

In *Diagnosis: Critical*, the HISGW built on the work of *Chronic Emergency*, covering a larger area and including the Shan State and Tenasserim region. In addition, *Diagnosis: Critical* considers a broader range of political and conflict situations throughout the area. The survey was undertaken by 45 surveyors who traveled to 221 villages in 21 townships, located in four states and two divisions in Eastern Burma. In each village, houses were selected at random for survey participation. The study established that the country’s recorded numbers for health event (per WHO) differ markedly from the population surveyed (example: the maternal mortality rate in Burma is 240 deaths per 100,000 live births <sup>(22)</sup>; *the equivalent figure for surveyed communities in eastern Burma is 721*. Clearly, the



Health Facility Assessment in the field

health-related population data that is “officially” available is not representative or inclusive of Bruma’s ethnic minorities, IDPs and vulnerable populations on the borderlands (for further information on the under-counting of minority ethnic people. see section titled “Understanding the Population Data.”

*Long Road to Recovery* contains the results of a large-scale health survey covering 64 townships, 6,620 households and 456,786 people. *Long Road* documents a trend of improving health outcomes post ceasefire (as of 2011). Seventy percent of participants reported receiving health care from ethnic and community-based health organizations; while only 8% reported receiving health care services from the Burma government. In a fundamental response to conflict, persecution and necessity, the report outlines the available health care resources – a network of rural clinics and mobile medic teams provided by ethnic and community-based organizations and operating outside of the government health network. *Long Road* emphasizes that genuine and lasting healthcare recovery for all the people of Burma will come only with peace and large-scale government reform.

\*Organizations involved:

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

HISGW website: <http://hisgw.org/>

## Health Convergence Core Group (HCCG), established 2012

Encouraged by on-going ceasefire negotiations in many ethnic communities in Burma, in 2012 the BPHWT and seven other ethnic- and community-based health organizations\* came together to determine how a re-formed government health system could best include the existing and vital network of ethnic and community-based health care. The HCCG drafted a model for convergence of these currently separate approaches, linking specific activities to stages of the peace process. Members of the HCCG are committed to being active players in shaping a new decentralized system of government and ensuring that Burma's ethnic minorities maintain agency over their own health services.

In 2013, the HCCG's "Building Trust and Peace by Working through Ethnic Health Networks towards a Federal Union," outlined nine principles necessary to support a fair and peaceful transition to a federal healthcare system. The HCCG expressed both a need for and interest in

dialogue between the government of the Republic of the Union of Myanmar and the United Nationalities Federal Council (UNFC), and also stressed the importance of continued humanitarian health assistance in support of peace building at community and state levels.

\*HCCG Member Organizations:

- Back Pack Health Worker Team (BPHWT)
- Burma Medical Association (BMA)
- Karen Department of Health and Welfare (KDHW)
- Civil Health Development Network (CHDN)
- Mae Tao Clinic (MTC)
- Mon National Health Committee (MNHC)
- National Health and Education Committee (NHEC)
- Shan State Development Foundation (SSDF)
- Chin Public Affair Committee (CPAC)



Health System Development Seminar participated by EHOs leaders, MoHS officials and NLD leaders



Health Reform Towards a Devolved Health System in Burma organized by the HCCG

## Ethnic Health Systems Strengthening Group (EHSSG; previously Health Systems Strengthening Working Group), established 2015

The WHO defines Health Systems Strengthening as *the process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges* <sup>(23)</sup>; *and, any array of initiatives and strategies that improves one or more of the functions*

*of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency.* <sup>(24)</sup>

In addition to wider health system drivers, the UNICEF has specified that health system strengthening is about “sustained improvements in areas of family care,



EHOs Coordination and Donor Meeting

preventive services and curative care that produce equitable health, nutrition and development outcomes for children, adolescents and women.” (25) This creates a system that is both resilient and responsive.

The EHSSG is a network of ethnic and community-based health organizations\* working together to improve the quality of and access to health services in Burma. It was established following an extensive evaluation and assessment of health facilities conducted with the UNHCR Balanced Score Card. The EHSSG seeks to

services and personnel), responsiveness to population need (through evidence-based planning and programming), financial and social risk protection (through prioritization and low-cost interventions and effective referral systems), and improved efficiency (via thorough review/improvement of underperforming facilities, programs and workers).

The strategy of how to best meet the health care needs of Burma’s ethnic minorities is outlined in the EHSSG’s Essential Package of Health Services (EPHS). This plan, with an intended 2-year on-going review, is



EHSSG Annual General Meeting

expand and enhance the sustainability of health care. It takes a holistic approach that is aligned with specific aims of ethnic organizations’ demands in conflict-affected regions. The EHSSG framework is designed with attention to access, equity, essentiality, appropriate technology, community participation and empowerment. It is the intention of the EHSSG to look beyond mere provision of services to the broader health care system within Burma, including governance, accountability and leadership. The EHSSG seeks to standardize and legitimize health worker services and status via improved health care delivery (through expanded access to health care

considered to be the first of its kind: an EPHS that has been wholly conceived and developed by a coalition of non-profit, non-governmental organizations. The Plan outlines responsibilities for facilities at village, township and district levels; and specific duties of Village Health Workers, Community Health Workers, medics, Maternal and Child Health Workers, Advanced Emergency Obstetric Care Workers, and Trained Traditional Birth Attendants.

The EPHS contains 11 primary service areas: Maternal and Newborn Health, Child Health, Reproductive Health,

School Health, Prevention and Control of Communicable Diseases, Emergency Health, Mental Health, Basic Eye and Dental Care, Trauma Care, Management of General Ailments, Prevention and Treatment of Non-Communicable Diseases. Each of these services is profiled along with the appropriate support services for each. Support services include pharmaceutical, diagnostic, infection prevention/control, monitoring and Health Management Information Systems (HMIS), and emergency referral support.

Burma is currently faced with both the challenge and opportunity of a Nationwide Ceasefire Agreement and a National Health Plan. While the ceasefire agreement has not received universal support and existing ceasefires are tenuous, there is hope that the peace process will move slowly yet steadily toward a peace that supports constitutional reform, a Federal Union, and a de-centralized power structure. The National Health Plan, spurred by the WHO mandate for universal health care by 2030, clearly articulates many of the challenges facing rural and minority ethnic people of Burma, yet it remains lacking in strategy and detail.

Within this environment, the EHSSG offers both a plan and a critical knowledge base. Comprised of ethnic and community-based health organizations offering healthcare in government-neglected areas of Burma, the EHSSG is best positioned to outline the structures and train the workforce for effective healthcare delivery. Similarly, they can best recognize the necessary credentials to legitimize current health workers so these individuals can be fully recognized and vital contributors in the future. At this writing, the Ministry of Health and Sport (MoHS) has not specified any EPHS within the NHP nor a strategy

for implementation. They do indicate that efforts are on going to draft such a package suitable for the entire population. Thus far they have merely indicated broad areas of coverage, prioritizing preventative and public health interventions as well as basic investigative and curative services in the areas of reproductive, maternal, neonatal, child and adolescent health, nutrition, communicable and non-communicable diseases, injuries and mental health.

Currently all health workers within Burma must be trained and accredited by the MoHS. As such, those trained by the BPHWT and ethnic health organizations and well practiced within their targeted areas may be seen as practicing outside of the law. Although the government does recognize the presence of Village Health Workers (still overseen by the centralized government but held to a lesser standard of training than fully-certified medical personnel), the BPHWT and other ethnic health workers are sometimes perceived to be members of the ethnic resistance and, as such, risk arrest, internment, torture and death.

\*EHSSG Member Organizations:

- Back Pack Health Worker Team (BPHWT)
- Burma Medical Association (BMA)
- Karen Department of Health and Welfare (KDHW)
- Mae Tao Clinic (MTC)
- Committee for Health and Development Network (Karenni) (CHDN)
- Mon National Health Committee (MNHC)
- Shan State Development Foundation (SSDF)
- Pa Oh Health Working Committee (PHWC)
- Loi Tai Li Health Committee (LTLHC)

# Fulfilling Our Promise: BPHWT Looks Toward the Future

## **The BPHWT Field in-Charges Answer the Question: What is the strength of the BPHWT?**

*We reach and treat people in very remote areas that other organizations cannot reach; there is no health care there from government.*

*We are a realistic, grassroots community organization.*

*We are multi-ethnic.*

*We have a deep understanding of our area — including speaking the local language, understanding current fighting situation, knowledge of local customs, traditions and superstitions.*

*We involve Village Health Leaders, Village Health Volunteers, religious leaders, schools, civil society, other ethnic health organizations and ethnic armed organizations. For community to be healthy everyone must be aware of health issues.*

*We help the community become in-charge of their own health care.*

*We help prevent problem and sickness with teaching how to build water filters, wells and where and how to build latrines; we also provide supplies for building.*

*The BPHWT is strong in our area because it is not project based — 1 or 2 years and then gone. The BPHWT bring continuous support to help community become more healthy.*

## Introduction

As we look toward the future, the BPHWT envisions a well-coordinated array of



Listening to the fetus' heartbeat

health services and systems accessible to vulnerable people living in remote and border regions of Burma. As fundamental and indispensable service providers in the Burma government's National Health Plan, the BPHWT and other ethnic health organizations (EHOs) and community-based ethnic health organizations (CBEHOs) shoulder an awesome responsibility. A thorough assessment of current practice and an implementation plan for the BPHWT's future delivery of care presents a complex yet critical task.

How does this differ from the life-saving work the BPHWT has accomplished thus far? No longer simply seeing isolated villages, village

tracts or field areas of needed service, we are swiftly entering a time that demands a more all-encompassing view. As the Burma government inaugurates a National Health Plan and gears up for the approaching WHO goal of Universal Health Coverage by 2030, the BPHWT has an integral role to play. The BPHWT and other EHOs/CBEHOs must be similarly astride such a plan, with our role unequivocally stated.

From a robust primary healthcare infrastructure, the BPHWT along with partner organizations will equip ethnic

communities to manage and address health-related problems and concerns at a local level — as both consumers and providers of care. Levels of care will be identified and systems of referral and means to access different services well delineated. In addition, throughout the BPHWT field areas a healthcare-literacy will be cultivated via workshops, small groups and individual instruction. In these forums, practical skills will be taught and information shared. In this way individuals will be empowered to maintain and strengthen personal wellness and raise healthy families.

## Collaboration

In order to effect this vision, the BPHWT is committed to examining how we can more fully and effectively collaborate and coordinate with other EHOs/CBEHOs. A thorough survey is needed of all health care resources, staff, means of delivery and service points in a given field area. Care is delivered by a multitude of actors and organizations across a range of levels and services. The roles, responsibilities and training of each service provider must be defined. Are the offered services of a good quality? Does staff possess the needed expertise and training? If not, what is needed to enable staff to be well-versed in their respective areas? In instances where a variety of actors and organizations work in the same area, how does everyone work together? Could communication and camaraderie be improved? What are the critical documentation practices and data collection points? When is it appropriate for information to be shared amongst providers? Is this happening in a systematic and standardized manner or does a



Teaching kids about health; distributing Vitamin A and de-worming medicine

mechanism for effective and meaningful data sharing need to be established?

The current availability and expertise of health workers must correspond to the healthcare needs of the community. Mapping geographic areas of coverage will help reveal service gaps and provide information for future planning. It is understood that services vary widely by area. Since the BPHWT is multi-ethnic, multi-



Opening ceremony for the BPHWT's Naung Kwee Clinic

lingual and well established throughout Burma, we have a unique role to play in the communication and coordination between entities.

Once a thorough survey reveals available staffing and services, duplications will become apparent. In areas where multiple organizations serve a community, how can responsibilities be coordinated so that essential functions are not duplicated and resources are best allocated? With collaboration, coordination and networking between the BPHWT and others well delineated, it will be necessary to establish a method of on-going monitoring, evaluation and improvement. On-going assessment will enable the BPHWT to monitor deployment of workers, examine the loss and retention of trained staff, inform training topics, and direct a critical eye on the utilization of resources and services.

Recipients of healthcare services have much to tell us in terms of preferred service delivery points. Focus group discussions can enable us to better understand the needs of our target population. What type

of health worker do patients seek for initial contact? What is the impact on choice due to factors of accessibility, preference and affordability? What can the BPHWT do to increase confidence and trust in essential providers in the system? Does patient feedback indicate a needed shift in the current model of delivery of care? Once needs are clearly understood, strategies can be devised to address unmet needs. Regular feedback and data review will enable us to remain current and responsive to trends and emergent needs. Some of this work is already taking place within the EHSSG and HISWG. See the "Building Coalitions for Lasting Change" section of this document for more information.

Burma Government as Partner: the BPHWT currently partners with the Burma government to offer services to individuals in our target areas. The BPHWT's Auxiliary Midwife (AMW) Training receives supplies (AMW kits) and technical support (trainers) from MoHS. On the state level, the Burma government supports the Expanded Program for Immunization (EPI), which brings 10 immunizations to children aged



Ethnic groups working together for the health of all!

2 to 12 years. In addition, on several occasions, representatives from the BPHWT (and partner EHOs/CBEHOs) have engaged in discussion with the Burma government on the drafting and logistics for the National Health Plan (NHP). We expect this participation to continue. Much work remains before the NHP can offer any real healthcare changes in the BPHWT’s target

areas — including, elucidating specific strategies and clearly acknowledging the role and authority of EHOs/CBEHOs. And, importantly, a solution must be reached on wresting management from a centralized system of control to a decentralized system where EHOs can assume authority for budgeting, dispersal, and allocation of funds for their areas.

## Expansion of the Scope of Services

As the BPHWT collects and analyzes information, it may spur an exploration of expanding the BPHWT spectrum of services. We are seeing growing numbers of patients with hypertension, diabetes, tuberculosis, and those who have experienced accidents of various kinds. Who currently provides services in response to these needs and

what is the level of acceptance and use of these service providers? Are needed services readily accessible? How long does it take to travel to these facilities and how is such travel accomplished? It may become apparent that a gap the BPHWT can fill is with select secondary level care. This would entail additional training and, in some cases, procuring medicines, facilities and equipment.



The BPHWT “ambulance” used for patient referral and other clinic needs. Along with the BPHWT monies, funds for purchase included contributions from many members of the local community.

In the case of needed secondary-level care that the BPHWT is unable to provide and is not available locally, is the established referral network functioning well? Do all involved parties thoroughly understand both the resources available and the mechanisms for referral? Is additional



Our kids are the future – brushing teeth and regular washing with soap will help make it a healthy one!

training necessary to ensure that all players are comfortable and well versed in carrying out their roles? Referrals for life-saving care take place on multiple levels depending on the particulars of each situation — from an ethnic health center to a government facility or from a community to a township health center. Some referrals require permissions at village and/or hospital levels. Is this a

smooth process with all players actively and quickly responding to patient need, or is improvement necessary? Referrals require clear protocol and procedure in terms of policy, clinical management and payment. These areas all need to be examined to determine best practice and ensure well-trained staff.

## **Expansion of the Scope of Services: Programmatic directions**

### ***Reproductive Health Services***

Within the BPHWT target area, most women of reproductive age will have at least two children, some will have many more. Typically, childbearing years begin for women between the ages of 18-22 (some women begin earlier) and can extend into a woman's 40s. A consistent and long-standing area of attention and concern is pregnancies with high-risk labor and delivery. The BPHWT's Maternal and Child Healthcare Program is critically important and very busy. In 2017 alone there were 4144 births amongst our target population — more than 11 per day!

Expanded Reproductive Health (RH) services are a much-needed area for program expansion. In order to prepare for any such growth, the BPHWT must first lay the necessary groundwork. A thorough survey will establish a clear blueprint for who can do what within the RH area. As an example, misoprostol is a controlled substance with a range of utility. It can be used to induce labor, induce abortion and to prevent postpartum hemorrhage. At this time, the Burma government only permits use of misoprostol for prevention of postpartum hemorrhage. Who within the BPHWT network has the skills, knowledge

and necessary credentials to administer this medicine?

Clinical management must be employed to standardize procedures among health workers. Standardization can and should lead toward accreditation that will, in turn, enable stability and sustained services from the standpoint of the NHP. A clear understanding of policy-level requirements and standards can and should drive any training. Another facet of RH and sexuality education that must be included is a comprehensive response to and education



Back Pack health worker providing implant to mother



Twin blessing



A new baby delivery by MCH worker

about gender-based violence (GBV). A thorough response to GBV necessitates identifying existing and/or devising new and

needed interventions including medical, social and legal services.

## ***Mental Health Services***

The BPHWT has offered mental health training to our workers on three occasions. At this time 74 people have completed this basic training, with 53 health workers already incorporating skills learned in the communities they support. At the time of writing this report, 64 people in various field areas are receiving mental health-related services. These mental health services include community consultation, individual counseling, case management and, when needed, activities of the WASH program

for those for whom personal hygiene and sanitation have become a concern. The BPHWT's mental health services, as indeed is the case with all our offerings, are fully integrated with primary health care.

The BPHWT would like to train additional health workers in this area who can subsequently offer those services within the village tracts they support. Beyond this, we would like to develop a system to train locally-based mental health volunteers thus empowering communities to carry on this important work. As the BPHWT moves toward identifying and training volunteers within the community, we will establish supports to assist and supervise them in these endeavors. This will include training, including documentation and session notes, and technical and supervisory assistance. It is envisioned that a "training the trainer" approach will be used to concentrate a network of knowledgeable people within the local community. Attention will be focused on ensuring that clients receive



Training On Managing Some Mental Disorders give to Back Pack health workers

appropriate medications and psychosocial supports. In exceptional cases, due to severity or crisis, the BPHWT will help establish an appropriate referral for clients and train mental health volunteers in how to access the referral system. Those who are working in a supervisory capacity

will have senior staff they can regularly communicate with in addition to on-going tiered training. In this way, local people with a deep understanding of and trust with those affected will be able to support their community in an on-going and sustainable way.

## ***Drug Addiction, Prevention and Rehabilitation Services***

Increasingly the BPHWT is receiving field reports of drug use, addiction and its impact on the individual, family, village and community. Some areas of Burma are major producers of yaba (methamphetamine) and heroin (opium). Drugs are easily obtained for nominal cost with some users as young as 14 years old. Deteriorated health, income loss, destructive and violent behavior, and suicide are only a few of the consequences that have been reported. Drug addiction is a chronic, progressive disease that, left unaddressed, can result in death.

Local ethnic leaders are eager to resolve this problem. Within the village and traditional way of life, drug addiction is a complicated issue that largely has not been openly addressed. The BPHWT would like to establish a multi-faceted approach to this problem, including drug resistance workshops, educational materials for distribution within communities, and a Drug Rehabilitation Center with a local governing body and staff of trained local workers. This could be accomplished through a partnership with a local community organization.



Closing Ceremony of Community Mental Health Training in the Kayan field Area



BPHWT's leading member study trip about community mental health in Sri Lanka

Effective treatment must address multiple needs of the individual to be effective; these can include medical, psychological, social, vocational and legal needs. The Drug Rehabilitation Center will be a place where those with drug addiction can first undertake, in a safe and supportive environment, medically-managed detoxification. When stabilized, individuals will engage in education on the effects of drug use on body and mind. Education will also address high-risk behaviors and risk-reduction techniques. Attention will be given to personal care, hygiene, and re-building strength of body and mind. Individual rehabilitation efforts will be aimed at the individual's return to a productive and happy member of the community. Steps to accomplishing this include: teaching

how to develop personal accountability and responsibility for one's actions; skill-building to support self-empowerment and restoring personal confidence; and, if necessary, re-training in potential employment opportunities. During the term of treatment at the Rehabilitation Center there will be repeated assessments to ensure that the treatment is appropriate and effective for the individual, with necessary adjustments made. An individual plan for follow-up care will be drafted that will utilize mental health workers and have a network of services clearly established and communicated. In keeping with the village approach to care, it is anticipated that the Drug Rehabilitation Center will involve family members as a vital and important support base for their loved ones.



Back Pack health worker visit to a mental health rehabilitation centre in the Kayan Field Area



Generations of caring

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*Dr. Cynthia Maung, From Rice Cooker to Autoclave*



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