



Back Pack Health Worker Team

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BPHWT Annual Report

2014

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Glossary of Terms

ACT	Artemisinin-based Combination Therapy
AMW	Auxiliary Midwife (under the Burma government structure)
ARI	Acute Respiratory-tract Infection
BBG	Burma Border Guidelines, the standard guidelines for diagnosis and treatment on the Thailand/Myanmar border
BPHWT	Back Pack Health Worker Team
CBO	Community-Based Organization
CSO	Civil Society Organization
CHEPP	Community Health Education and Prevention Program
Confirmed malaria	Malaria diagnosis confirmed with a Rapid Diagnostic Test
CHW	Community Health Worker
EHO	Ethnic Health Organization
EmOC	Emergency Obstetric Care
FIC	Field in-Charge
FPIC	Free, Prior and Informed Consent
HCCG	Health Convergence Core Group
HID	Health Information Documentation
HIS	Health Information Systems
HPCS	Health Program Convergence Seminar
HRV	Human Rights Violation
IDP	Internally Displaced Person
ITN	Insecticide-Treated Net
Joint funding	Funding of border-managed and Yangon-managed organizations
KIA	Kachin Independence Army
KIO	Kachin Independence Organization
KNLA	Karen National Liberation Army
KNU	Karen National Union
EAROs	Ethnic Armed Resistance Organizations
LF	Lymphatic Filariasis
M & E	Monitoring and Evaluation
MCP	Medical Care Program
MCHP	Maternal and Child Healthcare Program
MDA	Mass Drug Administration
<i>Pf</i>	Plasmodium falciparum, the most deadly type of malaria parasite
PLA	Participatory Learning and Action
<i>Pv</i>	Plasmodium vivax, another type of malaria parasite
Presumptive malaria	Malaria diagnosed using clinical criteria, not a Rapid Diagnostic Test
RDT	Rapid Diagnostic Test, used for diagnosis of plasmodium falciparum malaria
Tatmadaw	Burma Army
TBA	Traditional Birth Attendant
TMO	Township Medical Office (under the Burma government structure)
TNLA	Ta'ang National Liberation Army
TTBA	Trained Traditional Birth Attendant
TOT	Training-of-Trainers
VHV	Village Health Volunteer
VHW	Village Health Worker
WHO	World Health Organization
KBC	Karen Baptist Convention

Part I: 2014 Annual Report

1) Executive Summary

The Back Pack Health Worker Team (BPHWT) is a community-based organization that has been providing primary health care for fifteen years in the conflict and rural areas of Burma, where access to quality free/affordable primary healthcare is otherwise unattainable. The BPHWT 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 community members in Burma.



Providing Health Service to Displaced Populations in Kachin

Doctors and health workers from Karen, Karenni, and Mon States established the BPHWT in 1998. The organization initially included 32 teams, consisting of 120 health workers. Over the years and in response to increasing demand, the number of teams has gradually increased. In 2014, the BPHWT consisted of **100 teams**, with each team being comprised of three to five trained health workers who train and collaborate with five to ten village health workers/volunteers and five to ten trained traditional birth attendants; this network of mobile health workers with advanced skills and stationary health workers with basic skills ensures that community members have consistent access to essential primary healthcare services. Within the 100 Back Pack

teams, there are now **37** stationary teams, called Public Health Centers (PHCs). These PHCs, formerly mobile Back Pack teams, were established during 2013 in areas within Shan, Karenni, Karen, and Mon States and Tenasserim Division which are experiencing more stability and security. The PHCs provide both treatment and preventative health care, and a secure facility to store medicine and medical supplies/equipment.

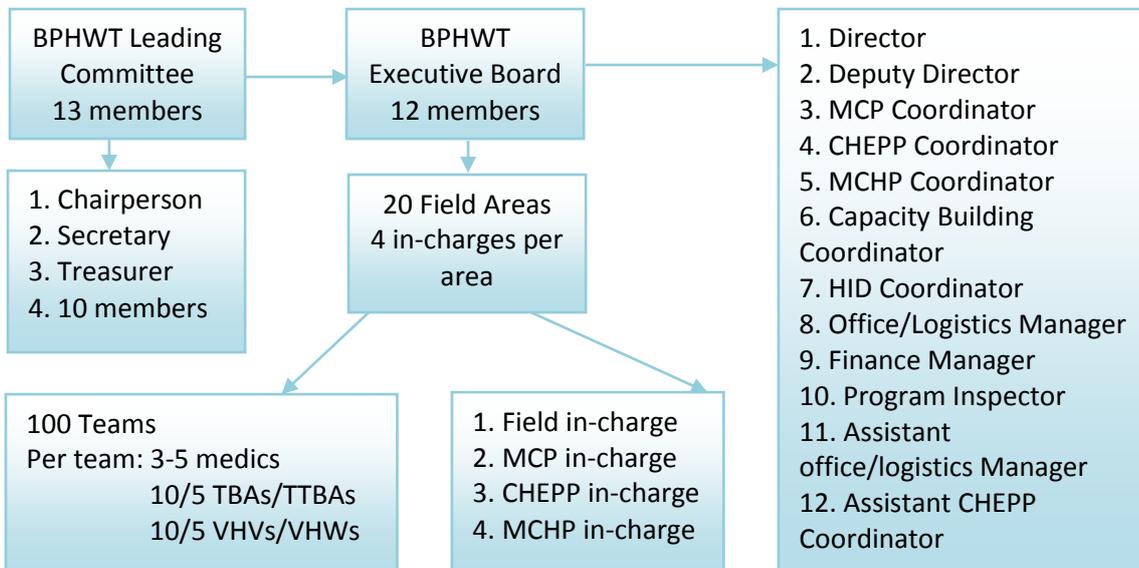
BPHWT teams target displaced and vulnerable communities with no other access to healthcare in Karen, Karenni, Mon, Arakan, Chin, Kachin and Shan States, and Bago, Sagaing and Tenasserim Divisions. The teams deliver a wide range of healthcare programs to a target population of almost **206,361** IDPs and other vulnerable people. The BPHWT aims to empower and equip people with the skills and knowledge necessary to manage and address their own health problems, while working towards the long-term sustainable development of a primary healthcare infrastructure in Burma.

In 2014, the BPHWT continued to work with communities in its target areas to implement its three health programs, namely the Medical Care Program (MCP), Maternal and Child Healthcare Program (MCHP), and Community Health Education and Prevention Program (CHEPP). The BPHWT encourages and employs a community-managed and community-based approach where health services are requested by communities and the health workers are chosen by, live in, and work for their respective communities.

2) Organizational Structure and Governance of the BPHWT

The Back Pack Health Worker Team is led by a Leading Committee, consisting of a Chairperson, Secretary, Treasurer, and ten other members. This committee provides overall guidance, and determines the principles and policies of the BPHWT. The Leading Committee appoints the Executive Board, which is composed of the Program Directors and Program Coordinators of the BPHWT.

2.1) Organizational Structure of the BPHWT



Governance: As depicted in the Organizational Structure, the BPHWT is governed by the Leading Committee elected by the BPHWT members. The Leading Committee is comprised of 13 members who are elected for a three-year term. The Leading Committee appoints all 12 members of the Executive Board, which is required to meet monthly and make decisions on current issues faced by the BPHWT. The BPHWT has a range of organizational documents that guide the leadership, management, healthcare delivery, health information systems and human resources of the organization. Full copies of any of these organizational documents are available upon request.

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

2.2) Financial Management and Accountability: The BPHWT has developed policies and procedures guiding the Leading Committee, Executive Board, Program Coordinators, Office Staff, and Field Staff in terms of financial management and accountability, the production of annual financial reports, and the requirement for an annual independent audit. These documents establish the financial records to be kept; the management of bank accounts; the procedures for cash withdrawals, deposits, transfers, receipts, disbursements and general administration funds; and the liquidation of cash assets. The BPHWT has also developed policies covering payments for lodging, travel and honoraria for services rendered.

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

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

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

3) Gender Policy and Analysis

In 2014, the participation of women in the Back Pack Health Worker has been increasing from 59 % to 79% excluding Traditional Birth Attendants/ Trained Traditional Birth Attendants (TBAs/TTBAs). However, the organization has a gender policy which aims to improve equity for women across all levels of the organization. The table below depicts the current targets and actual percentage of women across organizational tiers. To date, the BPHWT meets or exceeds all gender equity targets for the various organizational tiers.

Gender Policy and Analysis Table – 2014

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

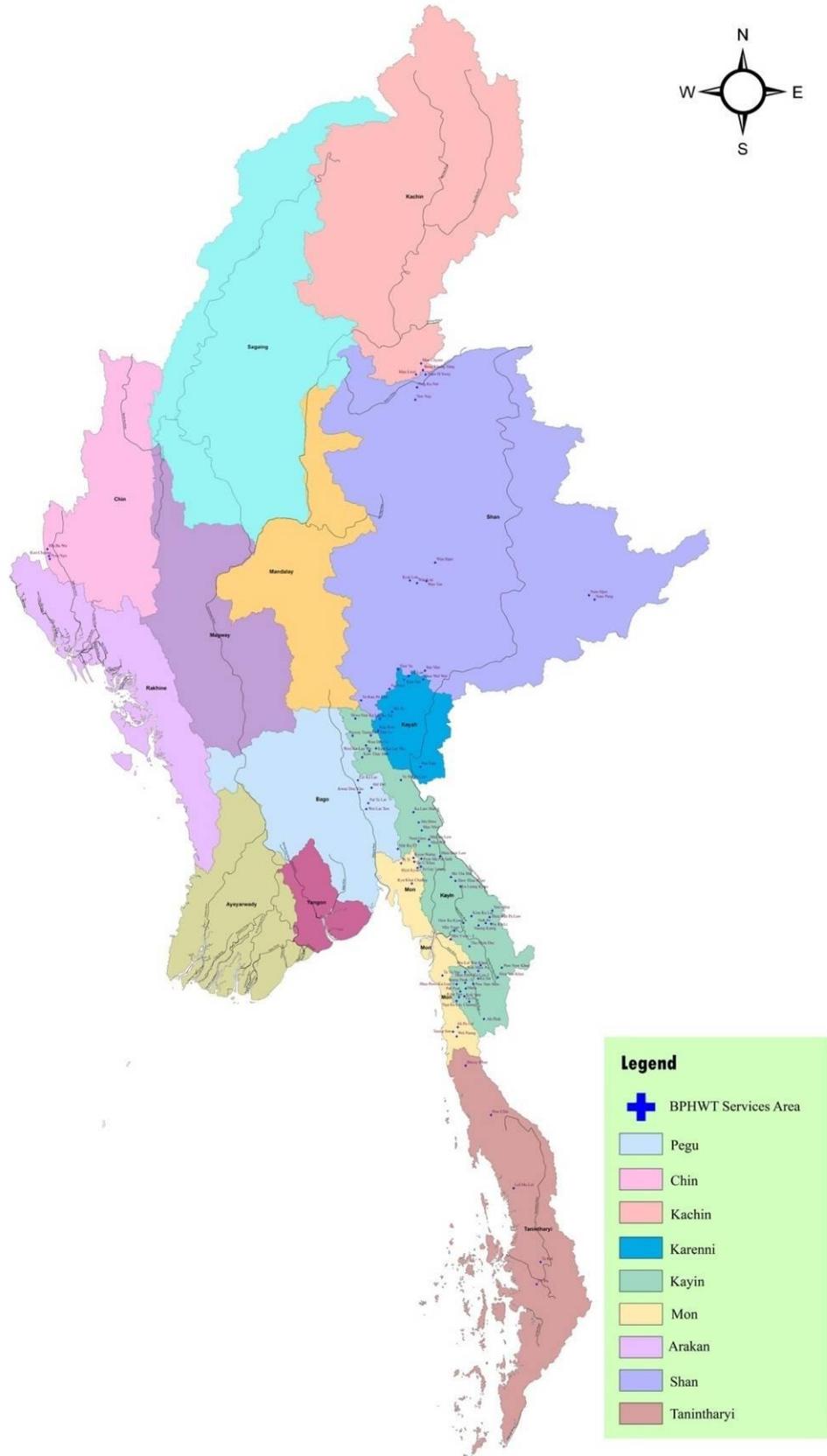
Service System: Since 1998, the Back Pack Health Worker Team has been working towards developing an accessible, community-based, primary healthcare service system within the BPHWT field areas, based on the health access indicators.

4) Health Access Targets for a Community-Based Primary Healthcare System

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

5) Map of Operational Areas

BPHWT Health Services Area Map



6) General Health Situation in Burma

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

Consequently, Burma has some of the worst health indicators in the world. Its maternal and child mortality health indicators rank among the worst in Asia. Burma continues to register the greatest number of malaria deaths and the highest malaria fatality rate of any country in Southeast Asia. The main causes of morbidity and mortality in the country are overwhelmingly preventable from diseases such as malaria, malnutrition, diarrhea, acute respiratory infections, tuberculosis, and HIV/AIDS.

While the Burma government has announced that it proposes to increase its 2015-16 budgets for health spending by 6.8% year-on-year, the relative share of the budget allocated to health would decrease from 3.7% to 3.3%. However, questions arise as to how much actual spending will occur and what has been the impact upon the health infrastructure and health indicators from the spending in the previous years of the nominal civilian government.

Lastly, the health system in Burma mirrors that of the government, that is, unitary and centralized. Decision making and funding comes from the center or "top down". Whereas the health systems of the ethnic health organizations tend toward community-based decision making or "bottom up". These "bottom up" systems of the ethnic health organizations are generally accepted as a best global primary healthcare model. This will be an issue as the health structure of Burma evolves in conjunction with positive progress toward durable peace within the country.

7) General Health Situation of Internally Displaced Persons

The Internal Displacement Monitoring Centre estimates that up to 400,000 people may be internally displaced in southeastern Burma and up to another 100,000 Internally Displaced Persons (IDPs) in Kachin State and Northern Shan State. Armed conflict, human rights abuses, and development-induced displacement continue to be the key underlying factors for these large numbers of IDPs.

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

IDPs, living in temporary or semi-permanent sites, have increased health risks due to inadequate sanitation, poor hygiene conditions and limited access to safe water. During the rainy season, the water borne disease situation becomes worse with pit latrine overflows and flooding in places around these sites used for open defecation places. Consequently, they face critical health challenges resulting in high morbidity and mortality rates attributable to largely preventable diseases such as diarrhea, malaria, and acute respiratory infections.

Until there is a durable peace in the ethnic areas, there will be the continuing need for primary health care for the IDPs and other vulnerable people which can only be currently met through the ethnic health organizations, not through the Burma Government.

8) Context to the Armed Conflict and Internal Displacement in Burma

The armed conflicts in Burma date back to the time of its independence in 1948 and have been virtually continuous since then through various Burma governments, both civilian and military. The key issues are related to the non-Burman peoples and their social, economic, and political aspirations. During the British

colonial period, the non-Burman ethnic peoples were generally administered separately and differently by the British than those in the predominately Burman area, i.e., Ministerial Burma. As the inducement to become part of a post-independence Burma, certain non-Burman ethnic peoples were promised local autonomy and ethnic quality. They were also offer the right of secession from Burma, if after ten years, they felt that their aspirations were not realized within Burma.

During the ensuing 14 years, the non-Burman people were unable to receive either local autonomy or ethnic equality, and thus in 1962, commenced a meeting to speak to this issue and the alternatives available to them. Immediately, the Burma Army, under Ne Win, mounted a coup under the rationale that the country was on the verge of breaking apart based along ethnic lines and the then-civilian government was not effectively addressing the ethnic issue. As a result over the next fifty years, many non-Burman ethnic people formed political/armed groups to initially fight for independence and later for local autonomy as manifested in some equitable form of political power sharing with the devolution of significant executive, legislative, and judicial authority to the constituent ethnic and multi-ethnic states; equitable representation at the Union level in both houses of parliament, government ministries, and the military; and a fair sharing of state resource revenues. Thus, successive Burma military and Burma military-supported civilian governments have held political power since 1962 in an attempt to address the ethnic issue primarily through military means, feeling that democratic civilian governments lack the capabilities to prevent a “disintegration of the Union”.

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

The new civilian Burma Government, elected in 2010, has seen the ethnic situation as a military stalemate and hampering its transition to more democratic country. Thus, it has initiated a series of negotiations with many EAROs, resulting in a series of individual temporary ceasefire agreements to try to begin a process of national reconciliation with the ethnic people. These ceasefire talks between the EAROs and the Burma Government have made some progress toward a more permanent Nationwide Ceasefire Agreement (NCA). But, there is still no explicit agreement by the Burma Government upon the key demand of the EAROs for a federal union. The EAROs want a federal union for Burma to a part of the NCA while the Burma Government would only agree that it should be a topic for discussion at a political dialogue to be held after the signing of the NCA.

In many of the areas of the country covered by the temporary ceasefire agreements, the Burma Army has engaged in offensive military operations which are violations of these agreements. Thus, the Burma Army may not perceive the situation in the same manner as the Burma Government and may try to continue to use force to try to bring about a military solution to the ethnic issue. Continued offensive operations by the Burma Army has increased the number of internally displaced persons (IDPS) in Shan and Kachin States, discouraged refugees from considering returning to Burma, and not contributed to confidence building among the EAROs. If the Burma Army does not cease their offensive military operations and expanding their reach, manpower, and armaments in the ceasefire areas, the ceasefire EAROs may resort again to fighting to protect their people and force the Burma Government and Burma Army into genuine peace negotiations.

Additionally, the Burma Government has been extending its administrative reach through economic development and humanitarian assistance in the mixed- and EARO-controlled areas, enhancing infrastructure (especially roads and bridges), tourism, and granting of access to international non-governmental organizations (INGOs). The ethnic people have made it clear, through their political leaders, that peace and security must come first before economic development and humanitarian assistance in the ethnic areas.

9) Security Situation in the BPHWT's Target Areas

Within the above context, active conflicts in Kachin and Shan States occurred throughout 2014 and now into 2015. The Burma Army still persists in offensive military operations in Kachin State and Northern Shan State against the Kachin Independence Army and Ta'ang (Palaung) National Liberation Army. Also the Burma Army continues with sporadic attacks against the Shan State Army – North and the Shan State Army – South in spite of signed temporary ceasefire agreements with both by the Burma government.

Elsewhere in Shan State, there were also some clashes between two ethnic armed resistance organizations (EAROs) in one of the BPHWT operational areas over disputed controlled territories. Moreover in this area, there are a number of landmines which have resulted in deaths and injuries. As of yet, the recent fighting in the Kokang Self-Administered Zone in Shan State has not affected BPHWT targeted areas.

Otherwise, this period in these other BPHWT target areas has been generally free of offensive military operations, excepting some periodic armed clashes around intrusions into informally-demarcated territories between the Burma Army and its Border Guard Forces with EAROs. Also there are the continuing problems with landmines and the checkpoints of the Burma Army and their allied People Militia Forces and Border Guard Forces.

10) Obstacles and Threats to Delivering Health Care in the BPHWT's Target Areas

Fighting in Kachin State and North Shan State remain of concern because of the presence in these areas of BPHWT health workers and their served populations, especially those people who have become internally displaced due to military activities. The situation is especially crucial in the Palaung areas of North Shan State with almost daily fighting between the Burma Army and EAROs. Back Pack teams in these areas are especially active in addressing the additional health situations resulting from the displacements and fighting.

The BPHWT health workers in the temporary ceasefire areas, while generally freer to travel, do report more Burma Army checkpoints on the roads and more extensive questioning and searches by Burma Army soldiers at these checkpoints. Some of the health workers report that Burma Army soldiers have taken photographs of them at the checkpoints. Also Back Pack teams have made changes to scheduled community activities due to Burma Army movements and presence.

For example during the last quarter 2014, BPHWT health workers in the Arakan Field Area encountered problems in freely providing medical treatment and conducting health workshops in some served communities because of the renewed presence of Burma Army camps. They were stopped and questioned by Burma Army soldiers and told they must obtain permission from local authorities before conducting such health worker activities.

The Burma Government opened a permanent health clinic in the Palaung Field Area at Tar Nay Village with two government health workers. However, these government health workers are not at the clinic full time and do not speak the local language. The clinic poses some obstacles to the continued delivery of BPHWT health services as requested by the local community. Also in the Palaung Field Area, there is genuine concern about the safety of the Back Pack health workers delivering needed medical treatment and conducting health workshops because of the encroaching presence of the Burma Army.

Fighting between two ethnic armed groups and landmines in the Pa O Field Area restricted the ability of Back Pack health workers to deliver medical services and conduct health workshops.

Naga Back Pack health workers tried to provide treatment to villages in local communities affected by environmental health hazards resulting from gold mining in Nain Yoon Township in Sagaing Division. They were confronted by U San Yoon, Township General Administrator, and told that they must first get permission from the Township Medical Officer or they would be arrested. He also questioned them about their organization and whether it was legally registered with the Burma Government.

Thus, major obstacles and threats result from the fighting in the BPHWT's targeted areas which endanger the health situation of civilians and the safety of BPHWT health workers, especially in its targeted areas in Kachin State and Shan State. Also of concern to the BPHWT are the possibilities of renewed fighting in Karen and Mon

States from the enhanced military capabilities of the Burma Army. There has already been sporadic fighting in this respect in Karen State. Moreover the health workers must continue to contend with the environment of landmines and weather. The BPHWT is continuing to monitor the situation to ensure that the civilian populations in its targeted areas have access to primary health care to reduce both morbidity and mortality, and that its health workers can safely provide its standard of care, especially to the large numbers of IDPs living in unsafe conditions.

11) Human Rights Abuses and Environmental Health Hazards in the BPHWT's Target Areas

During the second half of 2014, a number of Back Pack teams reported some human rights abuses and issues in respect to environmental health hazards in BPHWT targeted areas.

In Naung Kain Village (Na Boo Township in Hpa An District), an unknown armed group shot and killed U Tha Pwe, 80 years old, and his daughter, Naw Swet War, 47 years. After killing them, the armed group set fire to their house. Local authorities have yet to investigate this situation.

On 3 September 2014 in the Pa O Field Area, fighting occurred between two ethnic armed groups in Naung Kang Kwee Village which resulted in the destruction of a health clinic and its medicine supplies. Also, laid landmines by the groups killed three women and one man. Near another village, landmines killed three men and injured fourteen civilians.

In the Papun Field Area, two companies have gold mining activities, around Man Wint and Haw Hour Villages, which have resulted in environmental health hazards to local communities. Gold mine workers dispose food waste, especially fish and chicken, around their camp and into the rivers. Also chemicals used in the gold mining flow into the rivers. Consequently, local villagers have become sick with diarrhea and a number of their pigs and chickens have died from this polluted land and water. The companies have tried to address this problem with setting up ten shallow wells in Man Wint Village and a gravity flow water system in Haw Hour Village. However, this has not been sufficient to completely resolve the environmental health problem.

There have also been environmental health hazards and other problems from gold mining in the Naga Field Area. Chemicals from the gold mining operations flow into the rivers and are causing diarrhea and other diseases to people in local communities. The gold mining operations have stopped the normal flow of the rivers used by the gold mining operations and affected local livelihoods and health.

12) Activities of Back Pack Health Worker Team

The BPHWT delivers three programs: Medical Care Program (MCP), Community Health Education and Prevention Program (CHEPP), and Maternal and Child Healthcare Program (MCHP). Integrated within and bridging across these three health programs are projects and activities for capacity building, health information systems and documentation, and monitoring and evaluation.

In 2014, the BPHWT provided healthcare in 20 field areas, through 100 BPHWT teams, to a target population of **206,361** people. There is a pilot program which is implemented by Women's League of Chinland (WLC) and integrate Maternal and Child Healthcare program in Chin state and Karen Baptist Convention (KBC) in Pan Tha Naw. There are currently **1,323** members of the BPHWT primary healthcare system living and working in Burma: **351** health workers, **696** Traditional Birth Attendants / Trained Traditional Birth Attendants (TBAs/TTBAs) and **276** village health volunteers/village health workers (VHVs/VHWs).

The following table provides an overview of the BPHWT field areas, the number of BPHWT health workers, VHV/VHWs, and TBA/TTBAs in each field area, the target populations, villages, households and a breakdown of the **84,914** total cases treated in 2014. Compared with 2013, the BPHWT treated more cases from **76,466** to **84,914** cases.

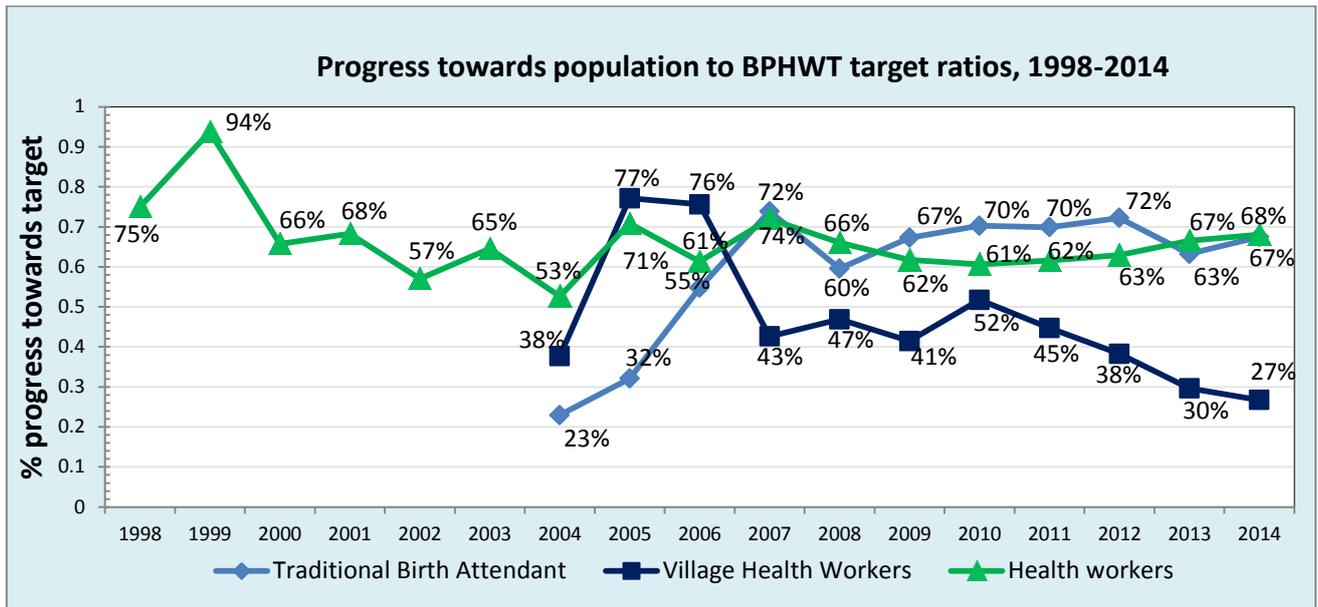
Summary of the BPHWT Field Areas, HWs, VHV/VHWs, TBA/TTBAs, Target Populations and Cases Treated

No.	Areas	# of Teams	# of HWs			# of VHWs			# of TTBAs			Total Villages	Total Households	Total Population	Total Case load
			M	F	Total	M	F	Total	M	F	Total				
1	Kayah	7	11	13	24	14	5	19	0	40	40	53	2,937	18,687	5,597
2	Kayan	5	8	10	18	5	13	18	0	32	32	34	1,161	7,106	12,726
3	Special	3	8	2	10	0	0	0	2	10	12	23	1,373	6,896	937
4	Taungoo	5	13	7	20	6	19	25	0	30	30	44	1,773	9,482	2,047
5	Kler Lwee Htoo	7	14	10	24	16	27	43	6	71	77	53	2,102	12,935	2,162
6	Thaton	7	12	12	24	4	22	26	0	75	75	34	3,183	18,156	8,017
7	Papun	9	24	7	31	7	22	29	20	71	91	90	3,878	24,938	4,353
8	Pa An	6	9	12	21	5	14	19	5	58	63	29	3,000	16,941	4,444
9	Dooplaya	7	11	12	23	8	15	23	10	47	57	56	3,929	21,260	5,838
10	Kawkareik	3	7	5	12	12	6	18	3	27	30	8	602	3,598	1,366
11	Win Yee	4	10	5	15	0	0	0	3	27	30	28	1,899	10,548	3,000
12	Mergue/Tavoy	5	8	10	18	4	18	22	12	41	53	20	1,813	10,100	7,519
13	Yee	6	3	18	21	0	0	0	0	26	26	15	1,761	8,706	5,594
14	Moulamein	6	3	18	21	0	0	0	0	0	0	17	2,481	12,243	5,495
15	Shan	6	11	9	20	11	9	20	0	10	10	22	860	4,336	4,853
16	Palaung	3	4	8	12	0	0	0	0	30	30	15	1,024	7,762	3,308
17	Kachin	4	1	13	14	0	0	0	0	10	10	2	204	1,100	4,449
18	Arakan	3	10	1	11	4	10	14	0	30	30	9	927	4,755	1,397
19	Pa O	2	5	3	8	0	0	0	0	0	0	11	496	2,221	567
20	Naga	2	4	0	4	0	0	0	0	0	0	19	1,119	4,591	1,245
	Total	100	176	175	351	96	180	276	61	635	696	582	36,522	206,361	84,914

Number of Health Workers, TBAs/TTBAs, VHV/VHWs, and Target Population by Year

Year	# of HWs	# of TBAs/TTBAs	# of VHV/VHWs	Target Population
1998	120	0	0	64,000
1999	150	0	0	64,000
2000	200	0	0	121,692
2001	208	0	0	121,896
2002	224	0	0	156,986
2003	238	0	0	147,537
2004	232	202	332	176,200
2005	287	260	625	162,060
2006	284	507	700	185,176
2007	288	591	341	160,063
2008	291	525	413	176,214
2009	289	630	388	187,274
2010	290	672	495	191,237
2011	318	722	462	206,620
2012	343	787	417	217,899
2013	379	711	333	224,796
2014	351	696	276	206,361

TBA/TTBAs, VHV/VHWs, and Health Workers-to-Population Ratios as a Percent of Target Ratios over Time^{1,2}



12.1) Medical Care Program

The Back Pack Health Worker Team currently consists of **100** teams working among Internally Displaced Persons and vulnerable communities in Karen, Karenni, Mon, Arakan, Chin, Kachin, and Shan States, and the Bago and Tenasserim Divisions of Burma. Under the Medical Care Program (MCP), the BPHWT health workers address six health problems identified as contributing most significantly to morbidity and mortality in the target areas: malaria, diarrhea, acute respiratory-tract infection (ARI), anemia, worm infestation, and war trauma injuries. The most common disease in the BPHWT areas is malaria, followed by ARI, worm infestation, anemia, diarrhea, and dysentery.



¹ While BPHWT began training TBAs in 2000, the MCHP only began systematically training TBAs in the BPHWT target areas in 2004. Therefore, only 2004-2010 TBA/population ratios are included. The BPHWT also began training VHWs in 2004.

² Targets are as follow: 1 BPHWT Health Worker: 400 people; 1 TBA: 200 people; 1 VHV: 200 people.

Back Pack Health Worker Team Caseloads

No	Condition	Age				Total
		<5		≥5		
		M	F	M	F	
1	Anemia	268	269	1566	3158	5,261
2	ARI(mild)	1851	1964	4066	4633	12,514
3	ARI(severe)	1040	1077	1426	1713	5,256
4	Beriberi	254	255	1560	2678	4,747
5	Diarrhea	810	766	1179	1199	3,954
6	Dysentery	431	441	1022	1064	2,958
7	Injury(gunshot)	0	0	10	3	13
8	Injury(landmine)	0	0	0	0	0
9	Injury Acute Other	129	110	790	448	1,477
10	Injury(old)	13	9	381	182	585
11	Malaria (P.v)	136	169	1123	880	2,308
12	Malaria (P.f)	123	132	779	580	1,614
13	Measles	122	109	108	108	447
14	Meningitis	23	10	26	32	91
15	SuspectedAIDS	0	0	10	9	19
16	SuspectedTB	15	40	216	175	446
17	Worms	849	858	1543	1694	4,944
18	Abortion	0	0	0	125	125
19	Post-Partum Hemorrhage	0	0	0	47	47
20	Sepsis	0	0	0	25	25
21	Respiratory Tract Infection (RTI)	0	0	13	247	260
22	Urenary Tract Infection (UTI)	26	26	864	1557	2,473
23	Skin Infection	535	570	1183	1094	3,382
24	Hepatitis	15	37	190	130	372
25	Typoid Fever	144	123	382	324	973
26	Arthritis	14	8	1163	929	2,114
27	Gastric Ulcer Deudinum Ulcer (GUDU)	29	17	2503	2804	5,353
28	DentalProblem	201	251	906	936	2,294
29	EyeProblem	313	341	871	976	2,501
30	Hypertention	1	1	1570	2093	3,665
31	Abscess	246	239	803	636	1,924
32	Others	1139	1316	4458	5859	12,772
Total		8,727	9,138	30,711	36,338	84,914
Grand Total		17,865		67,049		

Back Pack Health Worker Team Caseloads

Condition	Kayah	Kayan	Special	Taungoo	Kler Lwee Htoo	Thaton	Papun	Pa An	Dooplaya	Kawkaireik	Win Yee	Mergue/ Tavoy	Yee	Moulamein	Shan	Pa' O	Palauing	Kachin	Naga	Arakan	Total
Anemia	522	442	57	128	138	445	422	361	550	185	222	530	316	260	309	49	67	204	2	52	5261
ARI(mild)	1501	1335	109	169	519	883	623	1081	1227	397	600	746	510	482	470	17	543	1038	85	179	12514
ARI(severe)	40	470	52	125	144	1163	596	561	449	115	206	251	191	316	37	71	168	225	10	66	5256
Beriberi	10	886	103	80	89	1182	176	298	344	28	85	280	164	140	253	99	76	329	52	73	4747
Diarrhea	572	722	55	144	73	236	159	157	140	42	104	301	202	291	213	43	43	328	49	80	3954
Dysentery	200	556	37	122	28	377	133	85	319	40	72	244	182	197	74	14	71	97	27	83	2958
Injury(gunshot)	0	2	0	1	0	0	0	2	0	0	0	0	0	0	0	0	5	0	0	3	13
Injury(landmine)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injury Acute Other	36	129	11	17	57	117	33	52	15	3	18	108	343	339	48	0	75	62	10	4	1477
Injury(old)	6	7	21	15	37	138	45	14	139	0	17	100	11	1	17	0	4	9	2	2	585
Malaria (P.f)	183	68	30	177	135	19	281	28	110	74	101	361	203	68	44	12	82	0	39	293	2308
Malaria (P.v)	115	55	35	185	140	10	46	6	261	63	117	200	155	135	43	1	0	0	0	47	1614
Measles	0	108	0	16	7	7	6	3	4	1	4	21	99	102	18	0	30	4	1	16	447
Meningitis	2	23	0	1	11	2	9	0	0	3	0	10	5	18	0	0	2	0	0	5	91
SuspectedAIDS	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	16	0	0	19
SuspectedTB	16	256	0	0	1	26	1	2	2	0	7	81	8	0	7	0	3	8	25	3	446
Worms	256	1145	41	107	74	613	150	159	389	39	248	477	337	316	243	17	118	81	41	93	4944
Abortion	12	14	1	5	6	1	18	0	9	0	6	4	5	9	8	0	15	0	0	12	125
PPH	12	11	0	2	0	3	4	0	0	1	1	3	0	0	3	1	6	0	0	0	47
Sepsis	5	1	0	9	0	0	4	0	0	0	0	3	0	0	0	0	1	0	0	2	25
RTI	37	49	0	0	0	9	4	2	29	0	5	65	1	0	3	0	5	48	0	3	260
UTI	168	95	55	63	141	355	222	84	266	39	69	244	84	38	166	38	105	169	16	56	2473
Skin Infection	190	586	38	114	19	268	131	185	120	42	85	423	219	258	229	13	153	258	23	28	3382
Hepatitis	18	115	0	51	5	54	9	4	0	0	2	75	6	18	12	0	1	0	1	1	372
Typoid Fever	1	202	0	55	50	1	162	0	6	2	5	6	149	237	63	2	18	0	3	11	973
Arthritis	20	673	6	53	38	56	101	50	165	19	88	170	140	101	256	0	30	141	2	5	2114
GUDU	437	1022	68	81	128	403	246	230	346	60	132	364	402	357	333	9	239	372	70	54	5353
DentalProblem	148	409	22	109	28	113	28	65	97	10	97	230	170	228	350	0	74	98	5	13	2294
EyeProblem	247	605	12	91	17	192	45	26	82	28	38	336	155	183	159	5	63	205	5	7	2501
Hypertention	255	617	19	35	56	184	89	84	152	31	32	240	491	483	454	26	118	270	22	7	3665
Abscess	17	382	33	72	81	115	84	69	179	41	92	211	153	109	168	5	32	50	6	25	1924
Others	570	1741	132	20	140	1045	526	836	438	103	547	1435	893	809	873	145	1159	437	749	174	12772
Total	5597	12726	937	2047	2162	8017	4353	4444	5838	1366	3000	7519	5594	5495	4853	567	3308	4449	1245	1397	84914

i. Malaria

The BPHWT has used Paracheck, a rapid diagnosis test (RDT), to effectively confirm Plasmodium falciparum (*P.f.*) malaria diagnosis since 2007, and follows World Health Organization (WHO) guidelines to give Artemisinin-based Combination Therapy (ACT) treatment. The BPHWT aims to distribute insecticide-treated mosquito nets (ITNs) and engage in preventive health awareness-raising activities in order to decrease the prevalence of malaria. There were **18,000** ITNs distributed during 2013.

From 2003-2004, the BPHWT did not have small, portable diagnosis kits called Rapid Diagnosis Tests (RDT) to confirm cases of Plasmodium falciparum (*P.f.*) malaria. RDT usage began in 2005, but there were not enough RDTs available to cover all field areas; but by 2008 and 2009, there were enough RDTs to distribute to all field areas.

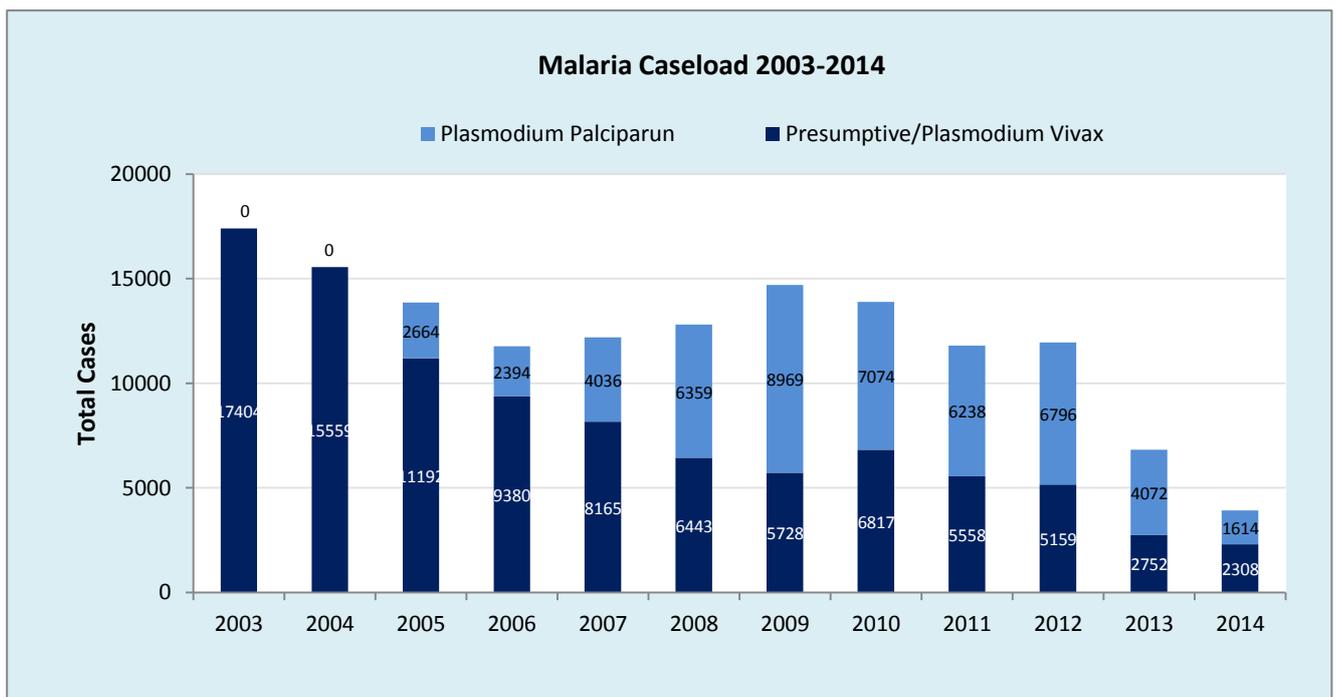


Providing Malaria Test

Thus, the Back Pack Health Worker Team updated its protocol for treating malaria to test all patients who have a fever with a Para-check RDT, and if the results are positive then *P.f.* malaria treatment must be provided using ACT treatment, which is in-line with the Burma Border Guidelines (BBG) protocol. However, the graphs below show that there are still cases of presumptive Plasmodium vivax (*P.v.*) malaria treatment because the Para-check RDTs only check for *P.f.* malaria. Since the early of 2014, the BPHWT has used the SD Biotline which can test for both *P.f.* and *P.v.* malaria.

During this period, there were **114** pregnant women with malaria cases. In addition, the BPHWT

also distributed educational malaria posters for the communities to encourage them to seek RDT testing within 24 hours of an onset of a fever. In addition, “The Long Road to Recovery” survey report showed that the prevalence rate for *P. falciparum* malaria decreased dramatically from 7.3% in 2008 to 2.3% in 2013.

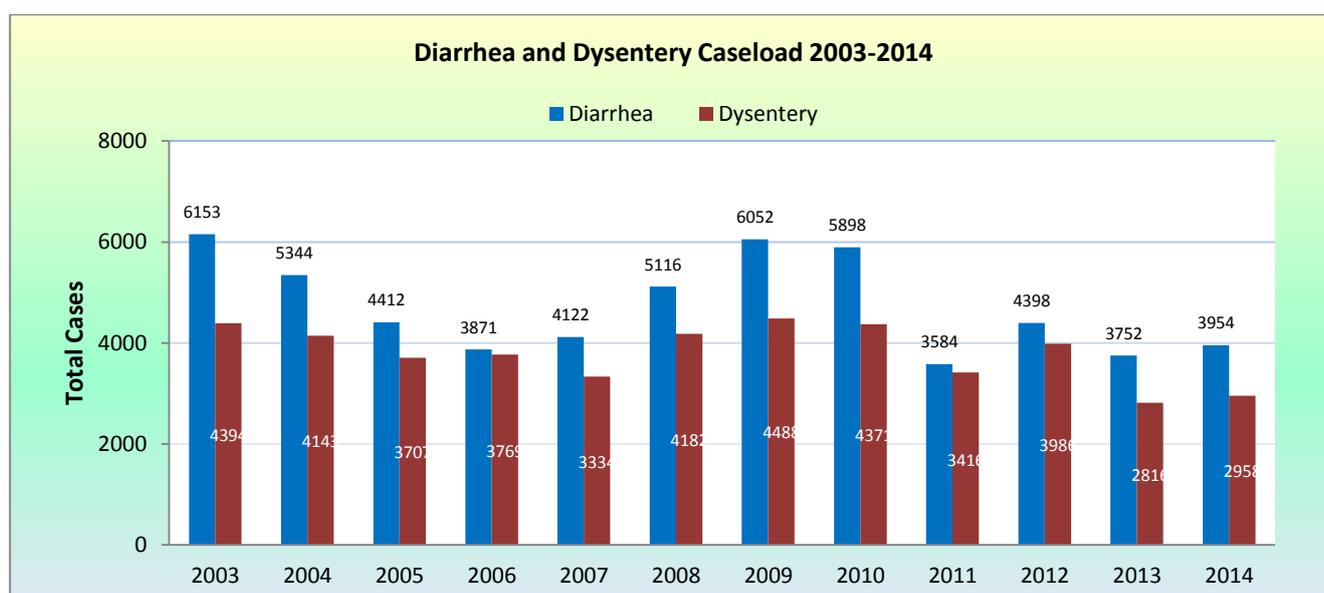


Malaria Rapid Diagnostic Tests (P.f & P.v)

No	Area	# of RDT Used	Plasmodium Vivax	Plasmodium Palciparun	Total Malaria
1	Kayah	483	115	183	298
2	Kayan	956	55	68	123
3	Special	550	35	30	65
4	Taungoo	457	185	177	362
5	Kler Lwee Htoo	742	140	135	275
6	Thaton	110	10	19	29
7	Papun	628	46	281	327
8	Pa An	1122	6	28	34
9	Doooplaya	1631	261	110	371
10	Kawkariek	477	63	74	137
11	Win Yee	675	117	101	218
12	Mergue/Tavoy	959	200	361	561
13	Yee	1166	155	203	358
14	Moulamein	1532	135	68	203
15	Shan	228	43	44	87
16	Pa'O	641	1	12	13
17	Palaung	137	0	82	82
18	Kachin	411	0	0	0
19	Naga	265	0	39	39
20	Arakan	247	47	293	340
Total		13,417	1,614	2,308	3,922

ii. Diarrhea and Dysentery

In general, diarrhea and dysentery cases increased steadily from those recorded in the previous year, especially for the under five children. There was a sharp increase in dysentery cases of under five children from 652 in 2013 to 1,313 in 2014. Likely, there was an increase of 407 from 1,169 in 2013 to 1,576 in 2014 of the diarrhea cases in under five children age group. Although, the BPHWT activities have had a clear impact in the healthy behavior of communities, diarrhea and dysentery were still high in the communities due to the complex operating environment, and wider social determinants of health (eg food security).



No	Area	Diarrhea Cases				Total
		Ages				
		< 5		> = 5		
		M	F	M	F	
1	Kayah	58	63	232	219	572
2	Kayan	293	229	106	94	722
3	Special	12	5	18	20	55
4	Taungoo	32	31	40	41	144
5	Kler Lwee Htoo	4	5	34	30	73
6	Thaton	43	52	55	86	236
7	Papun	31	31	49	48	159
8	Pa An	50	44	28	35	157
9	Dooplaya	15	25	51	49	140
10	Kawkareik	10	10	9	13	42
11	Win Yee	27	23	20	34	104
12	Mergue/Tavoy	56	64	90	91	301
13	Yee	24	28	75	75	202
14	Moulamein	43	40	119	89	291
15	Shan	7	12	95	99	213
16	Pa'O	21	16	4	2	43
17	Palaung	5	11	8	19	43
18	Kachin	48	66	105	109	328
19	Naga	24	6	9	10	49
20	Arakan	7	5	32	36	80
Total		810	766	1,179	1,199	3,954

No	Area	Dysentery Cases				Total
		Ages				
		< 5		> = 5		
		M	F	M	F	
1	Kayah	10	5	100	85	200
2	Kayan	176	183	94	103	556
3	Special	2	4	15	16	37
4	Taungoo	15	16	44	47	122
5	Kler Lwee Htoo	0	1	16	11	28
6	Thaton	43	47	118	169	377
7	Papun	19	17	46	51	133
8	Pa An	11	13	23	38	85
9	Dooplaya	28	16	139	136	319
10	Kawkareik	7	4	17	12	40
11	Win Yee	5	4	36	27	72
12	Mergue/Tavoy	45	40	76	83	244
13	Yee	23	24	69	66	182
14	Moulamein	16	29	67	85	197
15	Shan	0	1	41	32	74
16	Pa'O	1	1	5	7	14
17	Palaung	13	6	22	30	71
18	Kachin	14	21	28	34	97
19	Naga	1	7	11	8	27
20	Arakan	2	2	55	24	83
Total		431	441	1,022	1,064	2,958

iii. Acute Respiratory Infection (Mild)

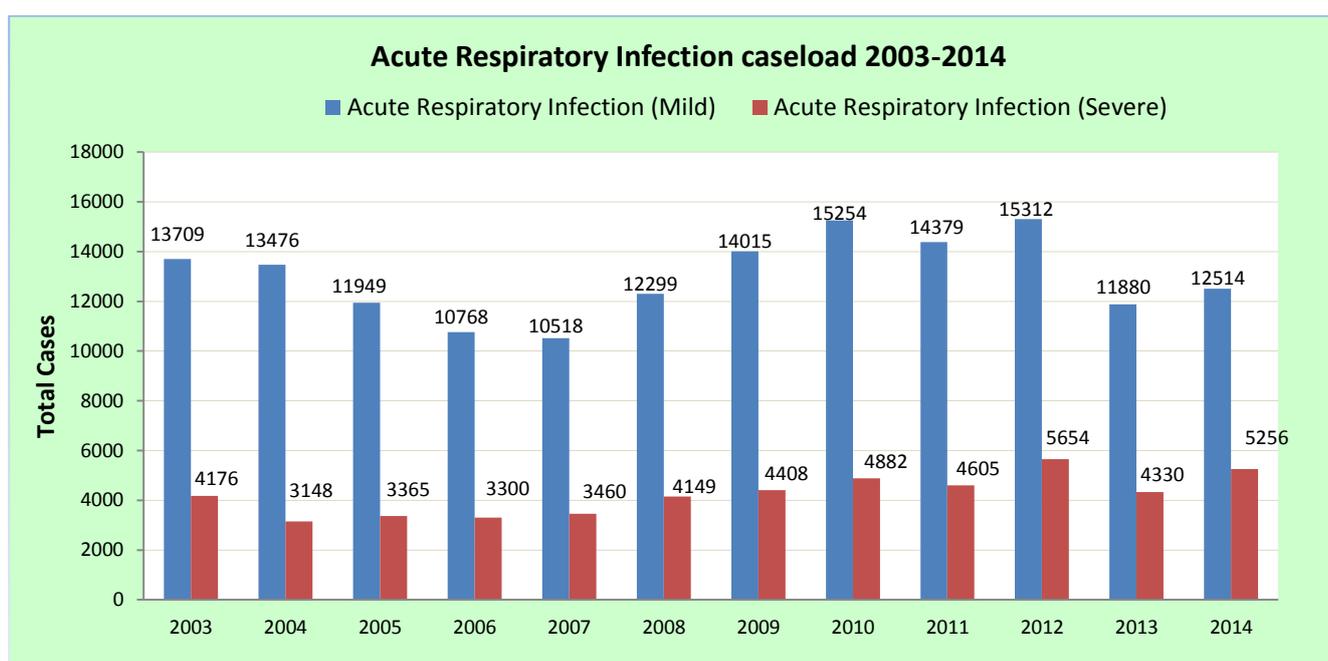
The annual cases of acute respiratory infection (mild) for both children under the age of five years and adult seem slightly more comparing to the previous year. There were **12,514** cases of Acute Respiratory Infection (mild) treated by the health workers including **3,835** under five age children. ARI (mild) is the most top cases founded during 2014.

No	Area	ARI (Mild)				Total
		Ages				
		< 5		> = 5		
		M	F	M	F	
1	Kayah	100	117	632	652	1501
2	Kayan	350	367	303	315	1335
3	Special	21	21	38	29	109
4	Taungoo	31	26	59	53	169
5	Kler Lwee Htoo	27	43	228	221	519
6	Thaton	113	137	267	366	883
7	Papun	93	107	215	208	623
8	Pa An	217	177	282	405	1081
9	Doooplaya	169	163	443	452	1227
10	Kawkareik	94	77	105	121	397
11	Win Yee	41	69	253	237	600
12	Mergue/Tavoy	179	174	180	213	746
13	Yee	70	72	176	192	510
14	Moulamein	72	86	134	190	482
15	Shan	59	71	145	195	470
16	Pa'O	0	0	7	10	17
17	Palaung	71	77	161	234	543
18	Kachin	124	142	324	448	1038
19	Naga	3	3	50	29	85
20	Arakan	17	35	64	63	179
total		1,851	1,964	4,066	4,633	12,514

iv. Acute Respiratory Infection (Severe)

In 2014, there were slightly more acute respiratory infection (severe) cases treated compared to those recorded during 2013 from 4,330 to 5,256 cases. 2,466 cases were men and 2,790 cases were women. In addition, there were 2,117 cases of under five children treated.

No	Area	ARI (Severe) Cases				Total
		Ages				
		< 5		> = 5		
		M	F	M	F	
1	Kayah	4	5	13	18	40
2	Kayan	155	135	85	95	470
3	Special	8	5	18	21	52
4	Taungoo	30	36	26	33	125
5	Kler Lwee Htoo	28	17	54	45	144
6	Thaton	200	242	255	466	1163
7	Papun	102	101	187	206	596
8	Pa An	148	169	115	129	561
9	Dooplaya	63	74	143	169	449
10	Kawkareik	34	26	21	34	115
11	Win Yee	73	57	45	31	206
12	Mergue/Tavoy	49	43	75	84	251
13	Yee	25	37	65	64	191
14	Moulamein	57	45	93	121	316
15	Shan	7	3	21	6	37
16	Pa'O	15	11	16	29	71
17	Palaung	12	14	80	62	168
18	Kachin	26	42	83	74	225
19	Naga	1	1	5	3	10
20	Arakan	3	14	26	23	66
Total		1,040	1,077	1,426	1,713	5,256



v. Worm Infestation

The BPHWT established a de-worming program in 2003 in order to reduce malnutrition among children. As part of the Community Health Education and Prevention Program, the BPHWT also provides health education, focusing on hygiene, clean water, and sanitation activities among the villages. Because of the wide distribution of the BPHWT's de-worming program in all the BPHWT target areas, cases for worm infestation decreased rapidly from year to year. However, there was an increase treated of 780 cases from 4,164 in 2013 to 4,944 in 2014. The table below also shows worm infestation cases seen in the targeted field areas.

No	Area	Worm Infestation Cases				Total
		Ages				
		< 5		> = 5		
		M	F	M	F	
1	Kayah	11	16	115	114	256
2	Kayan	274	263	271	337	1145
3	Special	14	21	4	2	41
4	Taungoo	28	25	29	25	107
5	Kler Lwee Htoo	12	14	25	23	74
6	Thaton	48	78	203	284	613
7	Papun	24	34	49	43	150
8	Pa An	24	19	51	65	159
9	Dooplaya	79	63	116	131	389
10	Kawkareik	7	9	14	9	39
11	Win Yee	67	54	76	51	248
12	Mergue/Tavoy	57	52	178	190	477
13	Yee	47	60	111	119	337
14	Moulamein	69	58	87	102	316
15	Shan	15	11	118	99	243
16	Pa'O	3	1	8	5	17
17	Palaung	29	35	20	34	118
18	Kachin	17	17	26	21	81
19	Naga	1	4	16	20	41
20	Arakan	23	24	26	20	93
Total		849	858	1,543	1,694	4,944

vi. Suspected Pulmonary Tuberculosis and AIDS Cases

The total number of suspected cases of tuberculosis (TB) was **446** cases – comprised of 215 women and 231 men and 55 cases were under five ages of children that recorded by the health workers. The highest figure founded in Kayan areas which was 256 cases and follow by Mergue/Tavoy – 81 cases. Health workers could not treat the suspected TB patients because the BPHWT is not equipped to oversee a TB treatment program in the target areas, and the health workers are not prepared to manage a TB program or TB patients. TB patients need long-term treatment and should receive appropriate care and oversight. The Back Pack Health Worker Team is not able to provide this level of sustained care since its activities are in target areas that are unstable. The BPHWT is only able to provide health education and advise patients where to access appropriate treatment and care. However, in the early of 2014, the BPHWT coordinates with Mae Tao clinic to refer TB positive patients to Shoklo Malaria Research Unit (SMRU). TB is considered one of the main health problems experienced by internally displaced persons.

There were also **19** suspected AIDS cases – comprised of 9 women and 10 men in Kayah, Palaung and Kachin areas. There were the most suspected AIDS cases – 16 cases recorded by health workers from Kachin area.

vii. Acute Landmine and Gunshot Injuries

In 2014, there was no landmine cases recorded by the health workers, but there were still 13 gunshot cases treated in Kayan, Taungoo, Pa An, Palaung, and Arakan areas. However, some cases in the field areas were not recorded because the field health workers recorded the cases that they evidenced.

No	Area	Gunshot Cases		
		Ages		
		>=5		
		M	F	Total
1	Kayan	2	0	2
2	Taungoo	1	0	1
3	Pa An	0	2	2
4	Palaung	4	1	5
5	Arakan	3	0	3
Total		10	3	13

12.2) Community Health Education and Prevention Program

The Community Health Education and Prevention Program (CHEPP) aims to empower the internally displaced persons and vulnerable populations of Burma with skills and knowledge related to basic healthcare and primary healthcare concepts. CHEPP focuses on the improvement of hygiene, water and sanitation systems, nutrition, and other health promotion-related issues. The main health issues addressed under the Community Health Education and Prevention Program are:

- Malaria prevention
- Hygiene and sanitation
- Diarrhea prevention
- Malnutrition
- High-risk pregnancy
- Breast feeding practices
- Landmine risk education
- HIV/AIDS education
- Prevention and awareness of bird flu and swine flu

The Community Health Education and Prevention Program is also integrated into school health programs and village health workshops. In terms of preventative activity, the BPHWT field workers distribute Vitamin A and de-worming tablets. They also provide latrines to schools and communities.

12.2.1 School Health Sub-Program:

In 2014, the BPHWT implemented its school health program in **474** schools with **1,984** teachers: **1,547** women and **437** men. There were **42,099** students - comprised of **20,589** boys and **21,510** girls receiving health education from BPHWT's health workers. The program also distributes de-worming medicine and Vitamin A, personal hygiene supplies, and materials for the construction of latrines. However, due to the funds shortage; there was no personal hygiene supplies distributed and no school latrine was installed.

12.2.2 Nutritional Sub-Program:

Under the Nutritional Sub-Program of the CHEPP, the BPHWT distributes de-worming medicine to children from the age of one to twelve year old and Vitamin A to the children from the age of six month to twelve year old. This is essential to preventing malnutrition. During 2014, **36,642** children received De-worming medicine (Albandozole) and **41,692** children received Vitamin A. The BPHWT did stop providing Vitamin A supplementation to prenatal and postpartum women according to the WHO recommendations since the beginning of 2013. In addition, BPHWT field health workers also provide health education regarding on this topic in village health workshop in every six month to improve the health knowledge of the communities.

Number of Children Receiving Vitamin A									
No	Area	CHILDREN'S AGES						Total	
		6-12 months		1-6 years		6-12 years			
		M	F	M	F	M	F	M	F
1	Kayah	51	63	1013	1021	750	754	1814	1838
2	Kayan	192	199	275	385	503	430	970	1014
3	Special	18	42	22	26	0	0	40	68
4	Taungoo	756	833	1237	1355	1423	1492	3416	3680
5	Kler Lwee Htoo	411	443	733	673	740	649	1884	1765
6	Thaton	105	107	951	976	737	729	1793	1812
7	Papun	341	286	736	766	779	869	1856	1921
8	Pa An	13	17	609	573	743	774	1365	1364
9	Dooplaya	419	352	695	617	914	895	2028	1864
10	Kawkareik	70	79	221	184	245	216	536	479
11	Win Yee	0	0	142	193	607	664	749	857
12	Mergue/Tavoy	252	270	568	561	762	791	1582	1622
13	Moulamein	91	128	207	273	343	401	641	802
14	Palaung	326	379	533	604	420	508	1279	1491
15	Arakan	260	285	196	176	127	118	583	579
Total		3,305	3,483	8,138	8,383	9,093	9,290	20,536	21,156
		6,788		16,521		18,383		41,692	

Number of Children Receiving De-worming Medicine				
No	Area Name	Ages (1 – 12 Years)		Total
		M	F	
1	Kayah	1340	1355	2695
2	Kayan	632	667	1299
3	Special	40	68	108
4	Taungoo	3245	3804	7049
5	Kler Lwee Htoo	1496	1283	2779
6	Thaton	1857	1956	3813
7	Papun	1898	1755	3653
8	Pa An	1333	1364	2697
9	Dooplaya	1565	1570	3135
10	Kawkareik	440	469	909
11	Win Yee	749	857	1606
12	Mergue/Tavoy	1138	1149	2287
13	Moulamein	562	673	1235
14	Palaung	1279	1491	2770
15	Arakan	323	284	607
Total		17,897	18,745	36,642
		36,642		

12.2.3 Water and Sanitation Sub-Program:

The BPHWT aims to provide one gravity flow for **60** household and **300** population; one shallow well for **10** households and **50** population, and one community latrine for every **5 to 10** people in all its target areas. The Back Pack Health Worker Team has established water and sanitation projects since 2005. During 2014, the BPHWT teams built **14** gravity flow water systems and the beneficiary population that has received gravity flow water system includes **1,013** households composed of **5,980** people. The BPHWT also built **34** shallow well water systems which have been received by **529** households and **2,528** beneficiaries. The BPHWT also provided **875** community latrines to **4,009** populations.

No	Field Area	Gravity Flow				Shallow Wells				Community Latrines			
		No.	HH	Pop.		No.	HH	Pop.		No.	HH	Pop.	
				M	F			M	F			M	F
1	Kayah	0	0	0	0	2	60	143	157	0	0	0	0
2	Kayann	1	50	120	110	2	35	77	84	0	0	0	0
3	Taungoo	0	0	0	0	0	0	0	0	50	50	110	140
4	Kler Lwee Htoo	0	0	0	0	9	137	362	353	120	120	380	272
5	Thaton	2	222	639	715	0	0	0	0	60	60	0	0
6	Papun	2	42	142	119	3	38	67	89	190	190	531	515
7	Pa An	3	251	722	906	3	61	123	148	115	115	308	267
8	Dooplaya	3	218	572	694	0	0	0	0	50	50	120	130
9	Kawkareik	2	168	413	476	0	0	0	0	40	40	89	97
10	Mergue/Tavoy	1	62	161	191	15	198	443	482	250	250	390	660
		14	1013	2769	3211	34	529	1215	1313	875	875	1928	2081
				5,980				2,528				4,009	

12.2.4 Village Health Workshop

The BPHWT organizes village health workshops every six months. These workshops cover topics such as water, sanitation, and disease prevention. Village health workshops typically focused on discussions of water-borne diseases. Strategies for preventing the spread of infection of malaria, diarrhea, respiratory infections, worm infestations, measles and typhoid are also addressed. Other topics discussed included malnutrition, waste disposal, Vitamin A, de-worming medicine, high-risk pregnancies, and how to make oral rehydration solution (ORS). The occurrence of workshops depended on the security situation in the community and the available time. Workshops usually involved small group discussions with the topics from these discussion groups then brought back to the main group for general discussion.



During 2014, the BPHWT organized **89** village health workshops in **12** targeted field areas, attended by **6,720** people – **2,949** men and **3,771** women. Communities were invited to send representatives from different sectors such as religious leaders, traditional birth attendants, and school teachers to attend discussions.

These representatives then go back to their respective communities and further transmit their knowledge about these health practices. The focus of the sessions is on primary healthcare concepts, such as prioritizing preventing the spread of infection as opposed to the curative treatments that villagers currently rely upon. These sessions also include a discussion period in which community members can raise further issues affecting their health. During these sessions, the health priorities of the community are identified and the community members participate in discussions about how the BPHWT can help to address these issues.

Village Health Workshops 2014

No	Area	Teachers		Students		TBAs/TTB A		HWs		VHVs/VHWs		Shop Keepers		Religion Leaders		Women Org		Youth Org		Village Leaders		Villagers		Authorities		Total
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
1	Taungoo	8	11	33	44	0	14	9	9	11	11	10	6	7	5	0	14	14	19	18	6	59	63	16	1	388
2	Kler Lwee Htoo	23	39	232	279	5	48	23	19	14	14	7	24	10	41	0	86	93	142	48	2	219	330	20	4	1722
3	Thaton	5	9	0	0	0	19	7	16	3	13	0	11	2	2	0	4	0	0	12	11	56	82	4	3	259
4	Papun	1	2	10	9	1	4	2	4	2	3	2	0	1	0	0	5	1	1	12	0	27	26	7	0	120
5	Pa An	4	21	0	0	4	30	3	11	6	20	8	24	13	3	0	6	21	13	35	3	154	179	6	1	565
6	Kawkareik	2	5	65	40	2	8	6	3	1	5	0	3	0	0	2	0	0	0	5	0	95	100	4	0	346
7	Win Yee	10	18	76	94	1	13	5	3	0	0	3	5	3	1	0	12	12	3	20	1	108	135	8	1	532
8	Mergue/Tavoy	1	16	28	33	0	14	5	10	1	10	3	10	15	6	0	36	31	26	18	6	67	92	17	9	454
9	Yee	2	20	10	14	0	15	2	8	0	2	0	0	23	11	0	10	61	82	25	1	131	169	26	6	618
10	Moulmein	6	12	0	0	0	1	0	6	0	0	0	0	8	0	0	0	54	108	13	0	112	114	12	0	446
11	Shan	1	6	35	52	0	4	13	11	0	0	0	3	6	0	0	16	15	12	16	0	196	292	12	2	692
12	Palaung	0	7	105	162	0	17	32	2	0	0	2	21	0	0	0	9	35	0	14	2	75	85	5	5	578
Total		63	166	594	727	13	187	107	102	38	78	35	107	88	69	2	198	337	406	236	32	1299	1667	137	32	6,720

12.3) Maternal and Child Healthcare Program:

The Back Pack Health Worker Team began the Maternal and Child Healthcare Program (MCHP) in 2000. The BPHWT has trained Traditional Birth Attendants (TBAs) every year in order to reach their goal of ten TBAs for every 2,000 people. Since 2012, the BPHWT has started to train Trained Traditional Birth Attendants (TTBAs) with higher skills to provide safe deliveries in order to reduce maternal and child deaths. However, there was no TTBA training conducted during this year because of the funds shortage. During 2014, **3,120** pregnant women received de-worming medicine (Mebendazole) and **3,388** women and pregnant women received iron supplements. In addition, **696** TBAs/TTBAs were working with the Back Pack Health Worker Team. They assisted in **3,779** births; of these, **3,760** were live births, **19** were stillbirths or abortions, and there were **18** cases of neo-natal deaths. The TBAs/TTBAs also recorded **2** maternal deaths. There were 1 obstetric cases referred during 2014.



Providing Ante-natal Care in Arakan area

12.3.1) Traditional Birth Attendant/Trained Traditional Birth Attendant Workshops: The BPHWT organizes TBA/TTBA workshops every six months in order to improve and upgrade TBAs/TTBAs' knowledge and skills, and to enable them to share their experiences and participate in ongoing learning opportunities. Delivery kit and maternity kit supplies were also restocked. These workshops provided a supportive environment for the discussion of issues faced in the field, which were then documented and reported at the reproductive health workshop and the BPHWT Six-Monthly General Meeting.

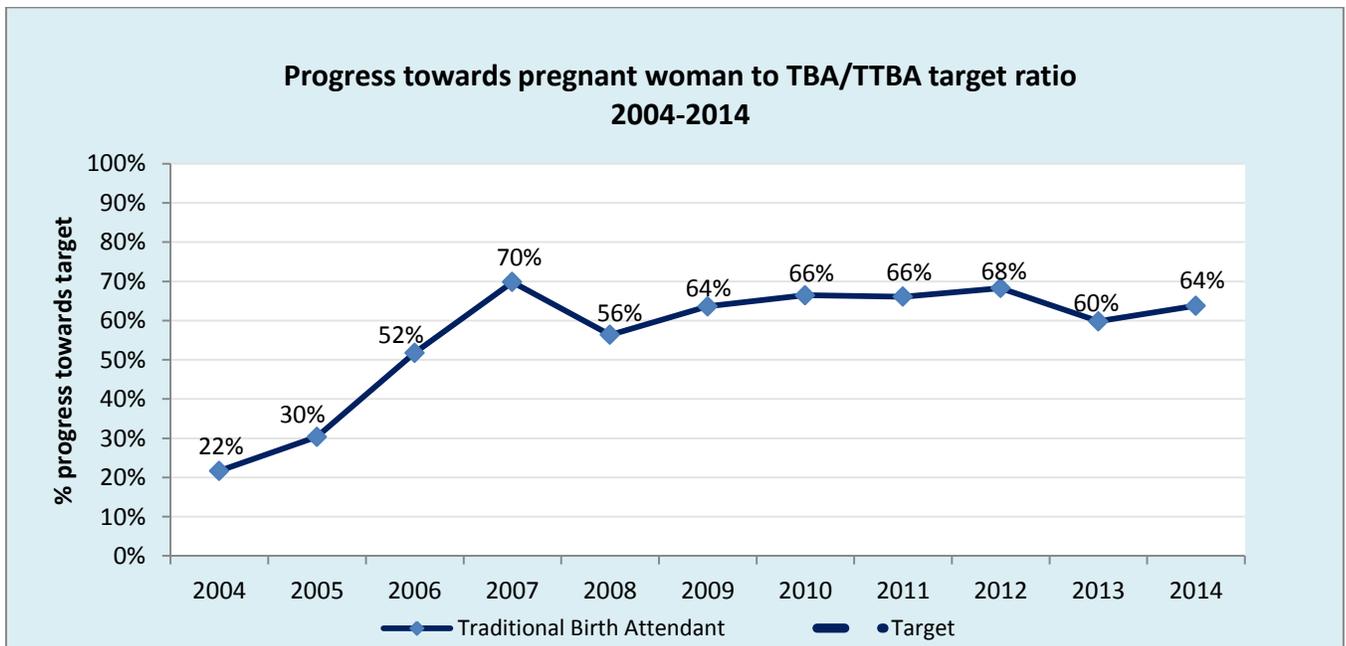
In 2014, **96** TBA/TTBA follow-up workshops were organized in **18** field areas which included **713** TBAs/TTBAs, comprised of **80** men and **639** women. However, some TBAs/TTBAs, who currently work with the BPHWT, could not participate in the workshop because of time limitations and workshop locations. During the workshops, **990** TBA/TTBA kits and **3,960** maternity kits were distributed in order to restock in field areas.

NO	Area	# TBA/TTBA workshops	Participants		
			Men	Women	Total
1	Kayah	4	0	47	47
2	Kayan	7	0	30	30
3	Taungoo	6	0	30	30
4	Kler Lwee Htoo	5	6	47	53
5	Thaton	7	0	75	75
6	Papun	8	31	78	103
7	Pa An	8	6	58	64
8	Doooplaya	6	11	47	58
9	Kawkareik	5	3	27	30
10	Win Yee	6	3	27	30
11	Mergue /Tavoy	10	11	37	48
12	Yee	2	0	22	22
13	Shan	2	0	10	10
14	Arakan	6	0	30	30
15	Palaung	6	0	31	31
16	Kachin	2	0	11	11
17	Special (Pa An)	1	2	8	10
18	KBC	5	7	24	31
Total		96	80	639	713

Progress toward TBA to Pregnant Women Target Ratio 2004-2014

Year	TBAs	Pregnant	TBA/Pregnant Ratio	Target TBA/Pregnant Ratio	% Progress to TBA/Pregnant Target
2004	202	7,453	37	8	22%
2005	260	6,855	26	8	30%
2006	507	7,833	15	8	52%
2007	591	6,771	11	8	70%
2008	525	7,454	14	8	56%
2009	630	7,922	13	8	64%
2010	672	8,089	12	8	66%
2011	722	8,740	12	8	66%
2012	787	9,217	12	8	68%
2013	711	9,509	13	8	60%
2014	696	8,729	13	8	64%

Traditional Birth Attendant-to-Pregnant Ratio as a % of the Target Ratio in BPHWT Target Areas over Time



Birth and Death Records – 2014

No	Area	Deliveries	Live Births	Still Births/ Abortions	Deaths		<2.5 Kg	=>2.5 kg
					Neonatal	Maternal		
1	Kayah	190	190	0	0	0	0	171
2	Kayan	131	130	1	0	1	0	131
3	Taungoo	100	99	1	0	0	0	48
4	Klew Lwee Htoo	124	122	2	0	0	6	116
5	Thaton	506	496	10	5	1	57	446
6	Papun	493	492	1	6	0	40	433
7	Pa An	364	364	0	0	0	12	351
8	Doolaya	357	354	3	4	0	62	291
9	Kawkareik	48	47	1	2	0	7	41
10	Win Yee	170	170	0	1	0	6	163
11	Mergue /Tavoy	107	107	0	0	0	9	98
12	Yee	157	157	0	0	0	3	154
13	Shan	46	46	0	0	0	1	45
14	Palaung	142	142	0	0	0	6	133
15	Kachin	6	6	0	0	0	0	0
16	Chin	323	323	0	0	0	2	304
17	Arakan	77	77	0	0	0	1	76
18	Special	32	32	0	0	0	0	16
19	KBC	406	406	0	0	0	0	169
		3,779	3,760	19	18	2	212	3,186

*Low Birth-weight Rate = 6 % out of 3,398 babies

Pre and Post Natal Distribution of De-worming, Ferrous Sulphate, and Folic Acid - 2014

No	Area	De-Worming	F/S & F/A
1	Kayah	170	170
2	Kayan	129	129
3	Taungoo	100	100
4	Kler Lwee Htoo	121	124
5	Thaton	330	398
6	Papun	368	430
7	Pa An	348	361
8	Doolaya	172	172
9	Kawkareik	47	47
10	Win Yee	170	170
11	Mergue/Tavoy	107	107
12	Yee	157	157
13	Shan	46	46
14	Palaung	142	142
15	Kachin	6	6
16	Chin	197	323
17	Arakan	74	74
18	Special Pa An	30	26
19	KBC	406	406
	Total	3,120	3,388

12.3.3) Family Planning Activities

The BPHWT introduced family planning activities in 2003 in order to improve maternal and child health status among internally displaced persons. The BPHWT provides family planning education and supplies to those communities who would like to access these services. The aim of the BPHWT family planning activities is to address urgent health concerns among the displaced communities. BPHWT distributes and promotes the use of three family planning methods, namely the contraceptive pill, Depo-Provera, and condoms.



In 2014, the BPHWT provided family planning services to **19** targeted field areas to **5,366** people, of whom **5,149** were women and only **217** were men. This statistic reflects that only a small number of men participate in family planning.

To improve the knowledge of family planning, BPHWT has included the family planning education session in the VHW's curriculum since 2012. In addition, the coordinator will update the form to collect MCHP targeted population such as women age from 15 to 45 years. BPHWT has learned from the external evaluating that it will help to analyze the program effectiveness and coverage.

Family Planning Activities – 2014

No	Area	Total Clients	Age		Gravida Parity (G/P)			Visits		Clients			Quantity		
			< 19	> = 19	0	1-4	>4	New	Follow Up	Depo	Pill	Condon	Depo (Inj)	Pill (Pack)	Condon (Pieces)
1	Kayah	160	4	156	0	82	78	20	140	127	30	3	230	180	270
2	Kayan	242	1	241	1	104	137	116	126	129	76	37	365	413	843
3	Taungoo	81	0	81	0	74	7	40	41	54	21	6	108	126	168
4	Klew Lwee Htoo	76	4	72	0	39	37	22	54	67	9	0	134	54	0
5	Thaton	712	3	709	0	280	432	162	550	546	135	31	1087	790	1122
6	Papun	399	1	398	0	118	281	86	313	135	250	14	274	1494	663
7	Pa An	395	2	393	0	294	101	84	311	197	176	22	345	721	906
8	Dooplaya	279	19	260	0	172	107	88	191	179	74	26	328	426	570
9	Kawkareik	214	7	207	1	174	39	35	179	153	61	0	308	304	0
10	Win Yee	228	0	228	2	142	84	58	170	75	130	23	133	700	1032
11	Mergue/Tavoy	155	1	154	2	84	69	76	79	78	73	4	167	450	576
12	Yee	626	81	545	88	500	38	95	531	533	78	15	605	234	430
13	Shan	143	13	130	22	113	8	51	92	89	51	3	178	199	78
14	Palaung	493	9	484	1	371	121	131	362	458	35	0	916	208	0
15	Kachin	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Chin	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Arakan	209	58	151	3	163	43	93	116	65	111	33	130	666	990
18	KBC	934	0	934	0	630	304	151	783	845	89	0	1690	534	0
19	Special	20	0	20	0	11	9	7	13	11	9	0	22	54	0
Total		5,366	203	5,163	120	3,351	1,895	1,315	4,051	3,741	1,408	217	7,020	7,553	7,648

12.3.4) Summary Fact Sheet of the MCHP's Activities 2000 - 2014

Years	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Total Deliveries	1432	2297	2693	3463	3156	3708	3770	3412	3961	3,508	3,779
Live Births	1347	2222	2594	3337	3095	3621	3704	3356	3927	3,486	3,760
Still Births/ Abortions	84	81	103	134	63	90	67	50	35	24	19
Neonatal Deaths	47	73	94	117	69	96	77	53	37	14	18
Maternal Deaths	8	15	15	27	13	16	9	13	9	7	2
Low Birth Weight	N/A	N/A	N/A	N/A	237	9540	279	254	263	103	212

In 2014, there were only two maternal deaths out of 3,779 total deliveries and the main causes of maternal deaths were eclampsia and Obstructive labour. Neonatal mortality rates during deliveries, attended by the BPHWT, have slightly increased in comparison with the previous year. However, the BPHWT is still trying to provide higher skills and knowledge of TBAs such as providing TTBA trainings to increase safe delivery, including health education, referral system. Additionally, the BPHWT conducts TBA/TTBA workshops to update those TBA skills and knowledge that will increase the implementation of safe birthing practices and improve maternal and child health in every six months.



Providing mothers and child healthcare

13) Field Meetings and Workshops

The BPHWT conducts field meetings and field workshops twice a year in the targeted field areas. In 2014, there were **33** field workshops and **25** field meetings conducted in the targeted field areas; there were **328** (200 men, 129 women) participants who attended field meetings and **359** (199 men, 161 women) participants who attended field workshops.

Field Workshops and Meetings – 2014				
Description	# of Field Workshops/Meetings	Men	Women	Total
Field Workshops	33	199	161	359
Field Meetings	25	200	129	328

Field Meeting Objectives:

The objectives of the field meetings are to meet with local community leaders to:

- Discuss the current healthcare situation and concerns in the community
- Review the various BPHWT programs – Medical Care Program, Community Health Education and Prevention Program, and Maternal and Child Healthcare Program
- Identify the healthcare and health education needs of the community and related issues; assign priorities according to these needs, and identify those needs that can be addressed by the BPHWT
- Collaborate to develop a plan for the BPHWT to meet the identified healthcare and health education needs of the community
- Obtain the approval, support, and active participation of community leaders in implementing the community healthcare and health education plan

Field Workshop Objectives:

The objectives of the field workshops are to:

- Improve the skill sets, knowledge, and clinical confidence of the health workers, especially concerning effective treatment and proper primary healthcare approaches
- Share skills, knowledge, and case experiences
- Talk about the importance of collecting health information in order to better understand and serve the current community healthcare needs as well as to evaluate the effectiveness of the BPHWT programs
- Discuss the current health care situation in the field and related issues
- Insure that the necessary medicines and medical supplies are delivered to the health workers
- Instill a strong sense of confidence in the health workers so that they will be highly motivated to successfully implement their BPHWT responsibilities in the field

14) Capacity Building Program

In 2014, the Back Pack Health Worker Team organized three community health worker trainings, one Public Health Supervisor Training and two Auxiliary Midwife (AMW) trainings which aim to improve the health workers' knowledge and skills as well as to provide updated health information to health workers to be better able to serve their communities. Additionally, trainings and workshops are also conducted for the health workers every six months in the Back Pack targeted field areas.

In addition, two coordinators attended the Payap course which is organized by IRC/PLE and one coordinator attended Public Health training course which is organized by MTC and trainers were from PLE trainer team. All program staff, including program coordinators and finance team attended Data Utilization training which supported by CPI one in two months. HIS coordinator also organized monthly meeting for HIS staff.

14.1) Community Health Worker (CHW) Training

During this period, the BPHWT organized two community health worker training in Htay Bay Hta of Karen State and one in Kayan area. The training is Basic Medical Training and lasted for six months. The purpose of the training is to recruit more health workers to provide healthcare services in their communities. The training objectives are:

- Provide health workers' knowledge and skills, and recruit more community health workers in local communities
- Provide healthcare services to the communities
- Improve the health situation, both preventive and curative, in communities
- Reduce the misuse of treatment within communities

The CHW training in Htay Bay Hta was conducted from 5 May to 30 December 2014. There were 85 trainees comprise of 41 men, 44 women from different areas and 13 trainers comprise of 9 men and 4 women) from BPHWT and IRC. The purpose of the training is to enhance the knowledge of the health workers about anatomy and physiology, basics of medical theory and diseases. After the training, they have undergone four-month internship at their respective clinics to apply the knowledge and skill from it.



Community Health Worker Training in Kayan

The Community Health Worker training in See Bu in Kayan State was conducted from 8 May to 5 October 2014. The total number of trainees were 34, comprise of 6 men and 28 women. There are 9 trainers comprise of 5 men and 4 women. After the training, they also do have practical in their area as to adapt and apply these concepts in their work.

Key Course Topics:

- Health information
- Pharmacology
- Anatomy
- Epidemiology
- First aid
- Basic Medical Care II with history taking and physical examination
- Diseases prevention and control (water borne, vector borne, air borne, non-communicable diseases)
- Environmental health
- Family health and reproductive health
- Rehabilitation
- Community health promotion

14.2) Public Health Supervisor Training

The BPHWT organized the Public Health Supervisor Training. This training is long for three months. PHS training started on May 3, 2014 at the BPHWT head quarter office in Mae Sod and completed in July. This is the first training ever. There are 24 trainees, comprised of 9 women and 15 men from different areas and ethnicities. This training is conducted by the trainers from IRC/PLE. The BPHWT also has training team to involve in the training as trainers' assistant. This training is an advance level and focuses on prevention program. The purpose of the training is to qualify and



Public Health Supervisor Training

improve health workers knowledge as to supervise other workers in their field areas. Moreover, they have to organize health education training to educate workers both prevention and treatment program. All the trainees must to complete CHW and Medic refresher before attend this training. Since they have to know the detail of the clinical diagnosis and technical method of prevention, the IRC/PLE training team has organized the training and divided the topics as below:

- First Aid
- Management on Minor Ailments
- Safe Water Supply
- Sanitary Excreta Disposal
- Garbage and Refuse Disposal
- Disposal of Sullage Water
- Rodent Control
- Vital and Health Statistics
- Epidemiological Surveillance and Control of Communicable Diseases
- Specific Communicable Diseases Control
- Malaria Control
- Filariasis Control
- Tuberculosis Control
- Leprosy Control
- STI Control
- Trachoma Control
- Health Education
- School Health
- Family Health Care
- Community Health Care
- Nutrition Promotion
- Health Management and Supervision
- Expanded Program on Immunization (EPI)

14.2) Auxiliary Midwife training

The BPHWT continuous supporting of the Auxiliary Midwife (AMW) training that has been running since 2013 funded by SV award. During 2014, the BPHWT with Phlon Education Development Unit (PEDU) and State Health Department (SHD) organized two Auxiliary Midwife trainings which participated by 47 AMWs. These are batch 3 and 4 of AMW trainings. Batch 3 was started on 21 April and completed on 20 July 2014; and the batch 4 AMW training was started from 27 July to October 2014. There were 23 trainees in batch 3 and 24 trainees in batch 4. These participants are from Kawkareik, Kyarr Inn Seik Kyi, Hlaing Bwe and Kyaik Ma Yaw Township. In addition, there are seven trainers: one from BPHWT, three from State Health Department (SHD) and three are retirees from the government. This training is focus on maternal child healthcare as to know how to deliver baby systemically include practical and theory. After the training, the trainees have to do three month internship at Mae Tao Clinic at Reproductive Health (RH) department. The key course topics of the AMW Training Course:

- Basic anatomy and physiology
- Basic nursing care
- Basic first aid
- Universal precaution
- Basic history taking and physical examination
- Common diseases (Diarrhea, ARI, Malaria, worm infestation, Measles, anemia, Vitamin deficiency)
- Anatomy and physiology of reproductive
- ANC, Delivery, PNC, abortion, < 5 year Care, IMCI, PHC concept and approach.

15) Health Convergence Initiative

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

This collaborative initiative began in May 2012 with the establishment of the Health Convergence Core Group (HCCG). The aim of the HCCG is to prepare existing ethnic community-based health networks, both inside Burma and those managed from the Burma border areas, for future possibilities to work together with Union

and state/region government health agencies, ethnic authorities, international donors, international non-governmental organizations (INGOs), and civil society organizations.

The purpose of the HCCG is to explore policy options for achieving the convergence of ethnic health networks with the health system of the Burma Government through political dialogue. At the end of 2014, the HCCG consisted of nine EHOs/HCBOs:

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

To guide its work, the HCCG has adopted the following principles related to health convergence:

1. Current health services, which are based on the primary healthcare approach, must be maintained and expanded.
2. The role and structure of the EHOs must be maintained.
3. Communities and community-based health organizations must be involved in the decision-making process and the implementation of healthcare services in the ethnic states.
4. INGOs must cooperate with local CBOs and EHOs by promoting their roles and capacity.
5. Healthcare programming should not create conflict among the community and between the health care providers.
6. Development of a national health policy and system should be according to the framework of a Federal Union.
7. Health programming and policy should complement and support the federal aspirations of the ethnic peoples throughout the peace process.
8. Any acceptance of health-related humanitarian and development aid must be in line with the existing health infrastructure that has been established by EHOs and CBOs.
9. The implementation of any health activities in ethnic areas should have approval from the local ethnic health organizations.

Potential outcomes of convergence:

1. Increased access to health care for populations in need
2. Ethnic and community-based health programs are supported and strengthened
3. Positive impact on peace-building
4. Basic needs and human rights are addressed
5. Recognition and accreditation of ethnic health workers
6. Increased decision-making and power sharing at the state and local level
7. International partnerships and networking are promoted

Until recently, the Burma Government has spent 3% or less of its national budget annually on health care and as a consequence, the healthcare system is rather inadequate, particularly in the rural and ethnic areas. In contrast over the past twenty-five years, international aid agencies and donors have invested heavily and successfully in building the capacity and network of the border-based health system through technical support and funding focusing on service delivery, program development and management, policies and procedures, reporting, medical and public health training, surveys, assessments, research, monitoring, evaluation, and other such capacity building. This investment of technical expertise and funding have resulted in an efficient and effective ethnic primary healthcare system which has been successful in addressing the healthcare needs of the ethnic people, despite situations of ongoing conflict and difficult working conditions. Also this system is community-based and has been providing the necessary knowledge, experience, and skill sets to local people for them to become more responsible for their own health care.

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

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



The 5th HCCG Strategic Planning Meeting

From these health system studies, devolved health systems, especially primary health care, seem most compatible with the situation in Burma as they are more

community-based, more responsive, and more in line with the aspirations of the ethnic people. Also devolved health systems appear to be the accepted global model.

The BPHWT has been moving forward with convergence activities at the program level: convergence at the policy, system and structural level will develop in conjunction with the ceasefire/peace process and as a durable, meaningful political change occurs in Burma.

These ongoing initiatives with both Union and state/region health officials in Burma include:

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

During 2014, the BPHWT has hosted and participated in a number of HCCG activities:

1. HCCG Policy Meeting: 1 - 2 February 2014, Mae Sot, Thailand
2. Health System Development Seminar: 31 March - 1 April 2014, Mae Sot, Thailand
3. Myanmar Peace Support Group Meeting: 21 May 2014, Mae Sot, Thailand
4. Canadian Health System Study Tour: 24 May - 8 June 2014
5. HCCG Convergence Presentation: Early June 2014, Kachin and Karenni States, Myanmar
6. UNHCR "Convergence of Service Consultations in SE Burma": 20 June 2014, Yangon, Myanmar
7. HCCG Convergence Presentation in a SWAN Workshop: 6 July 2014, Chiang Mai, Thailand
8. Fifth HCCG Strategy Meeting: 14 - 15 August 2014, Mae Sot, Thailand
9. BPHWT Field Area (18 Filed Areas) Convergence Workshop; September 2014, Mae Sot, Thailand
10. HCCG Convergence Presentation in a Civil Society Policy Workshop of the Ethnic Nationality Affairs Center: 3 December 2014, Chiang Mai, Thailand
11. HCCG, HSS, and HISWG Coordination Meeting: 22 December 2014, Mae Sot, Thailand

The Health HCCG Strategy Meetings addressed issues in relationship to various forms of health decentralization of political, administrative, and financial authority and responsibilities – deconcentration, devolution, and delegation - with their respective implications; the need for health convergence to be better

understood by the various parties to the ceasefire/political negotiations, local communities, INGOS, and donor organizations; Burma Government's recognition of community-based border-managed health programs and workers; health data collection to support health convergence; and related topics.

Additionally, some HCCG members, including the BPHWT, met separately with officials from the Union and State Ministries of Health. At these meetings, the HCCG members spoke to the concept of convergence, recognition of ethnic health workers and infrastructures, procurement strategies, health data sharing, possible health collaborative activities, and national health protocols.

In this similar respect during 2014, the BPHWT collaborated with the Phlon Education Development Unit (PEDU) and the Karen State Department of Health (KSDoH) to conduct Auxiliary Midwife (AMW) training. This is a continuation of the training collaboration began in 2013. There was two AMW training during this period with 23 and 24 participants, respectively.

The AMW training consisted of four months of classroom theory and three months of clinical internships/training at the Mae Tao Clinic in Mae Sot, Thailand. Following the clinical internships/training, the new AMWs are sent back to their respective communities in Burma Government-controlled townships to implement a Maternal and Child Healthcare Pilot Program planned by the BPHWT. The AMW trainers were from the BPHWT, KSDoH, and International Rescue Committee as well as retired Burma Government medical personnel. At the end of the training, the AMWs received AMW kits from the KSDoH and medical supplies from the BPHWT. Also they received accreditation certificates signed by the Directors of the KSDoH, PEDU, and BPHWT.

During the second half of 2014, the BPHWT conducted special HCCG Workshops in the following Field Areas:

1. Hpa An Field Area (10 HCCG Workshops): 780 people
2. Kawkareik Field Area (7 HCCG Workshops): 500 people
3. Kler Lwee Htoo Field Area (1 HCCG Workshop): 56 people
4. Palaung Field Area (2 HCCG Workshops): 30 people
5. Pa O Field Area (1 HCCG Workshop): 48 people

Participants who attended these special HCCG Workshops included:

- Villagers
- Village householder leaders
- Village/township administrators/leaders/committee members
- Local health authorities
- Village health workers
- Traditional birth attendants
- Burma Government midwives and auxiliary midwives
- BPHWT health workers
- Local education authorities and teachers
- Women's organization members
- Community-based organizations' members
- Religious leaders
- Ethnic political organizations members
- Union-registered political party local members
- INGO members

HCCG Workshops were also conducted within Field Workshops in the following Field Areas

1. Papun Field Area
2. Thaton Field Area
3. Kayah Field Area
4. Naga Field Area
5. Special Shan Kayah Field Area
6. Chin Field Area

Topics discussed at these HCCG Workshops included:

1. HCCG background
2. HCCG's member organizations
3. HCCG's aim
4. HCCG's Nine Principles
5. What is "health convergence" and why is it necessary
6. Community-based primary healthcare model
7. Recognition of ethnic health organizations and health workers
8. Relationships with and reporting by health INGOs entering villages

As mentioned earlier, the health convergence initiative works in concert and supports the ceasefire and peace negotiations between the Burma Government and the ethnic people. They also serve as a "Bridge for Peace" and a confidence building measure. However, while supporting these negotiations, the movement and timing of health convergence entails certain real risks to ethnic health workers and infrastructures should the negotiations breakdown and fighting resume. The temporary ceasefire agreements are breaks in the offensive military fighting to see if there are common grounds for negotiations among the parties. Hopefully, these negotiations will move to a next stage of a Nationwide Ceasefire Agreement whereas the parties have agreed that there are genuine common grounds for negotiations and that there should be framework implemented for political dialogue. At this stage, the risks to the ethnic health workers and infrastructures will be somewhat lessen and more comprehensive health convergence activities can be undertaken.

16) Monitoring and Evaluation

The Back Pack Health Worker Team organizes program activity meetings twice a year and a general meeting once a year. The meetings include discussions of monitoring and evaluation. In 2007-2008, the BPHWT conducted an Internal Programming Improvement Project (IPIP) in order to evaluate the improvement of its activities, focusing in particular on communications, appropriate drug use, and performance reviews of the clinical logbooks. In 2008, the BPHWT continued the IPIP process and the evaluation of program implementation to improve the quality of drugs administered, health workers' skills and knowledge, and logistics management.

During 2014, the Director of Executive Board with other office staff made monitoring trips to Dooplaya, Thaton, Karenni and Kachin targeted field areas to assess the situation, program effectiveness, and the health need in the field areas.

In addition, the BPHWT conducts a Program Impact Assessment Survey in every two year. During 2013, TBA Assessment Survey and Health Worker Assessment Survey were conducted in order to monitor and evaluate the effectiveness of the programs implemented in the target areas. Eastern Burma Retrospective Mortality Survey (EBRMS) were conducted instead of the Impact Assessment Survey (IAS). The report of EBRMS "The Long Road to Recovery" had been launched. The BPHWT reviews patient record books to assess the quality of care as well as the field workers' adherence to treatment protocols and case definitions during these periods.

Framework of Monitoring and Evaluation

Key Indicators	Methods	Period
Health Worker Performance	Logbook reviews	Every six months
Program Development	Annual report comparing planning and actual activities	Once a year
Program Management	Leading Committee elections and Executive Board appointments	Every 3 years
Outcome and Impact Assessment	Conducting surveys	Every 2 years
Training Effectiveness	Pre- and post-test examinations	Every year
Financial Management	Comparisons of planned and actual budgets	Every six months
	External audits	Once a year

**Back Pack Health Worker Team - Log Book Review for Three Diseases
(Diarrhea, Malaria, and Pneumonia)**

Sampling method

Using systematic random sampling: from the sampling frame, a starting point is chosen at random, and thereafter at regular intervals according to caseloads.

Sample size estimation

$$n = \frac{Z^2 \alpha / 2 P (1 - p)}{d^2}$$

$$n = \frac{1.962 \times 0.5 \times 0.5}{0.072}$$

Where n = Sample size

z = the reliability coefficient (confidence level) at 95% CI = 1.96

p = proportion of population which yield the largest sample size
= 0.5

d = absolute precision of study = 0.085 (acceptable error)

n = 196 (200)

Feedback on log book review & Health System Strengthening field assessment

BPHWT Log Book Review:

- BPHWT & IRC-PLE staffs reviewed
- Log Books recorded during Jan – Jun 2014
- Three main diseases
- Diarrhea, Pneumonia, Malaria
- Total 200 samples were reviewed for each disease
- Reviewed during January 2015

Sixty Different Clinics:

- | | | |
|---------------------|-------------------|---------------|
| • 1. Kayan | • 7. Kawkareik | • 13. Palaung |
| • 2. Kler Lwee Htoo | • 8. Win Yee | • 14. Shan |
| • 3. Thaton | • 9. Mergue/Tavoy | • 15. Kachin |
| • 4. Papun | • 10. Moulamein | • 16. Arakan |
| • 5. Pa An | • 11. Yee | |
| • 6. Dooplaya | • 12. Pa O | |

Areas covered in each disease:

- Proper recording of signs & symptoms of the patients
- Proper recording of vital signs
- Correct diagnosis
- Treatment according to guideline

2012 - 2014 result (scoring - fair and above)

Malaria (%)			Pneumonia (%)			Diarrhea (%)		
2012	2013	2014	2012	2013	2014	2012	2013	2013
77%	85%	97.5%	93%	89%	94.5%	26.5%	58%	97%
154/200	170/200	195/200	186/200	178/200	189/200	53/200	116//200	194/200

Pneumonia

- Duration of symptoms & no record from physical examination (32%)
- Body weight was not recorded in some areas
- Misdiagnosed (Severe P'nia but no severe s/s)
- Treatment was not relevant with diagnosis and physical examination
- No vit-A supplementary in some patients

Diarrhea

- Treatment not relevant with diagnosis
- Few records on signs of dehydration
- Diagnosis was not included level of dehydration
- Duration of s/s
- Body weight and blood pressure were not recorded in vital signs

Malaria

- Duration of symptoms?
- No anemia treatment was given in some areas

17) Program Development and Activity Reviews in 2014

Comparison of Planned and Actual Activities (Logistical Framework Activities)

Overall goal	To reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare						
OBJECTIVES	ACTIVITIES	INDICATORS OF ACHIEVEMENT	VERIFICATION SOURCES	2014 EXPECTED RESULTS	2014 ACTUAL RESULTS	VARIANCES OR DIFFERENCES	ASSUMPTION OR RISKS
Medical Care Program							
1. Provide essential drugs and treat the common diseases	Increase number of BP teams	No. of teams increased	Procurement delivery documents; logbooks; analysis of data collected; and field reports	BP teams will be increased from 95 to 100	100 BP teams (37 stationary BP teams)		
	Provide medicine and medical supplies	No. of target population and total case-load (w/m), under/over 5)		200,000 targeted population	206,361 covered population (<5 = 39,747 M=19,063 F = 20,684), (>=5 - 16,6614 M=80,338 F = 86,276)		
	Treat common diseases and minor injuries	No. of cases treated (w/m, under/over 5)		108,000 cases being treated (no. of families & HH, no. of w/m and under/over 5)	84,914 cases treated (36,522 HHs, no. of W - 36,338 M-39,438) & (<5-17,865, >= 5-67,049)	23,086 (21%) less cases treated	
	Provide ITNs	No. of ITNs provided and no. of HHs and people receiving ITNs	ITNs distributing lists	7,000 ITNs will benefit 7,000 HHs or 35,000 people	18,000 ITNs benefited for 1,1696 HHs & 66,810 pop	11,000 more ITNs were distributed	The BPHWT received ITNs from URC.
		Percentage of	2016 Impact	60% of people in			

		people in households sleeping under ITNs (Baseline-53%)	Assessment Survey	households sleeping under ITNs (63.9% in 2013)			
Provide malaria rapid tests	No. of malaria rapid tests provided	Rapid tests distributing lists	32,700 rapid tests will be provided	22,875 rapid tests were provided	9,825 (30%) less rapid tests were provided	Because there was less patient who had fever.	
Provide ACT to patients with malaria	Number of (CASES) women and men diagnosed with PF malaria by the BPHWT who are treated with ACT in the BPHWT target population (baseline – W-3103,M - 3606 Total: 6709 individuals in 2010)	Health worker logbooks; field in-charge reports; midyear and annual report	Women – 4,000 Men - 4530 Total: 8,530 individuals	Women – 1,761 Men - 2,161 Total: 3,922 individuals		The malaria medicines are delayed received by the field health workers.	
		Percentage/Number of children (CASES) under 5 treated by BP health workers who receive appropriate anti-malarial treatment	Health worker logbooks; field in-charge reports; (malaria data analysis)	95% of children under 5 treated who receive appropriate anti-malarial treatment. (95% in 2013)	N/A		
		Malaria mortality rates per 1,000 population	2016 Impact Assessment Survey	2.5 malaria mortality rates per 1,000 population	N/A		

		(baseline-3.5 malaria case deaths per 1000 population)		(2.4 in 2013)			
		Mortality rates among children under 5 years old per 1,000 live births in target population (baseline-138)	2016 Impact Assessment Survey	130 mortality rates among children under 5 year old per 1,000 live births in target population (195.3 in 2013)			120.7 (overall excluding SSDF)
		Percentage of under 5 children with malnutrition (according to accepted guidelines for MUAC cutoffs) (Baseline – 16.5%)	2016 Impact Assessment Survey	14% of under 5 children with malnutrition (2013 - 4.0% severe (MUAC< 11.0) (BP specific) 12.2% moderate (MUAC<12.5) (BP specific)	N/A		2.5% severe (MUAC< 11.0) (overall excluding SSDF) 10.4% moderate (MUAC<12.5) (overall excluding SSDF)
2. Respond to disease outbreaks and emergency situations	- Purchase emergency medical supplies and immediately take action	Prompt reporting Population affected No of cases treated (w/m, under & over 5)	Delivery document; field rep reports; annual report	Effective response and treatment for disease outbreaks or emergency situations (w/m & under/over 5	There are emergency teams in some targeted field areas. But there was no emergency situation responded		
3. Improve health workers skills and knowledge	Organize Field meetings and workshops	No. of health workers participated	Field meeting and workshop report	Twice a year for 19 areas	25 field meetings and 33 field workshops		

		No. of participants		300 people participate in field workshop and 200 in meeting	were organized 359 (M-199, W-161) HWs attended field meeting and 329 (M-200, W-129) HWs participated in field workshops		Underestimated the attendants
	6 month workshops	No of health workers participated	Workshop report; mid-year and annual report; workshop attendance list	100 health workers attend 6 month workshops(w/m)	76 health workers attended 6 month workshops(W-32, M-44)	24 less health workers attended 6 month workshop	Only two field representative from each area were invited to attend the 33th six month meeting.
4. Improve patient referral systems	Refer patients to the nearest hospitals or clinics.	No of referrals patients(w/m) List of referral sites	Mid-year and annual reports; patient's referral for	90 patients referred to clinics or hospitals (w/m)	88 patients referred to clinics or hospitals (W-47, M-41)	2 less cases referred	1 obstetric cases referred
Community Health Education and Prevention Program							
1. Reduce the incidence of malnutrition and worm infestation	Distribute de-worming medicine to children between 1 to 12 years	No of children receiving de-worming medicine	Worker data form; mid-year & annual reports	35,000 children will receive de-worming medicine	36,642 (M-17,897, F-18745) children received de-worming medicine	1,642 more children received de-worming medicine	

	Distribute Vitamin A to children between the ages of 6 months to 12 years	No. of children receiving Vitamin A		40,000 children will receive Vitamin A	4,1692 (M-20,536, F-21156) children received Vitamin A	1,692 more children received Vitamin A	
2. Educate students and communities about health	Provide school health education	No. of school sessions and no. of students (w/m)	Field reports; mid-year & annual report	95 school sessions attended by 9,500 students (w/m)	95 school sessions attended by 42,099 students (20,589 boys and 21,510 girls)		
	Provide Village Health Workshops	No. & category of people in Village Health Workshops (w/m)		9,500 people participate in 95 sessions Village Health Workshops (w/m)	6,720 people (W-3,771 & M-2,949) participated in 89 Village Health Workshops	2,780 (29%) less people participated in VH workshop	
	Provide health campaign	No. of people participate in event (w/m), (World AIDS Day)	Village Health Workshop reports	95 World AIDS events for 14,250 people	No World AIDS events organized		
3. Improve community level knowledge and participation in health	Organize village health worker trainings and workshops	No. training and VHW attended (w/m)	Field report; mid-year & annual report; VHW training and workshop reports	20 VHW trainings for 400 new VHWs (w/m)	No VHW trainings was conducted		Because of the funds shortage.
		No. workshop and VHW participate (w/m)		180 VHW workshop for 592 VHWs (w/m)	No VH workshop was conducted		

	Provide VHW kits	No. of VHW kits provided	VHW kits distributing list; field, mid-year & annual reports	180 VHW kits will be provided for 592 VHWs	No VHW kit was provided		Because of the funds shortage and they used the kits together with HWs
4. Improve water and sanitation systems in the community to reduce water-borne diseases	Provide water and sanitation systems	No. & type of latrines built and No. of HHs and people benefit from latrines	Field reports; mid-year & annual report	100 school latrines will be benefited 2,000 students	No school latrines installed		Because of the funds shortage.
				3,000 community latrines or will be benefited 30,000 populations	875 community latrines benefited for 4,009 populations (W-2,081, M-1,928)	2,1250 (70%) less latrines installed	
		No. & type of water systems installed		20 gravity flow water systems 1,200 house-holds (6,000 pop)	14 gravity flow water systems for 1,013 house-holds (5,980 pop) (W-3,211, M-2,769)	6 less gravity flow water systems installed	
		No. of HHs and people benefit from water systems (w/m)		40 shallow well systems 400 house-holds (2,000 pop)	34 shallow well systems for 529 house-holds (2,528 pop), (W-1,313, M-1,215)	6 less shallow wells were installed	
		No. of cement frames		20 cement frames will be provided	26 cement frames will be	6 more cement frames were	

		% of people who own a latrine using latrines (always and sometimes) (Baseline -98%)		99% of people who own a latrine using latrines (always and sometimes) (99.2% in 2013)	provided N/A	provided	
		% of people who own a latrine (Baseline - 70% in 2010)	2016 Impact Assessment Survey	85% of people who will own a latrine (55.8% in 2013)	N/A		The survey might not take place in the areas where BP implements Water & Sanitation projects. Shan & Mon clusters were assigned to EHOs. 61.4% (overall excluding SSDF)
5. Prevent and control communicable disease of Lymphatic Filariasis	Provide final assessment for program effectiveness	% of people who are suffering from LF	Final LF assessment report	% of people who are suffering from LF	N/A		There was no activity for Lymphatic Filariasis during year. It is in process for LF 5 yrs assessment.
	Provide awareness workshop	No. of participants	LF workshop attendance list	5 awareness workshop to 1,500 (w/m) population	No awareness workshop organized		
Maternal and Child Healthcare Program							
1. Increase maternal and child healthcare	Distribute Vitamin A and Albandazole	No. of pregnant women receiving Mebendazole	TBA's form	4,000 pregnant women will receive Mebendazole	3,120 pregnant women received	880 (22%) less pregnant women received Albandazole	

	Provide iron prenatally and postnatally to pregnant women	No. of pregnant women and women receiving iron		4,000 pregnant women and women will receive iron	Mebendazole, 3,388 pregnant women and women received iron	612 (15%) less pregnant women and women received iron	
	Referral of serious obstetric cases	No. of serious obstetric cases	Patient's referral form; mid-year & annual report	25 obstetric cases referred	1 obstetric cases referred	24 less obstetric cases referred	Obstructive labour from KBC
	Provide ANC to pregnant women	No. and % of pregnant women in target population with at least four ANC (Baseline – 44.7% in 2010)	2016 Impact Assessment Survey	50% of pregnant women in target population with at least four ANC (15.7% in 2013)	N/A		The protocol of ANC was changed in 2012. 19.4% (in last 2 years) (overall excluding SSDF)
		% of children 0-5 months who are fed exclusively with breastfeeding in target population (Baseline -23%)	2016 Impact Assessment Survey	30% of children 0-5 months who are fed exclusively with breast milk in target population (35.1% in 2013)	N/A		22.9% (in last 2 years) (overall excluding SSDF)
		No. and % of Trained Traditional Birth Attendants who can identify at least 3 signs of pregnancy	2016 Impact Assessment Survey	50% of TBAs/TTBAs who can identify at least 3 signs of pregnancy complications, according to	N/A		

		complications, according to agreed standardized and harmonized health guidelines(Baseline-45% -2010)		agreed standardized and harmonized health guidelines (69% in 2013)			
2. Raise awareness among villagers on family planning and provide them with family planning supplies	Provide family planning supplies	No. of clients receive the family planning supplies (w/m)	Mid-year and annual reports	4,500 people using family planning methods (w/m)	5,366 people using FP methods (W-5,107, M-180)	866 (19%) more people using FP methods	BPHWT has done more FP education.
	Provide family planning education	% of people using family planning methods (Baseline-22.9%)	2016 Impact Assessment Survey	40% of 44,941 people of reproductive age	N/A		
	Provide family planning posters	No. of posters provided	Distributing list, mid-year and annual report	170 family planning posters will be provided	No family planning posters will be provided		Because of the funds shortage
	Conduct TTBA training	No. of new TBAs complete the training		12 TTBA training for 240 people (w/m)	No TTBA training conducted		
	Conduct TBA/TTBA workshops	No. of TBA/TTBA Follow-up Workshops held & no. of TBAs attending (w/m)		170 follow-up TBA/TTBA Workshops for 850 TBAs/TTBAs (w/m)	102 follow-up TBA/TTBA workshops attended by 773 (W-699, M-00)	63 (37%) less follow-up workshop organized	
	Provide safe birthing kits	No. of births attended by trained TBAs/TTBAs and health workers,	TBA's/TTBA's form; mid-year & annual report	4,000 babies delivered by trained TBAs/TTBAs and health workers	3,779 babies delivered by trained TBAs/TTBAs and health	221 (6%) less babies delivered by trained TBAs/TTBAs and health workers	

		among total target population % of births attended by trained TBAs/TTBAS % of births attended by health workers (Baseline – TBA - 67%, health worker – 27%)	2016 Impact Assessment survey	- 60% of births will be attended by TBAs/TTBAS (78.6% - 2013) 35% of birth will be attended by health workers (15.7%-2013)	workers		
	No. of TBA/TTBA kits provided	Kits distributing list; midyear & annual report	1,700 TBAs/TTBAS kits	990 TBAs/TTBAS kits	710 less kits was provided	Because of the cash flow and less TBA/TTBA workshop.	
	No. of maternity kits provided		6,800 maternity kits	3,960 maternity kits	2,840 less maternity kits		
	Appropriate sterile instrument (new razor blade, sterile scissors, etc) = 326 (79%)-2010, povidine/Iodine or other antiseptic = 354 (85%) -2010	TBA assessment survey - 2016	- 85% of new razor blade, sterile scissors, and etc were used (96% - 2013) - 90% of povidine/Iodine or other antiseptic were used (91% - 2013)	N/A			
	At the last pregnancy that you delivered provide at least 3 information = 353 (85%) -2010	2016 TBA Assessment Survey	- 90% of postpartum women were given at least 3 information (99%- 2013)				

4. Provide delivery records	Document deliveries	No. of newborn baby received delivery records	Delivery record issued copies, midyear and annual report	2,200 delivery records	2,037 delivery records	163 less delivery records	
5. Converge and coordinate with the Burma government's state administered Reproductive healthcare program in Karen State.	Organize Auxiliary Midwife Training	No. of AMW training provided	AMW training report & attendance list	2 Auxiliary midwife training will be provided	2 Auxiliary midwife trainings organized		
		No. of AMWs participate in the training		20 AMWs will participate in each AMW training	47 AMWs participated in 2 AMW trainings	7 more AMWs attended AMW training	
		No. of AMW kits will be provided		110 kits for 75 AMWs	35 kits for 35 AMWs	75 kits less were provided for 35 AMWs	Delivery supplies from Karen State Health Department & Basic medicines from BPHWT
Capacity Building							
1. Improve health worker and staff knowledge and skills	CHW ToT training	No. of CHW attend the ToT training (w/m)	CHW ToT training report & attendance list	1 CHW ToT for 20 CHW	No CHW ToT		There are still former trainers who have already completed ToT
	VHW ToT training	No. of health workers attend ToT training (w/m)	VHW ToT training report & attendance	1 VHW ToT for 20 health workers	No VHW ToT		Because of no VHW training

MCH/TTBA ToT training	No. of MCH supervisors attend the ToT training (w/m)	list MCH ToT training report & attendance list	1 MCH ToT for 20 MCH supervisors	No TTBA ToT		Because of no TTBA training
CHW training	No. of trainees completed CHW training (w/m)	CHW training report & attendance list	4 CHW trainings for 120 CHW (w/m)	3 CHW trainings attended by 119 (W-72, M-47) participants	1 less CHW training was conducted	
MCH refresher training course	No. of trainees complete medical refresher course training (w/m)	MCH training report & attendance list	1 MCH refresher training course for 30 MCH	No MCH refresher training coursed conducted		Instead of this training, the BPHWT has sent 17 MCH workers to attend Certificate of Midwife which is organized by MTC.
Public Health Training	No. of trainees complete PH training (w/m)	training report & attendance list	1 Public Health training for 30 medics (w/m)	1 Public Health training attended by 24 (W-9, M-15) participants		
Technical refresher training for AMWs (Pa An)	No. of trainees complete the training (w/m)	training report & attendance list	2 Technical refresher training for 60 people (M/W)	1 Technical refresher training attended by 35 AMWs	1 less Technical refresher training was conducted	Due to funds shortage and time limitation

	Attend international conferences and meeting	No. of times and participants in international conferences & meeting	Mid-year & annual report	Attend 2 international conference or meetings attended by 2 staff members	Attended 2 international conference by 6 staff members		
	Attend local conferences and meeting	No. of times and participants in local conferences & meeting	Mid-year & annual report	6 local conferences or meeting will be attended by 8 staff members	7 local meetings attended by 10 staff members		
	Attend international and local short course training	No. of participants attend short course training	Mid-year & annual report Attendance list	4 staff members will attend short course training	3 staff members attended short course training	1 Less staff attended the course	Payap course and Public Health
	Organize organization development training	No. of participants attend OD training		10 staff members will attend OD training	2 staff members attended Payap course	8 Less staff attended the course	Payap course includes this project.
	Organize project management training	No. of participants attend project management training		10 staff members will attend project management training	2 staff members attended Payap course	8 Less staff attended the course	Payap course includes this project.
	Organize internship program at MTC	No. of participants	Attendance list	60 staff members will attend internship program	30 CHWs attended the internship program	30 less CHWs attended the internship	MTC has interns from other health organizations such BMA & KDHW
2. Promote gender equality in leading positions	Review adopting polies	% of women leading health programs	Field report & staff list	At least 30% of women leading health programs	At least 75% of women leading health programs		

		% of women field in-charges	Field report & staff list	At least 30% of women field-in charge	At least 46% of women field-in charge		
		% of women in leading committee	Annual report & staff list	At least 30% of women in leading committee	At least 40% of women in leading committee		
	Hold the BPHWT general selection triennially	% of women was elected	Annual report & staff list	At least 30% of women in leading committee	At least 40% of women in leading committee		
Health Information and Documentation							
1. Assess and document community health situation and needs	Produce HID materials	No. of calendars produced	HID staff report	1,000 calendars provided	No calendars provided	30 less cameras were provided	Because of funds shortage.
		No. of digital cameras and no. of video cameras provided		40 digital cameras and 2 video cameras will be provided	10 digital cameras & no video were provided		
2. Standardize health data collection processes	Analyze data collected by health workers	Frequency of analysis	Six months workshop report	Twice a year	Once in every six month		
		No. of participants		10 participants each time.	7 participants		
3. Make evidenced based health status comparisons with the target community	Organize field meetings and workshops	No. of field meetings or workshops provided	Field meeting and workshop report	Twice a year for 20 areas	33 field meetings and 27 field workshops were organized		
		No. of participants		300 people participate in field workshop and 300 in meeting	25 field meetings and 33 field workshops were organized		

4. Raise awareness of the community health problem	Produce health information, education and communication materials	No. of health information and communication (IEC) materials provided	IEC distributing list; village health workshop report form	No. of posters provided	359 (M-199, W-161) HWs attended field meeting and 329 (M-200, W-129) HWs participated in field workshops		
5. Advocate local and international organizations about the health situation in Burma	Organize health program coordination and development seminars	No. of seminar	Seminar attendant list	At least once a year	1 Health System Development Seminar		Coordinated with BMA, MTC, KDHW, and NHEC
		No. of participants		30 people will participate in the seminar	93 (W-28, M-65) participants		
Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	Conduct impact assessment survey	Frequency of impact assessment survey conducted	Midyear & annual report	Once every two year	N/A		The survey had already conducted in 2013.
	Conduct monitoring trip	No. monitoring trips and no of staff		3 monitoring trips in a year	4 monitoring trip to Kachin, Karenni, Dooplaya, and Thaton areas	1 more monitoring trip had been done	
	Conduct six months meeting	No. of health workers attend the six months meeting		100 health workers attend the six months meeting	76 health workers attended 6 month workshops(W-32, M-44)	24 less health workers attended 6 month workshop	Only two field representative from each area were invited to attend the 33th six month meeting.

	Provide Leading Committee meetings	No. of Leading Committee meetings provided	Office records	2 Leading Committee meetings per year	2 Leading Committee meeting was organized		
	Provide Executive Board meetings once in a month	No. of Executive Board meetings provided		12 Executive Board meetings per year	8 Executive Board meetings conducted		
	Provide staff meetings	No. of staff meetings provided		24 staff-meetings per year	19 staff meetings were organized		
Health Convergence							
1. Converge the extensive border-based health system with the Burma government's health system	Standardize curriculum between border-based health CBOs and Burma government	No. of seminars and meetings No. of participants	Attendance list	Twice in a year	Canadian Health System Study Tour		
	Health program convergence between border-based health CBOs and the Burma government	No. of seminars and meetings No. of participants No. of field visits	Attendance list	Twice in a year	BPHWT Field Area (18 Filed Areas) Convergence Workshop		
	Health system convergence between the border-based health system and Burma government	No. of seminar and meetings No. of participants	Attendance list	Twice in a year	1 Health System Development Seminar attended by 93 (W-28, M-65) participants		Coordinated with BMA, MTC, KDHW, and NHEC
	Health program coordination and	No. of seminar and meetings	Attendance list	Once in a year	-HCCG Policy		

development seminar	No. of participants			Meeting -Myanmar Peace Support Group Meeting -UNHCR “Convergence of Service Consultations in SE Burma -HCCG, HSS, and HISWG Coordination Meeting -Fifth HCCG Strategy - HCCG Convergence Presentation in a Civil Society Policy Workshop of the Ethnic Nationality Affair Center:		
Organize Auxiliary Midwife Training	No. of AMW training provided No. of AMWs participate in the training	AMW training report & attendance list	2 Auxiliary midwife training will be provided 20 AMWs will participate in each AMW training	2 Auxiliary midwife trainings attended by 47 AMWs		

18) Back Pack Health Worker Team Financial Report – 2014

BPHWT Income and Expenditures: January – December 2014			
ITEMS	Income (Thai Baht)	Expenditure (Thai Baht)	%
Opening Balance 2014	115,400		
Period Income			
Burma Relief Centre (CA/DFID)	5,284,319		18%
Burma Relief Centre (IP/ CIDA)	6,750,000		23%
Burma Relief Centre (NCA)	870,645		3%
International Rescue Committee (IRC)	3,227,872		11%
Stichting Vluchteling (SV)- Netherlands	6,279,325		21%
Thai Border Consortium (TBC) No.1	1,500,000		5%
Burma Relief Centre/ Just Aid Foundation	1,090,919		4%
Open Society Institute	2,464,684		8%
BRC/TdH Germany	828,147		3%
Mae Tao Clinic (Monitoring & Evaluation)	1,019,000		3%
KDHW (TBC fund) No.2	513,000		2%
Burma Relief Centre (Crossroads Charity)	22,059		0%
Other Donation	28,659		0%
Bank Interest	9,418		0%
TOTAL PERIOD INCOME	29,888,047		100%
TOTAL INCOME	30,003,447		
Note: Expenditure according to auditor statement			
Period Expenditures			
Back Pack Medicine and Equipment(MCP)		4,985,362	19%
Back Pack Field Operation Supplies and Services		2,889,991	11%
Community Health Education and Prevention Program(CHEPP)		4,069,538	16%
Maternal and Child Healthcare Program(MCHP)		3,446,255	13%
Capacity Building Program(CBP)		3,524,946	14%
Health information and Documentation (HID)		374,607	1%
Program Management and Evaluation(PME)		2,871,148	11%
General Administration		3,526,812	14%
TOTAL PERIOD EXPENDITURES		25,688,659	100%
CLOSING BALANCE -31 DECEMBER 2014		4,314,788	

Part II: Program Workshops & 33rd Annual Meeting Report – 2015

1. Program Workshops:

- 1.1) Medical Care Program Workshop
- 1.2) Community Health Education and Prevention Program Workshop
- 1.3) Maternal and Child Healthcare Program Workshop
- 1.4) Malaria Treatment Protocol Workshop

2. 33rd General Meeting of the Back Pack Health Worker Team

1) Program Workshops

During the second six-months meeting period of 2014, there were three main program workshops -Medical Care Program Workshop, Community Health Education and Prevention Program Workshop, and Maternal and Child Healthcare Program Workshop and Malaria Workshop. There were Nutrition, Health System Strengthening, The Long Road to Recovery and Mental Health presented to the field representatives. All were held at the BPHWT head office in Mae Sot and conducted by the BPHWT Program Coordinators, URC, SMRU, and Capacity Building Program staff.

1.1) Medical Care Program Workshop

Facilitator - Naw Hsa Mu Na Htoo (MCP coordinator)
Duration - 2-4 March 2015
Participants - 26 (18 men and 8 women)

Discussion Topics:

- MCP in-charge presentation
- Review report forms
- Review data from reports (Field In-Charge Report, Worker Report, VHW Report /Medicine Inventory, & Other Reports)
- Review logbooks
- Discuss about the essential drugs and supplies for stationary back pack teams
- Review malaria and general medicines
- Review program meeting and workshop recommendations

1.2) Community Health Education and Prevention Program Workshop

Facilitator - Saw Eh Mwee (CHEPP Coordinator)
Duration - 2-3 March 2015
Participants - 8 (7 men and 1 women)

Discussion Topics:

- Review village health workshop
- Review data and forms
- Water and sanitation water systems
- School health
- Vitamin A and De-worming medication
- Future plans

1.3) Maternal and Child Healthcare Program Workshop

Facilitator - Thaw Thi Paw MCHP Coordinator) and Naw Htoo
Duration - 1, 3, 4 March 2015
Participants - 36 (6 men and 30 women)

Discussion Topics:

- MCHP supervisor presentations
- Reviewing job description of MCH in-charge and workers
- Case study (PPH Refer , Obstructive labor Maternal death)
- Reviewing TBA/TTBA Kits
- Reviewing all MCH supervisor report forms
- Meeting with AMWs and discussing about their activities and future plans
- Future plans

1.4) Malaria Treatment Protocol Workshop

Facilitator - Dr. Thein Thein Chit (URC), Dr. Aung Pyae Phyo , Pe Wani (SMRU), and Pe Dour (SMRU)
Duration - 2-4 March 2015
Participants - 76 (44 men and 32 women)

Discussion Topics:

- Malaria case management
- Transmitted/ Treatment protocol/ Prevention and control
- Pre-test and post-test
- Update of treatment presentation
- Update of malaria on Thai Myanmar Border and Malaria Targeted Chemo- Elimination
- Mass-Drug Administration (MDA) sharing

2) 33rd Annual General Meeting of the Back Pack Health Worker Team

The 33rd Back Pack Health Worker Team Semiannual Meeting was conducted from 6 to 7 March 2015 in Mae Sot at the BPHWT head office. Attending this meeting were **76** staff members – 44 men and 32 women. During this annual meeting, the representatives from Kachin and Shan could not join the meeting because of the security situation in their areas.



A week before the beginning of the meeting, the BPHWT's data team entered, checked the quality of, and analyzed the data obtained from the field. The data were discussed in program meetings before being discussed in the general meeting. During the general meeting, the Leading Committee discussed the data within a programmatic perspective in order to monitor events taking place in the field.

After this analysis, they discussed how to improve data collection methods.

During the meeting, the Leading Committee also offered advice for any issues that health workers could not solve by themselves, and provided input and suggestions to plans for the next period of implementation. The purpose of the meeting was to discuss health workers' experiences in the field, share knowledge, review which activities were and which were not implemented as well as why some activities could not be implemented, compare outcomes in relation to plans made at the previous six-months meeting, and share difficulties encountered in field. After the meeting, the Leading Committee discussed possible ways to handle the problems identified during the workshop and came to decisions about how to take action to solve these problems.

1) Schedule of BPHWT's 33rd annual General Meeting:

Day (I) { 6 March 2015 }	
Description of Presentation	Responsibility
Opening Speech	Mahn Mahn
Introduction	Facilitators
Review and Discussion about the 32 nd Six Monthly Meeting and the Last Executive Board Meeting Decisions	All members of the BPHWT
MCHP Coordinator's Report & MCHP Workshop Report	Naw Thaw Thi Paw
MCP Coordinator's Report & MCP Workshop Report	Naw Hser Mu Nar Htoo
Day (II) { 7 March 2015 }	
CHEPP Coordinator's Report & CHEPP Workshop Report	Saw Eh Mwee
Chin Reports and Discussions	Field in-charges
Health Information and Documentation report	S' Aung Than Oo
Capacity Building Program Report	Saw Soe Hla Oo
Office Administration Report	S' Moe Naing
Financial Report	Saya Chit Win
Conclusion of Meeting Decisions	Facilitators
All Other Business	All members of the BPHWT
Closing Speech	Saw Win Kyaw

2.2) 33st General Meeting Decisions:

1. The MCHP Coordinator and Field Supervisors will discuss the TBA Report Form, including the TTBA information in it, during the second six-month period of 2015.
2. There is plan to conduct TTBA training in Kawkaeik, Yee, Palaung, Arakan, Win Yee, Papun and Pa An Field Areas during the second six-month period of 2015.
3. The BPHWT made the decision to distribute thirty maternity kits to each area in every six month period.
4. There will be a discussion in the Leading Committee and Field in-Charge Meeting about the requests made by the field areas.
5. The CHEPP Coordinator and Field in-Charges are responsible for updating the School Health Form and report it to the Leading Committee and Field in-Charge Meeting.
6. There will be one participant from Kayan, two participants from Kayah, two participants from Yee, one participant from Win Yee, one participant from Thaton, one participant from Kawkaeik, one participant from Dooplaya, one participant from Mergue/Tavoy, two participants from Pa O, one participant from Palaung, one participant from Naga, and one participant from Arakan Field Areas who will attend the MCH training organized by the Mae Tao Clinic. All participants must arrive at the BPHWT Head Office in Mae Sot at the end of April 2015.
7. There will be one participant from Papun, two participants from Taungoo, and two participants from Kler Lwee Htoo field areas who will attend the MCH training conducted at Ei Thu Hta in March 2015. All participants must arrive at Ei Thu Hta on 20 March 2015.
8. There will be forty participants from the Karen field areas, five participants from the Mae Tao Clinic, five participants from the Arakan Field Area and thirty-two participants from other ethnic Back Pack field areas who will attend the Community Health Worker Training at Htay Bay Hta in May 2015. All participants must arrive at the BPHWT Head Office in Mae Sot on 1 April 2015.
9. The remainder of the health worker assessment must be submitted to the BPHWT Head Office in Mae Sot at the end of March 2015.
10. There EBRMS report "The Long Road to Recovery" will be presented on 9 March 2015 at 9:00 AM for the field representatives. Four copies of this report will be distributed to each field area.

11. The BPHWT made the decision to finalize the annual narrative report and financial report of 2014 at the end of April 2015.
12. There will be Focus Group Discussion Training for the SDC project (PHC), in coordination with CPI, from 16 -20 March 2015 at the BPHWT Head Office in Mae Sot.
13. The MCP Coordinator and Field in-Charges are responsible for the listing of essential drugs and criteria for stationary Back Pack teams, and must report this to the Leading Committee and Field in-Charge Meeting.
14. There will be a discussion in the Leading Committee and Field in-Charge Meeting about the requests made by field areas for four Village Health Worker Trainings, Village Health Worker Workshops, and adult weight scales.
15. The report of the Health Convergence Core Group (HCCG) activities must be reported to the HCCG Coordinator. Also, the HCCG Coordinator will coordinate with the BRC about the future HCCG plans.
16. There will be a discussion in the Leading Committee and Field in-Charge Meeting about the request made by MNHC field areas for Community Health Worker Training.
17. There will be a Leading Committee and Field in-Charge Meeting on 12 March 2015.
18. A decision will be made in the Leading Committee and Field in-Charge Meeting about the request made by the Arakan Field Area for moving the Palet Chaung Back Pack Team in Palat Wa Township to Pe Chaung Village in Kyauk Taw Township during the first six-month period of 2015.
19. A decision will be made in the Leading Committee and Field in-Charge Meeting about the request made by the Palaung Field Area for moving the stationary Back Pack team in Northern Mam Lway in Nant San Town to Thet Yah Village in Lashio Township during the first six-month period of 2015.

Recording:

1. Naw Thu Zar replaces Saw Soe Than as a health workers on the Tha Main Dwont Back Pack Team in the Dooplaya Field Area.
2. Naw Htee Wah replaces Nant Khant Bway as a health worker on the Hto Lel Wah Kee Back Pack Team in the Dooplaya Field Area.
3. Naw Jue Lar Paw replaces Saw Poe Dah as a health worker on the Hto Lel Wah Kee Back Pack Team in the Dooplaya Field Area.
4. Saw Poe Dah replaces Naw Paw Ka Yeh as a field supervisor in the Dooplaya Field Area.
5. Naw Poe Naing replaces Saw Thar Moo as a health worker on the Ta Kel Back Pack Team in the Mergue/Tavoy Field Area.
6. Saw Poe Aye replaces Saw Hser Eh as Field in-Charge and Saw Than Win is appointed as Second in-Charge in the Papun Field Area.
7. Saw Chit Will Htoo is appointed as a supervisor on the Mae Wai Back Pack Team and Naw Paw Gay is recruited as a health worker in the Papun Field Area.
8. Saw Poe Win replaces Saw Maung Gay as a supervisor on the Htee Tha Blu Hta Back Pack Team in the Papun Field Area.
9. Naw Khu Paw is recruited as a health worker on the Lay Kaw Htee Back Pack team in the Papun Field Area.
10. Saw Kyaw Yeh replaces Saw San Win as a supervisor on the Lay Poe Hta Back Pack Team and Saw Shel Moo is recruited as a health worker in the Papun Field Area.
11. In Palaung Field Area, the Mam Lway Back Pack Team will be moved to the Thet Yah area during the first six-month period of 2015 because the World Bank will build a new clinic in area of the Mam Lway Back Pack Team.
12. Saw Than Zaw is appointed as a MCP Supervisor on the Ta Oh Kee Back Pack Team in the Thaton Field Area.
13. Naw Paw Paw is recruited as a MCH Worker on the Htee Par Doh Htar Back Pack Team in the Thaton Field Area.
14. Naw Hay Blu is appointed as a MCP Supervisor, Saw Wah Blu Moo is appointed as a CHEPP Supervisor and Naw Myat Gay Khaing is appointed as a MCHP Supervisor on the Thay Kaw Deh Back Pack Team in the Kler Lwee Htoo Field Area during the first six-month period of 2015.
15. Saw Eh Tha Dah replaces Naw Shel Moo Lar Paw as a MCHP Supervisor in the Kler Lwee Htoo Field Area.

16. Mi Pa Kaut Zoe replaces Mi Myat Maung Chaung as a Second Field in-Charge in the Moulamein Field Area.

17. Two TBAs in the Pa An Field Area died during the second six-month period of 2014 due to old age.

2.3) Leading Committee and Field In-Charges Meeting Decisions: (12 March 2015)

1. The decision was made to conduct sixty-eight TBA/TTBA Workshops and distribute fifty-two TBA/TTBA kits during the first six-month period of 2015.
2. The decision was made to distribute twenty cameras, requested by the field areas, during the second six-month period of 2015.
3. The decision was made to allow the Palaung and Pa O Field Areas to purchase fluid inside Burma; however, the quotations from the suppliers must be submitted to the BPHWT Head Office in Mae Sot.
4. The Back Pack field areas, planning to have stationary Back Pack teams, must report the following information to the BPHWT Head Office in Mae Sot.
 - Number of health workers who will be on the stationary Back Pack team
 - List of the training of each of the health workers who will be on the stationary Back Pack team
 - Their propose position on the stationary Back Pack team
5. The decision was made to distribute eight weight scales to the field areas requesting them and twenty-six sets of instruments to the field areas which have never received the instruments. The remaining field areas will receive distributions during the second six-month period of 2015.
6. The decision was made to provide 1,500 Thai baht in support for Field in-Charges and 1,200 Thai baht in support for health workers per month during the first six-month period of 2015.
7. Because of the funds shortage, the BPHWT cannot provide the per diem for the TBAs/TTBAs during the first six-month period of 2015; however, the decision was made to provide per diem for the TBAs/TTBAs during the second six-month period of 2015.
8. The decision was made to support the CHW training, requested by the MNHC, through the TBC Dry Food Project.