B.P.H.W.T
Primary Health Care

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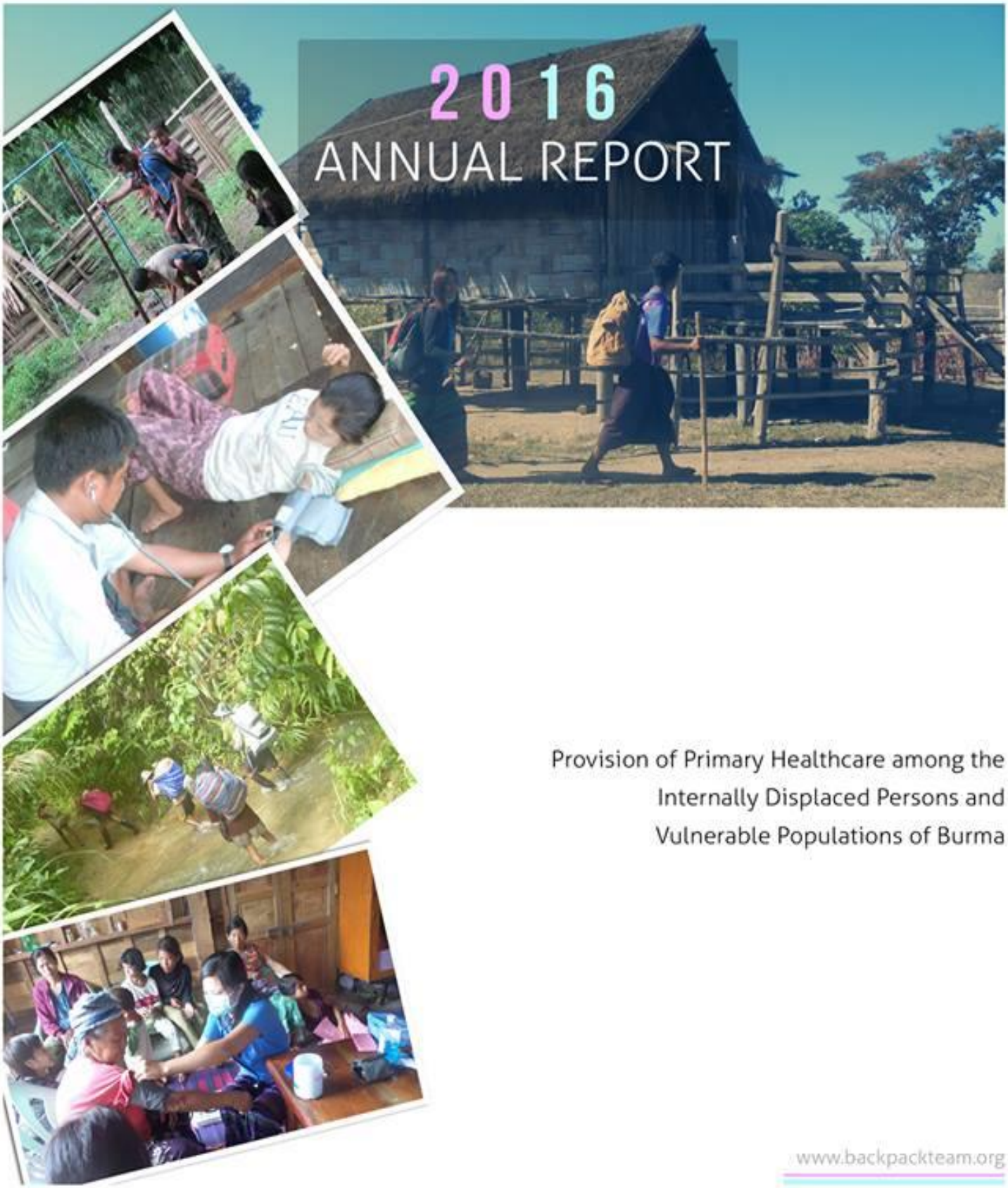

2016 ANNUAL REPORT

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

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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
IAS	Impact Assessment Survey
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
M & E	Monitoring and Evaluation
MCP	Medical Care Program
MCHP	Maternal and Child Healthcare Program
MDA	Mass Drug Administration
Pf	Plasmodium falciparum, the most deadly type of malaria parasite
PLA	Participatory Learning and Action
Pv	Plasmodium vivax, another type of malaria parasite
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

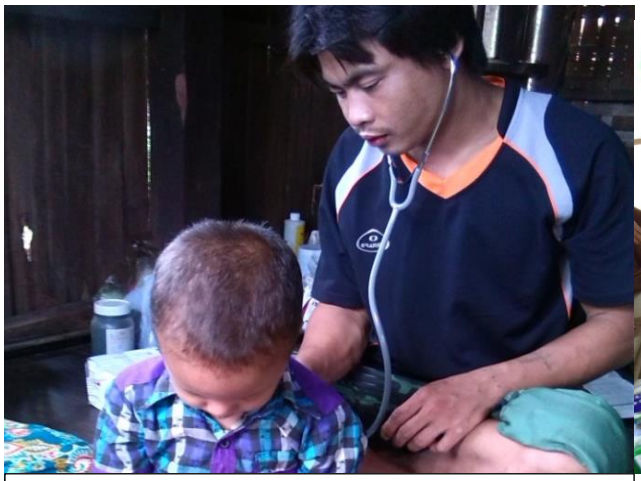
Part I: 2016 Annual Report

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.

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 2016, the BPHWT consisted of 113 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 113 Back Pack teams, there are now 48 stationary teams. These teams, formerly mobile Back Pack teams, were established during 2013 in areas within Shan, Karenni, Karen, and Mon States and Tenasserim Region 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.



Providing healthcare to a child in Taungoo

Providing Health Service to Populations in Remote Areas

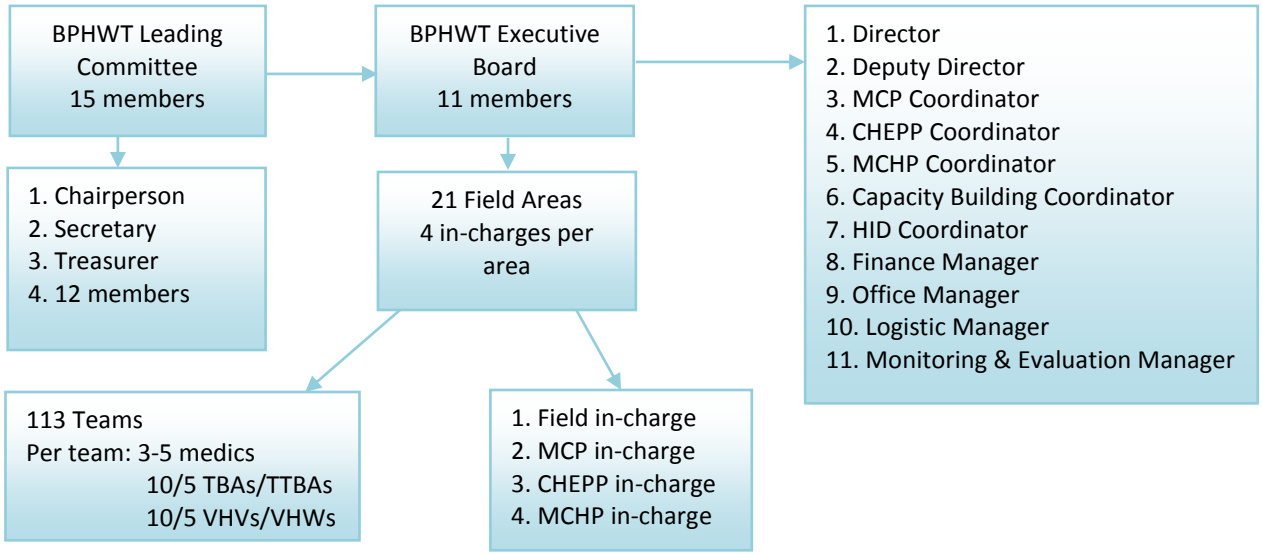
The BPHWT teams target displaced and vulnerable communities with no other access to healthcare in Karen, Karenni, Mon, Arakan, Chin, Kachin and Shan States, and Pegu, Sagaing and Tenasserim Regions. The teams deliver a wide range of healthcare programs to a target population of almost 280,103 (135,205 men and 144,898 women) 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 2016, 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 thirteen 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, Program Coordinators, and Managers 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 15 members who are elected for a three-year term. The Leading Committee appoints all 11 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 that of a healthy society in which accessible and quality primary health care is provided to all ethnic people in a Federal Union of Burma.

2.4) Mission: The Back Pack Health Worker Team is a community-based organization established by health workers from their respective ethnic areas. The BPHWT equips ethnic people, living in rural and remote areas, with the knowledge and skills necessary to manage and address their own health care problems, while working 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 promote the emergence of quality and accessible health care for all ethnic people so as to reduce morbidity and mortality, and minimize disability by enabling and empowering communities through primary health care.

3) Gender Policy and Analysis

In 2016, the participation of women in the Back Pack Health Worker was 55 % excluding Traditional Birth Attendants/ Trained Traditional Birth Attendants (TBAs/TTBAs). 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.

Table 1 : Gender Policy and Analysis

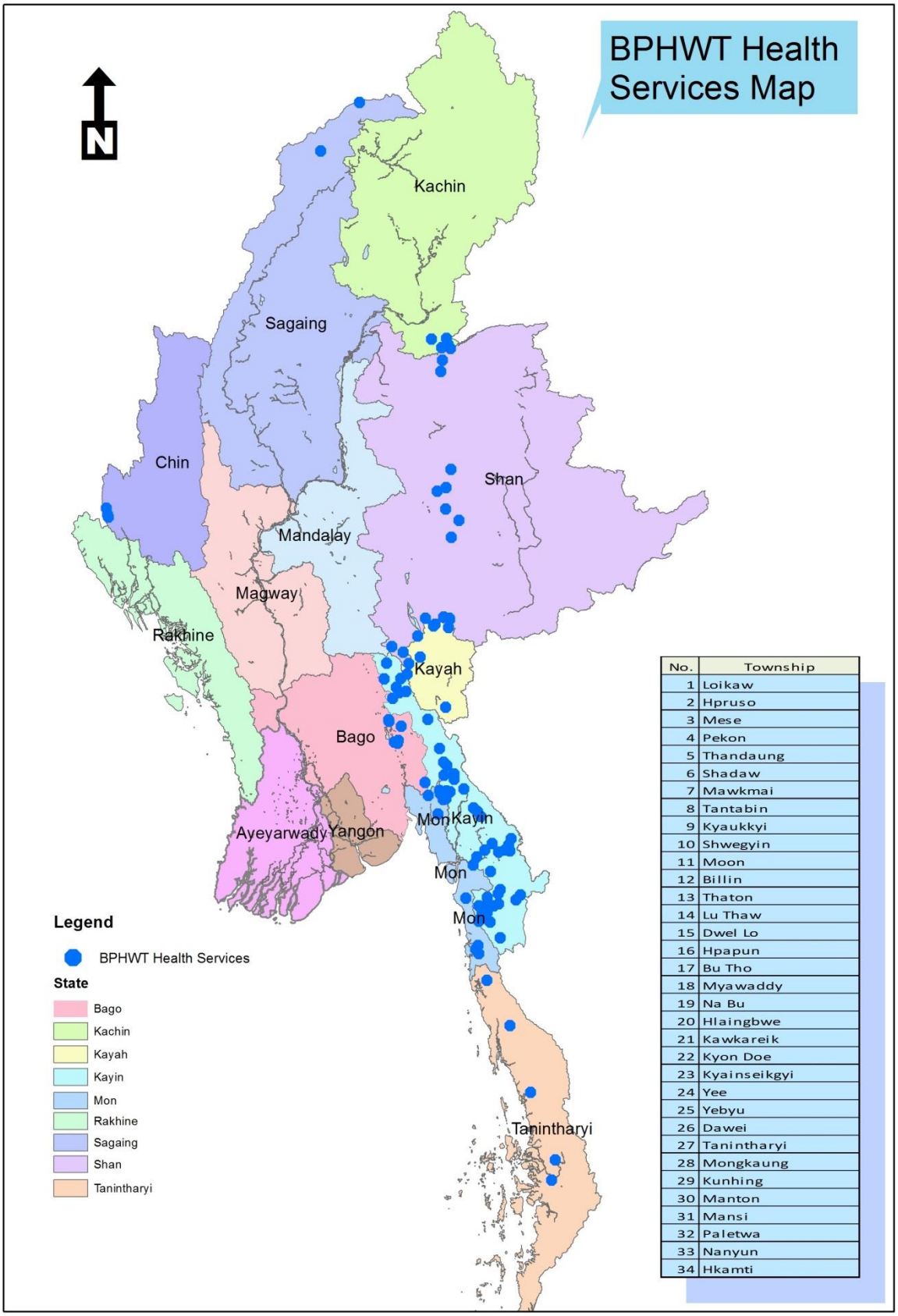
Category	Total Workers	Total Women	Actual Women %
Leading Committee/Executive Board	16	5	31%
Office Staff	12	3	25%
Field Management Workers/FICs	60	25	42%
Field Health Workers	333	180	54%
Trained Traditional Birth Attendants	839	776	92%
Village Health Workers	256	161	63%
Organizational Total	**1,516**	**1,150**	76%
Total Organization excluding TTBAs			**55%**

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.

Table 2: 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**

4) Map of Operational Areas



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

5) General Health Situation in Burma

Health in Burma is another casualty of decades of government misrule, ethnic conflict, centralized decision making, and the exodus of qualified health professionals. There has been, and continues to be, a shortage of qualified physicians, nurses, midwives, and community health workers as well as inadequate medicine, medical equipment, and hospital/clinic beds. Hospital facilities are run down and require renovation. The reliability of electricity in health facilities is a constant problem. Also, people living in armed conflict, internally displaced, and remote areas have no reasonable access to Burma Government health care within a few days' walk. Many rural and urban areas lack clean water and proper sanitation. There is no real Burma Government healthcare scheme and patients have out-of-pocket healthcare expenditures in excess of 80%, and must pay for medicine, food, blankets, and bribes to medical personnel.

Global data from the World Bank show Myanmar as one of the countries with lowest health expenditure per capita. Consequently, the country has some of the worst health indicators in the world. The main causes of morbidity and mortality in the country are overwhelmingly preventable from diseases such as malaria, malnutrition, diarrhea, acute respiratory illnesses, and tuberculosis.

While increasing during the recent years of democratic transition, the Burma Government had still allocated fewer than 4% of General Government Expenditures to health care. The current National League of Democracy (NLD) Government Minister of Health and Sports is proposing a health sector spending of just over 5% of the Government budget for the coming fiscal year. Of the Ministry's proposed budget, two thirds will be for regular expenditures while the remaining third will be allocated toward capital expenditures - building hospitals and housing for medical staff and purchasing medical equipment.

However, questions arise as to whether this proposed health sector budget will be approved by parliament, how much of this spending will actually occur, and what will be the impact upon the before-mentioned health infrastructure and health indicators from any such spending. Also in the past, much of this spending has been in the urban, not rural, areas where most of the ethnic people live.

6) General Health Situation of Internally Displaced Persons

The Internal Displacement Monitoring Centre (IDMC) estimates that there were up to 644,000 IDPs in Burma during 2015 due to armed conflicts. Another 422,000 were displaced due to flooding as of July 2016. Unknown thousands have also been displaced due to development.

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 the eastern areas of the country are demonstrably worse than Burma's national rates. IDPs face harsh living conditions in the jungle: their means of survival are a constant challenge. In addition to dealing with the burden of protracted conflict and the high frequency with which they are forcibly displaced, access to the healthcare system of the Burma Government is either extremely limited or non-existent.

This is how field health workers refer their patients in remote areas

These remote, internally displaced, and conflict

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

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

7) Current Political Context

During this period, the new NLD Government came to power in Burma. The president and one of the vice presidents are from the NLD; while the other vice president is from the Burma Army. The NLD has a majority in both houses of the Union parliament and is able to pass its legislative agenda, excepting changes to the 2008 Constitution which would require approval by the members of parliament of the Burma Army.

The NLD used its power in the Union parliament to create a new position for Aung San Suu Kyi, that of State Counselor. She has effectively pre-empted the new president in most matters of state. The NLD Government also appointed its own members to the chief executive positions of all the states and regions, even in the two states – Arakan and Shan – where the NLD did not win a majority of the votes. This was not well received by the ethnic people in those states.

The NLD government appears to be very autocratic and holding power close to the center. It allows little dissent from its Union members of parliament and little discussion in the Union parliament about issues which it considers important. They use their majority to push legislation through with little or no discussion or negotiations.

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

The peace negotiations have continued with the new NLD-led Government. In August 2016, this Burma Government convened a 21st Century Panglong Conference in furtherance of peace negotiations and confidence building. A second 21st Century Panglong Conference is scheduled for March 2017. The State Counselor, Aung San Suu Kyi, stated that these conferences are among the steps for peace and a democratic federal union as noted in the following *Seven Step Roadmap*:

1. Review of the political dialogue framework
2. Amend the political dialogue framework
3. Convene the Union Peace Conference—the 21st Century Panglong Conferences in accordance with the amended and approved political dialogue framework

4. Sign a Union Agreement— the 21st Century Panglong Conference Agreement based on the results of the 21st Century Panglong Conferences
5. Amend the Union Constitution in accordance with the Union Agreement and approve the amended Union Constitution
6. Hold multi-party democracy general elections in accordance with the amended and approved Union Constitution
7. Build a democratic federal union in accordance with the results of the multi-party democracy general elections

However, the NLD Government did not declare a nationwide ceasefire to facilitate a positive environment for the first 21st Century Panglong Conference or so far, for the next scheduled 21st Century Panglong Conference. Also, it has not yet invited the three EHOs against whom the Burma Army is still fighting. The United Nationalities Federal Council, an alliance of EAOs who have yet to sign the NCA, has been invited to the next scheduled 21st Century Panglong Conference as observers, not participants. They have stated that they will not attend the Conference unless they can participate in the discussions and decisions. Thus, not much is expected from the Conference by the ethnic political and armed organizations. Sustainable peace is the country still seems to be distant even with the new NLD Government.

Overarching issues to this Burma Government roadmap are demobilization, disarmament, and reintegration (DDR) and security sector reform (SSR), These two issues relate to when and under what conditions that the EAOs give up their arms and be integrated back into Burmese society and how should the Burma Army, police, and related Burma Government security sector actors be structured within a federal union. The EAOs consider DDR to be accomplished as a component of, and not separate from, SSR and carried out only after the successful building of a democratic federal union in accordance with the implementation of a federal union constitution. However, the Burma Government, especially the Burma Army, therefore sees no necessity for SSR and wants DDR accomplished separately before the completion of the Government's *Seven Step Roadmap*.

The Myanmar Ministry of Health and Sports have developed a five year National Health Plan (NHP). Despite inviting the EHOs to workshops for developing the NHP, the Plan, while recognizing the EHOs as health service providers, failed to address the issue of devolving health decision making, administrative, and funding powers to sub-Union levels. It appears the focus is upon strengthening the existing centralized health system – following the path set by the previous government of President Thein Sein.

8) Security Situation in the BPHWT's Target Areas

Despite the ceasefire and peace negotiations and a new government led by the NLD, the Burma Army has engaged in offensive military operations in Northern Shan and Kachin States. The Burma Army continues to use force to bring about a military solution to the ethnic issue. These offensive operations by the Burma Army has increased the number of IDPs in Kachin and Shan States, discouraged refugees from considering returning to Burma, and not contributed to confidence building among the EAOs. Because the Burma Army has not ceased their offensive military operations and have been expanding their reach, manpower, and armaments in the ceasefire areas, certain EAOs have conducted offensive military operations in Northern Shan and Kachin States against the Burma Army during the latter part of 2016. Thus, Back Pack teams in the Palaung and Kachin Field Areas are unable to travel freely in these conflict zones and face the risks of being arrested/ killed by the Burma Army or being maimed/killed by landmines in order to provide health care to their targeted populations, many of whom may be injured or displaced due to the fighting.

Pa An Field Area

On 19 August 2016, a local Border Guard Force (BGF) of the Burma Army came into Thi War village and exchanged fire for about five minutes with a unit of the Democratic Karen Buddhist Army (DKBA). Fortunately, there were no injuries or deaths.

Burma Army Light Infantry Battalions (LIBs) 547, 548, and 549 from the Na Boo military camp came for military maneuvers into the Back Pack areas of Htee Ka Lay and Naung Kine villages. These Burma Army soldiers remained for five days, causing fear among the villagers.

Palaung Field Area

During this period, there has been an increased level of fighting between the Burma Army and EAOs which has resulted in a negative environment for health workers and the communities they serve in this field area. Freedom of travel for the health workers is restricted due the continuous fighting.

There is ongoing fighting between two EAOs in Pan Hang and Yae Kwet villages of Namhkan Township. Due to the fighting, villagers fled to Mie Gee village.

The fighting between two EAOs caused 500 IDPs to flee and stay in Pan Yaung village. The IDPs come from Man Ei, Thet Let, and Naung On villages in the Mine Yout village tract of Man Ton Township.

The main transportation roads became blocked from Nan Ma Too and Nan Hynen villages to/from Man Ton during the second half of 2016. Consequently, people were forced to find and use alternatives routes to/from Man Ton. Travel on the main road normally took only three hours, while travel on alternative routes now takes twelve hours.

Arakan Field Area

There is frequent fighting between the Arakan Army (AA) and Burma Army between Pa Lat Wat, and Kyet Taw villages The fighting lasted one or two days. Due to the fighting, villagers were unable to work in Yet Khon Tye, Tan Myar, Kynn Gyi, and Za Lin Taung villages. In those villages, the main means of livelihood is farming.

There are a number of police checkpoints in Pa Lat Wat and Da Let May villages. Also, there are both police and Burma Army checkpoints in Chin Let Wot and Tha Yor Wai villages. These checkpoints are asking very detailed questions, looking for AA soldiers and supporters, and collecting intelligence about AA activities.

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

Back Pack health workers in its field areas continue to contend with the environment of conflict, landmines, checkpoints, weather, and difficult terrain in providing their health services, especially to those in conflict, remote, and internally displaced areas. The following specific obstacles and threats to delivering health care were reported by Back Pack teams:

Taungoo Field Area

The Burma Army makes frequent enquires about the BPHWT mobile clinic. Also, a dam was completed on the Pa Lat Wat River in the Thauk Yae Khut area and has caused the transportation of health workers and medicine by boat to be of a much long duration.

Thaton Field Area

To transport medicine and medical supplies by road to this field area, official documents are required. Additionally, fees of 2,000 kyat must be paid at each checkpoint along the road - there are four checkpoints. This is adds to the costs and delays in deliveries to this field area.

Papun Field Area

There are Burma Army camps in Mwe Waie and Kout Kout villages which make it very difficult for travel by the Back Pack team.

Pa An Field Area

At the Myawaddy Trade Zone, Burma Government customs officials take at least 1,000 kyats to bring Back Pack medicine and medical supplies into Burma from Mae Sot. The actual prices depend upon the situation at the customs' office at the time.

Doopalaya Field Area

Burma Government officials at the Myawaddy Trade Zone are checking documents and charging fees for medicine and medical supplies being delivered to this field area.

Kawkareik Field Area

The local Back Pack team has been required to pay a 1,000 kyat fee to transport medicine and medical supplies through each of the three gates along the road around Tin Gan Ntyi.

Shan Field Area

The Burma Government's National Malaria Control Programme (NMCP) has implemented malaria control training in the area without involving the BPHWT. The duration of the training is one month and participants receive a salary and medicine. The BPHWT field in-charge is worried that Back Pack health workers may resign and go to work for the NMCP.

Palaung Field Area

The Burma Army has been maintaining checkpoints every one to two days each week on roads in the Man Ton area. All of these events have resulted in delays by the Back Pack team in serving people in the targeted areas.

Back Pack health workers were unable to work and stay in the Taw Nay and Pan Ka Nine targeted areas due to fighting between Burma Army and the Ta'ang National Liberation Army (TNLA).

When the Burma Army arrived in the Man Sut and Taw Nay areas, they camped close to the Back Pack mobile clinic.

Kachin Field Area

Between July and December 2016, the Burma Army was expanded their presence and operations in the Man Win area and medicine transportation became very difficult.

Due to the security situation in the Hukawng Valley area, the Back Pack team identified itself with another organization so as to be able to facilitate travel.

Arakan Field Area

The transportation of medicine is difficult because the main means of transportation is by boat. Consequently during rainy season with storms and heavily raining, there are many transportation delays.

Pa O Field Area

The Pa O Back Pack team has had to pay fees to transport medicine at the Tin Gan Nyi Naung and Tha Ton checkpoints: the fee was 1,000 kyats at each checkpoint.

Whenever the BPHWT wants to implement a workshop or training in Si Sine Township, they must get permission from immigration, police, and township General Administration Department.

Chin Field Area

When the Burma Army hears about treatments or workshops from Back Pack health workers, they always investigate about them with the chairperson of the local village.

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

Special Field Area

During August 2016, a BGF captain demanded 1.7 million kyat in compensation for the alleged cursing of the captain by the village leader's husband at Met Sa Mate village.

Papun Field Area

In Mwe Wai village, the Burma Army ordered a villager to carry rations, but gave only a very small amount of compensation.

The Shin Thant Company implemented a road project in the area and took villagers' land without compensation.

A local BGF is logging in the field area and taking villagers' land for teak tree cultivation without compensation.

Pa An Field Area

Between November 2015 and February 2016, BGF Brigades 1017 and 1016, and Burma Army LIBs 548, 547, 549, and 230 conducted operations in both Hlaingbwe and Kawkareik Townships. In Thi War and Noy Bay villages, the LIB soldiers bullied the villagers to give them alcohol, chicken, and some vegetables without any payment of money.

On 23 January 2016, the Naung Kai Back Pack Team reported that the fighting in upper Kaw Mou village resulted in a villager getting wounded in his back. In response, Back Pack health workers tried to refer him to Kawkareik Hospital for immediate treatment: this was refused by a local BGF. He was then successfully treated in the village. This incident could be construed as a violation of medical neutrality under international law which forbids obstructions to the delivery of health care.

On 25 January, 2016, the local BGF and the Burma Army burnt down Pyar Pin village in Kawkareik Township – only one house was left in the village. Villagers quickly fled to Kyar Shar Koon village.

On 2 February 2016, a local BGF burned a villager's rubber plantation because they accused the plantation of providing rations and other support to the DKBA.

On 3 February 2016, the local BGF arrested a villager and his son, who live in Kyar Shar Koon village, for allegedly supplying rations to the DKBA. The BGF finally released the father, but continued to detain the son.

On 12 August 2016, General Thein Tayzar Than led Burma Army LIB 548 to do illegal logging of over 1,000 trees which belonged to Kot Phan Ya village. The villagers had looked after their trees so as to provide roofing for the houses. Both the village administrator and local monk had prohibited local logging; however, the general and his LIB 548 continued with the illegal logging.

Kawkareik Field Area

On 19 September 2016, a BGF unit fired at DKBA soldiers hiding in a villager's hut outside of Mi Phar Lal village. The firing went on for about forty minutes with three villagers, twenty years old, killed and the hut owner injured. Two DKBA soldiers were also killed and one was wounded. The local Back Pack team stabilized and referred the wounded DKBA soldier to Kawkareik Hospital. On the way to the hospital, the BGF stopped and detained the wounded DKBA soldier. His family has not seen or heard from him since. The hut owner received treatment at the Kawkareik Hospital and his situation improved.

Palaung Field Area

On 16 March 2016, Burma Army Brigade 77 arrested fifty-five villagers from Pa Hlaing village. In response, a monk from the village requested the Burma Army to release them. The Burma Army only released thirteen villagers, but continued to detain the remaining forty-two villagers. The monk then asked the Burma Army to release the remaining villagers. The Burma Army responded by demanding 50,000 kyats per day for the release of the detained villagers. To comply with this demand, the monk asked each household in the village to contribute 5,000 kyat. However, the villagers are very poor and had difficult to give this amount of money. The monk told the Burma Army about the villagers' financial situation. The Burma Army did not like this reply and continued to detain the villagers, but did not torture them. They further said that they would not release the villagers unless ordered to do so by their Burma Army commanding major. This period is very important for the villagers as it is the time for harvesting their green teas to get income for their families.

An EAO has established a military camp between the Hang Pan and Sai Lain villages. They stopped villagers who went the Mie Gee market, asked questions, wanted to see documents, and took photographs. After finishing everything, the EAO allowed the villagers to go the Mie Gee market. When the villagers returned back, they are again asked questions, and told to show documents and pose for photographs. When villagers went to that market to sell cows or water buffalos, that EAO took 50,000 kyats. If a charcoal truck goes to market to sell its charcoal, that EAO then charged 150,000 kyats. Also, the EAO does not allow the transportation of medicines and certain other supplies and equipment into the area, and restricts other items over a designated weight.

During the fighting between two EAOs, twenty innocent villagers were bullied by one of the EAOs. These villagers came from Man Set and Lwe Moon villages, and worked at a corn plantation

One of the EAOs setup a roadblock between Nan Ma To and Mine Bar villages. They allowed Shan, Myanmar, and Chinese to through road block, but not Palaung people.

When villagers fled to Mie Gee village due to fighting between two EAOs, one of the EAOs then searched each house, took money, and killed and cooked cows for food.

After fighting in Lwe Moon village in the Taw Nay area, the Burma Army failed to remove the landmines they had planted. As a consequence, one villager lost a leg due to a landmine and underwent treatment in the Lashio Hospital.

Kachin Field Area

On 10 June 2016, two Burma Army soldiers stopped a villager from Kyet Pyar village going to Man Yone market, stole 100,000 kyats from him and burned his motorcycle. The two soldiers were from the Burma Army LIB 601 from the Burma Army camp in La Gat Dot village. The villager went to the local pastor who made a complaint to the Burma Army commander. As a result, the Burma Army commander gave compensation for new motorcycle and 100,000 kyats to the affected villager. The two soldiers also had made bad ethnic remarks to villagers from Kyet Pyar villages.

A Burma Army battalion in the Shin Bwe Yan area fired their weapons indiscriminately and a forty-five year old woman was killed from a bullet injury to her neck in Tine Kaut village, Tanai Township.

There is a great problem with land confiscation and human rights abuses in the Hukawng Valley from 2007 to the present due to the activities of the Yuzana Company. Over this period, the Company has confiscation 200,000 acres of land in this area for large scale sugar cane and tapioca production, providing unfair compensation and poorly constructed housing for displaced villagers. Also, the Company hires their workers from Yangon and other places outside the area. Villagers have tried to apply for jobs, but the Company has denied their applications. Thus, the displaced villagers have no daily income, and face food and other related livelihood problems. Additionally, local women face gender based violence with instances of rape during 2016, the Burma Army has erected checkpoints

and is stopping everyone, and drug abuse is becoming more prevalent – all as a direct result of this project.

During the first week of August 2016, the Yuzana Company confiscated twenty acres of land in Bangkok village located between Ja Htu Up and Wa Ra Zup villages. As a result, 1,700 villagers became homeless. The Yuzana Company negotiated with villagers for compensation. However, the Yuzana Company compensation was only for temporary housing, so villagers refused this offer. The Yuzana Company then proceeded to destroy their houses with a bulldozer.

In December 2016, further land confiscation occurred in the Hukawng Valley by the Yuzana Company and an anonymous person from China. Three hundred acres of villagers' agricultural land were confiscated. Because of the land confiscation, the villagers were forced to become daily laborers and fisherman in the Mogoung River.

Arakan Field Area

During January 2016, there was fighting between the AA and Burma Army LIBs 376, 375, 374, and 539 in Pon Nar Kyon. Due to this fighting, local villagers fled from the village, leaving their agriculture and property. Also, the Burma Army made arbitrary demands for laborers. Moreover, a Burma Army soldier shot and wounded one villager, who lives in Kyi Yar Pyin village, Myok Oo Township, in the hand.

Additionally, the Burma Government and the China National Petroleum Corporation began gas production on Yanbye Island of Kyauk Phyu Township. People in the local communities had their land forcibly confiscated and are receiving no benefits from this mega-project. Local fishermen are not allowed to catch the fish near the gas production project. All of this results in the loss of daily wages and livelihoods in the affected communities.

Pa O Field Area

The Burma Government Department of Forestry confiscated land from twenty villagers in Sike Khaung village of Si Sine Township. This issue is now in the local court system.

Environmental and Other Health Issues in the BPHWT's Target Areas

Kayan Field Area

Since June 2016, fourteen villages have a rat infestation which has been destroying local agriculture. The number of rats has been estimated at 800 - 1000. As a result, an affected population of 7,127 people has faced food and livelihoods problems. This situation typically occurs once every 50 years. In response, Kan Baw Za Bank donated 50 million kyats and the community donated 20 million kyats. However, each household was only able to receive one kilogram of rice. Due to this food crisis, there are diarrhea and skin infections in the affected local communities as well as malnutrition among the pregnant women and newborn babies.

Special Field Area

Near a BPHWT area, there is cement mining project between Ng Yat Chaung Phyar and Tha Yae Chaung Phyar villages. Due to this project, acute respiratory infection occurred in Ng Yat Chaung Phyar and Tha Yae Chaung Phyar villages.

Kler Lwee Htoo Field Area

In Met Ka Thi village, there is a logging project which is causing environmental damage.

Papun Field Area

There is a gold mine operating in and near the Bilin and Mae Wae Rivers which has altered the flow of the water such that boats often sink there. The river water is becoming polluted and posing health issues to both humans and animals. This gold mine is also very deep and has lowered the water table

that local villagers use to source water. Consequently, these villagers face hygiene and drinking water problems. Furthermore, there has been an increase in the cases of diarrhea, deaths of the villagers' chickens from unknown causes, and damage to village land and transportation routes - all of which are being attributed to the poor environmental conditions resulting from the gold mine.

Kawkareik Field Area

A Telenor Myanmar cell tower has caused local people, especially the elderly, to have sleep and depression issues.

Win Yee Field Area

Twenty-two villagers came down with diarrhea after they ate some packaged dry noodles.

Shan Field Area

This field area has many users of heroin and amphetamines with even children over ten years old starting to use amphetamines.

Palaung Field Area

Heroin and amphetamines can easily get into Mie Gee village: thus, their prices are not expensive. Consequently, most villagers as well as internally displaced persons use heroin and amphetamines. The area around Namkhan and Mie Gee villages has a high incident of homicides.

Kachin Field Area

The Yuzana Company implemented a cassava plantation in Bangkok village. The Company discharged garbage and chemicals into the Mogoung River, killing the fish and causing the villagers to get diarrhea and skin diseases. The Yuzana Company also constructed a canal around the cassava plantation to protect it from intruding cows and water buffalos. Due to the canal, many cows and water buffalos from Bangkok and nearby villages fell into the canal and died.

Pa O Field Area

Rape, homicide, heroin, and amphetamine cases increased over the past year in this field area. More is now known about them because of better communications and media attention. Recently, there have been two reported youth rape cases and four homicide cases. Heroin and amphetamine use contributed to the homicides as well as increased quarrelling and fighting.

Naga Field Area

A measles outbreak occurred in the Nanyun and Lahe Townships. There are 500 households in Nanyun Township and 530 households in Lahe Township. According field information, 100 children contracted measles in Than Kho Lar Mar village of Lahe Township. Due to the measles outbreak, forty-two children died in Kho Lar Mar village. It is estimated that 200 children had measles in five to six villages in Nanyun Township.

In response to the outbreak, a medic from the Lahe Hospital came and gave treatment to the children. A medic from the Burma Army also came to assist. They had insufficient medicine, but Lahe Hospital was unable to send additional medicines. The Naga Students Organization provided food in this situation. The BPHWT's field in-charge and second field in-charge gave treatment in Kel San village of Nanyun Township which had a hundred households.

Due to this response, the outbreak has been contained. The Burma Government started giving immunization for measles in Than Khol Lar Mar village of Lahe Township. However, a nearby village was not involved in this immunization program. According to field reports, the Lahe Hospital no longer has immunization medicines.

In this field area, there are also problems with heroin use. The Eastern Naga Development Organization has taken responsibility for the health and rehabilitation of heroin users in their operational areas.

Chin Field Area

There are many male heroin users in Koon Pyin, Gar La Mit, and Kha Mee villages. In Koon Pyin village, of the seventy households, forty households have heroin users. In Gar La Mit village, fifty of the one hundred households have heroin users. There are no treatment and rehabilitation stations in these villages. When there is no heroin available, users get sick, especially with diarrhea. In response, Back Pack health workers from the Chin Public Affairs Committee provide treatment to them.

Special Situations in the BPHWT's Target Areas

There were no emergency assistance operations during 2016 which would have activated the Emergency Assistance and Relief Team (EART) of which the BPHWT is a leading member organization. The EART is the emergency response unit of the Forum for Community-based Organizations of Burma, a collective of Burmese civil society organizations operating along the Thai-Burma border. It aims to assist Burmese people who are in need due to natural or manmade disasters through the provision of food, water, shelter, clothing, health services, and rehabilitation. This is provided by working directly with the affected communities who are not receiving aid or not receiving sufficient aid from the Burma Government or INGOs.

9) 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. The BPHWT provided healthcare in 21 field areas, through 113 BPHWT teams, to a target population of 280,103 (women – 144,898 and men – 135,205) people. There were 37 stationary Back Pack teams during this year. There are currently 1,315 (women – 1,006 and men – 309) members of the BPHWT primary healthcare system living and working in Burma: 389 (women – 197 and men – 191) health workers, 781 (women – 723 and men – 58) Traditional Birth Attendants / Trained Traditional Birth Attendants (TBAs/TTBAs) and 256 (women – 161 and men – 79) village health volunteers/village health workers (VHVs/VHWs).

Patient Referral in Naga area

Providing Health Care in Kawkareik area

Table 3: BPHWT's Coverage Population

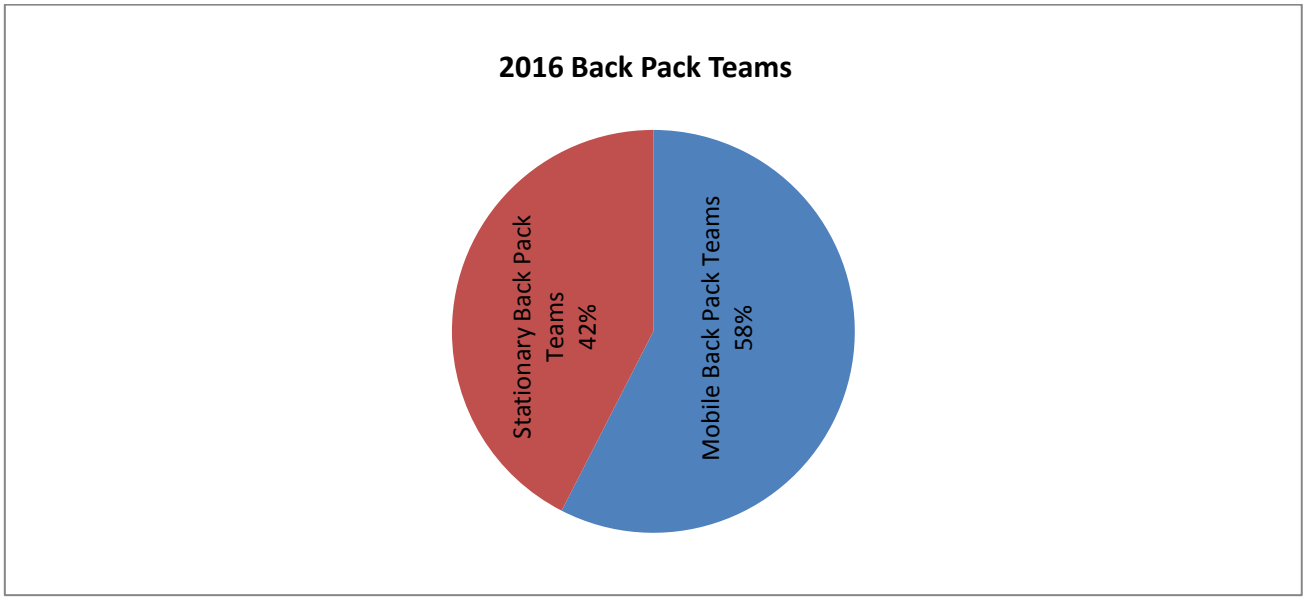
Ages	Gender		Total
	Men	Women	
Under five years of age	24,888	27,692	52,580
Five years of age and over	110,317	117,206	227,523
Total	**135,205**	**144,898**	**280,103**

Table 4: Summary of the BPHWT Field Areas, HWs, VHV/VHWs, TBA/TTBAs, Target Populations and Cases Treated

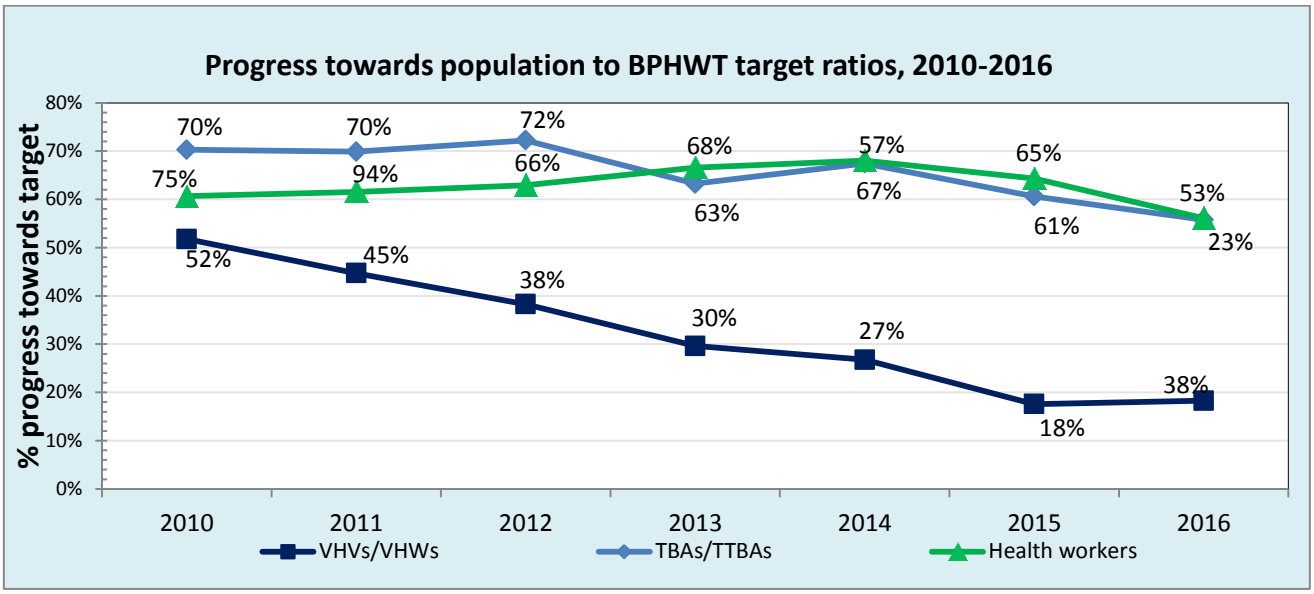
No.	Areas	# of Teams	# of HWs	# of VHWs	# of VHVs	VHVs & VHWs	# of TBAs	# of TTBAs	TBAs &T TBAs	Villages	Households	Population	Caseloads
1	Kayah	7	24	16	0	16	21	19	40	51	3,603	19,873	6,714
2	Kayan	7	24	8	0	8	1	44	45	67	2,504	13,767	6,571
3	Special	3	12	15	11	26	6	0	6	12	1,329	7,291	2,391
4	Taungoo	5	19	19	0	19	30	15	45	51	2,098	11,205	1,086
5	Kler Lwee Htoo	7	24	23	3	26	48	2	50	42	1,444	10,845	2,765
6	Thaton	7	24	24	4	28	47	28	75	38	4,065	24,310	6,758
7	Papun	12	39	26	29	55	64	45	109	138	5,810	35,300	11,503
8	Pa An	8	26	31	0	31	27	58	85	48	3,907	23,155	5651
9	Dooplaya	7	24	9	3	12	40	44	84	54	4,474	24,495	3805
10	Kawkareik	3	12	11	7	18	14	31	45	11	926	4,221	1881
11	Win Yee	4	15	0	0	0	32	18	50	30	2,247	12,198	3276
12	Mergue/Tavoy	7	24	5	0	5	38	0	38	29	2,267	13,130	12,834
13	Yee	6	21	0	0	0	9	20	29	19	2,185	10,357	10,263
14	Moulamein	6	20	0	0	0	0	0	0	17	2,543	12,599	4,959
15	Shan	6	21	0	0	0	10	0	10	54	2,285	14,164	4,075
16	Palaung	6	18	0	0	0	35	0	35	38	3,005	18,994	11,739
17	Kachin	4	16	0	0	0	0	0	0	11	2,029	6,972	3,986
18	Arakan	3	12	0	2	2	15	0	15	10	1,256	7,429	1,388
19	Pa O	2	4	10	0	10	0	20	20	14	555	3,171	1,042
20	Naga	2	7	0	0	0	0	0	0	6	730	3,227	1,120
21	Chin (WLC)	1	3	0	0	0	0	0	0	7	494	3,400	1,001
Total		**113**	**389**	**197**	**59**	**256**	**437**	**344**	**781**	**747**	**49,756**	**280,103**	**104,808**

Table 5: Number of Health Workers, TBAs/TTBAs, VHVs/VHWs, and Target Population by Year

Year	# of HWs	# of TBAs/TTBAs	# of VHVs/VHWs	Target Population
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
2015	359	741	215	244,410
2016	389	781	256	280,103



TBA/TTBAs, VHV/VHWs, & Health Workers-to-Population Ratios as a % of Target Ratios over Time[1],[2]



9.1) Medical Care Program

The Back Pack Health Worker Team currently consists of 113 teams working among Internally Displaced Persons and vulnerable communities in Karen, Karenni, Mon, Arakan, Chin, Kachin, and Shan States, and the Pegu and Tenasserim Regions 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. As the back pack teams were increased, the numbers of cases treated were increased. The complex operating environment and wider social determinants of health (eg food security) were other reasons increasing the numbers of cases.

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[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 VHVs in 2004.

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

Table 6: Back Pack Health Worker Team Caseloads

No	Condition	Age				Total
		<5		>=5		
		M	F	M	F	
1	Anemia	319	329	2246	4266	7160
2	ARI(mild)	2595	2653	6277	6714	18239
3	ARI(severe)	1373	1353	1750	1994	6470
4	Beriberi	97	138	1742	2868	4845
5	Diarrhea	893	958	1654	1778	5283
6	Dysentery	328	327	1086	1127	2868
7	Injury(gunshot)	1	0	69	18	88
8	Injury(landmine)	0	0	115	3	118
9	Injury Acute Other	247	139	1572	960	2918
10	Injury(old)	45	44	624	329	1042
11	Malaria (PF)	62	76	480	372	990
12	Malaria (PV)	73	109	359	250	791
13	Measles	73	49	33	45	200
14	Meningitis	8	12	28	28	76
15	SuspectedAIDS	1	1	10	16	28
16	SuspectedTB	20	33	188	150	391
17	Worms	1034	1052	2005	2191	6282
18	Abortion	0	0	0	120	120
19	Post-Partum Hemorrhage	0	0	0	38	38
20	Sepsis	3	0	9	39	51
21	Respiratory Tract Infection (RTI)	0	0	0	349	349
22	Urenary Tract Infection (UTI)	47	58	1260	2148	3513
23	Skin Infection	726	827	1585	1632	4770
24	Hepatitis	10	9	201	221	441
25	Typoid Fever	65	83	522	570	1240
26	Arthritis	41	36	1180	1248	2505
27	Gastric Ulcer Deudinum Ulcer (GUDU)	26	21	3465	4059	7571
28	DentalProblem	231	273	1068	1183	2755
29	EyeProblem	222	275	988	1107	2592
30	Hypertention	0	0	2358	2868	5226
31	Abscess	272	239	1037	843	2391
32	Others	1390	1380	4436	6251	13457
Total		10,202	10,474	38,347	45,785	**104,808**
Grand Total		**20,676**		**84,132**		

Table 7: Gender Disaggregation of Case Loads Treated

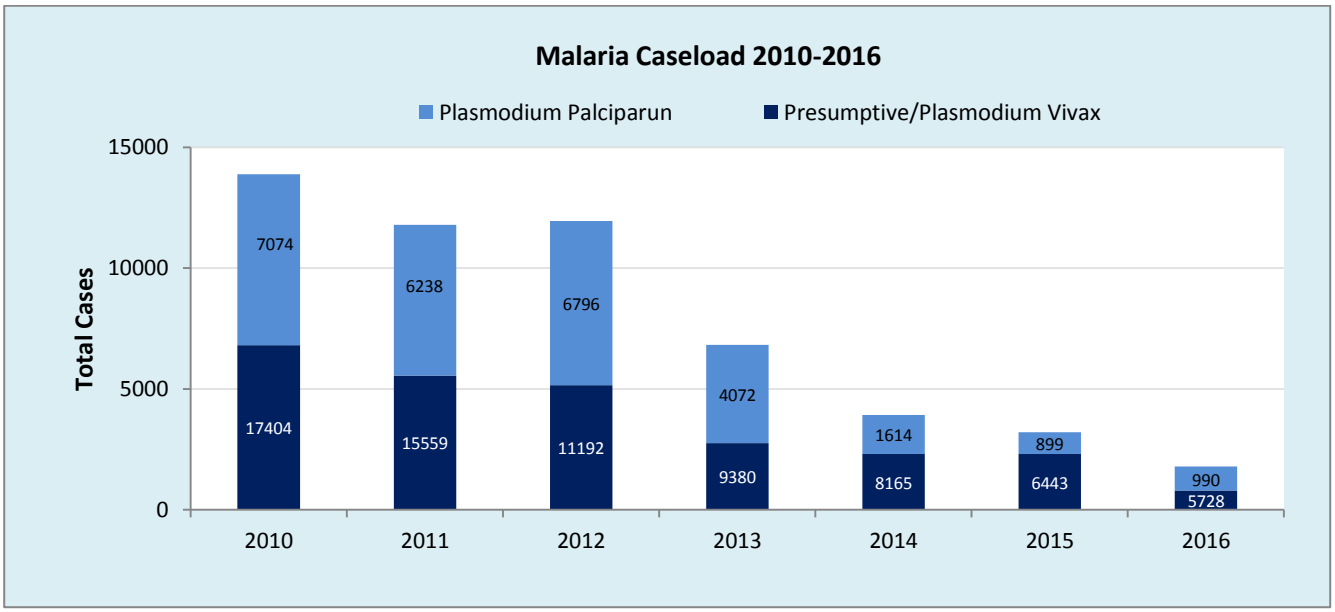
Category	Men	Women	Total
Patients <5	10,202	10,474	20,676
Patients >=5	38,347	45,785	84,132
Total	**48,549**	**56,259**	**104,808**

i. Malaria

The BPHWT has used Para-check, 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 Arteminisin-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.

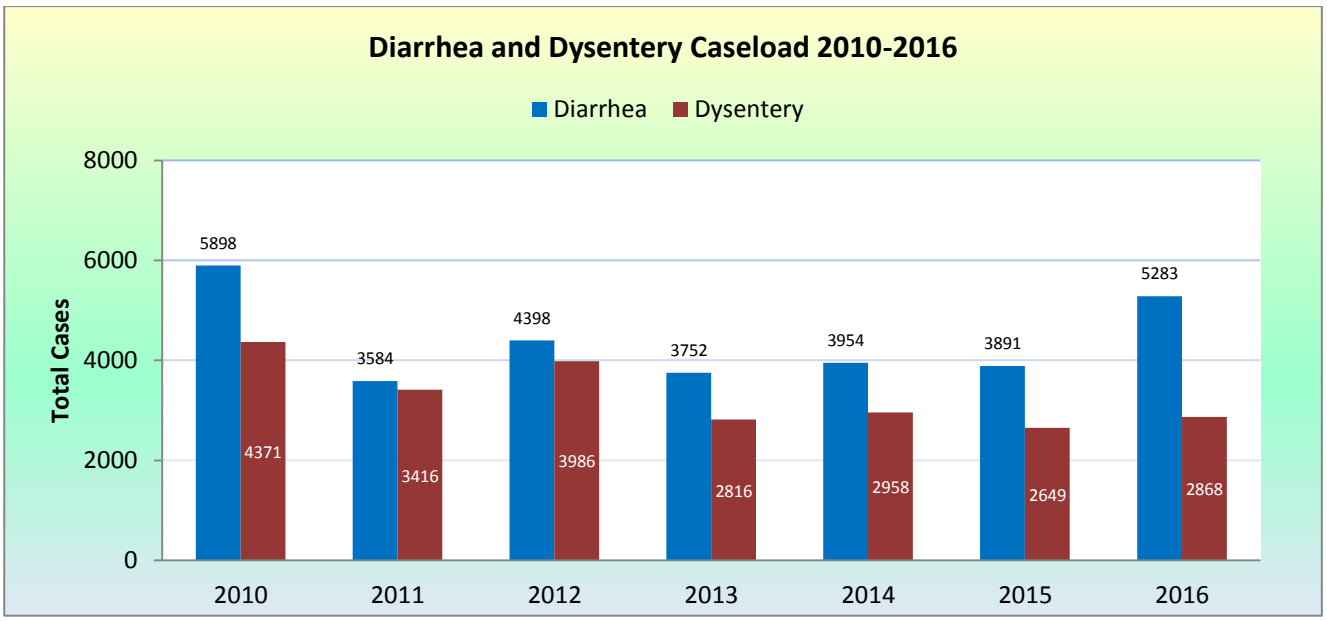
From 2003-2004, the BPHWT did not have small, portable diagnosis kits called Rapid Diagnosis Tests (RDT) to confirm cases of Plasmodium falciparum (*P.f.)* malaria. RDT usage began in 2005, but there were not enough RDTs available to cover all field areas; but by 2008 and 2009, there were enough RDTs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

Since the early of 2014, the BPHWT has used the SD Bioline which can test for both P.f and P.v malaria. Due to malaria intervention from other partner such as SMRU, the malaria prevalence have been decreased. During 2016, there were 1,781 malaria cases treated by the field health workers. According to the graph showing below, malaria has sharply decreased. In addition, "The Long Road to Recovery" survey report also showed that the prevalence rate for P. falciparum malaria decreased dramatically from 7.3% in 2008 to 2.3% in 2013. However, there are still malaria cases that the field health workers will have to continue providing treatment.



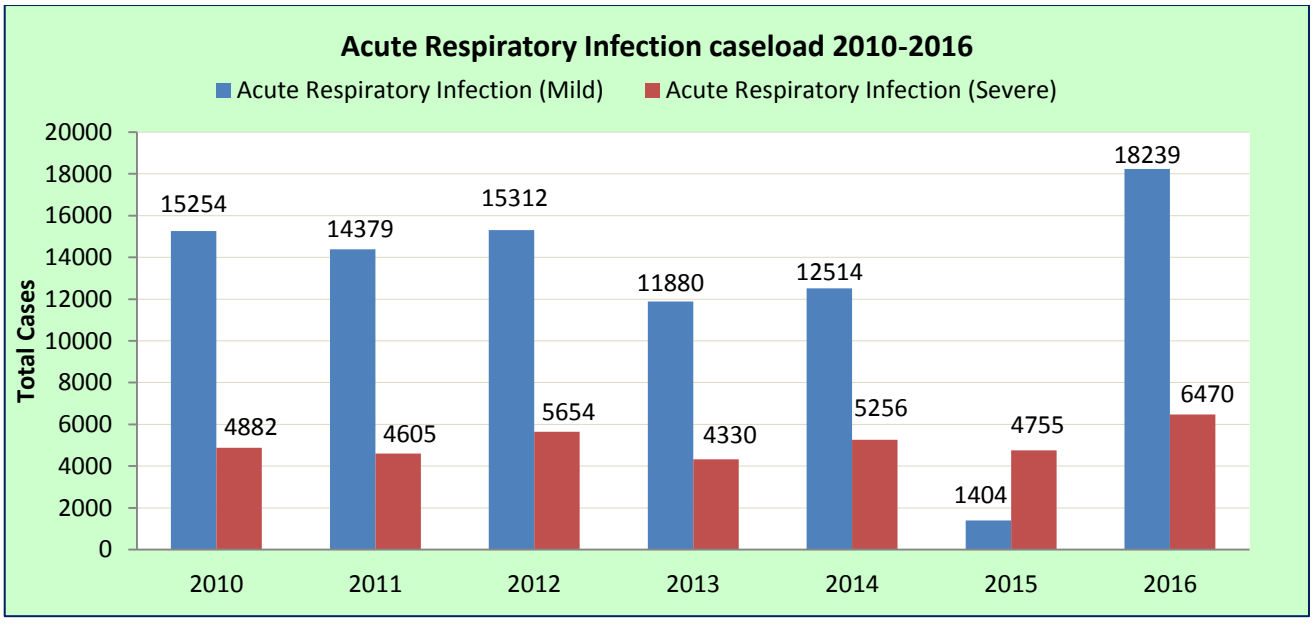
ii. Diarrhea and Dysentery

In general, diarrhea and dysentery cases were still steadily from those recorded since 2013 to 2015 year. However, the cases were slightly increased during 2016 compared to the past years. 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).



iii. Acute Respiratory Infection (Mild/Severe)

The annual cases of acute respiratory infection was 24,709 – 18, 239 mild and 6,470 severe. The totals of 7,974 were under five children. It seems a lot more comparing to the previous year. However, it cannot be interpreted that there was more ARI case during this year because it depends on the process of the medicine for this case. There are also some other reasons such as due to the complex operating environment, and wider social determinants of health and increase numbers of back pack teams. This graph can only indicate the numbers ARI cases treated by the field health workers by yearly.



iv. 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. There were 6282 worm infestation cases, 2,086 were under five children treated in 2016.

v. Suspected Pulmonary Tuberculosis and AIDS Cases

The total number of suspected cases of tuberculosis (TB) was 391 cases (183 women and 208 men) that recorded by the health workers. The highest figure founded in Kayan areas which was 174 cases and follow by Mergue/Tavoy – 54 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. 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 28 suspected AIDS cases – 17 women (26 cases in Kachine, 1 cases in Palaung and 1 case in Taungoo) that recorded by the health workers.

vi. Acute Landmine and Gunshot Injuries

In 2016, there 118 landmine cases (3 women and 115 men) and 88 gunshot cases (19 women and 70 men) recorded and treated by the health workers. There was one under-five gunshot case. The highest figure founded in Palaung areas in both gunshot and landmine cases. The reason is that there was active fighting in Palaung area during 2016 However, some cases in the field areas were not recorded because the field health workers recorded the cases that they evidenced.

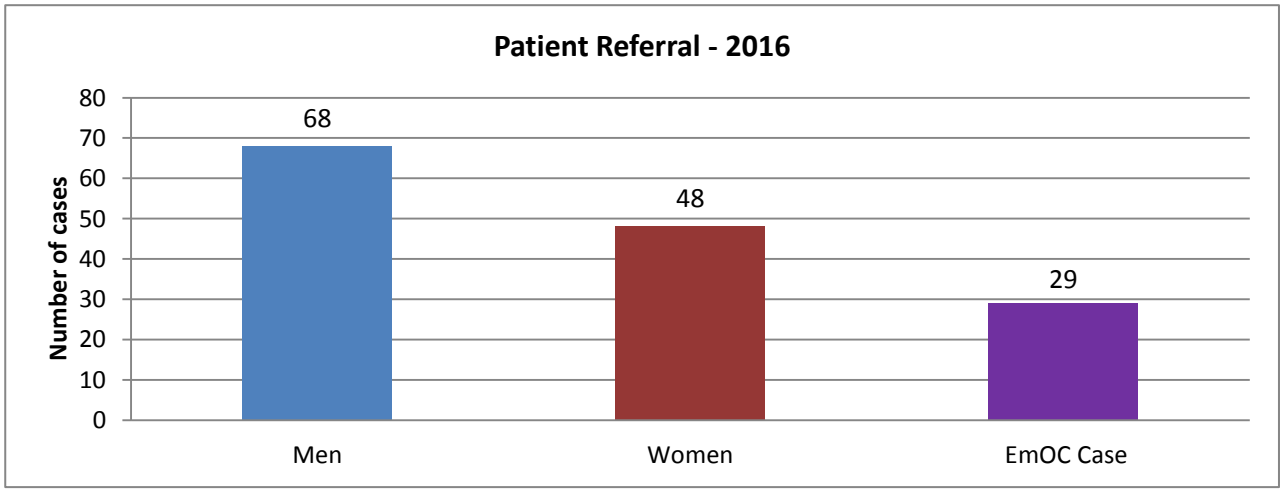
Table 8: Gunshot Injury cases

No.	**Field Areas**	**< 5 ages**		**> = 5 ages**		**Total**
		M	**W**	**M**	**W**	
1	Papun	0	0	10	5	15
2	Pa An	0	0	2	0	2
3	Mergue/Tavoy	0	0	3	0	3
4	Palaung	1	0	54	11	66
5	Kachin	0	0	0	2	2
	Total	**1**	**0**	**69**	**18**	**88**
Landmine Cases						
1	Palaung	**0**	**0**	**115**	**3**	**118**

vii. Patient referral

Table 5: Referral sites		
• Taungoo Hospital	• Num Ma Tu Hospital	• Tavoy Hospital
• Kyaut Kyi Hospital	• Thay S'Yah Hospital	• Kawkariek Hospital
• Ta Eu Wah Plaw Clinic	• Kacharna Bori	• Mae Tao Clinic
• Hpa An Hospital	• Hlaing Bwe Hospital	• Mae Sot Hospital
• Naung Khain Clinic	• Than Daw Public Hospital	• Myaweddy Hospital
• Malamyein Hospital	• Phruso Hospital	• Kaw Mu Del Clinic
• Loi Kaw Hospital	• Pa Pum Hospital	• Yan gon Hospital
• De Morso Hospital	• Klay Kee Clinic	•
• Loi Nan Pha Hospital	• Loi Lin Hospital	

Table 6: Referral cases		
• 8 Suspected TB	• 1 Hernia and Hydroced	• 8 Gastritis (PU/DU)
• 2 Motorbike Acciden	• 8 Post Abortion care	• 2 Appendicitis
• 6 Hypertension	• 3 Very Sever Pneumonia	• 6 Acute Injury Gunshot
• 10 Obstetric Labor	• 5 Acute Incident Injury	• 2 Chronic Asthma
• 2 Eye Problem	• 3 Rheumatic Fever	• 2 Gall bladder Stone
• 3 Menigitis	• 6 Tumour	• 1 Burm
• 3 Abscess	• 3 Severe Dehydratiion	• 4 Prolong Labour
• 1 Snake bite	• 5 Eclampsia	• 4 Urinary Stone
• 3 Severe Amemia	• 6 Hepatitis	• 2 Chronic heart disea
• 1 Suspceted HIV	• 4 Nephritis Sydrone	• 5 Land mine injury
• 2 UTI	• 3 Suspected Cancer	• 2 Cesarean Section
• 2 Severs Malnutrition	• 7 Placenta Retailed/PPH	• 2 Antepartum haemorrhage
• 5 Dengue Hemorrhage Fever	• 2 Ascites	• 1 Polyhydramnios



9.2) 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
- HIV/AIDS education
- Prevention and awareness of communicable diseases

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.

9.2.1) School Health Sub-Program:

In 2016, the BPHWT implemented its school health program in 432 schools with 2,002 teachers: 1,596 women and 406 men. There were 38,310 students – comprised 18,679 boys and 19,631 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.

9.2.2) 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 2016, 26,737 children received De-worming medicine (Albandozole) and 32,983 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.

Health workers together with school teachers are providing Vitamin A, De-worming medicine, and personal hygiene kits to students in the Thaton Field Area.

Table 9: Numbers of Children Receiving Vitamin A

No.	Area Name	CHILDREN'S AGES							
		6-12 Months		1-6 years		6-12 years		Total	
		M	F	M	F	M	F	M	F
1	Kayah	97	102	488	495	546	530	1131	1127
2	Kayan	170	182	404	430	469	483	1043	1095
3	Special	22	42	63	125	188	284	273	451
4	Taungoo	110	102	328	339	546	487	984	928
5	Kler Lwee Htoo	197	215	427	440	380	439	1004	1094
6	Thaton	83	90	595	622	652	697	1330	1409
7	Papun	80	95	269	302	596	583	945	980
8	Pa An	2	10	455	450	764	811	1221	1271
9	Dooplaya	103	99	324	339	488	509	915	947
10	Kawkareik	67	68	184	201	249	236	500	505
11	Win Yee	1	2	107	120	352	343	460	465
12	Mergue/Tavoy	88	98	371	387	557	555	1016	1040
13	Yee	65	89	265	403	540	667	870	1159
14	Moulamein	136	124	204	259	338	348	678	731
15	Shan	174	182	595	783	315	379	1084	1344
16	Palaung	417	518	756	946	743	915	1916	2379
17	Arakan	112	102	138	145	97	94	347	341
Total		**1924**	**2120**	**5973**	**6786**	**7820**	**8360**	**15717**	**17266**
		4,044		**12,759**		**16,180**		**32,983**	

Table 10: Numbers of Children Received De-worming Medicine

No.	Field Area	Age (1-12 Years)		
		M	F	Total
1	Kayah	978	984	1962
2	Kayan	980	988	1968
3	Special	272	455	727
4	Taungoo	836	801	1637
5	Kler Lwee Htoo	618	597	1215
6	Thaton	796	784	1580
7	Papun	876	864	1740
8	Pa An	928	1013	1941
9	Dooplaya	811	871	1681
10	Kawkareik	376	351	727
11	Win Yee	468	466	934
12	Mergue/Tavoy	749	760	1509
13	Yee	788	996	1784
14	Moulamein	534	618	1152
15	Shan	1055	1345	2400
16	Palaung	1498	1817	3315
17	Arakan	236	236	472
Total		**12,795**	**13,943**	**26,737**

9.2.3)) 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 2016, the BPHWT teams built 20 gravity flow water systems and the beneficiary population that has received gravity flow water system includes 2,137 households composed of 9,333 people. The BPHWT also built 35 shallow well water systems which have been received by 629 households and 3,934 beneficiaries. The BPHWT also provided 1,689 community latrines to 1,689 households and 2 water filters for 1,369 students.

Table 11: Numbers of Gravity Flows, Shallow Wells, and Latrines Installed

No.	Area Name	No. Gravity Flows	HHs	Population		
				M	W	Total
1	Papun	3	255	651	684	1,335
2	Pa An	6	436	1,000	1,049	2,049
3	Dooplaya	3	337	997	986	1,983
4	kawkariek	1	568	634	633	1,267
5	Mergue/Tavoy	2	235	716	663	1,379
6	Taungoo	2	100	253	271	524
7	Yee	1	138	232	267	499
8	Shan	2	68	148	149	297
Total		**20**	**2,137**	**4,631**	**4,702**	**9,333**
No.	**Area Name**	**No. Shallow Wells**	**HHs**	**Population**		
				M	**W**	**Total**
1	Kayah	4	66	178	189	367
2	Special	2	104	400	426	826
3	Kler Lwee Htoo	5	31	441	357	798
4	Thaton	14	242	598	482	1,080
5	Papun	2	37	100	60	160
6	Dooplaya	1	30	70	80	150
7	Win Yee	1	30	37	63	100
9	Mergue/Tavoy	3	45	127	119	246
9	Arakan	3	44	111	96	207
Total		**35**	**629**	**2,062**	**1,872**	**3,934**
No.	**Area Name**	**No. Latrines**	**HHs**	**Population**		
				M	**W**	**Total**
1	Kayah	268	268	679	726	1,405
2	Kayan	100	100	421	450	871
3	Special	100	100	500	410	910
4	Taungoo	100	100	253	271	524
5	Kler Lwee Htoo	50	50	160	170	330
6	Thaton	100	100	272	304	576
7	Papun	97	97	241	255	496
8	Pa An	109	109	273	291	564
9	Dooplaya	40	40	90	110	200
10	kawkariek	100	100	643	695	1,338
11	Win Yee	50	50	130	145	275
12	Mergue/Tavoy	100	100	249	265	514
13	Yee	60	60	73	129	202
14	Shan	275	275	630	671	1,301
15	Palaung	140	140	337	400	737
	Total	**1,689**	**1,689**	**4,951**	**5,292**	**10,243**
No.	**Area Name**	**No. Water Filters**	**HHs**	**Population**		
				M	**W**	**Total**
1	Pa An	2	228	685	684	1,369
Total		**2**	**228**	**685**	**684**	**1,369**

9.2.4)) 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.

Organizing Village Health Workshop in Pa An area

During 2016, the BPHWT organized 179 village health workshops in 16 targeted field areas, attended by 12,151 people – 5,544 men and 6,607 women. Communities were invited to send representatives from different sectors such as religious leaders, authorizes, villagers, women organization, youth organization, health workers, TBAs/TTBAs, VHVs/VHWs, shop keepers 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.

Table 12: Number of Village Health Workshop and Participants

No	Areas	# of VH workshops	Participants		Total
			M	W	
1	Kayah	24	402	314	716
2	Kayan	5	329	419	748
3	Special	4	183	266	449
4	Taungoo	14	462	559	1,021
5	Kler Lwee Htoo	9	409	475	884
6	Thaton	11	242	295	537
7	Papun	16	404	475	879
8	Pa An	15	308	433	741
9	Kawkareik	10	442	535	977
10	Win Yee	8	205	259	464
11	Mergue/Tavoy	17	506	606	1,112
12	Yee	20	524	696	1,220
13	Moulamein	12	394	429	823
14	Pa Oh	2	43	5	48
15	Palaung	10	549	674	1,203
16	Kachin	2	162	167	329
Total		**179**	**5,544**	**6,607**	**12,151**

9.2.5) Village Health Committee

During the period of 2016, the BPHWT started to establish Village Health Committee (VHC) in four field areas: Win Yee, Kawkareik, and Pa An. There were twenty VHCs established - 6 VHCs in Pa An, 3 VHCs in Kawkareik, 4 VHCs in Win Yee, and 7 VHCs in Dooplaya. There were 198 participants, comprised of 70 women and 128 men. The purpose of establishing VHC is to improve community participation and to sustain development of a primary healthcare. The target goal was to have at least 30% participation from women in the VHCs. The VHCs surpassed that goal with 41% of VHC members being women. Each VHC targets to have 7-9 members. These representatives are from village administration committee, local health workers, teachers, religious leaders, women and youth groups.

Table 13: Village Health Committee Participant list

NO	Area	# of VHCs	Men	Women	Total
1	Pa An	6	38	16	54
2	Kawkareik	3	17	12	29
3	Win Yee	4	19	16	35
4	Dooplaya	7	54	26	80
Total		**20**	**128**	**70**	**198**

The VHCs are responsible for patient referral, community empowerment and participation, providing health education and environment cleaning, over sight of clinic management, and coordination with other CBOs and NGOs activities. These VHCs organize quarterly regional meeting among themselves in their villages.

Table 14: Village Health Committee Meetings and Participant list

NO	Area	# of VHC meetings	Men	Women	Total
1	Win Yee	7	32	35	**67**
2	Pa An	18	184	104	**288**
3	Kawkareik	4	34	23	**57**
4	Dooplaya	2	14	11	**25**
Total		**31**	**264**	**173**	**437**

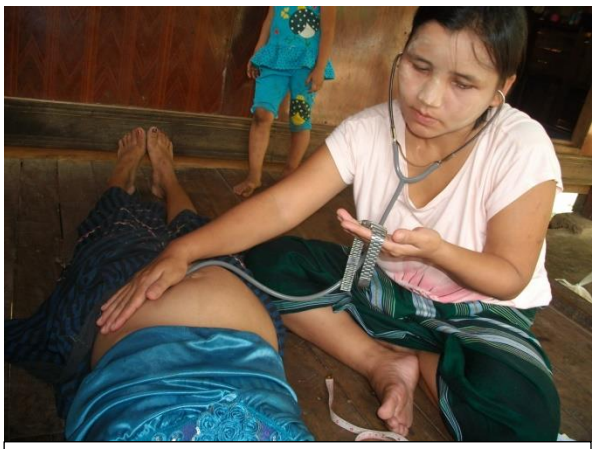
Organizing VHC in Dooplaya area

Organizing VHC in Kawkareik area

Table 15: Number of World AIDS Events and Participants					
No	**Areas**	**# of World AIDS Events**	**Participants**		**Total**
			M	**W**	
1	Kayah	7	395	440	835
2	Palaung	2	56	117	173
3	Win Yee	1	27	59	86
4	Pa Oh	1	13	10	23
Total		**11**	**491**	**626**	**1,117**

9.3) 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.



A MCH supervisor is providing ANC to a pregnant woman in Win Yee area

During 2016, 3,159 pregnant women received de-worming medicine (Mebendozole) and 3,212 women and pregnant women received iron supplements. In addition, 839 TBAs/TTBAs were working with the Back Pack Health Worker Team. They assisted in 3,513 births; of these, 3,328 were live births, 12 were stillbirths or abortions, and there were 9 cases of neo-natal deaths. The TBAs/TTBAs also recorded 9 maternal deaths. There were 29 obstetric cases referred during 2016.

9.3.1) Trained Traditional Birth Attendant (TTBA) Training

In 2010-2011, an external evaluation facilitated by Burma Relief Center (BRC) recommended that TBAs in the targeted villages must have more knowledge and skills in order to be more effective. Therefore, since 2012, the BPHWT has decided to train TBAs to become TTBAs who will have greater knowledge and skills to provide safe deliveries, related health education, and an effective referral system. It is twenty-day training. The trainers are MCHP supervisor who have done TTBA ToT. During 2016, there were six TTBA trainings for 122 TTBAs (8 men and 114 women) in the five field areas at the table below.

Table 16: TTBA training					
NO	**Area**	**# TTBA Trainings**	**Participants**		
			Men	**Women**	**Total**
1	Kayah	1	0	15	15
2	Dooplaya	2	8	44	52
3	Yee	1	0	20	20
4	Pa Oh	1	0	20	20
5	Arakan	1	0	15	15
Total		**6**	**8**	**114**	**122**

9.3.2) 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 2016, 128 TBA/TTBA follow-up workshops were organized in 18 field areas which included 720 TBAs/TTBAs (56 men and 664 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, 1,230 TBA/TTBA kits and 4,305 maternity kits were distributed in order to restock in field areas.

Table 17: Number of TBA/TTBA Workshop and Participants

NO	Area	# Workshops	Men	Women	Total
1	Kayah	8	0	40	40
2	Kayan	6	0	30	30
3	Taungoo	6	0	28	28
4	Klew Lwee Htoo	10	3	42	45
5	Thaton	14	0	64	64
6	Papun	18	20	89	109
7	Pa An	12	7	73	80
8	Dooplaya	8	9	50	59
9	Kawkareik	6	4	29	33
10	Win Yee	8	0	50	50
11	Mergue /Tavoy	10	6	32	38
12	Yee	2	0	20	20
13	Shan	2	0	10	10
14	Palaung	5	3	32	35
15	Chin	6	0	46	46
16	Arakan	3	0	15	15
17	Special	2	1	7	8
18	KBC	2	3	7	10
Total		**128**	**56**	**664**	**720**

9.3.3) Maternal and Child Healthcare refresher workshop

During this period, the BPHWT organized a maternal and child healthcare refresher workshop at Mae Sot office. This workshop was organized from 2-13 December 2016. There were 21 MCH supervisors and workers (3 men and 18 women) who attended this workshop. The facilitators were the MCH coordinator and staff from BPHWT and MTC. The discussion topics are:

- Introduction of SDC Project
- MCH Supervisor report presentation
- ANC & Normal Pregnancy
- Bleeding in Early & late pregnancy
- Normal Labor & Delivery
- PPH Prevention and Treatment
- New born care/PNC
- Review of MCH forms
- Future plans

Table 18: Progress toward TBA to Pregnant Women Target Ratio 2004-2016

Year	TBAs/TTBAs	Pregnant women	TBAs/TTBAs/ 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%
2015	741	10,339	14	8	57%
2016	839	17,927	23	8	35%

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

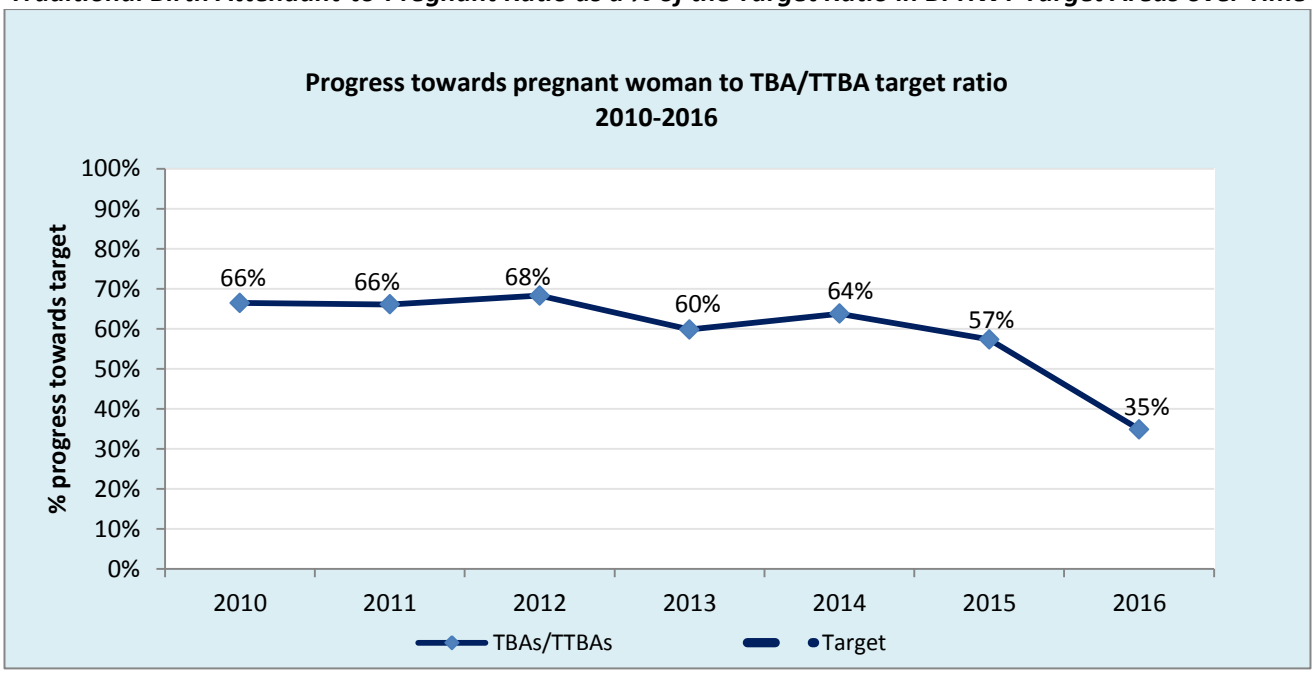


Table 19: Birth and Death Records

No	Area	Deliveries	Live Births	Still Births/ Abortions	Deaths		<2.5 Kg	=>2.5 kg
					Neonatal	Maternal		
1	Kayah	207	208	0	0	0	1	207
2	Kayan	198	198	0	0	0	1	197
3	Taungoo	135	135	0	1	0	0	135
4	Klew Lwee Htoo	121	121	0	0	0	1	120
5	Thaton	340	336	4	1	4	25	315
6	Papun	474	473	1	0	0	23	451
7	Pa An	414	413	1	3	1	22	392
8	Dooplaya	245	245	0	0	0	12	233
9	Kawkareik	98	98	0	0	0	6	92
10	Win Yee	295	293	2	3	1	1	294
11	Mergue /Tavoy	141	141	0	0	0	6	135
12	Yee	161	161	0	0	0	0	161
13	Shan	41	41	0	0	0	0	41
14	Palaung	244	240	4	0	3	3	241
15	Kachin	0	0	0	0	0	0	0
16	Chin	107	107	0	0	0	0	107
17	Arakan	142	142	0	0	0	4	138
18	Special	60	60	0	0	0	1	59
19	KBC	90	90	0	0	0	0	90
Total		**3,513**	**3,502**	**12**	**8**	**9**	**106**	**3,408**

Table 20: Pre and Post Natal Distribution of De-worming, Ferrous Sulphate, and Folic Acid

No	Area	De-Worming	F/S & F/A
1	Kayah	129	129
2	Kayan	166	157
3	Taungoo	130	135
4	Kler Lwee Htoo	120	121
5	Thaton	340	340
6	Papun	387	405
7	Pa An	379	401
8	Dooplaya	171	171
9	Kawkareik	97	97
10	Win Yee	295	295
11	Mergue/Tavoy	141	141
12	Yee	161	161
13	Shan	41	41
14	Palaung	235	235
15	Kachin	0	0
16	Chin	107	107
17	Arakan	119	131
18	Special Pa An	51	55
19	KBC	90	90
Total		**3,159**	**3,212**

9.3.4) 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. The BPHWT distributes and promotes the use of three family planning methods, namely the contraceptive pill, Depo-Provera, and condoms.

A MCH supervisor is providing implant to a woman

In 2016, the BPHWT provided family planning services to 5,227 people, of whom 253 were men. This statistic reflects that only a small number of men participate in family planning. This is due to some barriers of tradition belief. To improve the knowledge of family planning, BPHWT has included the family planning education session in the VHW's curriculum since 2012.

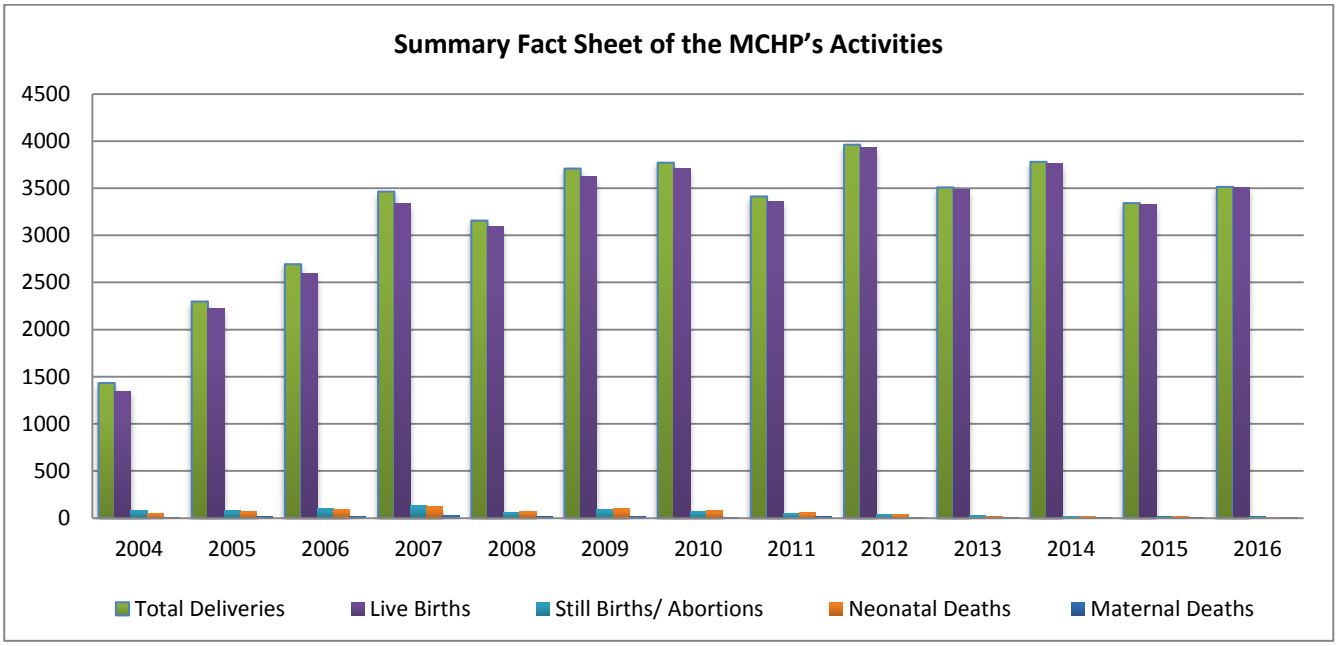
Table 21: Family Planning Activities

No	Area	Age		Visits		Clients				
		< 19	> = 19	New	F/ U	Depo	Pill	Condon	Implant	Total
1	Kayah	6	283	120	169	169	90	15	15	289
2	Kayan	11	296	108	199	104	146	42	15	307
3	Taungoo	0	179	90	89	95	56	23	5	179
4	Klew Lwee Htoo	0	116	30	86	64	31	1	20	116
5	Thaton	8	691	178	521	337	332	30	0	699
6	Papun	0	419	38	381	146	262	11	0	419
7	Pa An	3	469	66	406	224	180	18	50	472
8	Dooplaya	6	242	83	165	109	109	30	0	248
9	Kawkareik	13	235	62	186	124	120	4	0	248
10	Win Yee	2	200	74	128	66	104	20	12	202
11	Mergue/Tavoy	2	94	44	52	57	35	4	0	96
12	Yee	4	85	3	86	0	89	0	0	89
13	Shan	18	136	53	101	100	51	3	0	154
14	Palaung	19	718	88	649	640	97	0	0	737
15	Arakan	113	244	144	213	141	164	52	0	357
16	KBC	0	590	33	557	464	126	0	0	590
17	Special	0	25	18	7	0	25	0	0	25
Total		**205**	**5022**	**1232**	**3995**	**2840**	**2017**	**253**	**117**	**5,227**

9.3.5) Summary Fact Sheet of the MCHP's Activities

Years	2011	2012	2013	2014	2015	2016
1. Total Deliveries	3412	3961	3,508	3,779	3,341	3,513
2. Live Births	3356	3927	3,486	3,760	3,329	3,502
3. Still Births	50	35	24	19	12	12
4. Neonatal Deaths	53	37	14	18	19	9
5. Maternal Deaths	13	9	7	2	3	9
6. Low Birth Weight	254	263	103	212	168	106

In 2016, there were 9 maternal deaths out of 3,513 total deliveries and the main causes of maternal deaths were post-partum hemorrhage and anti-partum hemorrhage. 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.



TBA/TTBA and Maternity Kit Distributed:

Maternity Kit Contents:	TBA/TTBA Kit Contents:	
• Providone	• Syringe ball	• Compress
• Cotton	• Non-sterilized gloves	• Multicolor bag for kit (smallest size)
• Vitamin A	• Sterilized gloves	• Plastic sheet
• Albendazole	• Plastic bags for medicine	• Package of plastic bags for kit
• Folic C	• Providone	• Towels
	• Terramycin eye ointment	• Nail clippers
	• Thread	• Scissors
	• Ink	

9.3.6) 13.3.7 Reproductive Health Awareness

During the period of 2016, the MCHP supervisors started conducting RH awareness workshop in 19 field areas as showed in the below table. Each workshop takes about three hours. The key topics discussed in this workshop are ANC, PNC, abortion, high risk pregnancy, danger signs in pregnancy, referral, family planning, breast feeding, nutrition, and anemia. This RH workshop is conducted six monthly in the communities. There were 96 workshops - 8,074 participants, comprised of 5,070 women and 3,004 men and 84 were under 15 age groups. The BPHWT plans to continue this RH awareness to improve the knowledge and awareness of reproductive ages.

Reproductive Health Awareness Workshop in Pa An area

Table 22: Reproductive Health Awareness participant list

NO	Area	# of RH Awareness	<15		> = 15		Total
			Men	Women	Men	Women	
1	Kayah	4	6	14	105	200	325
2	Kayan	3	6	8	73	119	206
3	Taungoo	3	6	17	47	103	173
4	Klwe Lwee Htoo	5	31	33	93	200	357
5	Thaton	7	35	22	144	345	546
6	Papun	8	40	66	221	302	629
7	Pa An	13	44	89	295	611	1,039
8	Dooplaya	14	208	245	589	748	1,790
9	Kawkareik	6	10	23	216	282	531
10	Win Yee	8	47	85	208	374	714
11	Mergue /Tavoy	3	35	36	63	163	297
12	Yee	6	7	3	156	240	406
13	Shan	3	30	32	67	117	246
14	Palaung	3	0	37	3	165	205
15	Arakan	3	36	35	68	101	240
16	Chin	3	0	27	10	44	81
17	Pa Oh	2	11	17	44	88	160
18	Special	1	0	0	18	49	67
19	KBC	1	0	0	32	30	62
Total		**96**	**552**	**789**	**2,452**	**4,281**	**8,074**

9.3.7) Nutrition for Pregnant Women

Maternal nutrition is a great concern in the areas that BP teams serve. MCH workers often provide information about nutrition for pregnant women, however; pregnant women cannot afford the necessary nutrition for a healthy pregnancy. According to the Impact Assessment Survey result, 14.1% of women of reproductive age were moderately/severely malnourished in 2016. Malnutrition during pregnancy is linked to poor birth outcomes such as intrauterine growth retardation and low birth weight infants.

Therefore, during the second six month period of 2015, the MCH program has started nutrition project for pregnant women in four field areas – Pa An, Kawkareik, Win Yee and Dooplaya and 20 BP

teams in those areas. The MCH workers provide oil, yellow bean, eggs, canned fish, dried fish, iodized salt, and sugar. The table below shows the numbers of pregnant women receiving nutrition food during 2016. Because of the nutrition program, it is easier for pregnant women to participate in Back Pack's ANC program.

Table 22: Distribution Nutrition Food to Pregnant Women

Areas	# of BP teams	Mar	Apr	May	Jun	Oct	Nov	Dec
Pa An	6	213	0	49	259	258	250	265
Kawkareik	3	0	54	56	98	82	81	82
Win Yee	4	0	112	118	111	220	220	220
Dooplaya	7	0	0	210	210	253	252	254
Total	**20**	**213**	**166**	**433**	**678**	**813**	**803**	**821**

9.3.8) Testimonials from the Thaton Field Area

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

A mother with her child who is suffering from congenital disease

I had planned to go back as soon as I made sure the mother and the baby had safely arrived to the hospital. However, I decided to accompany them because the mother was sick and did not understand or speak Burmese.

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

Thaton Field Area, MCHP Supervisor, Ta Gay Laung Back Pack Team

10) Field Meetings and Workshops

The BPHWT conducts field meetings and field workshops twice a year in the targeted field areas. In 2016, there were 37 field workshops and 30 field meetings conducted in the targeted field areas; there were 370 (216 men, 154 women) participants who attended field meetings and 402 (192 men, 210 women) participants who attended field workshops.

Table 24: Field Workshops and Meetings				
Description	**# of Workshops/Meetings**	**Men**	**Women**	**Total**
Field Workshops	37	192	210	402
Field Meetings	30	216	154	370

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

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

11) Capacity Building Program

In 2016, the Back Pack Health Worker Team organized four community health worker trainings, one medic training, one Certificate in Public Health training, one Auxiliary Midwife (AMW) training, one trauma management training, three village health worker trainings, two mental workshops and one organizational development workshop 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 field health workers every six months in the Back Pack targeted field areas.

In addition, 7 administration staff completed Certificate in Public Health training (Tharmasat University course) which was organized by MTC and 9 administration staff and field supervisors (3 women and 6 men) attended Health Facility Management training (Khaw Kan University).

Table 25: Trainings Implemented during 2016

Training Courses	Periods	Training sites
1. Community Health Worker Training	10 months	Thay Bay Hta,Mergue/Tavoy ,Mon, Kayah
2. Certificate in Public Health	6 months	Mae Sot
3. Medic training	9 months	Papun
4. Trauma Management training	1 month	Kler Lwee Htoo
5. Village Health Worker Training	3 months	Pa An, Papun, Kler Lwee Htoo
6. Auxiliary Midwife training	4 months	Pa An
7. Basic Computer & Office Management training	2 months	Mae Sot
8. Metal Health Workshop	2 weeks	Mae Sot
9. Organizational Development workshop	2 Days	Mae Sot
10. IMCI Training of Trainer	2 weeks	Mae Sot

11.1) Community Health Worker (CHW) Training

During the reporting period, the BPHWT organized four Community Health Worker (CHW) trainings in Htway Bay Hta, Kayah and Mon. The total participant were 172 - 100 women and 72 men. The CHW training aims to scale up the number of health workforce members and enhance the skills and relevancy of health workers to enhance health condition of local populations in the target areas. This CHW training is lasted for six months and four-month internship at their respective clinics to apply the knowledge and skill from it. 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 misusage of treatment within communities

Key Course Topics:

- Anatomy and Physiology
- Universal Precaution
- Nursing Care
- First Aid and Minor surgery
    - Medicine
    - Essential drugs
- Pharmacy Management
- Primary Health care concept and principle
- Basic Obstetrics and Gynecology
- Primary Eye Care
- Public Health

Table 26: Number of Community Health Worker Trainings and Participants

No	Areas	# of CHW Trainings	Participants		Total
			M	W	
1	Thay Bay Hta	2	53	52	105
2	Kayah	1	13	20	33
3	Mon	1	6	28	34
Total		4	72	100	172

11.2) Medic Training Course

In this period, the BPHWT organized a nine months' Medical Refresher Training Course in Papun are which began on 21 April to 31 December 2016. The purpose of this training course was to improve the health workers' knowledge and skills as well as to provide updated health information to the health workers so that they will be better able to serve their communities. There were 31 participants - 21 men and 10 women - from different field areas and ethnic groups. The trainees are being trained by Mae Tao Clinic (MTC) staff, the International Rescue Committee (IRC) Trainer Team, KDHW and BPHWT senior staff who completed medic ToT.

Medic Training Closing Ceremony at BPHWT office in Mae Sot

11.3) Certificate in Public Health 4th Batch Training

During this period, the Back Pack Health Worker Team (BPHWT) organized the 4th batch of certificate in public health Training. This is six months training including field trip to schools and community. This certificate in public health Training successfully completed the program on 6th September 2016 at the BPHWT head quarter office in Mae Sot. There were 34 participants (17 women and 17 men) from different areas and ethnicities. This training was conducted by the trainers from IRC/PLE and MTC.

The BPHWT also has training team to be involved 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 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

Certificate in Public Health Training Field Visit to Community

- School Health
- Family Health Care
- Community Health Care
- Nutrition Promotion
- Health Management and Supervision
- Expanded Program on Immunization (EPI)

Certificate in public health Training Course Criteria for Participants:

- Completed community health worker training
- At least 2 years working experience as a health worker
- Recommended by their community or the mother organization
- At least one woman from each area
- Must be a health worker who is currently responsible for a Back Pack team
- At least 3 years working experience as a Back Pack health worker
- Be interested in primary healthcare

11.4) Auxiliary Midwife training

The BPHWT continuous supporting of the Auxiliary Midwife (AMW) training that has been running since 2013 funded by SV award. The BPHWT with Phlon Education Development Unit (PEDU) and State Health Department (SHD) organized one Auxiliary Midwife training during 2016. This is the 6th batches of AMW trainings and comprised of 21 participants who are from Hlaing Bwe & Kawkareik and Kyar In Seik Kyi townships. This training was organized from 26 October 2016 to 31 January 2017. The trainers of this AMW training are from Back Pack Health Worker Team (BPHWT), Karen State Department of Health (KSDoH), IRC/PLE and retired Burma Government medical personnel. 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.

Batch 6th AMW Training in Hpa An, Karen state

11.5) Auxiliary Midwife training follow-up workshop

The BPHWT has continuously supported the Auxiliary Midwife (AMW) training since 2013 through close coordination with Phlon Education Development Unit (PEDU) in Hpa An and Burma's State Health Department (SHD). After the training, the AMWs return and work in their respective community. To ensure effective collaboration in the BPHWT's targeted areas, AMWs need medicine

and medical kits along with follow-up training. During this reporting period, the BPHWT organized one AMW follow-up workshop in Taung Ka Lay, Pa Hpa and attended by 18 AMWs. There were less AMW attended the workshop than expected. According to the field trip assessment, some of the AMWs are working with Sub-Rural Health Centers. Some of AMWs could not join the workshop according to the distance transportation and family issue. 27 kits were provided to 27 AMWs.

In addition, the BPHWT coordinated with doctors from IRC/PLE and organized eight meetings with AMWs at some Sub-RHC in their respected communities. The detail visited locations are showed at the below table:

Date of visits	Locations
3.1.2106	1. Naung Pa Lain Sub-RHC
4.1.2016	2. Wah Pyan Gone Sub-RHC
6.1.2016	3. North Kyarin Sub-RHC
7.1.2016	4. Tha Yat Taw Sub-RHC
9.1.2016	5. Thone Se Thone Su RHC
9.1.2016	6. Ta Yi Ta Khaung Sub-RHC
13.1.2016	7. Kya Khat Chaung Sub-RHC
13.1.2016	8. Kyar In Sub-RHC

11.6) Trauma Management Training:

This Trauma management training began on 25 April to 10 May 2016 in Kler Lwee Htoo. This training included three weeks. There were 22 participants (12 men and 10 women). The trainees were trained by BPHWT senior trainer. The key course topics are:

- Chain of survival
- Triage and referral system
- Shock and shock trauma action plan
- Check injuries management
- Limbs injuries and landmine injuries management
- Universal precaution
- Local anesthesia and ketamine general anesthesia

11.7) Village Health Worker Training

The BPHWT conducted three Village Health Worker (VHW) trainings in Papun, Pa An, and Kler Lwee Htoo field areas for 64 participants, comprised of 45 women and 19 men. The VHW training is three-months long and intends to increase a skill level to perform a treatment of common diseases, provide follow-up healthcare sessions, and examine a suspicious individual with feverish body temperature though a malaria test kit or "***Paracheck***" within 24 hours.

Table 27: Number of VHW Trainings and Participants

No	Training	# of VHW Trainings	Participants		Total
			M	W	
1	Papun	1	7	16	23
2	Pa An	1	7	20	27
3	Kler Lwee Htoo	1	5	9	14
Total		**3**	**19**	**45**	**64**

11.8) Mental health Workshop

During this reporting period, the BPHWT organized two mental health workshops which were facilitated by Dr. San San Oo, Andrew Riley, and Dr.Ganesan Mahesan from Open Society Foundations (OSF). The first workshop was organized at Queen Palace which participated by 58 health workers (men – 40 and women – 18) and the other workshop was at BPHWT office which participated by 31 health workers (men - 20 M and women – 11).

The first workshop discussion topics:

- Case scenario and role play: violent case / withdrawn case
- Building up mental health services from scratch
- Psychological first aid and ethic
- Psychological first aid and crisis management
- Mental health care: principle and approaches
- Community based mental health program:

The second workshop discussion topics:

- Review the last field Health worker have facing case study assessment
- Main four Clinical feature of Schizophrenia
- Schizophrenia Statistics
- Schizophrenia differential diagnosis
- Treatment of Schizophrenia
- Clinical feature of depression
- Statistics
- Questions to ask
- Treatment depression
- Clinical feature of Psychosis
- Burn out questionnaires

11.9) Organizational Development Workshop

In this reporting period, the Back Pack conducted a three-day organizational development (OD) training on 22-24 March 2016 in Mae Sot with 28 participants (7 female and 21 male). The topics of training involved the definition of project management, process of project cycle management and logical framework. BPHWT Deputy Director Nang Snow facilitated the training to managerial health workers-field-in-charge (FIC).

11.10) Basic Computer and Office Management Training

Table 28: Computer and Office Management Training and Participants

No	Location	# of Trainings	Participants		Total
			M	W	
1	BPHWT office (Mae Sot)	1	7	11	18
Total		**1**	**7**	**11**	**18**

11.11) Integrated Management of Childhood Illness (IMCI) Training of Trainer

Table 29: Number of Conduct IMCI Training of Trainer and Participants

No	Training	# of IMCI Training	Participants		Total
			M	W	
1	IMCI	1	5	16	21
Total		**1**	**5**	**16**	**21**

12) Health Convergence Initiative

The health convergence initiative began in May 2012 with the establishment of the Health Convergence Core Group (HCCG), consisting now of nine ethnic health organizations (EHOs) and health community-based organizations (HCBOs):

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

The aim of the HCCG is to prepare existing ethnic community-based health networks, both inside Burma and those managed from the Burma border areas, for future possibilities to work together with Union and state/region government health agencies, ethnic authorities, international donors, international nongovernmental organizations, 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.

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

The health convergence initiative works in concert and supports the ceasefire and peace negotiations between the Burma Government and the ethnic people. 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. With the signing of a Nationwide Ceasefire Agreement by some of the ethnic armed organizations, the risks to the ethnic health workers and infrastructures maybe be somewhat lessen in some targeted areas and more comprehensive health convergence activities can be delivered safely to those targeted populations. It is hoped that the new Burma Government and Parliament will actively support genuine peace negotiations with the EAOs such that the active conflicts will cease on a true nationwide basis in Burma to ameliorate the associated negative health outcomes.

During 2016, the BPHWT participated in the following convergence activities:

1. EHO/HCBOs consultations with the National Health Governance Core Group (health reform advisory group for the National League for Democracy): 16 January 2016, Mae Sot, Thailand.
2. *Health Reform towards a Devolved Health System in Burma* Seminar: 24-25 March 2016, Mae Sot, Thailand.
3. Health coordination meeting between the BPHWT and the District Medical Officer in Naung Kine's Clinic to discuss cooperation between the Burma Government and EHOs in regard to referral systems and nutrition programs: 7 July 2016, Kawkareik Township, Karen State, Burma.
4. Expanded Program on immunizations (EPI) coordination meeting with the BPHWT, Myanmar Ministry of Health and Sports (MMoHS) from Nay Pyi Taw, and the District Medical Officer from the Karen State Public Health Department: 16 August 2016, Pa An, Karen State, Burma.

***Health Reform towards a Devolved Health System in Burma* Seminar**

5. *Healthcare Governance in a Federal Union Country Workshop*. The HCCG organized this workshop with guest speakers, Dr. Penny Ballam and Dr. Junice Melgar, to review structural elements of the federal system in Canada and the Philippines in respect to health. The three-day workshop included presentations about health governance in Canada's British Columbia, the experience of devolved health care in the Philippines, and an examination of the new Burma Government's National Programme of Health Reforms in comparison to the HCCG's ethnic health policy: 16 - 18 August 2016, Mae Sot, Thailand.
6. Health policy consultation meeting was held by the HCCG with the Ethnic Nationalities Affairs Center (ENAC): 28 - 29 October 2016, Chiang Mai, Thailand.
7. Family planning meeting was conducted with the BPHWT, Myanmar Ministry of Health and Sport, and District Medical Officer from the Karen State Public Health Department: 17 – 18 November 2016, Pa An, Karen State, Burma.
8. *Seminar to Strengthen the Decentralized Health System in Burma*. *T*here were 90 participants from HCCG member organizations, ethnic health organizations (EHOs), women organizations, community-based organizations, civil society organizations, ethnic leaders, ENAC, international nongovernment organizations, and MMoHS, Presentations and discussions were directed toward a political situation update, federal devolved health system for Burma, Health System Strengthen Project, ideal health policy for a Federal Union of Burma, Federal Health Policy, Kaw Thoo Lei National Health Plan, National Health Plan for Myanmar, roles of the EHOs in the National Health Plan, Universal Health Coverage, and health financing: 19 - 20 December 2016, Mae Sot, Thailand.
9. Birth certificate meeting was held with the BPHWT, Minister of Border Affairs, Ministry of Home Affairs, Karen State Public Health Department, and Karen State Department of Education: 26 December 2016, Pa An, Karen State, Burma.

At the above-mentioned *Seminar to Strengthen the Decentralized Health System in Burma,* it was seen that both the Burma Government, through its National Health Plan (NHP), and the HCCG shared the same goal of Universal Health Coverage (UHC). However, each party had a different perspective about the approach to this goal. The NHP's envisions that the NHP will be implemented through a

centralized/ deconcentration health sector with all political, administrative, and fiscal authority at the Union level.

In stark contrast, the HCCG maintains it long-held policy perspective that there must be a devolved health sector with only a general national health policy set at the Union level. Political decision making, administrative control, fund pooling (collection of funding from taxes, Union government transfer/equalization payments, and donors), and pool funding allocation/management (purchasing) for UHC and the health sector in general should be at the state/region level. Also, geographic prioritization should be community-based and come, bottom up, from the states/regions using both quantitative and qualitative methods in consultations with the townships in accordance with Union guidelines.

The point of convergence of these two perspectives is an amendment to the 2008 Constitution which adds health to Schedule Two (Region or State Legislative List) so as to share political, administrative, and fiscal authority/responsibilities between the Union and states/regions in respect to a devolved health sector. Such a constitutional amendment can be accomplished through either a NHP-inspired parliamentary Schedule 2 amendment to the 2008 Constitution or a peace negotiations' agreement to amend Schedule 2 of the 2008 Constitution. However, the NHP fails to consider a parliamentary Schedule 2 amendment to the 2008 Constitution within its plan timeline of 2016-2021.

The NHP also envision of a pooling of funds from all health sector donors and the Union budget in a Union government entity. This Union entity would be the purchaser of health services with the EHOs and other health sector organizations as health service providers through funding from this central funding pool. All decision making, administrative control, and funding would remain concentrated at the Union level as it is now. This approach is contrary with a democratic federal union which has been stated as a priority of the NLD-led government and the ethnic people. Also, it is not consistent with a true reform of the health sector and health sector convergence.

International donors have spent million of dollars over the past two decades helping to build a devolved community-based ethnic healthcare system. They should not allow a centralized/deconcentrated health system to control this ethnic healthcare system through forcing international donor pool funding at the Union level and prior to the implementation of a Peace Accord and a true federal system of government and equitable power sharing. Also, international donors should do an objective *Do No Harm* Analysis in regard to funding which considers:

- Obstruction of ongoing peace negotiations by unintentionally favoring one side (NOTE: The Ethnic Health Policy of a devolved health sector as been accepted by the UNFC as part of its peace negotiations with the Burma Government and is politically consistent with their position of a federal union which supports self-government/autonomy).
- Obstruction of health power sharing negotiations by intentionally favoring one side/system through funding decisions
- Denial of existing health services to EHO/HCBO-served populations in EAO-controlled areas

13) Monitoring and Evaluation

The Back Pack Health Worker Team organizes program activities meetings twice a year and a general meeting once a year, which include a monitoring and evaluation session. During these meetings, the Leading Committee specifically focuses on monitoring and evaluation. The Leading Committee monitors and analyzes data brought back from the field (e.g., caseload data and field in-charge reports) by looking at the presentations provided by the Program Coordinators. This allows for discussion on improvements which need to be made to the programs. During these meetings, Program Coordinators also offer advice on some health issues which the health workers could not solve by themselves, and then provide some suggestions for future planning.

The BPHWT's Leading Committee members evaluate the improvement of its activities, focusing in particular on communications, appropriate drug use, and performance reviews of the clinical logbooks.

In addition, the table shows the key indicators, methods and period of the BPHWT's monitoring and evaluation. The BPHWT also coordinate with Health Information System Working Group (HISWG) to conduct Eastern Burma Retrospective Mortality Survey (EBRMS) in every four years. The last EBRMS result report is "The Long Road to Recovery". During 2016, Impact Assessment Survey was conducted and there is IAS detail result report that can be shared.

During 2016, the Director of Executive Board and Leading Committee members made 14 monitoring trips to Dooplaya, Win Yee, Kawkareik, Pa An, Thaton, and Papun field areas to assess the situation, program effectiveness, and the health need in the field areas.

BPHWT Leading Committee with IRC/PLE organizing Surveyor training for Program Impact Assessment in the Pa An Field Area

CHEPP Coordinator's field visit to Thaton area

Table 30: Framework of Monitoring and Evaluation

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

Activities	Methods	Participants	Frequency	Evidence & Reporting
Quality of field health workers' medical skills	Logbook reviews	- External physicians - Field in-Charges - Program Coordinators	Annually	Logbook review and analysis included in the annual report
Program implementation	Comparison of planned and actual activities	- Leading Committee - Field in-Charges	Annually	Comparison and reasons for variance included in the annual report
Effectiveness of VHW & TTBA training	Pre-and post-testing of participants	- Field In-Charges - MCH supervisors - Program Coordinators	Annually	Results of training evaluation included in the annual report
Effectiveness of programs	Calculating morbidity rates of common diseases	- Director - HIS staff - Program Coordinators	Annually	Morbidity rates over time included in the annual report
Improving health outcomes	Impact assessment	- Survey team	Biennially	Impact assessment included in the corresponding annual report
Financial management	Comparison of budget & actual income & expenditure financial audit	- Leading Committee - Field in-Charges	Semi-annually	Comparison and explanation of variances included in the 6 month and annual reports
Satisfaction with organizational management	Election of Leading Committee	- External auditing firm - Director - Finance Manager - Accountant - All BPHWT members	Annually Triennially	Audited financial report included in the annual report Outcome of elections included in corresponding annual report

Log Book Review for Diarrhea and Pneumonia

BPHWT and IRC PLE staff reviewed the medical logbooks from 13 different areas/clinics in Eastern Burma regarding the medical management of two common communicable diseases; diarrhea and pneumonia. The reviewed log books were recorded during January to June 2016. IRC PLE team performed this reviewed during 21-22 November, 2016 at BPHWT office, Mae Sot.

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

$$n = \frac{Z2\alpha/2\ P\ (1 - p)}{d2}$$

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

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)

Total 200 samples were reviewed for each disease. Therefore, total of 400 cases were reviewed from 13 different areas/ clinics (Papun, Mague/Tavoy, Taungoo, kachin, Win Yee, Kawkareik, Thaton, Pa An, Kler Lwee Htoo, Yee, Arakan, PaLaung, and Dooplaya.

Areas covered in each disease:

1. Proper recording of signs and symptoms of the patients
2. Proper recording of vital signs
3. Correct diagnosis and
4. Treatment according to guideline

And using Grading of-

Excellent	≥ 90%
Good	80-89%
Fair	60-79%
Poor	40-59%
Very Poor	< 40%

Table 31: 2012 – 2016 result (scoring – fair and above)

Pneumonia (%)					Diarrhea (%)				
2012	**2013**	**2014**	**2015**	**2016**	**2012**	**2013**	**2014**	**2015**	**2016**
93% (186/200)	89% (178/200)	94.5% (189/200)	91% (182/200)	96.50% (193/200)	26.5% (53/200)	58% (116/200)	97% (194/200)	84% (168/200)	75.70% (151/200)

14) Program Development and Activity Reviews

Overall goal	***To reduce morbidity and mortality, and minimize disability by enabling and empowering the community through primary healthcare***						
OBJECTIVES	***ACTIVITIES***	***INDICATORS OF ACHIEVEMENT***	***VERIFICATION SOURCES***	***2016 EXPECTED RESULTS***	***2016 ACTUAL RESULTS***	***VARIANCES OR DIFFERENCES***	***ASSUMPTION OR RISKS***
Medical Care Program							
1. Provide essential drugs and treat the common diseases	*1.1 Maintain the existing BPHWT teams*	*No. of teams existing*	*Procurement delivery documents; logbooks; analysis of data collected; and field reports*	*113 BP teams*	*113 BP teams*		*14 teams from BHM support will be integrated*
	1.2 Provide medicines and medical supplies	*No. of target population and total case-load (w/m), under/over 5)*		*228,000 targeted population (no. of families & HH, no. of w/m and under/over 5)*	*280,103 pops (M-135,205 W-144,898) (< 5 - 52,580 >=5-227,523)*		*It can be more targeted population because the BPHWT integrates the 14 teams that have been supported by BHM to overall targets.*
	1.3 Treat common diseases and minor injuries	*No. of cases treated (w/m, under/over 5)*		*114,000 cases being treated (w/m, under/over 5)*	*104,808 cases (M-48,549 W-56,259) (< 5 - 20,676 >=5-84,132)*		
	1.4 Provide ITNs, malaria rapid diagnosis tests (RDTs) and malaria medicine	*No. of ITNs provided and no. of HHs and people receiving ITNs*	*ITNs distributing lists & annual report*	*15,000 ITNs will benefit 18,000 HHs*	*No ITNs distributed during this year.*		*The BPHWT planned to request ITNs only from URC but, did not receive any ITNs from URC during 2016.*

		Percentage of people in households sleeping under ITNs (Baseline-53%)	*2016 Impact Assessment Survey*	*65% of people in households sleeping under ITNs*	*64% (4,046/6,348)*		
		Malaria mortality rates per 1,000 population (baseline-3.5 malaria case deaths per 1000 population)	*2016 Impact Assessment Survey*	*2.2 malaria mortality rates per 1,000 population*	*N/A*		*The target population have been increased and the BPHWT could not provide ITNs every year.* *There was a problem of data collection and calculation for malaria mortality rate.*
		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*	*105 per 1,000 population*		
		Percentage of under 5 children with malnutrition (according to accepted guidelines for MUAC cutoffs) (Baseline – 16.5%)	*2016 Impact Assessment Survey*	*14% of under 5 children with malnutrition*	*6.4% (moderately and Severely malnourished)*		
2. Respond to disease outbreaks and emergency situations	*2.1 Purchase emergency medical supplies and immediately take action*	*Prompt reporting Population affected No of cases treated (w/m, under & over 5)*	*Delivery document; field reports; exception reports; annual report*	*-Effective response and treatment for disease outbreaks or emergency situations (w/m & under/over 5*	*- No response*		*It depends on the political and environmental factors.*

3. Improve patient referral systems	*3.1 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*	*30 patients referred to clinics or hospitals (w/m) including EMoC cases*	*145 patients M-68 & W-77*		*Before, we did not provide any funds for patient referral, but in 2016, the BPHWT received some funding for patient referral for four townships.*
4. Promotion awareness of mental health in communities	*4.1 Conduct mental health workshop to the health workers*	*No. of workshops No. of participants*	*Mid-year & annual report*	*1 workshop 20 participants*	*2 workshops 1. 58 HWs (M -40, F- 18) 2. 31 HWs (M-20 F-11(*		*The workshop only planned for field in-charges, but attended by health workers.*
	4.2 Providing counseling to the patients	*No. of targeted areas and population*		*2 areas (Pa An & Papun)*	*1 in Pa An*		*Health workers from Papun do not adequate skill to implement and manage this project.*
Community Health Education and Prevention Program							
1. Reduce the incidence of malnutrition and worm infestation	*1.1 Distribute de-worming medicine to children between 1 to 12 years*	*No. of children receiving de-worming medicine*	*Worker data form; mid-year & annual reports*	*40,000 children*	*2,6737 Boys – 12,795 Girls - 13,943*		
	1.2 Distribute Vitamin A to children between the ages of 6 months to 12 years	*No. of children receiving Vitamin A*		*40,000 children*	*32,983 children Boys - 15,717 Girls - 17,266*		

2. Improve health knowledge of students and communities	*2.1 Provide school health education*	*No. of school health sessions and no. of students (w/m)*	*Field reports; mid-year & annual report*	*90 sessions attended by 13,500 students (w/m)*	*38,310 Boys - 18,679 Girls - 19,631*		*1 session for 150 students 432 schools with 2,002 teachers*
	2.2 Organize Village Health Workshops for communities	*No. & category of people in Village Health Workshops (w/m)*		*9,500 people participate in 95 Village Health Workshops*	*12,151 M - 5,544 W - 6,607*		*179 VH workshops were organized. Some workshops supported by communities*
	2.3 Provide health campaign	*No. of participants (w/m)*	*Mid & annual reports*	*100 World AIDS events 15,000 participants (w/m)*	*11 World AIDS Events 1,117 (M-491, W-626*		*Funds limitation Other activities were prioritized*
3. Improve community level knowledge and participation in health	*3.1 Organize village health worker trainings and workshops*	*No. training and VHW attended (w/m)*	*mid-year & annual report*	*10 VHW trainings for 100 new VHWs (w/m)*	*64 VHWS M – 19 W - 45*		*1 VHW training for 20 participants*
	3.2 Establish Village Health Committee	*No. of VHC organized*	*Mid-year & annual report*	*12 VHCs*	*20 VHCs*		
	3.3 Organize Village Health Committee meeting quarterly	*No. of VHC meeting and participants*	*Mid-year & annual report*	*48 VHC meeting 144 participants (F/M)*	*31 meetings 437 (M-264, W -* 173)		*9 members in each VHC Four meetings per VHC per year*
4. Improve water and sanitation systems in the community to reduce water-borne diseases	*4.1 Build community latrines*	*No. of latrines built No. of HHs*	*mid - year & annual report*	*2,400 community latrines for 2,400 HHs*	*1,689 latrines 1,777 HHs 10,243 pop (M-4,951, F -5,292)*		*1 latrine per household.*
	4.2 Install gravity water systems	*No. gravity flows installed No. of HHs and people (W/M)*	*mid - year & annual report*	*30 gravity flow water systems 1,800 house-holds (9,000 pop)*	*20 gravity flow 2,137 HHs 9,333 pop M - 4,631*		*1 gravity flow for 60 HHs & 300 Pop.*

					F - 4,702		
	4.3 Install shallow well water systems	*No. shallow wells installed* *No. of HHs and people (W/M)*	*mid - year & annual report*	*50 shallow wells for 500 HHs & 2,500 Pop*	*35 shallow wells* *629 HHs* *3,934 pop* *M - 2,062* *W - 1,872*		*1 shallow well for 10 HHs & 50 pop.*
	4.4 Install school water filters	*No. of water filters installed*	*mid - year & annual report*	*30 water filters for 3,000 students*	*2 water filters* *1,369 student* *M – 685* *W-684*		*1 water filter for 100 students*
		% of people who own a latrine using latrines (always and sometimes) (Baseline -98%)	*2016 Impact Assessment Survey*	*99% of people who own a latrine using latrines (always and sometimes)*	*99.3% (814/820)*		
		% of people who own a latrine (Baseline - 70% in 2010)	*2016 Impact Assessment Survey*	*85% of people who will own a latrine*	*69% (820/1197)*		*The target population have been increased*
Maternal and Child Healthcare Program							
1. Increase maternal and child healthcare	*1.1 Distribute de-worming medicine to pregnant women*	*No. of pregnant women receiving de-worming medicine*	*TBA's form, mid -year & annual report*	*4,000 pregnant women*	*3,159*		
	1.2 Distribute folic acid and ferrous sulphate tablets to pregnant women and women	*No. of pregnant women and women receiving iron*	*TBA's form, mid -year & annual report*	*4,000 pregnant women and women*	*3,212*		*There is assumption that women will take all the iron provided*
	1.3 Train Emergency Obstetric care	*No. of EmOC trainees*	*Mid & annual report*	*8 EmOC trainnes*	*7 EmOC (all women)*		

	(EmOC) workers						
	1.4 Provide EmOC supplies	*No. of EmOC supplies provided*	*Mid & annual report*	*8 EmOC supplies*	*No supplies*		
	1.5 Provide nutrition food for pregnant women	*No. of pregnant women receive nutrition foods*	*Mid & annual report*	*700 pregnant women (35 per team x 20 teams)*	*561 pregnant women*		*(Oil, yellow bean, eggs, fish cans and dry fish in 2015 under SDC project)*
	1.6 Provide ANC to pregnant women	*% of pregnant women in target population with at least four ANC (Baseline – 44.7% in 2010)*	*2016 Impact Assessment Survey*	*55% of pregnant women in target population with at least four ANC*	*21% (227/1,040)*		*It depends on sample size of the survey conducted.*
		% of children 0-5 months who are fed exclusively with breastfeeding in target population (Baseline -23%)	*2016 Impact Assessment Survey*	*35% of children 0-5 months who are fed exclusively with breast milk in target population*	*40%*		
		No. and % of Trained Traditional Birth Attendants who can identify at least 5 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines(Baseline -45% -2010)	*2016 Impact Assessment Survey & TBA assessment*	*55% of TBAs/TTBAs who can Identify at least 5 signs of pregnancy complications, according to agreed standardized and harmonized health guidelines*	*56% of 533*		*3 signs have been changed to 5 signs since 2013. So, the % is still low.*

	1.7 Provide obstetric gynecology (OG) instruments to skilled MCH workers	*No. of OG instruments*	*Mid - year and annual reports*	*30 OG instruments*	*No OG instrument distributed*		*Funds limitation*
	1.8 Refer serious obstetric cases	*No. of serious obstetric cases*	*Patient's referral form; mid & annual report*	*15 obstetric cases referred*	*29 cases*		*Before no funding support, but now receive some support by SDC project.*
2. Raise awareness among villagers on family planning and provide them with family planning supplies	*2.1 Provide family planning supplies*	*No. of clients using the family planning (w/m)*	*Mid - year and annual reports*	*4,500 (w/m)*	*5,227 (M-253, W-4,857)*		*Included 117 Implants*
	2.2 Provide family planning education	*% of people using family planning methods*	*2016 Impact Assessment Survey*	*35%*	*25% 262/1040*		*There is still traditional cultural barriers*
	2.3 Organize Reproductive Health awareness workshop	*No. of workshop No. of participants (M/F)*	*Mid - year and annual reports*	*60 RH workshops for 3,000 participants (M/F)*	*96 RH workshops 8,074 (M-3,004 W-5,070) pop*		*50 participants per workshop More support from MSI*
	2.4 Providing joint IEC materials	*No. of IEC materials (Antenatal care, Antenatal services Hand washing & Danger sign of pregnancy) distributed*	*Mid & annual report*	*No. of IEC materials distributed*	*21 Family planning and 21 Nutrition posters*		*Supported by MSI.*
3. Improve the knowledge and skills of TBAs/TTBAs and MCH Supervisors	*3.1 Conduct TTBA training*	*No. of new TTBAs complete the training*	*mid-year & annual report*	*6 TTBA training for 120 people (w/m)*	*6 trainings 122 (M-8, W – 114)*		
	3.2 Conduct TBA/TTBA	*No. of TBA/TTBA Follow-up*	*mid-year & annual*	*150 follow-up TBA/TTBA*	*128 workshops*		

	workshops	*Workshops held & no. of TTBAs attending (w/m)*	*report*	*Workshops for 750 TBAs/TTBAs (w/m)*	*720 (M-56, W – 664)*		
	3.3 Provide TBA/TTBA kits	*No. of TBA/TTBA kits provided*	*Kits distributing list; midyear & annual report*	*1,500 TBAs/TTBAs kits*	*1,230 Kits*		*It depends on the numbers of deliveries.*
	3.4 Provide maternity kits	*No. of maternity kits provided*		*4,500 maternity kits*	*4,305 kits*		
		No. of births attended by trained TBAs/TTBAs and health workers, among total target population	*TBA's/TTBA's form; mid-year & annual report*	*4,000 babies delivered by trained TBAs/TTBAs and health workers*	*3,513 babies*		
		% of births attended by trained TBAs/TTBAS *% of births attended by health workers (Baseline – TBA -67%, health worker – 27%)*	*2016 Impact Assessment survey*	*60% of births will be attended by TBAs/TTBAs* *35% of birth will be attended by health workers*	*65% (758) by TBAs/TTBAs* *25% (290) by health workers* *10% (112) others*		*- Currently, more TTBAs are trained*
		Appropriate sterile instrument (new razor blade, sterile scissors, etc) = 326 (79%)-2010, povidine/Iodine or other antiseptic = 354 (85%) -2010	*2016 TBA assessment survey*	*- 85% of new razor blade, sterile scissors, and etc were used* *- 90% of povidine/Iodine or other antiseptic were used*	*- 92%* *- 79%*		*- 489/533 (92%)* *- 422/533 (79%)*

		At the last pregnancy that you delivered provide at least 3 information = 353 (85%) -2010	*TBA Assessment Survey*	*- 90% of postpartum women were given at least 3 information*	*94% of postpartum women were given at least 3 information*		*422/533 (94%) TTBs/TTBAs*
4. Every newborn baby attended by TBAs/TTBAs, MCH workers, & health workers will have birth record.	*Provide delivery records*	*No. of newborn baby received delivery records*	*Mid-year and annual report*	*2,000 delivery records*	*2,100*		*Some communities can access to government services.*
5. Promote awareness of gender based-violence in the communities	*5.1 Conduct training for post-rape care to MCH workers*	*No. of training No. of MCH workers*	*Mid-year and annual report*	*1 training for 20 participants*	*No training*		*The proposal was not successful.*
	5.2 Organize community awareness raising workshops	*No. of meetings No. of participants (M/F)*	*Mid-year and annual report*	*12 workshop for 480 participants (M/F), (40 participants per workshop)*	*No workshop*		
	5.3 Provide primary care to survivors of SV	*No. of cases treated*	*Mid-year and annual report*	*No. of cases treated*	*No case*		
Capacity Building							
1. Improve health worker and staff knowledge and skills	*1.1 Community Health Worker training*	*No. of trainees completed CHW training (w/m)*	*CHW training report & attendance list*	*3 CHW trainings for 90 CHW (w/m)*	*4 CHW trainings for 172 (M-72, W-100)*		
		% of trainees show improved knowledge from pre and post test	*Training report*	*80 % of trainees show improved knowledge from pre and post tests. (disaggregate by*	*86% (147/172)*		

			gender)			
1.2 Medic refresher training course	*No. of trainees complete training (w/m)*	*Mid-year & annual report*	*1 training* *30 participants*	*1 training* *31 (M-21, W-10)*		
	-% of Improving diagnosis & treatment (baseline – 96.3% in 2014)	*- Logbook review & analysis*	*- 98% of improving diagnosis & treatment*	*86 %*		*New staff are recruited*
1.3 Conduct organizational development training	*No. of training* *No. of participants*	*Mid- year & annual report*	*1 training* *30 participants*	*1 training* *28 participant* *M – 21* *F – 7*		
1.4 Organize Field workshops	*No. of field workshops and participants*	*Annual report*	*38 workshops* *300 participants*	*37 workshops* *404 (M-192, F – 210) HWs*		*Twice a year for 19 areas (15-20 participants in each workshop or meeting)*
1.5 Organize Field meetings	*No. of field meeting and participants*	*Annual report*	*38 meetings* *300 participants*	*30 workshops* *370 (M-216, F – 154) HWs*		
1.6 Organized six month workshops and meeting	*No. of field health workers*	*mid-year and annual report; workshop attendance list*	*100 health workers (w/m)*	*96 participants (M-54, W-42)*		*This happens in Mae Sot every six monthly. The security for the HWs is important while they travel.*
1.7 Attend local and international conferences and meetings	*No. of meeting times and participants*	*Mid - year & annual report*	*6 conferences or meeting* *8 staff members*	*5 conferences /meetings* *7 (M-4, W-3)*		
1.8 Attend local and international short course	*No. of participants attend short course training*	*Mid - year & annual report Attendance*	*4 participants*	*8 (F- 4, M- 4)*		

			list				
	1.9 Conduct computer training for field interns	*No. of training* *No. of participants*	*Mid - year & annual report* *Attendance list*	*1 training* *20 participants (F/M)*	*18 (M-7, F-11)*		
	1.10 Organize internship program	*No. of participants*		*40 interns*	*29 AMWs* *32 Medics*		
2. Promote gender equality in leading positions	*2.1 Review adopting policies*	*% of women leading health programs*	*Field report & staff list*	*At least 30%*	*54%*		
		% of women field in-charges	*Field report & staff list*	*At least 30%*	*42%*		
		% of women in leading committee	*Annual report & staff list*	*At least 30%*	*31%*		
	2.2 Hold the BPHWT general selection triennially	*% of women was elected*	*Annual report & staff list*	*At least 30%*	*31%*		
Health Information and Documentation							
1. Assess and document community health situation and needs	*1.1 Produce Health Information and Documentation (HID) materials*	*No. of digital cameras and no. of video cameras provided*	*HID staff report*	*40 digital cameras and 2 video cameras*	*No camera*		
	1.2 Conduct services mapping training	*No. of training* *No. of participants*		*1 training for 10 participants*	*1 training* *14 (M-10 F – 4)*		
2. Standardize health data collection processes	*2.1 Analyze data collected by health workers*	*Frequency of analysis*	*Six months workshop report*	*2 times*	*2 times*		*-HIS teams* *-10 participants each time.*
		No. of participants		*20 participants*	*15 (M-9 W – 6)*		

3. Make evidenced based health status comparisons with the target community	*3.1 Organize field meetings and workshops*	*No. of field meetings or workshops provided*	*Field meeting and workshop report*	*38 meetings* *38 workshops*	*37 workshops* *30 workshops*		
		No. of participants		*300 participants in workshop and 300 in meeting*	*404 (M-192, F – 210) HWs* *370 (M-216, F – 154) HWs*		
4. Raise awareness of the community health problem	*4.1 Produce health information, education and communication materials*	*No. of health information and communication (IEC) materials provided*	*Mid-year and annual report*	*No. of IEC materials distributed*	*21 Family planning and 21 Nutrition posters*		*Distributed by MSI*
5. Advocate local and international organizations about the health situation in Burma	*5.1 Organize health program coordination and development seminars*	*No. of seminar*	*Annual report*	*1 time*	*1 time*		
		No. of participants	*Annual report*	*30 participants*	*94* *M - 61* *W - 33*		
Program Management and Evaluation							
1. Monitor and evaluate the programs' improvement	*1.1 Conduct impact assessment survey*	*Frequency of impact assessment survey conducted*	*2016 Impact Assessment survey report*	*1 every 2 year*	*1 IAS* *1 TBA/TTBA Assessment conducted*		
	1.2 Conduct monitoring trip	*No. monitoring trips and no of staff*	*Mid-year & annual report*	*4 trips*	*14 trips* *W – 7* *M – 4*		*More trips organized by SDC project.*
	1.3 Conduct six months meeting	*No. of health workers attend the six months meeting*	*Mid-year & annual report*	*100 health workers*	*96 participants (M-54, W-42)*		
	1.4 Provide Leading Committee meetings	*No. of Leading Committee meetings provided*	*Office records*	*2 times*	*2 times*		

	1.5 Provide Executive Board meetings once in a month	*No. of Executive Board meetings provided*	*Office records*	*12 times*	*7 times*		*There has been decided to organize quarterly meeting.*
	1.6 Provide staff meetings	*No. of staff meetings provided*	*Office records*	*24 times*	*18 times*		
Health Convergence							
1. Converge and coordinate with the Burma government's state administered Reproductive healthcare program in Karen State and public health institution	*1.1 Conduct AMW training*	*No. of trainees complete the training (w/m)*	*Mid & annual report*	*1 AMW training 30 participants*	*1 AMW training for 21 AMWs*		
	1.2 Conduct AMW follow-up workshop	*No. of trainees complete the training (w/m)*	*Training attendance list & report*	*1 AMW follow-up workshop for 45 participants*	*1 workshop 18 AMWs*		*AMWs are working with Sub-Rural Health Centers. Some of AMWs could not join the workshop according to the distance transportation and family issue*
	1.3 Provide AMW kits	*No. of AMW kits provided*	*AMW training report & attendance list*	*81 kits*	*27 kits*		*Supported by State Health Department*
	1.3 Certificate in Public Health Training	*No. of trainees complete training (w/m)*	*Training attendance list & report*	*1 training for 30 health worker (w/m)*	*34 (113%) (F 17, M 17)*		
		% increase in field skilled health workers who have certificate which is recognized by the	*Annual training reports*	*Increase from 6.9 % to 12.5 % of field skilled health workers who have certificate which is*	*11.5% (43/393)*		***2015*** *(25/360=6.9%)* ***2016*** *(18/393=4.6%)*

		state/union government		*recognized by the state/union government*			
		% of trainees show improved knowledge from pre and post test	*Training report*	*80 % of trainees show improved knowledge from pre and post tests. (disaggregate by gender)*	*99%*		*This will focus on CHW and Certificate in Public Health training.*
	1.4 Organize meetings between midwives from Ministry of Health and BPHWT trained Auxiliary midwives	*No. of meeting* *No. of MW* *No. AMW*	*Meeting report*	*2 meetings* *60 participants (AMWs & MWs)*	*8 meetings with AMWs without MWs*		*Due to the time constraints from both sides*
	1.5 Providing joint IEC materials	*No. of IEC materials (Anti-natal care* *Anti-natal services* *Hand-washing* *Danger sign of pregnancy) distributed*	*Mid & annual report*	*No. of IEC materials distributed*	*21 Family planning and 21 Nutrition posters*		*Supported by MSI.*

15) Back Pack Health Worker Team Financial Report

ITEMS	Income (Thai Baht)	Expenditure (Thai Baht)	%
OPENING BALANCE -1 JANUARY 2016	**669,497**		
PERIOD INCOME			
International Rescue Committee / DFID	11,614,077		30%
Burma Relief Center/CIDA/Inter Pare	6,553,962		17%
CPI / Swiss Agency for Development and Cooperation (SDC)	5,381,821		14%
Stichting Vluchteling (SV)- Netherlands	3,909,075		10%
International Rescue Committee / PLE / USAID	3,507,035		9%
Open Society Foundation(OSF)	2,787,430		7%
Thai Border Consortium (TBC)	1,500,000		4%
Burma Humanitarian Mission (BHM)	1,353,011		3%
Burma Relief Center/NCA	983,518		3%
Marie Stopes International Myanmar (MSI- Myanmar)	660,455		2%
Mae Tao Clinic (MTC)	300,000		1%
Bank Interest	12,094		0%
Other Donation	147,703		0%
TOTALPERIOD INCOME	**38,710,181**		**100%**
TOTAL INCOME	**39,379,678**		
PERIOD EXPENDITURES			
Back Pack Medicine and Equipment(MCP)		9,494,913	25%
Back Pack Field Operation Supplies and Services		2,122,700	6%
Community Health Education and Prevention Program(CHEPP)		5,965,965	16%
Maternal and Child Health Care Program(MCHP)		5,542,816	15%
Capacity Building Program(CBP)		5,570,155	15%
Health information and Documentation (HID)		858,589	2%
Program Management and Evaluation(PME)		4,132,866	11%
General Administration		3,717,974	10%
TOTAL PERIOD EXPENDITURES		**37,405,978**	**100%**
CLOSING BALANCE - 31 December 2016		**1,973,700**	

Part II: Program Workshops & 37rd Annual Meeting Report – 2017

1. Program Workshops and training:

1.1) Medical Care Program Workshop

Facilitators : Naw Hsa Mu Na Htoo, S'Aung Than Oo, Pa Pa Win and Naw Aye Than
Duration : 23-25 January 2017
Participants : 27(21men and 6 women)

Discussion topics:

- MCP in-charge presentation
- Data analysis and feedback
- Review report forms
- Checked the medicines and supplies inventory list
- Update the stationary BP in each area
- Review program meeting and workshop recommendations
- Review data from reports (Field In-Charge Report, Worker Report, VHW Report /Medicine Inventory, & Other Reports)

1.2) Community Health Education and Prevention Program Workshop

Facilitators : Saw Moo Tha & Naw Pway Wah Poe
Duration : 23-25 January 2017
Participants : 17 (14 men and 3 women)

Discussion topics:

- CHEPP in-charge presentation
- Reviewed the objectives of CHEPP
- Reviewed village health workshop and school health
- Vitamin A and De-worming medication
- Reviewed criteria for establishing of village health committees
- Review data and forms
- Future plans

1.3) Maternal and Child Healthcare Program Workshop

Facilitators : Naw Thaw Thi Paw & Naw Htoo
Duration : 23-25 January 2017
Participants : 24(3 men and 21 women)

Discussion topics:

- MCHP supervisor presentations
- Reproductive health
- Review MCH forms
- Future plans

1.4) Village Health Committee (VHC) workshop

Facilitators : Naw Thaw Thi Paw & Naw Htoo
Duration : 20 January 2017
Participants : 54 (31 men and 23 women)

Discussion topics:

- The objective of the establishment of village health committee (VHC)
- The information that involve in the establish of village health committee (VHC)
- Responsible of VHC
- Group discussion
- Recommendation

1.5) Mental Health workshop

Facilitators : Dr. San San Oo (OSF), Dr. Ganesa (OSF) & Saya Ma Hpeh (OSF)
Duration : 09-10 February 2017
Participants : 52(25 men and 27 women)

Discussion topics:

- Schizophrenia
- Depression
- Dhallucination
- Mood charge
- Treatment

1.6) Gender Based Violence workshop

Facilitators : Naw Shee Ta Hla
Duration : 27-28 January 2017
Participants : 35(8 men and 27 women)

Discussion topics:

- What is gander based violence
- Types of GBV
- The complication of GBV
- Understand of the BGV

1.7) Referral form review workshop

Facilitators : Ei Ei Hlaing (IRC)
Duration : 23 January 2017
Participants : 46(21 men and 25 women)

Discussion topics:

- Shared information on the observation of government hospital
- Reviewed and updated referral form
- Practiced the form

1.8) Organizational Development (OD) Training

Facilitators : Nang Snow
Duration : 27-28 January 2017
Participants : 36 (29 men and 7 women)

Discussion topics:

- Introduction to culture and communication
- Cross culture communication
- Culture dimension
- Perceptions and attitudes
- Organizational values
- How values affect cultures

2. 37th Annual Meeting of the Back Pack Health Worker Team

The 37th Back Pack Health Worker Team annual meeting was conducted from 4 to 5 February 2017 in Mae Sot at the BPHWT head office. Attending this meeting were 96 staff members (54 men and 42 women). 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 members 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.

37th Annual General Meeting at BPHWT office in Mae Sot

2.1) Schedule of BPHWT's 37th annual General Meeting:

Day (I) { 4 February 2017}	
Description of Presentation	**Responsibility**
Opening Speech	Saw Win Kyaw
Introduction	Facilitators
Review and Discussion about the 36th 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
CHEPP Coordinator's Report & CHEPP Workshop Report	Saw Moo Thar
Day (II) { 5 February 2017 }	
Field updated situation report and HCCG activities report	Ko Gyi Kyaw
Health Information and Documentation report	S' Aung Than Oo
Capacity Building Program Report	Saw Del Del
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	Dr. Cynthia Maung

Program meeting facilitated by Deputy Director in Mae Sot

Mental health workshop facilitated by OSF in Mae Sot

2.2) 37th General Meeting Decisions:

1. Requests for oxytocin for the first six-month period of 2017 must be submitted to the MCHP Coordinator.
2. The following MCHP activities will be implemented during the first six-month period of 2017:

Activities	Number
TTBA Training	1
TBA/TTBA Workshops	62
RH Awareness Raising Workshops	69
Baby Weight Scales (Units)	150
VHC Meetings	20
Pregnant Women Nutrition	20
TBA Kits (Units)	42

3. The BPHWT made the decision to organize two Gender Based Violence (GBV) Workshops during the second six-month period of 2017.
4. The following CHEPP's water and sanitation activities will be implemented during the first six-month period of 2017:

Items	Amount
1. School latrines	30
2. Village Latrines	1,525
3. Water filters	9
4. Shallow Wells	22
5. Gravity Flows	15

5. The BPHWT made the decision to establish 15 village health committees in the following field areas during the first six-month period of 2017: 2 in Thaton, 2 in Papun, 2 in Palaung, 1 in Kachin, 1 in Naga, 1 in Pa An, 4 in Kler Lwee Htoo, 1 in Shan, and 1 in Special.
6. The BPHWT made the decision to conduct one Village Health Worker Training in each of the following field areas during the first six-month period of 2017: Thaton, Papun, Pa An, Palaung, and Shan.
7. The BPHWT made the decision to conduct Village Health Worker Workshops in each of the following field areas during the first six-month period of 2017: 2 in Thaton, 2 in Papun, 1 in Pa An, 1 in Kler Lwee Htoo, 2 in Taungoo, and 1 in Kayan.
8. The BPHWT made the decision to conduct a water and sanitation workshop during the second six-month period of 2017 Program Workshops.
9. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about requests made by the MCP.
10. The BPHWT made the decision to send 10 health workers from the following field areas to attend MCH training organized by the KDHW; 1 from Special, 1 from Chin, 1 from Arakan, 1 from Naga, 2 from Thaton, 1 from Kachin, 1 from Taungoo, 1 from Papun, and 1 from Kler Lwee Htoo.
11. The BPHWT made the decision to send 28 health workers to attend MCH training organized by the MTC: 1 from Palaung, 1 from Yee, 1 from Arakan, 1 from Naga, 1 from Kachin, 2 from Pa O, 1 from Maw Kee Clinic, and 20 AMWs.

12. The CBP Coordinator is responsible for preparing and reporting the list of health workers, who will attend the Health Facility Management Training, Medic Refresher Training and Community Health Worker Training, to the Leading Committee and Field in-Charges' Meeting.
13. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about pharmacy management.
14. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about the request made by the Kachin Field Area for a new Back Pack team.
15. There will be a discussion in the Leading Committee and Field in-Charges' Meeting about the request made by the Taungoo Field Area for the CHW training's budget.
16. The BPHWT made the decision to conduct a one day Financial Reporting Workshop after the General Meeting.

2.3) Leading Committee and Field In-Charges' Meeting Decisions:

1. The following CHEPP's activities will be implemented during the first six-month period of 2017 with IRC/PLE's funding.

Items	Amount
1. Village Latrines	620
2. Shallow Wells	13
3. Gravity Flows	9

2. The CHEPP Coordinator is responsible for preparing the information needed and the Finance Team is responsible for communications with the IRC/PLE.
3. The BPHWT made the decision to hold two day ToT Workshops for those field areas which will conduct VHW training. The CBP Coordinator is responsible for conducting these VHW ToT Workshops.
4. The BPHWT made the decision to convert six pilot Back Pack teams into permanent Back Pack teams starting from the first six-month period of 2017 in the following field areas: one in Mergue/Tavoy, two in Kayan, two in Papun, and one in Palaung.
5. The BPHWT made the decision to distribute cameras and related guidelines to the field areas. The HID Coordinator is responsible for preparing the list of the Back Pack teams which will receive the cameras.
6. In respect to moving two Back Pack teams in Special Shan-Kayah Field Areas, the field in-charge is responsible for collecting more information and discussing this situation with local authorities.
7. Mi Pa Kaw, Mon CHEPP in-Charge, is responsible for reporting information requests and decisions from the Six Months General Meeting affecting the Mon Field Area to her field in-charge.
8. The BPHWT made the decision to support the transportation of 10 MCH workers who will attend MCH training which is organized by the KDHW.
9. The BPHWT made the decision about the health workers who will attend Medic Refresher Training and CHW Training in Thay Bay Hta and Papun areas as indicated in the below table:

Trainings	Participants
1. Medic referral training	35
2. CHW (Thay Bay Hta)	36
3. CHW (Papun)	31