



HEALTH SYSTEM DEVELOPMENT

SEMINAR

16-18 JANUARY 2006

REPORT

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*National Health and Education Committee (NHEC) and
Burma Medical Association (BMA)*

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Preface

Health System Development seminar was successfully completed on January 18, 2006. It was held by NHEC and BMA at Thai-Burma border on January 16-18, 2006 and brought together 78 participants from 31 organizations including academics, professionals and health workers from both local and international to discuss the situations of health system in Burma and along the border areas. Actually, a health system includes the resources, actors and institutions related to the financing, regulation and provision of health actions which, in turn, mean any set of activities whose primary intent is to improve or maintain health. Assessment on health system performance in member countries was done by the World Health organization (WHO) in 2000 and Burma ranked the second last in the world. Even inside Burma, health situations at border and remote areas are the worst and on the verge of humanitarian crisis as the whole Burma is now designated as one of the worst 'Fragile State' by WHO and World Bank in 2005. In fact, the current situation in Burma asked for better health system in response to worsening health, education, economic and social circumstances. The starting point for addressing the effectiveness of health systems is not only to define the elements of a clear and actionable agenda which recognizes and responds to underperformance in the sector itself but which also acknowledges on the fact that the level of success depends on a range of factors in a diversified population of the society.

NHEC and BMA envision that for these improvements of health system of ethnic areas where NHEC members and affiliated organizations are operating, action agenda should be based on (1) health policy development (2) strengthening networking among the health organizations and (3) developing the institutional capacity of health organizations and, hence these three themes become the objectives of the health system development seminar.

The seminar proved to be extremely successful in enabling discussions among people involved in health care services from local regions as well as from international. Group discussions and workshops have been conducted by active participants in the seminar and provided fruitful recommendations within the framework of 3 major objectives. These recommendations are clearly the action agenda of NHEC and local health departments for the improvement of health system at the border and remote areas of Burma. However, in order to implement these agenda effectively, the hard work by NHEC and local health departments will not be sufficient without the support of political leaders and local authorities. The last but not the least is the participation of community. Community participation is the most important of all for the successful implementation of these action plans.

Health Department
National Health and Education Committee (NHEC)

Objectives of the seminar

- To develop health policy by sharing and learning the programming aspects of the different ethnic health departments and, by reviewing the current health situations of the Internally Displaced people, refugees and migrant workers in their respective areas.
- To strengthen networking among the health organizations in order to provide effective health care services in all ethnic areas.
- To develop institutional capacity of health organizations on all Burma borders in order to carry out the systematic health care services at the remote and border areas of Burma.

**Agreements on Policy, Promoting Skills and Cooperation Resulting from Conference Hosted by
National Health and Education Committee (NHEC) and Burma Medical Association (BMA)
(January 16-18, 2006)**

Guiding principle

1. To continue to practice following the guidelines, which were adopted by 2000 Health Conference regarding promotion of health care and social development for the activities on public health:

(i). Changing Directions

- Aiming to shift from curative to comprehensive health development
- Aiming to shift from curative to preventive healthcare
- Aiming to collaborate with various sectors rather than implementing health care activities alone

(ii) Approaches

- Preparation
- Protection
- Promotion of skills

2. To continue to implement the approach of 'Primary Health Care', which was adopted by the Health Conference in 2000, to promote the needs of health care for those who were forced to relocate inside Burma, illegal immigrants in the border areas and refugees in Thailand.

3. To agree on a long-term objective regarding health care by a majority of concerned groups.

(i). Health care projects should be written based on existing public education and economic situations, security concerns, condition of transportation, culture and traditional customs. To gain official recognition for the trained health workers by the international organizations and local authorities.

(ii). Even in the presence of differences amongst local areas, human resources, experiences, skills and organizational activities should be developed as priorities. To fulfill those needs in basic health care, it is essential to receive support and cooperation from political organizations and developmental agencies and groups.

(iii). Health care policies should be adopted according to the wish of local people and the norms of human rights.

(iv). Health care information and data systems should be shared with not only other health organizations, but also community based organizations and political organizations.

4. While promoting community based health activities, it should focus on having equal access to health care and self-reliance amongst people.

(i). It is important to recognize the role of local organizations while promoting the activities of public health care.

(ii). It is needed to recognize the effectiveness of the system of health care education through schools while implementing community health care activities.

5. While implementing health care activities, it is important to practice according to equality and democratic rights.

6. To use the opportunity of health care effectively, it is essential to achieve human security for the people.

(i). To implement the rights of migrant workers regarding health care according to international and regional standards.

(ii). To issue birth certificates for those children born of Burmese parents who have no birth certificates.

(iii). The social stability of health workers is particularly important while implementing health care activities. The physical well being of health workers should be taken seriously. Besides, their status should be recognized as legal health workers.

(iv). Regarding health care for migrant workers, it is needed to survey and cooperate with their employers.

7. Health care research should primarily lead to the benefit of local people. There should be cooperation between the local population and international and local researchers. A steering committee, which monitors the results of research should be set up in order to protect the benefit of local people.

Capacity Building

1. To develop working policies in the field, administrative skills and regulations for promoting health care.

2. To develop self-reliance amongst the public through community based health care education.

3. To train volunteer health workers with simple and clear methods of promoting health care and prevention of diseases.

4. To train current health workers with appropriate techniques to be more skillful and educate them that health care activities are for the national cause.

5. To review current trainings for health workers for relevance and effectiveness in relation to needs.

6. To adopt appropriate system for giving standardized trainings. (adopting standardized system, maintaining, reviewing the skills)

7. To seek cooperation from training schools and educational organizations, which can provide legal accreditation to the health workers.

8. To promote skills for those workers who are working in administrative sectors. (Supervising, Team work and Field management skills)

9. To promote skills for senior health workers for their leadership, policies on health, implementation of policies, monitoring, etc.
10. Through skillful workers and necessary assistance provided, to change to an effective mechanism.
11. To promote public communication skills for health workers.
12. To promote Codes of Conduct for health workers.
13. To educate health workers to understand and respect human rights.
14. To train health workers on documentation, research and reporting on human rights abuses.
15. To educate the local population to know their rights and respect human rights through health workers.
16. To educate health workers to understand the code of conducts and ethics of research services.

Setting up Networks for Health Care

1. The National Health and Education Committee will discuss and cooperate with different organizations and departments in order to implement community based health care, health policy and trainings.
2. The NHEC will systematically set up lines of communication with local authorities to implement its objectives on health.
3. The NHEC will seek and consult with experts and search for the necessary funds in order to implement its policies successfully.
4. The NHEC will cooperate with organizations, which are fighting for health rights within and outside of Burma.
5. The NHEC will produce research, documentation and reports on the health problems, which derive from human rights violations. In this matter, NHEC will closely collaborate with concerned organizations.
6. The NHEC will cooperate with organizations, which are working for the health rights of migrant workers.
7. The NHEC will provide migrant workers with necessary information, knowledge and techniques for their rights to health.

Health Policy

Dr. Khin Saw Win and Dr. Tun Kyaw

This presentation includes 3 sections. Section I is an introduction to public health and why do we care about public health policy and management. Section II describes about the policy process, formulation and implementation. Section III concludes with the policy measures, evaluation and monitoring of health policies.

I. Introduction

Public health is the combination of science, practical skills, and values (or beliefs) directed to the maintenance and improvement of the health of all the people. The programs and services of public health emphasize the *prevention of disease* and the *health needs of the population* as a whole. (Table-1)

There are 3 levels of prevention:

Primary prevention is to maintain health by removing the precipitating causes and determinants of departures from good health, e. g. vaccination, clean water and sanitation.

Secondary prevention means the early detection of disease, before it has had time to produce irreversible damage, by screening procedure, detection of early signs and symptoms of disease.

Tertiary prevention is to prevent deterioration and complications from occurring disease or disability already established; which is basically the same as “high-quality” health care. It is applied when seriously ill, carefully nursed to prevent bed sores, venous thrombosis etc.

Our situation: What have we been doing? Primary only? or primary and secondary? What level can we do?

Progress of public health: WHO defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The 1978 Declaration of Alma-Ata called on nations to ensure the availability of *the essentials of PHC*. The World Health Organization (WHO) launched a policy framework called “Health for All” by the Year 2000 since then and have been advocating the HFA framework for health policy making to all its member states.

The Ottawa Charter on health promotion (1986) mentions peace, shelter, food, income, a stable ecosystem, sustainable resources, social justice and equity as basic requirements for health. The Charter also includes in health promotion foci a wide range of public policies, communities, and daily social and physical environments.

The definition of health enshrined in the WHO Constitution was an important step in helping to move health thinking beyond a limited biomedical and pathology-based perspective towards the more positive domain of well being, understood to include recognition of individuals and their need, and to change or cope with their social environments. The societal dimensions of this effort were emphasized in both the Declaration of Alma Ata and the Ottawa Charter for health promotion. It is now clear that regardless of the effective technologies, the underlying civil, cultural, economic, political and social conditions have to be addressed as well for health promotion.

HFA was developed as an international synthesis of emerging policy ideas of the 1970s. The Alma Ata Declaration was adapted to combining new public health with local socio-economic development in the developing countries (the primary care concepts). The best way to achieve HFA would be to provide PHC for all people. With WHO support and enhanced activity by UNICEF much progress has been made toward improving health in the developing world, through the WHO expanded Programme on Immunization (EPI), tropical disease research etc., and in recent years, the World Bank.

As we approach to the year 2000, in 1995, the WHO report on “Bridging the Gaps” spelled out the challenges and failure of HFA By 1995, target problems identified, such as early adolescent pregnancy and STDs, new problems – HIV disease, and drug abused – had emerged. (homelessness and increasing crime rates in western countries). Emerging health problems differ in nature and quality from those of the past

In 2000, the UN Millennium Declaration was signed by 189 countries, and resulted in eight MDGs (target date of 2015) which together form a mutually reinforcing framework for human development and constitute a tool to tackle health inequalities. Three of the Goals are directly related to health; reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other diseases.

We care for health policy because:

- policies can address the health needs and expectations of the population
- policies can identify health problems and find ways to improve health
- policies can provide guidance to what interventions should be delivered in order to promote and protect health of all people
- policies can provide health indicators and evaluate the health system and performance

Table- 1.Public health responsibilities and functions

Policy development	Collection and dissemination of evidence for public health policies, strategies, and actions	Prevention and control of disease	Intersectoral action for better health	Human resource development and capacity building for public health
Public health regulation and enforcement Evaluation and promotion of equitable access to necessary health services Assurance of the quality of personal and population-based health services Health policy formulation and planning Financing and management of health services Pharmaceutical policy, regulation, and enforcement	Health situation monitoring and analysis Research, development, and implementation of innovative public health solutions Provision of information to consumers, providers, policymakers, and financiers Development of health information and management systems Research and evaluation	Surveillance and control of risks and damages in public health Management of communicable and non-communicable diseases Health promotion Behavior change interventions for disease prevention and control Social participation and empowerment of citizens in health Reducing the impact of emergencies and disasters on health	Environmental protection and health, including road safety, indoor air pollution, water and sanitation and disease vector control in infrastructure, management of medical wastes, tobacco legislation, school health, and education	Development of policy, planning, and managerial capacity Human resources development and training in public health Community capacity building

a. Pan American Health Organization, World Health Organization, and the U.S. Centers for Disease Control “essential” public health function.² Source: Reference 1.

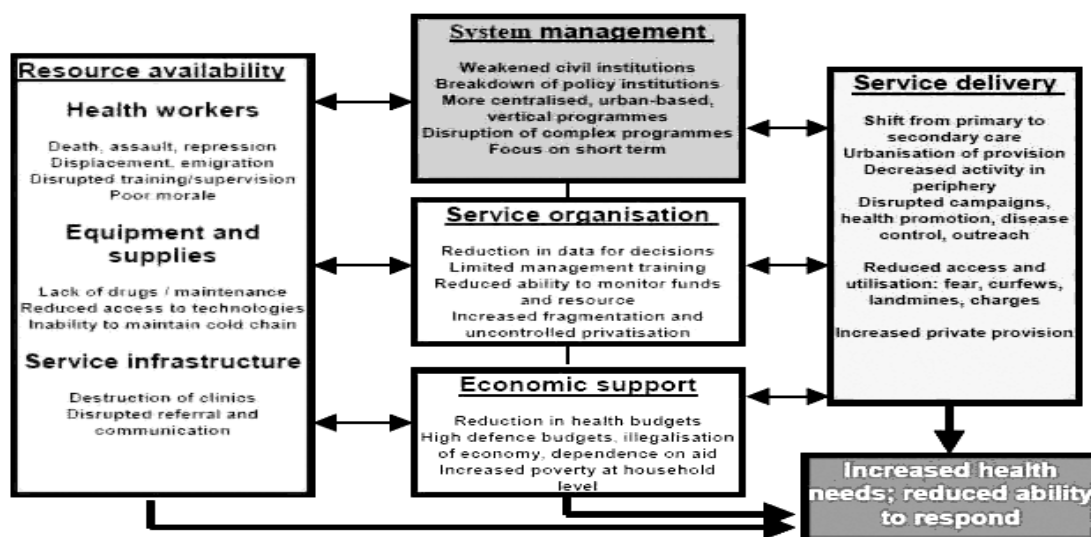
II. The Policy Process, Formulation and Implementation

Health policy is a responsibility of nation state and how health was distributed in society becomes a political issue. The challenge was to put health in the political agenda.

Goals:

- prevention and promotion of health
- quality health system
- promote human rights and equity in access to basic health care and health service delivery
- capacity building and training
- empowerment of communities especially women empowerment
- transparency and accountability

Issues and Challenges:

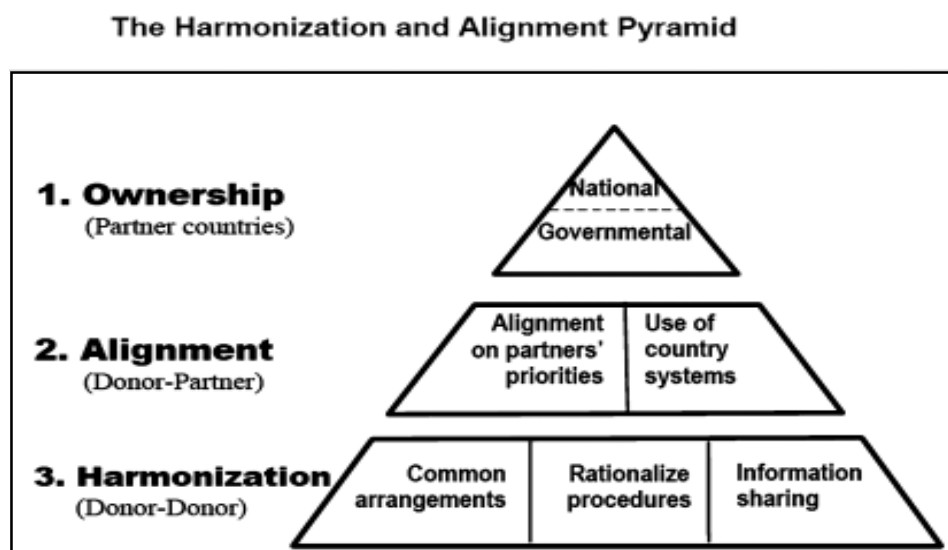


Effects of chronic conflict on health system components

- our situation – unstable, conflict zones – as a consequence there is increased health needs; reduced ability to respond to effects of chronic conflict on health system components
- poor governance (inside country) – fragile state, poor health system, poor morale of health staff including doctors, low levels of trust between aid donors and government, unreliable HIS
- for us to organize and deliver effective and equitable health services in resource-constrained settings
- capacity building and retaining of trained health workers (problem of 3rd country migration)
- multisectoral approach
- how to integrate vertical, disease-specific approaches with horizontal, system-wide approach
- convincing donors

The approach (Formulation and Implementation)

Figure-2



- **Alignment** – between alignment of donors with partner priorities (in our case, NHEC’s priorities) / OR alignment between ethnic groups/NHEC, BMA/NHEC etc.

Alignment includes addressing specific health priorities, such as reproductive health, infectious diseases, STDs and HIV etc. (NHEC paper of local health workshop findings, BMA reports, MTC annual reports etc.), while at the same time strengthening health systems, defining health projects

- **Harmonization** – between the groups mentioned as above

Harmonization also includes developing common, shared arrangements between, using the same reporting or monitoring evaluation framework etc.

Failures of Health Policy Planning: can be caused by poor planning, inadequate organization, and misplaced values. These human factors contribute to several problems, of which the following are the most obvious:

- inequitable access to health care
- lack of health information and inappropriate health priorities, wrong target of health problems
- inappropriate training programs
- lack of community approach
- communications breakdown and lack of harmony
- administrative inadequacies/ corruption, lack of accountability and transparency

Our main focus should be:

- primary health care (PHC) – expanded / upgraded
- community approach and development including households and schools

- mobilization, training /skills upgrading of health workers/TBAs/Nurses/traditional healers
- integration/net work/ communication
- focus/attention on major problems rather than attempting to deal superficially with a great many at once
- equity, human rights and ethics

III Policy measures, monitoring and evaluation of health policy

The Millennium Development Goals provide a chance to refocus health policy on health outcomes and the major determinants, core interventions, and delivery strategies—and in the process to forge closer links between health departments and other organizations that can help achieve these outcomes.

As the objectives of health policy represent long-term goals, it will need to be achieved over a long period. Annual changes in the outcomes will necessarily be small, and will be difficult to monitor given the weakness of current health information systems. In fact, performance-based monitoring cannot be based on outcome or impact indicators because of the long-term nature of such changes and the measurement challenges.

Performance-based monitoring involves reporting on intended results and progress towards achieving intended results. It requires that clear, achievable objectives, that are within the control of a program or ministry, are set and agreed on by all stakeholders, with sufficient resources available to deliver the results. It also requires the selection of indicators to monitor performance, and an agreed plan for when, how and by whom the indicators will be generated and used. Performance-based monitoring can only be achieved if programs routinely and accurately track policies, inputs, actions, and outputs related to the interventions.

MDG health targets are longer-term outcomes that can only show minimal improvements on a yearly basis, and can lead to the mistaken conclusion that there is minimal return on investment.

Intermediate – or proxy - indicators measure changes in coverage or use of interventions known to have an impact on health outcomes. Tables shows available preventive and treatment interventions for the health-related MDGs. Such interventions can then be transformed into indicators of coverage and utilization by measuring the number of people who are in need of the intervention, and those who actually receive them. Such indicators include immunization coverage, use of child and maternal health services, and individual or household behaviors.

Table-2 Relationship between intervention and indicators

Goal	Preventive interventions	Treatment interventions	Recommended options: Examples of intermediate or “proxy” indicators
Reduce child mortality	Breastfeeding. Hand-washing, safe disposal of stool, latrine use and safe preparation of weaning foods. Use of insecticide-treated nets. Complementary feeding. Immunization. Micronutrient supplementation (zinc and vitamin A). Antenatal care, including steroids & tetanus toxoid. Antimalarial intermittent preventive treatment in pregnancy. Newborn temperature management; Nevirapine and replacement feeding; Antibiotics for premature rupture of membranes; Clean and safe delivery including management of pregnancy-related complications such as eclampsia and obstructed labour.	Case management with: Oral rehydration therapy for diarrhea; antibiotics for pneumonia, dysentery and sepsis; and, antimalarials for malaria. Newborn resuscitation and management of hypothermia. Breastfeeding, Complementary feeding during illness, and micronutrient supplementation (zinc and vitamin A).	<ul style="list-style-type: none"> • Proportion of 1 year old children immunized against measles • Proportion of children with diarrhea in the past two weeks who received ORT • Proportion of children with fast or difficult breathing in the past two weeks who received an appropriate antibiotic
Reduce maternal mortality	Family planning: contraceptives. Maternal nutrition and micronutrient supplementation. Prevention and treatment of STI and HIV. Prevention and treatment of malaria and other infections. Antenatal care.	Safe delivery with skilled birth attendance; Essential/ Emergency obstetric care; Post partum and post abortion care.	<ul style="list-style-type: none"> • Percentage of pregnant women with any antenatal care • Percentage of births with skilled birth attendant and/or institutional delivery • Contraceptive prevalence rate
Improve Nutrition	Exclusive breastfeeding-6 months. Appropriate complementary child feeding 6-24 months. Iron and folic acid supplementation of children. Improved hygiene and sanitation. Dietary intake-pregnant and lactating women. Micronutrient supplementation for prevention of vitamin A deficiency & anemia in mothers and children. Anthelmintic treatment in school aged children	Appropriate feeding of sick child and ORT. Control and timely treatment of infectious & parasitic diseases. Treatment and monitoring of severely malnourished children. High dose treatment of clinical signs of vitamin A deficiency	<ul style="list-style-type: none"> •Prevalence of underweight children under five • Proportion of infants under six months who are exclusively breastfed • Proportion of children 6 – 59 months who received one dose of vitamin A in the past six months

Prevent and combat HIV/AIDS	Safe sex, including condom use. Unused needles by drug users. Treatment of STIs. Safe, screened blood supplies. Universal precautions including safe injections. Antiretrovirals in pregnancy to prevent maternal to child transmission and after occupational exposure.	Treatment of opportunistic infections. Cotrimoxazole prophylaxis. Highly active anti-retroviral therapy. Palliative care.	<ul style="list-style-type: none"> • Percent of persons using a condom at last higher risk sex • Percent of sexually transmitted infection clients who are appropriately diagnosed and treated • Percent of HIV-positive women receiving antiretroviral treatment during pregnancy
Prevent and combat TB	Directly observed treatment of infectious cases to prevent transmission and emergence of drug resistant strains & treatment of contacts. BCG immunization.	Directly observed treatment to cure, including early identification of TB symptomatic cases.	<ul style="list-style-type: none"> • Percent of registered new smear positive TB cases in a cohort that were successfully treated • Percent of estimated new smear positive TB cases that were registered under DOTS approach
Prevent and combat Malaria	Use of insecticide-treated nets. Indoor residual spraying (in epidemic-prone areas). Intermittent presumptive treatment of pregnant women.	Rapid detection and early treatment of uncomplicated cases. Treatment of complicated cases (e.g., cerebral malaria and severe anemia).	<ul style="list-style-type: none"> • Percent of patients with uncomplicated malaria who received treatment within 24 hours of onset of symptoms • Percent of children/ pregnant women sleeping under insecticide treated nets • Proportion of women receiving antenatal care who receive at least two or three intermittent preventive malaria treatments during pregnancy

Table-3 Relationship between Millennium Development and indicators

Millennium Development Goal	Targets	Indicators	Additional monitoring indicators
Goal 1: Eradicate extreme poverty and hunger	Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day.		
	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under five years of age Proportion of population below minimum level of dietary energy consumption	<i>Core intermediate indicators</i> <ul style="list-style-type: none"> • Prevalence of underweight children under five • Proportion of infants under six months who are exclusively breastfed • Proportion of children 6 – 59 months who received one dose of vitamin A in the past six months
Goal 4: Reduce child mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	Under-five mortality rate Infant mortality rate Measles immunization among children under one	<i>Core intermediate indicators</i> <ul style="list-style-type: none"> • Proportion of 1 year old children immunized against measles • Proportion of children with diarrhea in the past two weeks who received ORT • Proportion of children with fast or difficult breathing in the past two weeks who received an appropriate antibiotic
Goal 5: Improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio Proportion of births attended by skilled health personnel	<i>Core intermediate indicators</i> <ul style="list-style-type: none"> • Percentage of pregnant women with any antenatal care • Percentage of births with skilled birth attendant and/or institutional delivery • Contraceptive prevalence rate

Goal 6: Combat HIV/AIDS, malaria, and other diseases	Halt by 2015 and begin to reverse the spread of HIV/AIDS.	HIV prevalence among 15- to 24-year-old pregnant women Condom use rate of the contraceptive prevalence rate Number of children orphaned by HIV/AIDS	<i>Core intermediate indicators</i> • Percent of persons using a condom at last higher risk sex • Percent of sexually transmitted infection clients who are appropriately diagnosed and treated • Percent of HIV-positive women receiving antiretroviral treatment during pregnancy
	Halt by 2015 and begin to reverse the incidence of malaria and other major diseases.	Prevalence and death rate associated with malaria Proportion of population in malaria risk areas using effective malaria prevention and treatment measures	<i>Core intermediate indicators</i> • Percent of patients with uncomplicated malaria who received treatment within 24 hours of onset of symptoms • Percent of children/ pregnant women sleeping under insecticide treated nets • Proportion of women receiving antenatal care who receive at least two or three intermittent preventive malaria treatments during pregnancy
		Prevalence and death rates associated with tuberculosis Proportion of tuberculosis cases detected and cured under DOTS	<i>Core intermediate indicator</i> • Percent of registered new smear positive TB cases in a cohort that were successfully treated • Percent of estimated new smear positive TB cases that were registered under DOTS approach

Conclusion

In conclusion, Burma is designated as one of the 8 worst countries of fragile states by WHO and The World Bank because of currently un-controlled health problems and dysfunction health system. It means that it will be very difficult to reach the targeted MDGs in health sector. However, we have to do what we can do to protect and promote the health of our people. (Figure-1)

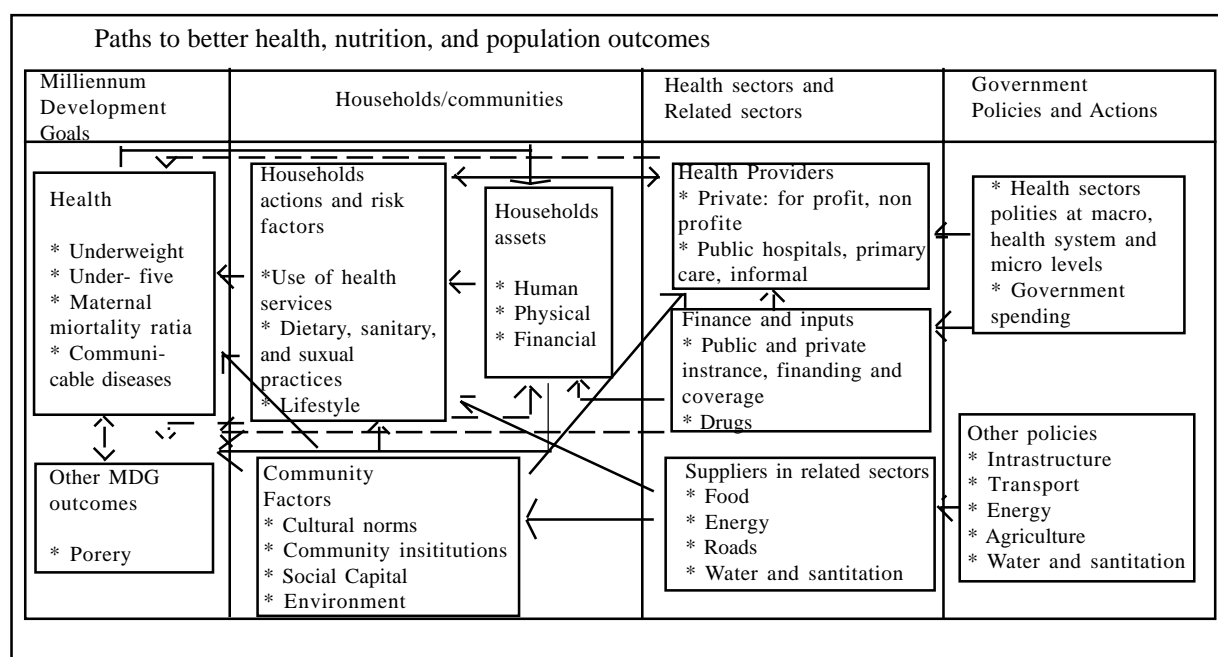
Households are pivotal but often overlooked

Households play two roles in the health system. They are demanders of community-based and facility based interventions, and they are deliverers of home-based interventions. For interventions that are—or ought to be—delivered by a professional (antenatal care, the safe delivery of a newborn, immunization), the patient (or the caregiver for a child) is crucial. He or she makes the initial contact and plays a key part in what follows, in compliance, follow-up, referral, and so on. If a mother fails to recognize the signs of a sick child and does not take the child to a provider, the consequences can be fatal. A recent study in Bolivia found that 60 percent of children who died during the period covered by the study had never been taken to a formal health care provider in the sickness episode culminating in their deaths.²³

The household's role as a deliverer of care is also crucial. It is mothers who breastfeed their children, and it is they and other household members who purchase, treat, and use bednets. It is in the household that timely and appropriate complementary feeding gets provided to the growing child. It is the caregiver who administers oral rehydration therapy to a child with diarrhea and antimalarials to a child with fever. Much of a child's health is—or at least can be—"produced" in the household.

Policymakers can influence households through the resources households have at their disposal, including their knowledge of health matters, and through their influence on community factors, by affecting both social norms and infrastructure. All too often, however, health policy toward households is piecemeal and half-hearted, even failing to acknowledge that households are deliverers of health intervention.

Figure-3



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“Listening to the grass-roots”

(A Learning/Sharing Experience with Frontline Health Workers from Interior & Border Areas)

A Report on Local Health Workshops

(July 2003 – November 2005)

Dr. Salai Pacin

Aim:

- Review “Recommendations: HC 2000” for additional inputs.

Objectives:

- reflect on common health problems
- determine possible solutions (with locally available resources)
- recommend topics of interest (continuing learning/education)
- outline the constraints and challenges faced.

Guiding principle:

“Promote community-based health movements”

Promote Community-based Health Movements

- Changing the direction
 - From disease-centered to health-centered
 - From isolated health sector to multisectoral
 - From reactive curative to proactive preventive.
- Life span approach to health
 - Preparation for life
 - Protection for life
 - Quality of life.

Recommendations: HC 2000

- 6 Priority Groups of Health Problems Identified:
 - Major infectious diseases (malaria, TB, STIs including HIV/AIDS, ARIs & diarrhoea)
 - Nutritional disorders/deficiencies: Vitamin A, Iron & Iodine
 - Reproductive Health Problems (Unwanted pregnancies, Unsafe abortions & Maternal Care, etc.)
 - Mental Health (anxiety/depression)
 - Drug abuse: alcohol & psycho-stimulants (*Yaba*)
 - Trauma & injuries: mine injuries/war casualties.
- Major Interventions Outlined.
 - Major interventions outlined were:
 - Educate, counsel, communicate
 - Work with groups (youths, women, and religious leaders)
 - Health service provision & networking with NGOs/GOs for referrals (e.g. TB).

Local Health Workshops (Follow-up to HC 2000)

Major findings

1. Who are participating health workers?
 - a few - administrative/managerial functions
 - some - basic clinical responsibilities
 - few - specific surgical skills (e.g. amputation).
2. Inputs into Recommendations: HC 2000
 - Major infectious diseases: focus on health promotion/community development activities
 - Reproductive & Child health + Nutrition: preventive, promotive action in the community
 - Community Involvement in Health & Development.
3. Common Health Problems:
 - Infectious diseases
 - Non-infectious (PU, HT, Joint pains)
 - Childhood illnesses
 - Reproductive health problems
 - Mental Health & Drug abuse
 - Trauma & injuries.
4. Required Skills: to carry out interventions
 - Project management
 - Operational and case management
 - Communication & counseling
 - Community mobilisation.



Note: Similarities & overlaps with Training Needs identified by 'BMA Health Conference: 2003' delegates.

5. Structure & Functions of Health dept./org.
 - at different stages of development
 - leadership/management/supervision in the field – inadequate
 - system for policy formulation/implementation – non-existent
 - skilled staff to organize/manage programs – limited.
 - proper mechanisms to improve such skills – insufficient
 - Community involvement in decision-making process – rare.

Recommendations

- Educate individuals, households and local communities (self-care at the household level)
- Train volunteers to use simple, effective tools (a skilled person to promote health/prevent illness at the community level)
- Train middle level & front line health workers with appropriate skills including community mobilisation. (skilled workers at the facility)
- Review all trainings: match job requirements with competency skills to perform efficiently (to have measurable/comparable competency standards)
- Initiate a systematic approach to training (to install a mechanism for setting & maintaining standards, including assessment procedures)

- Explore/liaise with training schools & educational institutions: matching competencies for recognition of trainings and accreditation procedures
- Develop protocols/management guidelines (workplace policies and procedures)
- Upgrade the skills of staff at the administrative and managerial level (enabling supervision & team building + project management skills)
- Build the capacity of senior staff for leadership and health policy development, monitor implement and evaluate polices into actions.

To NHEC:

- Initiate & maintain a process of dial/disc. with respective dept. & org. for the issues related to: policies, trainings, and community level initiative (acting as a nodal point)
- To explore/consult/secure necessary expertise & funds to bring into effect of mutually agreed sets of policies & activities
- To manage the whole 'change' process efficiently and effectively through appropriate staffing and support.

Rewards and Challenges of Health Workers on the Thai-Burma Border

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Columbia University, U.S.A.

Duration: June ~ July, 2005

Objective and Research Questions

To study health care workers at the Mae Tao Clinic (MTC) and the Back Pack Health Worker Team (BPHWT) about:

- (1) the motivations for being a health care worker
- (2) rewards gained
- (3) challenges faced being a health care worker
- (4) if they will resettle in a third country

Background: Human Resources for Health

- Health workers are important for producing good health; they perform key social roles in all societies
- The World Health Organization (WHO) has recognized the importance of human resources for health, and they have made “Working for Health” the tentative title of their World health report 2006

Methods

- Semi-structured interviews with health workers (MTC & BPHWT), and long-term foreign volunteer health workers (MTC)
- Participant observation (MTC)
- Focus group discussion (BPHWT)

I. Results: Mae Tao Clinic Overview

Table 1: Comparison between Interviewees and the Mae Tao Clinic Health Staff

	Interviewees	MTC Health Staff
Total Number	31	131
Gender ratio (Female : Male)	3.9 : 6.1	5.5 : 4.5
Marital Status ratio (Single : Married/ Widowed)	5.5 : 4.5	6.7 : 3.3
Ratio of Self- ascription of Ethnicity (Karen/ Karenni : Burman : Others *)	7.7 : 0.3 : 1.9	8.1 : 0.7 : 1.2

* These include : Arakhan, Chin <kachin, Luha, Mon, Pa-O, Shan and Tavoy



Table 2: Number of Interviewees and Staff at Various Departments in MTC

	MOPD	MIPD	CHIPD	CHOPD	RHIPD	RHOPD	Surg
Sample	3	4	2	4	3	2	3
Total	12	20	11	10	13	12	9
	Lab	BT	VCT	Eye	Pharm	Ref	TOTAL
Sample	4	0	1	2	2	1	31
Total	20	3	4	6	6	5	131

* MOPD: medical out-patient department, MIPD: medical in-patient dept, CH: child health, RH: reproductive health, Surg: surgical department, Lab: laboratory, BT: blood transfusion, VCT: voluntary counseling and treatment, Pharm: pharmacy, Ref: referral

Table 3: Demographics of the Interviewees from MTC

Characteristic	Number	Range
Number of women to men	12 : 19	NA
Average age (years old)	29.6	22 – 45
Number of persons in management positions to staff	16 : 15	NA
Average time at clinic (years)	4.25	0.25 – 15
Average time being a health worker (years)	6.00	0.08 – 16
Number of Christians to Buddhists	16 : 15	NA
Number of single to married/widowed persons	17 : 14	NA
Average number of children in those married	1.43	0 – 3
Average level of education* (standard)	9.21	5th – 10th
Location where highest level of education received (Burma to refugee camps to India)	21 : 9 : 1	NA

* Excluding two who went to college and university

Motivations in Becoming a Health Worker: “All in the Same Boat”

- Altruism – “being in the same boat” as others:
 - (1) lack of health care inside Burma
 - (2) wanting to help others who are sick
 - (3) own experience of being ill
 - (4) own interest in health care
- By default:
 - (1) decided or needed by organization
 - (2) few opportunities for jobs and higher education
 - (3) forced to leave Burma



Rewards of Being a Health Worker at MTC: “Like a Family”

- Job satisfaction:
 - (1) ability to help fellow countrymen
 - (2) opportunities for continued education
- MTC is “like a family”:
 - (1) stipends for self and family
 - (2) lodgings and food
 - (3) children's education
- Non-tangible benefits:
 - (1) relative security and safety



Training

Challenges of Being a Health Worker: Stoicism vs. Burnout

- Challenges at the macro level:
 - (1) legality of stay in Thailand
 - (2) risks of arrest
- Difficulties living at the clinic:
 - (1) proximity and space
 - (2) leisure activities
 - (3) food provided
- Problems at the clinic level:
 - (1) funding, e.g. for patient referral
 - (2) facilities and space
 - (3) lab and diagnostic tests available
 - (4) supply of medicines
 - (5) equal opportunities for staff
 - (6) on-the-job trainings and refresher courses
 - (7) patient follow-up
 - (8) patient communication
- Inter- and intra-departmental problems:
 - (1) staff motivation and attitudes
 - (2) burnout and drinking problems
- Family and personal problems:
 - (1) stipend
 - (2) managing child care and work
 - (3) children's education
 - (4) communications with and visiting families in Burma

Factors for Resettling in Third Countries: “Abandoning the Sinking Ship”

- Push factors: situation in Thailand and Burma
- Pull factors:
 - (1) opportunities for further education
 - (2) security
 - (3) better prospects for children
- Retaining factors at home: want to stay to help people
- Restrictive factors abroad: qualifications may not be recognized, would not be able to work in health care

Recommendations for Mae Tao Clinic

- Motivation of health workers to remain at MTC is very high
- Clinic can make improvements to retain staff, e.g.
 - (1) improve living conditions and stipends
 - (2) address department-specific problems
 - (3) improve the quality of trainings, not quantity
 - (4) long-term: solve problem of legality of stay

II. Results: Back Pack Health Worker Team Overview

Table 4: Demographics of the Interviewees from BPHWT

Characteristic	Number	Range
Number of women to men	0 : 8	NA
Average age (years old)	31.75	22 – 45
Number of persons in management positions to staff	8 : 0	NA
Average time with BPHWT (years)	3.21	0.25 – 15
Average time being a health worker (years)	8.28	0.08 – 16
Number of Christians to Buddhists	7 : 1	NA
Number of single to married persons	1 : 7	NA
Average number of children in those married	1.43	0 – 3
Average level of education (standard)	7.38	5th – 10th
Location where highest level of education received (Burma to refugee camps)	4 : 4	NA

Rewards of Being a Health Worker at BPT

- Job satisfaction and learning experience:
 - (1) have the chance to help the people in health
 - (2) BPT focuses more on prevention and public health on top of curative work
 - (3) have the chance to be in contact with the people
 - (4) able to see the situation in Burma
- Tangible benefits:
 - (1) BPHWT provides more support for medicines and equipments than other organizations

Macro Level

- security (being shot at by the SPDC and DKBA, landmines, cannot work freely in the area)
- communication between field & head office, and between different teams in the area
- the villagers have more pressing concerns, e.g. food, so they cannot pay attention to health and prevention

Clinical Level

- lack of equipment to treat patients, e.g. Foley catheter, NG tube, dental instruments
- patient referral:
 - (1) reasons for referral: lack of equipment, medicine, knowledge and skills of the health worker, and severity of the case
 - (2) difficulty in transporting patients



Personal Level

- cannot support family and self financially, e.g. food, children's education
- security of family inside Burma
- cannot be with family often, which cause:
 - (1) not being able to work with/for family
 - (2) cannot help spouse with raising the children
 - (3) cannot take care of own family when they are sick
 - (4) problems with marital relationship
 - (5) unable to take care of aging parents

Support Required from BPHWT

- communication equipment, e.g. satellite phones, walkie-talkies
- video camera to document human rights abuses
- emergency kits with equipments such as Foley catheter, NG tube, forceps to stop bleeding, artificial delivery aids, basic dental instruments
- salary for health workers
- means for income generation for each team so that they can purchase medicines or equipments in Burma



Recommendations for BPHWT

- Researcher's impression:
 - (1) working for the BPHWT is also a good learning experience for the team leaders
 - (2) each team does too much work but has too little time, since they have to conduct health education talks and various programs on top of treating patients when they visit the villages; however, the actual time they spend on each trip is very little (5 to 8 weeks)
- In addition to those suggestions given, the researcher would like to recommend:
 - a thorough evaluation of the roles and function of each team member, and to look for ways to improve efficiency while balancing the health workers' mental well-being, e.g. specialization of tasks, using more local health workers to decrease need for travel, and providing means for them to support their families

Comparison of Findings between MTC and BPHWT

Table 5: Comparison between Demographics of Interviewees from MTC & BPT

Characteristic	MTC	BPHWT
Number of women to men	12 : 19	0 : 8
Average age (years old)	29.6	31.75
Number of persons in management positions to staff	16 : 15	8 : 0
Average time with organization (years)	4.25	3.21
Average time being a health worker (years)	6.00	8.28
Number of Christians to Buddhists	16 : 15	7 : 1
Number of single to married persons	17 : 14	1 : 7
Average number of children in those married	1.43	1.43
Average level of education (standard)	9.21	7.38
Location where highest level of education received (Burma to refugee camps to India)	21 : 9 : 1	4 : 4 : 0

Notes about Differences between Interviewees from MTC and BPHWT

- BPHWT interviewees consist of field in-charge, team leader, TBA trainer, etc
- So BPHWT interviewees are all men, older, have been a health worker longer, and are mostly married
- Their average level of education is lower (perhaps because they have less chance for education?)
- Because BPHWT was established for a shorter period of time, the average duration for working with BPT is also shorter

Comparison of Findings between MTC and BPHWT

- Health workers from MTC and BPHWT face different challenges in their work
- More health workers from BPHWT have immediate family in Burma than those from MTC
- Less BPHWT health workers express willingness to resettle in other countries
- However, most of them would like to continue with their present work as long as they can

Health and Human Rights

Dr. Khin Saw Win

I. Introduction

Since the creation of United Nations over 50 years ago, international responsibility for health and human rights has been increasingly acknowledged. Yet, the actual linkages between health and human rights had not been recognized until late 1980s, when the call for human rights and for compassion and solidarity with people living with HIV/AIDS was first embodied in the first WHO global response to AIDS (WHO 1987).

II. Health and Human Rights

What is health?

The WHO projected a vision of health as a state of complete physical, mental and social well-being – not merely the absence of disease or infirmity. The 1978 Declaration of Alma-Ata called on nations to ensure the availability of the essentials of primary health care, including:

- education concerning health problems and the methods for preventing and controlling them
- promotion of food supply and proper nutrition
- an adequate supply of safe water and basic sanitation
- maternal and child health care, including family planning
- immunization against major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common disease and injuries
- provision of essential drugs



Motto “HFA by the year 2000”

The Ottawa Charter for Health Promotion (1986) proposes that the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. The WHO definition of health was an important step in helping to move health thinking beyond a limited biomedical and pathology based perspective towards the more positive domain of well-being, understood to include recognition of individuals and their need to realize aspirations, to satisfy needs and to change or cope with environments. The societal dimensions of this effort were emphasized in both the Declaration of Alma-Ata and the Ottawa Charter for health promotion.

In 1998, the World Health Assembly reaffirmed the commitment of nations to strive towards these goals in a World Health Declaration and stress the “will to promote health by addressing the basic determinants and prerequisites for health” and the urgent priority “to pay the greatest attention to those in need, burdened by ill health, receiving inadequate services for health or affected by poverty” (WHO 1998)

What are human rights?

HR are legally guaranteed by human rights law, protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. HR are principally concerned with the relationship between the individual and the state. Government obligations with regard to HR broadly fall under the principles of respect, protect and fulfill.

In the aftermath of WW II, the international community adopted the Universal Declaration. The preamble to the UDHR proposes that human rights and dignity are self evident, the “highest aspiration of the common people,” and the “foundation of freedom, justice and peace”. Although the UDHR is not a legally binding document, nations have endowed it with a tremendous legitimacy through their actions, including invoking it legally and politically at the national and international levels.

UDHR – Basic HR

CCPR – classic duty to meet a particular objective

ICESCR – duty to provide the means, create the necessary conditions

Others – Human rights on specific issues

CEDAW (1979)

Convention on rights of the child (1989)

Convention against Torture and other Cruel,

Inhuman or Degrading Treatment or Punishment

International convention on the elimination of All Forms of Racial Discrimination (1965).

Regional Human Rights Treaties

African Charter on Human People’s Rights (1986)

The American Convention on Human Rights (1992)

The European Convention on the Protection of Human Rights (1959)

Only the Asian region does not have such a regional treaty.

There are numerous international declarations and recommendations to express the political commitment of governments to promote and protect human rights.

Special Nature of Human Rights

It is the relation of a state and individuals under its control rather than interstate relations.

People have rights simply because they are human.

HR are universal

HR treats all people as equal

Rights are absolute – for example, right to life, freedom from torture

Limitation is limited

No national boundaries – HR hold nations accountable for meeting the conditions which satisfy the requisite, promotion, protection and respect.

Rights is not a privilege / special favor

HR recognize the rights of others as obligation



Health Rights:

- UDHR – article 25
- ICESCR – article 12, GC 14
- Alma-Ata Declaration (1978)
- Ottawa Charter for Health Promotion

Subsequent Conferences:

- International Conference on Population and Development (ICPD) 1994
- World Conference on HR (1993)
- World Summit for Social Development

The conference documents help to clarify:

Rights of vulnerable groups

Women's HR

Broader concepts of H and HR and the steps needed for implementation

III. A Human Rights Perspective on Health

A health and government responsibility for health is codified in almost every human rights document. The right to the highest attainable standard of health appears in one form or other in most every one of them, for example, the rights to information, to education, housing and safe working conditions etc. From them, there are three most significant rights:

- the right to nondiscrimination
- the right to the benefits of scientific progress
- the right to health

- Non discrimination:

is the key to human rights thinking and practice. Under international human rights law, all people should be treated equally. Common forms of discrimination include racism, gender-based discrimination, homophobia.

- Right to enjoy the benefits of scientific progress and its application

is recognized explicitly in the ICESCR at article 15. The implications of this right have been explored recently with respect to access to drugs for the developing world, regarding access to antiretroviral therapies and other forms of HIV/AIDS care.

- The Right to Health

is being set out in a number of international legal instruments. UDHR, article 25, and ICESCR article 12. The most authoritative interpretation of the right to health is outlined in article 12 of the ICESCR, which has been ratified by 145 countries (as of May 2002). In May 2000, the Committee on Economic, Social and Cultural Rights, which monitors the Covenant, adopted a General Comment on the right to health. GC 14 serves to clarify the nature and content of individual rights and States Parties obligations. The GC 14 recognized the right to health is closely related to and dependent upon the realization of other human rights, including the right to food, housing, work, education, participation, the enjoyment of the benefits of scientific

progress and its applications, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.

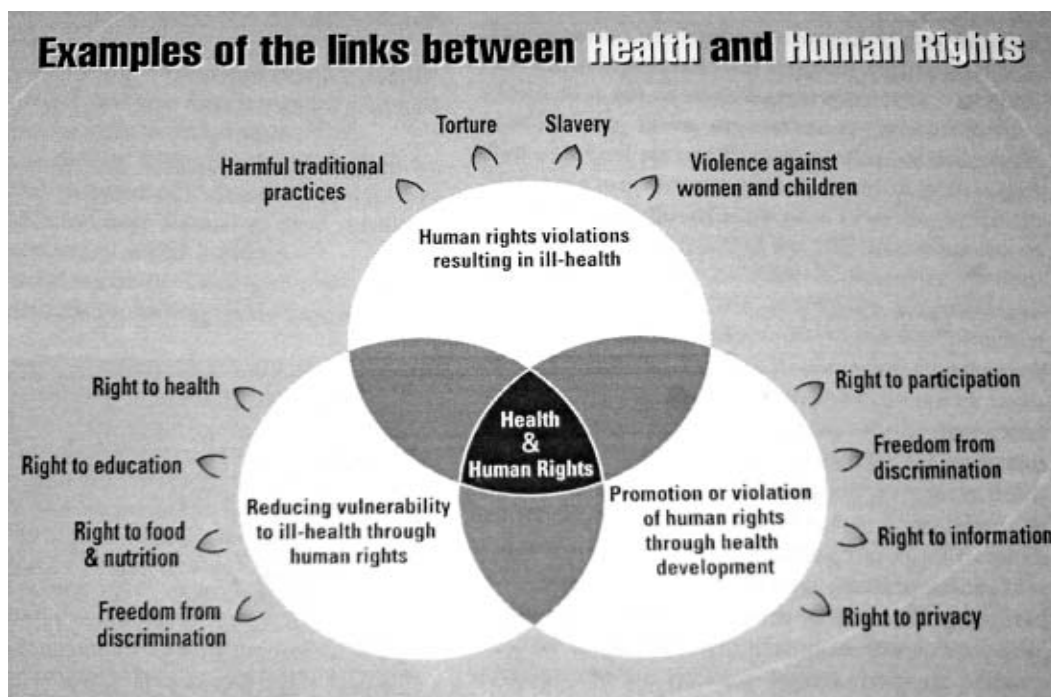
Further, the Committee interpreted the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and portable water and adequate sanitation, an adequate supply of safe food, nutrition, housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

Note: International human rights treaties are binding on governments that ratify them; Declarations are non-binding, although many norms and standards enshrined therein reflect principles which are binding in customary international law; United Nations Conferences generate non-binding consensual policy documents and programmes of action.

IV. What is the link between health and human rights?

There are complex linkages between health and human rights:

1. Violations or lack of attention to human rights can have serious health consequences
2. Health policies and programmes can promote or violate human rights in the ways they are designed or implemented
3. Vulnerability and the impact of ill health can be reduced by taking steps to respect, protect and fulfill human rights



V. Strategic Directions to Better Health

HR can help to provide an approach for better health. This requires an understanding of the health issues most relevant to the well-being of individual and populations. Four main areas:

1. Reducing excess mortality and disability

Needs effective disease prevention and control programs targeted to their special needs, priority given to poor and marginalized communities.

2. Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioral causes:

- issues such as reproductive health, access to safe blood transfusion, access to clean water
- need to create conditions conducive to health through information, education, social support

systems that promote healthy behaviors

3. Developing health systems that equitably improve health outcomes

The type of services, interventions, and technologies we offer – the concept of equality applies

- who require additional attention?
- systems should enable all individuals to seek and receive services that are commensurate to their needs and economically affordable
- nondiscrimination
- protection of confidentiality
- respect for dignity

4. Developing a policy in the health sector

- to what extent does the proposed public health policy represent good public health?
- is the proposed policy respectful and protective of human rights?
- how can we achieve the possible balance between protecting public health and promoting HR?
- will the proposed policy be periodically reviewed? For public health effectiveness and impact on human rights?

VI. Conclusion

We as health workers, how can human rights framework be applied to enhance the value and impact of our health work?

- promoting awareness / HR education
- the development of human rights monitoring tools
- application of human rights framework to health practice
 - ethics
 - discrimination
 - confidentiality
 - equity
- the creation of research agenda to advance our collective understanding of the health and human rights relationship.

Latest Development:

- UN Special Rapporteur on the right to health, Dr Paul Hunt (2002)
- Development of right to health indicators – submission to UNGA (2004)

MIGRANT HEALTH RIGHT

Dr. Zin Min Than Oo
MAP Foundation

Migration

- People are increasingly on the move for political, humanitarian, economic and environmental reasons. This population mobility has health and human rights implications both for migrants and for those they leave behind. Migrants often face serious obstacles to good health due to discrimination, language and cultural barriers, legal status and other economic and social difficulties.

- Approximately 175 million people, or 2.9% of the world's population, currently live temporarily or permanently outside their countries (WHO data)

Migrant Health Right (EU)

- Both Registered and unregistered migrants
- UN Sub-Commission for the Protection and Promotion of Human Rights to draw the attention of the EU Commission to the right of equal access to health care for undocumented migrants living in the European Union.
- For unregistered migrants, they should get
 - emergency health care
 - communicable diseases treatment
 - health care to their children(International Health and Human Right)

Migrant Workers in Thailand

- In 2005, registered Migrants - 705,293
- 539,416 from Burma
- Estimated Burmese migrant workers- >2,000,000
- 500,000 new migrants will be registered in March,2006 (health services?)

Common health Problems in Migrant community

- Fungal infection (skin, vaginal)
- Eye infection
- Anaemia
- STIs
- Respiratory Tract Infection
- Tuberculosis
- PU
- Unwanted pregnancy
- Induced Abortion
- workplace related injuries
- Back pain, joint pain
- HIV/AIDS

Health Insurance Card (30 Baht card)

- Registered migrant workers
 - 30 baht scheme
 - entitle to universal health care system, but workers have to pay around 100 US\$
- Undocumented migrant workers
 - Employer has responsibility for their health cost (a/c to 20th Dec,2005 cabinet resolution)

Health Services available with 30 baht card in Hospitals

- ANC, Child delivery
- Treatment of communicable diseases
- Family Planning (Contraception, Sterilization)
- ARV for HIV infected pregnant women to prevent MTCT
- Home visit
- Health Education to patients and their related families
- Health promotion, counseling
- Dental Care – treatment to Dental caries and oral cavity infections
- Prevention of communicable diseases

PAID SERVICES (Cannot get with 30 baht)

- Mental Illness
- Diseases related with using narcotic drugs
- Injuries from (Accident with vehicle that has Insurance)
- Infertility
- Test tube fertilization
- Body and face cosmetic plastic surgery without Doctor's advice
- Self Medical check up without Doctors advice
- Chronic diseases (Hospital stay >180 days) and complicated diseases

Continue Paid Services

- Kidney transplant, Renal Dialysis, Kidney diseases
- ARV for AIDS patients
- Sex change
- Migrants' children
- Tooth insertion

Paid services together with 30 baht

- Case Diagnosis and Management, Special Treatment with specialist according to National Medical Association's recommendation
- Food and Ordinary In-patient room cost
- Tooth extraction, filling and scratching
- Supportive kit (eg, walking aids) and nationally listed high potency drugs
- Labour cost if > 2 child deliveries after starting using 30 baht
- Referral costs (from current Hospital to another Hospital)

One Stop Crisis Centre

- To help women and children abuse
- Domestic as well as other abuses
- Different experts (Doctors, Nurses, Psychiatric, social workers, Polices, Lawyers and people) in OSCC
- In OSCC
 - Medical treatment
 - Counseling
 - Help to current economic problem
 - Arrange temporary stay
 - Referral to Social welfare organizations

Compensation for Occupation related Injuries and Diseases

- Right to get a leave for occupational accident injury, right to get daily wages for those resting days
- Right to get wages for leave days as well as special compensation for body parts damage or lost injuries according to the extent of injury.
- Right to complain Social security, Labour Protection Office with medical report written by Thai registered medical doctor if the employer did not give compensation

Limitation to Migrants (In Hospital)

- Have to wait for long time to get health care
- Most migrants received only symptomatic treatment
- Hospital directory signs and hospital documents are not written in Migrant's language
- Communication barrier

In their workplace

- No proper sanitation
- No enough ventilation/ crowded
- No occupational health and safety
- No enough break time (many painting attacks, gastric problems)

Recommendation

- Register migrant health workers
- Including the migrant workers leaders (women and man) in policy decisions affecting their lives
- Ensure the safety of migrants in detention and deportation including protection of women from the sexual violence
- Create mechanisms which ensure migrant workers can exercise their right through Thai law especially labour right.
- Provide more Health Care Services
- Provide Quality Health Service
- Directory signs and Hospital documents written in Migrant's language
- Provide more interpreters in Hospital
- Include migrant workers access to ARV under 30 baht scheme
- Help migrant health workers to get information and knowledge of health rights and health education easily

- Improve the workers' environment (living, working)
- Enough resting hours for migrant workers
- Enough break time to eat
- To get time off to seek health care during the day.
- Right of access to adequate health care for all migrant children

HEALTH RIGHT KIT



Australian Health System: A case study

Dr. Myint Cho

Health System Structure

- Public Health Sector
- Private Health Sector.

Public Health Sector

- National (funding/regulatory)
- Regional (services)
- Community
- Family.

Private sector

- NGOs/International organization
- Pharmaceuticals
- Private Practice (allopathic/traditional or folk medicine).

Australian Govt. System

- National Government (Commonwealth)
- State/Territory Governments (6/2)
- Local Government (Council).

Health Policy Making

- Negotiation between the Commonwealth & the States
- Australian Health System – relatively equitable
- Complex Health Care System.

Public Health Insurance System (Medicare)

- Commonwealth:
 - collect taxes
 - funding
- States:
 - receive financial assistance
 - run public hospitals, mental health & community health services
 - rules/regulation for health workers.

Who benefits?

- People who:
 - reside in Australia
 - hold Australian citizenship
 - hold permanent visa
 - hold New Zealand citizenship
- Residents of UK, Ireland, New Zealand, Italy, The Netherlands, Finland, Sweden & Malta (have restricted access).

What are the benefits?

- Medical benefits schedule
 - consultation fees (doctors, specialist, radiological pathological tests, eye test by optometrist, surgical & therapeutic procedures)
- Pharmaceutical benefit scheme (PBS)
 - General beneficiaries
 - Concessionary beneficiaries (pensioner card holders & other entitlement card holder).

Services excluded from Medicare

- Dental treatment
- Ambulance services
- Home nursing
- Physiotherapy
- Occupational therapy
- Speech therapy
- Chiropractic services
- Treatment by psychiatrist
- Visual & hearing aids
- Prosthesis
- Some medical services that are not listed under Medicare as clinically necessary (e.g. cosmetic surgery).

Private Health Insurance System

- Voluntary
- Encouraged by the current government.

Who pays?

Source of finance	Percentage of total (%)
Public:	
• taxes	71.2
Private:	
• out of pocket	16.2
• private insurance	7.1
• other	5.5

Expenditure

- 8.5% of GDP
- Public health receives less than 2 % of total health budget
- 48 % of health expenditure
 - from the Commonwealth govt.
- 23 % of health expenditure
 - from the State govt. & local govt.
- 29 % of health expenditure
 - from private sources.

Tax rates

< 5400	No tax
5401-27,000	17%
27,001-50,000	30%
50,001-60,000	42 %
>60,001	47%

Significant Problems

- Financial barriers to dental treatment
- Shortages of health professionals in some areas
- Geographic and cultural barriers to the use of health services
- Huge differentials in health status between indigenous people and the Australians.

Research Ethics and Human Subjects Protections

Chris Beyrer MD, MPH
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Research Ethics:

What are the Requirements?

- Human Subjects Research
- Ethical Review
- Human Subjects Research Committees
- Institutional Review Boards—Ethics Committees
- Informed Consent
- Training Requirements
- Assurances of Compliance with the Office of Human Research Protection (OHRP)
- Community Participation and Community Advisory Boards

Human Subjects Research

- Any research project involving humans, subject to same standards of ethics, ethics review, and regulatory oversight
- Includes lowest risk studies:
 - only questions asked
 - no blood or other specimens taken, no experimental therapy or agent used
- For example:
 - Studies done on stored specimens collected from humans in which no contact with participants will occur

Ethical Review

- US Ethical Reviews bodies
- Belmont Report
- International Organizations & many countries
- Helsinki Guidelines
- CIOMS Guidelines
- ICH International Code of Harmonization
- All agree on several common principles of ethics:
 - Beneficence [First, do no harm]
 - Balance of research risk versus benefit for subjects
 - Fairness

Human Subjects Research Committees Institutional Review Boards

- Is this study of real or potential benefit?
- Are the rights of human subjects adequately protected?
- Are the risks to participants minimal, significant but warranted, or too high to justify the study?
- Will the community at risk have access to the findings?
- To the benefits of research, if there are any?
- How can we work towards this goal?
 - Every study requires 2 key documents:
 - Study protocol & Informed Consent Document
- Who reviews them?

Institutional Review Boards- IRBs in US, Ethical Committee

- Ethical review committee that reviews, monitors, and oversees human subjects protections in every study. Needed by every US research institution
- Review protocols, proposals, and informed consent documents for human subjects research
- Established under Code of Federal Regulations (CFR) rules
- Must comply with US Federal Office of Human Research Protections (OHRP)
- Independent from researchers
- Must avoid conflicts of interests: family, financial, or research collaboration relationships with investigators
- Must have at least 1 non-scientific member

IRBs outside the US

- To collaborate with US researchers, a second country researcher or organization must have its own IRB to partner with US
- US and In-country IRB reviews required before study can be initiated.
- IRB must be established along internationally accepted standards
- CIOMS, Helsinki, ICH, or UN/ WHO Guidelines
- Many countries have National Review Bodies
- Additional review body- not to replace local IRB

Informed Consent

What does it mean?

Informed Consent is a process

- Research participants:
- Understand a study
- Fully informed of the risks and benefits
- Have all questions and concerns answered
- Truly informed before they consent

Information should be reviewed at many, if not all subsequent visits

- Subject has:
- Consented freely and independently
- Consented without coercion or force
- Suffers no ill effects for refusal or withdrawal from study

Community consent or partner consent may be necessary, but never replaces individual consent

The Informed Consent Document

- Legal record that subject has been given all relevant information and has voluntarily consented to participation
- Carefully reviewed by US IRBs
- Can be written or verbal
- Verbal informed consent – illiterate subjects or those who do not want to sign documents (usually with witness who signs on their behalf)

Non-English Consent

- Documents must be back-translated into English
- Must be independently verified as true translation

- US IRB will review:
- English document
- Non-English document
- Back-translation
- Verification of translation

Training Requirements

Who must receive human subjects training and verification?

- Any investigator named on a research grant
- For US funded research, all international investigators named on proposals or grants, and all who will have “significant subject interactions”
- For all researchers for each new study

Assurances of Compliance:

Office of Human Research Protection (OHRP)

- OHRP – in Department of Health and Human Services
- Requires IRBs to be in compliance with US regulations
- Gives Assurance certification: Federal-Wide Assurance (since 2001), International Collaborative Project Assurances, etc.
- Reviews IRB:
- Membership, Numbers of members, Independence, Conflict of Interest

Community Participation & Community Advisory Boards (CAB)

- Additional requirement of many studies
- Independent advisory body associated with a study or group of studies
- Composed of members of community at risk
- Helps investigators know more about their communities, hear directly from community, and do better research
- Plays key role in ethics

CAB Members

For example:

Study: HIV infection among drug users in Xistan

CAB Members:

- Xistan drug users
- Persons living with HIV/ AIDS
- Xistan religious leader
- Head of a local women’s or youth organization
- Members from local NGOs

Conclusions

- New US requirements – a significant burden on researchers
- US remains single largest funder of human biomedical research worldwide
- Access to US research dollars vital to many research efforts Spirit behind regulations and requirements is protection of human research subjects from:
- Abuse, harm, unnecessary risk, exploitation Compliance is demanding, yet essential
Global research effort on human health problems demands working towards the highest ethical standards possible

Websites

CIOMS:

<http://www.cioms.ch/>

OHRP:

<http://ohrp.osophs.dhhs.gov/>

Bellmont Report:

<http://ohrp.osophs.dhhs.gov/humansubjects/guidance/>

Code of Federal Regulations:

<http://www.access.gpo.gov/nara/cfr/>

ICH Guidelines

Informed Consent

- Consent before involvement
- Provide an opportunity to consider
- Minimize coercion and undue influence
- Use language understandable to subject
- No waiver of rights
- No release from liability

Basic Elements of Informed Consent

- ICH 4.8.10
- Describes requirements for both written informed consent forms and oral discussions of consent
- Must provide an explanation of the following 20 items

Components of Informed Consent ICH 4.8.10

- a) State that the study involves **research**
 - Must mention this explicitly
- b) Explain the **purpose** of the study,
 - Why are you doing this trial?
- c) The trial **treatment(s)** and probability for **random assignment** to each
- d) The trial **procedures** to be followed
 - **Include all procedures that are part of the trial:**
 - **Medical and behavioral assessments, specimen collection, injections, follow-up evaluations etc.**
- e) The **subject's responsibilities**
- f) Those aspects of the trial that are **experimental**
- g) The **Reasonably Foreseeable risks**
 - **Risks to embryo, fetus, nursing infant**
- h) Any **Benefits** to the subject–
 - If none, state there are none
- j) Describe **Compensation** and/of treatment available to subject for trial-related injury
- k) Anticipated prorated **payment**, if any, for participation in the trial
- l) Any **Anticipated Expenses**, if any, to the subject– If none state there are none
- m) **That participation is voluntary**, subjects may refuse to participate or withdraw at any time without penalty or loss of benefits
- n) **Access to their records** will be granted to monitor(s), auditor(s), IRB/IEC, and the regulatory authorities

- o) Records identifying the subject will be kept **confidential** to the extent permitted by laws and/or regulations. Their identity remains confidential in publications
- p) The subject or Legally Acceptable Representative (LAR) will be informed of **information that may be relevant to the subject's willingness to continue participation**
 - Adverse Events
 - Poor outcome
- q) The **name of person(s) to contact**
 - For further information about the trial and rights of the trial subjects
 - For research related injury
- r) Foreseeable circumstances and/or **reasons under which the subjects participation may be terminated**
 - Illness, pregnancy, failure to show for appointments
- s) Expected **Duration** of the subject's participation
- t) The approximate **number of subjects** involved in the trial

Documentation of Consent

- Written consent form approved by IRB
- Signed by subject or Legally Authorized Representative (LAR)
 - Local laws determines who is LAR
 - If unable to read, it should be read to them and signed by a witness
- Use non-technical language when possible

Guidance

- NCI Informed Consent Guidance
<http://cancertrials.nci.nih.gov/researchers/safeguards/consent/index.html>
- NCI Informed Consent Working Group
 - Recommendations
 - Sample Consent Form: Phase 2 ... trial
 - Sample Consent Form: Phase 3 ... trial

Health Access & Utilization at Mae Tao Clinic (1989-2004)

Dr. Cynthia Maung

Overview

- Introduction
- Objectives
- Current Health Services
- Demographic Information
- Mae Tao Clinic Caseload
- General Medicine Department
- Communicable Diseases (Malaria, HIV/AIDS, TB)
- Trauma and Violence
- Reproductive Health and Child Health
- Partnership
- Conclusion

Migration from Burma to Thailand



Introduction

- Established in 1989, Located in Mae Sot District of Tak Province
- Catchments area of approximately 100,000 migrant workers and 50,000 internally displaced person
- In 2004,
 - 100 beds inpatient facility
 - 200 ethnic health volunteers
 - 8 international volunteer

Mae Tao Clinic Objectives

- To provide health care services for displaced Burmese people along the border
- Initial training of health workers and subsequent ongoing medical education
- To strengthen health information systems along the border
- To improve health knowledge, attitudes, and practices within local Burmese populations
- To promote networking and collaboration between local ethnic and international health organizations

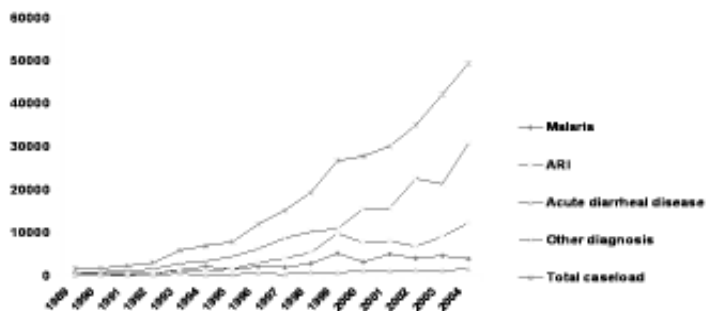
Current health services in Thailand

- Medical Service (OPD/IPD)
- Surgical (OPD/IPD)
- Reproductive health OPD/IPD including basic EmOC services
- Child health services (OPD/IPD)
- Laboratory / Blood Bank
- Primary eye care and eye surgery
- Prosthetics and rehabilitation
- HIV/AIDS prevention (Safe Blood, VCT and PMTCT)
- Malaria management
- Tuberculosis case finding and referrals
- Mae Sot Hospital referral
- Migrant outreach and Cross border collaboration (Support home delivery services, school health promotion and primary health care services)

Demographic information

Total Visits	102,241 (average visit per day = 328)
Total Patients	52,290 (2 visit/person/per year)
Total Admission	9,321 (25/day)
Total Caseload	68,790
Female Reproductive age (15-45)	41%
Under 5 Children	19%

Mae Tao Clinic Yearly Caseload (Medical and Surgical department)



Hospital Admissions Cases

	2003	2004	% increase
Medical IPD	3786	5179	36.8%
Surgical IPD	275	420	53%
RH IPD	2734	3186	16.5%
Eye (surgery)	121	331	175%
Prosthetics	137	205	50%
Total	7053	9321	32%

Comparison of Burma and Thailand Cases:

Health Service 2004	Number	Burma:Thailand Ratio
Total Visits	102,241	2:3
Referrals	644	3:2
Blood Transfusions	890	3:1
Tubal Ligation	184	3:1
Eye Surgery	331	4:1
Malaria (PF)	2649	3:1
Pul: Tuberculosis	234	2:1
Severe Malnutrition	40	2:1
ANC Client	4,122	2:3
Delivery Admission	1,704	1:2

Hospital Admissions (cont:)

Cases	2003		2004	
	No.	Average days stay & range	No.	Average days stay & range
Malaria PF Confirm	1233	4	1051	4.7
Acute Diarrhea	247	4	194	4
ARI Pneumonia	313	6	460	6
TB Sputum Confirm	77	9	15	11(0 to 119)
AIDS Confirm	40	20	61	22
Meningitis	39	7	48	7
Severe Malnutrition	44	15	40	19
CVS Diseases	116	9	212	10

Mae Sot Hospital Referral

Referral Case	Average per month	Average Cost	Total Referral Burma	Thailand
Delivery Complication	9.6	6600	115	7:8
HIV (C/S and Normal)	1.3	7095	16	3:4
Non-Delivery/Gynecological	9	12305	107	3:2
Tubal Ligation	15	814	184	2:1
Neonatal Problems	1.4	5626	17	1:1
Medical Problems	5.8	13383	70	1:1
Surgical Problems	8.6	15627	104	1:1
Eye Problems	0.6	9142	7	1:0
War Wounded (Gun Shot)	0.4	25200	5	1:0
Landmine	1.6	32155	19	1:0
Total	54	12795	644	7:6

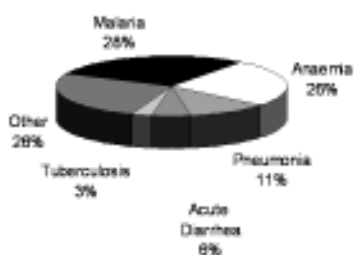
General Medicine Department

Seven most common OPD cases (Total 37074)



General Medicine Department (Cont:)

Five most common IPD diagnoses (Total 5179)



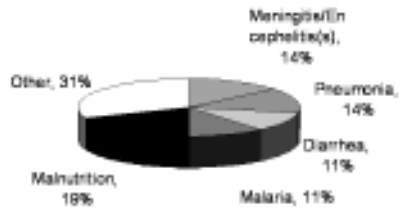
IPD's annual case Fatality rates and Referral rates

	2002	2003	2004
Number of IPD Admissions (1st Diagnosis)	3037	3791	3802
Fatalities	95 (3.1%)	174 (4.9%)	194 (5.1%)
Referrals	NA	81 (2%)	170 (4.5%) (101 for TB)

* 35% of death occur within 48 hours of admission.

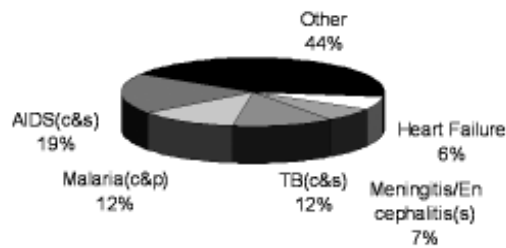
Common causes of mortality for each age group

Five most common mortalities, age 1 month to <5 yrs (Total 36)



Common causes of mortality for each age group (Cont:)

Five most common mortalities, IPD all age (Total 194)

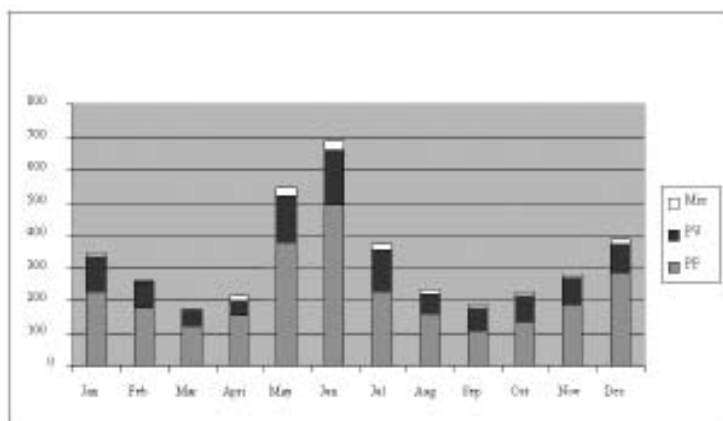


Blood transfusion to a baby in Child IPD

Feeding program



Malaria cases by Month, 2004



IPD Malaria Cases (1st and 2nd diagnosis)

Case	Total	Deaths	Case Fatality
PF Simple	659	-	-
PF Hyper	251	-	-
PV / PM	90	-	-
Mixed (PF + PV)	28	-	-
PF Severe	74	9	12.2 %
PF Cerebral	39	10	25.6 %
PF Cerebral Presumptive	41	5	12.0 %
Total IPD	1182	24	2.0 %

Tuberculosis case finding and Referral

Trend of TB cases & mortality.

	2003	2004
Suspected cases referred to MSF	578	735
Confirmed TB cases (from MSF report)	197 (34%)	234 (32%)
TB cases in IPD (confirmed & suspected)	135	210
TB deaths in IPD (confirmed & suspected)	10 (7.4%)	24 (11.4%)

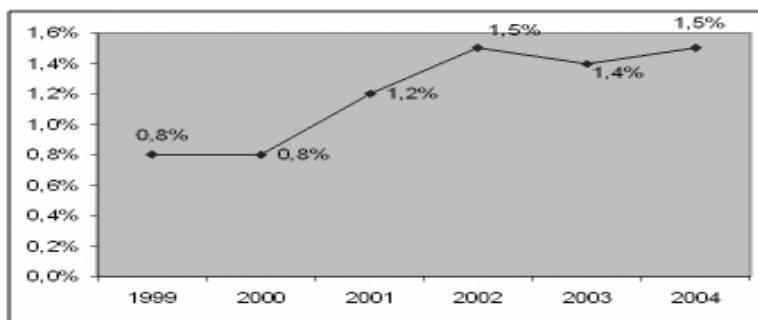
IPD TB demographics (first diagnosis)

	Total number	< 5 : 5 +	Male : Female	Burma : Thai
Patients –				
TB sputum confirmed	108	1:99	7:3	2:1
Deaths –				
TB sputum confirmed	13	0:100	3:1	2:1

STI/HIV prevalence in 2004

Testing	Pregnant Women	Blood Donor screening	VCT
HIV	1.54%	0.85%	14.86%
Hep B	7%	7.3%	4%
VDRL	1.6%	1%	2.4%

Trend of HIV prevalence in ANC pregnant women at MTC from 1999 to 2004



Demographics of confirmed HIV/AIDS cases and fatalities for IPD patients

	Total	Male : Female	%Burma resident	%Thailand resident
Cases –HIV/AIDS confirmed	61	2 : 1	53%	47%
Mortality –AIDS Confirmed	24	3 : 1	38%	62%

Communicable diseases recommended for 24 hour reporting

Disease under surveillance

Cholera

Meningococccemia

Diphtheria

AFP/Suspected Polio

Anthrax

Typhoid

Filariasis

Number of cases In 2004

None Reported

None Reported

None Reported

None Reported

1 skin suspected

51 (suspected)

2 patients with a previous history

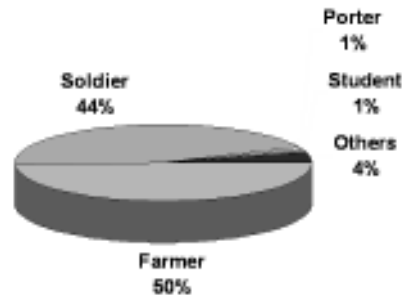
Abnormal cluster of the diseases in special surveillance Food poisoning occurred in 1 factory in more than 100 cases admitted at MTC.

Trauma and Violence

Trauma cases seen in the Surgical Department

Cases	2002	2003	2004
Dental Care	795	1811	2583
Non Trauma	2486	3523	4810
War casualty	26	10	49
Injury from violence	23	70	102
Burn	46	75	98
Work accident	430	258	805
Motor vehicle accident	61	100	160
Total	3867	5847	8607

Occupation of prosthetic patients (Total 201)



Inside of Prosthetic



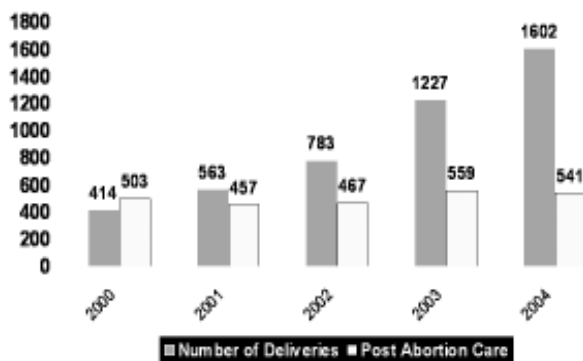
Reproductive Health and Child Health

Trend of selected RH indicators

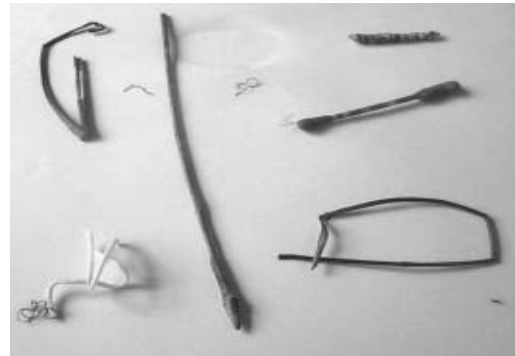
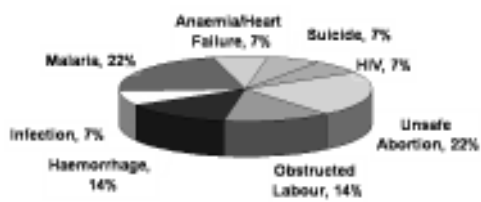
	2001	2002	2003	2004
% of teenage pregnancy at ANC (<20 yrs)	23%	26%	21%	22%
% of live births with low birth weight <2500 gm	20%	18%	13%	12.7%
% of delivery patients with no ANC visits	NA	10%	9%	11%
% of delivery patients with at least 2 tetanus doses	65%	NA	66%	70%
% of delivery clients referral to Mae Sot Hospital	NA	NA	14%	6%

Reproductive Health and Child Health

Number of Deliveries and Post Abortion Care at Mae Tao Clinic, 2000-2004

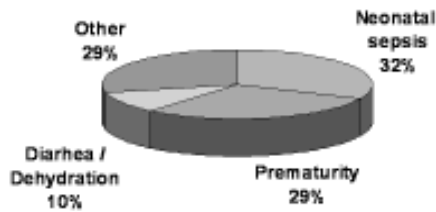


Causes of Maternal Death in the Thai Public Hospital, 2001-2002 (Total 14 Burmese Women)



Abortion Sticks

Three most common Neonatal Mortality causes (Total: 21)



New born with jaundice taking sunlight



New born with jaundice taking sun light (RH-IPD)

Kangaroo Care for New Born Baby



Partnership

Thai Public Health and Mae Sot hospital (Technical and Logistics)

- Vaccine
- Special Laboratory tests
- X-ray / Ultrasound facilities
- Medical waste disposal
- Obstetric emergency and medical emergency referrals
- Surveillance System
- HIV/AIDS prevention, including prevention of mother to child transmission

Partnership (cont:)

Community Based Organization and International NGOs

- Community health education and disease prevention
- Review and revision of health worker training curriculum
- Standardized data collection system
- Strengthen community based organization network
- Financial support and resource allocation
- International advocacy

Conclusion

- Poor access to health services
 - inside Burma : cost, security, travel restriction
 - Thailand : cost, security, language
- Logistic/finance constraint for long-term care/referral services
- Increasing stress and violence
- Increasing stateless children and street children



Living Condition of Migrant Workers **Burmese recycling woman with baby in pushcart on the streets of Mae Sot**



Burmese migrant workers in the working time

Fear for Security



Recommendation

- Strengthen community health education and prevention services.
- Specific clinical skills need to be improved.
- All organizations which provide health services to displaced Burmese population should share mortality and morbidity statistics.
- Thai government should monitor the working conditions of Burmese workers and implement the laws that do exist to protect workers rights.
- Improve coordination among health organizations.
- Projects or programs which assist displaced people out of poverty should be funded.

KANGAROO MOTHER CARE

Dr.Thein Win

Free Burma Campaign [South Africa]

INTRODUCTION

- Global perspective on neonatal health
- Commonest causes of death in Newborn
+ HYPOTHERMIA -> HYPOGLYCAEMIA, HYPOXIA, INFECTION
- Why Saving Newborn Lives?
 1. high risk of death among all
+ eight millions deaths/yr mostly in developing world
 2. Save their live by simple means without much expenses
 3. Prevent huge painful complications
 4. Save enormous money :- individual, country to global level



KANGAROO MOTHER CARE

- Why the title KMC?
 - Ø Mother kangaroo is a mammal (just like us) feeds its baby milk like we do (or like we should!) from inside its pouch.
 - Ø Provides total environment:- warmth, food, comfort, stimulation, protection.
- The baby [Kangaroo baby] is *CARRIED* for all the time
- WITHOUT INTERRUPTION !
- NEVER SEPARATE !

WHAT IS KMC? - 1

• POSITION

Upright position against the mother's bare chest and between her breasts. The infant is kept naked except for a nappy, socks and woolen cap. Both mother and infant are usually covered by a blanket or shirt.

• CORNERSTONE OF KMC- 3 COMPONENTS

1. *Skin-to-skin contact*

between the baby front and the mother's chest. The more skin-to-skin, the better. For comfort a small nappy is fine, and for warmth a cap may be used. Skin-to-skin contact should ideally start at birth, but is helpful at any time. It should ideally be continuous day and night.

2. *Exclusive breastfeeding*

3. *Support to the mother infant dyad*

It means that whatever is needed for the medical, emotional, psychological and physical well being of mother and baby is provided to them, without separating them. Purely intense psychological support.



WHAT IS KMC? - 2

- Philosophy of KMC
 1. Natural
 2. brain-wiring (neurophysiology)



BRITH OF KMC AND HISTORY

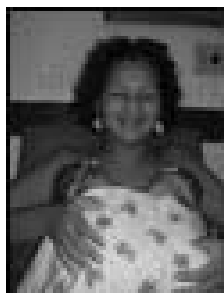
- 1979 - Started in Columbia in during crisis large number of LBW
- 1983 - UNICEF brought attention to programme
- 1986 onwards - Research in Europe and USA. Implementation widespread in Scandinavia and Germany. Early implementation in Mozambique and other African countries.
- 1991 - First review of research came out.
- 1996 - First International Workshop, in Italy. Noted over thirty different terms used, agreed to use “Kangaroo Mother Care”
- 1998 - First International Conference on Kangaroo Care, Baltimore.
- 1998 - Second International Workshop, Bogota, Colombia, focus on research and implementation. Bogota declaration came out.
- 2000 - Third International Workshop, Indonesia.
- 2004 – 5th International workshop

RESEARCH BASED KMC

- Research KMC and breastfeeding
- Research KMC and cognition development
- Research KMC and social
- Research KMC in high technology hospital
- Research KMC maternal perception
- Research KMC physiology
- Research KMC reduce mortality in LBW
- Research KMC save method
- Research KMC Vs Incubator
- Research KMC Vs traditional care
- Research long term effects of early KMC
- Research KMC Non-medical reason

KMC IN EVERYWHERE

- Any where
- Any place
- Any time
- Any person



NEVER SEPARATE !



WITHOUT INTERRUPTION!



KMC POSITIONS



ADVANTAGES OF KMC - 1

- **BABY**
 1. Especially Good for LBW : decreased MR in LBW
 2. Decreased risk of apnoea
 3. Decreased risk of bradycardia
 4. Less infection
 5. Promote breast feeding
 6. Less stress and stability
 7. Grow faster

- MOTHER
 1. confidence
 2. bonding
 3. Mothers are empowered to play an active role
 4. Less neglect and abandonment

ADVANTAGES OF KMC - 2

- FATHER
 1. Fathers are able to play a far greater role in the care of their infants
 2. improves bonding between fathers and infants
- HEALTH CARE PROVIDERS
 1. Discharge earlier
 2. Fewer staff and less equipment are needed in hospital setting
 3. Less cost
 4. Less neonate mortality and morbidity rate

CHALLENGES TO DEISION MAKERS/COMMUNITY

- KMC is the research based suggestion especially for LBW
 - Encourage breastfeeding
 - Empower to mother and families
 - No cost and most effective approach in newborn care
 - Appropriate for less resources setting
 - Advantages for clinics and hospitals.
 - Advantages for individual: newborn, mother, father
 - Although there are above-mentioned advantages KMC is not very simple as “just to put newborn into mother’s chest”
 - Many constrains: stay in comfort zone, resist to change, worry in unfamiliar approach, reluctant to start etc
- If say so, think about this which way you are going to choose!

YOUR CHOICE !

Either keep lonely to your innocent child as it is (or) Keep baby strong, stability and healthy by nursing your baby in this natural way [KMC]



MOM!

Please! MOM
Please keep me in front of your chest
as close as you can....

You are my life!



CHILD VICTIMS OF BIRDFLU (In Burma)

Dr. Saw Po Thaw Da
BMA

Introduction

Minister of Health (MOH) Burma, once announced, “There is no avian flu in Burma, because no infected migrating bird can fly cross over the high northern mountain of Burma.”

If there is an outbreak under military regime with poor health care service and if children become orphan or suffer by themselves, will we simply call them “Child Victims of Bird Flu”?

Back ground

The people of Burma have been suffering under repressive military regime with a record as one of the world’s worst abusers of human and political right. Thousands of Burmese people become internally displaced people (IPD) because of civil war and their suffering is intensified by the regime. Will we call them victims of civil war?

People from suburban areas in central or peripheral of some states & divisions are relocated by force from place to place, to occupy their land, inherited from ancestors by government or military officers for their benefit (Victims from inheritance). There are migrating migrant workers from one place to another or to neighboring countries (Victims of poverty). Because of poverty children can not access low price health care service and education services (Victims of health & education system)

Rehabilitation

After 40 years under military control, Burma become one of the poorest, under developed (backward) or backsliding country. There are two classes of people, the ruling class including their friends or partners and the other group, the subject, who are the majority group, more than 80% of the total population. Thus there are two systems in all sectors or fields. For rehabilitation, first we must make the two systems to become one, that is democratization.

Education & health are two sectors, most important in developing the country. But the military government allocates an average of less than 3% of the total government budget (GDP) for education & 2% for health. As a result the majority lost their rights to enjoy free or low cost education and health services.

Once as a health worker, I do not know & learn the reality of child rights I know only, they need health care services like vaccination. But the reality revealed when I become a coordinator for primary level education program for some Burmese migrant children, for this academic year (2005-2006) With out modern education, we cannot improve knowledge, altitude and practice of the citizen, we cannot develop the country. At present some children have to leave schools, as their parents cannot pay the schooling fees. Some have to accompany their parents, who are migrant workers to neighbors countries. (Victims of Health & Education Systems)

Living standard of people in Burma

- A. **Economic condition:** There is prosperity with ruling group & Their friends or partners. Common man or layman and the subject of the country become victims of economic depression & the consequences. The country is rich in natural resources (off shore gas & oil), but the majority of people are poor. (Both government servants and layman.) No equal income and rights or chance are followed by strife, strike and military rule and the circle will go on for sometime or how long.
- B. **Education condition:** It is very expensive for schooling in Burma. Common people cannot send their children to schools. We notice the dropout rate is up to 44.5% in primary school level (child victims of education rights)

C. Health condition: The military government allocates an average of less than 2% of the total government budget for health, resulting not enough health workers, medicines, medical materials and tools. Because of corruption many sick cannot enjoy health care services and the consequences are shorter life expectancy, high rate of malnutrition in children, high morbidity & mortality due to infections and parasitic diseases, especially due to malaria, TB, HIV/AIDS. What about Avian flu & etc? According to WHO 2000 report, health status of Burma is 191 out of 192 nations of the world.

Note the following datas

- Adolescents in the world population & Burma during round about 1995 Age group 10-19 as % of total population

World	= 19 %
Developed regions	= 14 %
Developing regions	= 20 %
Burma	= 20.5 %
- life expectancy at birth combined for both sexes in major regions of the world & in some South East Asia region during round about 1995

More development regions	= 74 %
Less development region	= 62 %
Indonesia	= 63 %
Thailand	= 70 %
India	= 61 %
Burma	= 58 %
- Malnutrition (nutritional status)

Calorie intake	= 80 %
Protein intake	= 86 %
Anaemia	= 26 %
- Maternal Mortality Rate (MMR) - in Burma & neighbor country during round about 1995

Indonesia	= 450
Thailand	= 44
India	= 410
Burma	= 230
- Infant Mortality Rate in Burma & neighbor country during round about 1995

Indonesia	= 58
Thailand	= 32
India	= 78
Burma	= 94

Note common causes of infant death - ARI
 - Malaria
 - Diarrhoea diseases
 - Malnutrition (protein energy)

- Adolescent pregnancy - 8.9% of total deliveries
- Prevalence of STD (15 - 24 age group) - 32%
- HIV infection rate among IV drug users - 59%
- Incidence of unprotected sex - 17.4%
- What about Avian Influenza (“Bird Flu”) with Burma? Very recently (1-2weeks) about 10,000 domestic poultry died from passing white excreta and choke, in Mon State between Tha Ton and Paung

Significance of Bird Flu Transmission to Human.

Avian influenza is an infectious disease of birds caused by type "A" strains of the influenza viral disease, which was first identified in Italy more than 100 years ago, occurs world wide.

All birds are thought to be susceptible to infection with avian flu, though some species resistant to infection than others. Infection causes wide spectrum of symptoms in birds, from mild illness to a highly contagious & rapidly fatal diseases resulting in severe epidemics. Known as "highly pathogenic avian influenza" Characterized by sudden onset & rapid death, with mortality that can approach 100%

Fifteen subtypes of influenza virus are known to infect birds. To date, all outbreaks of the highly pathogenic form have been caused by influenza "A" viruses of subtypes H5 and H7

Migratory water fowl (water ducks) are natural reservoir of avian flu. These birds are also the most resistant to infection. Domestic poultry (Chickens) are particularly susceptible to epidemic of rapidly fatal influenza.

Direct or indirect contact of domestic flocks with wild migratory water fowl has been implicated frequent cause of epidemics. Live bird markets also played an important role in epidemics.

Recent research has shown that viruses of low pathogenicity can, after circulation for some periods in a poultry population, mutate into highly pathogenic viruses. During 1983-1984 in United States of America, the H5 N2 virus initially caused low mortality, but within six months became highly pathogenic, with mortality approaching 90%. During 1999-2000 epidemic in Italy, the H7 N1 virus initially of low pathogenicity, mutated within 9 months to pathogenic form. More than 13 million birds died. Highly pathogenic viruses can survive for long periods, when temperature are low. For example an epidemic of H5 N2 avian influenza, which began in Mexico in 1992 and was not controlled until 1995. Virus are constantly mutating.

Human infection with avian influenza virus. They do not normally infect species other than birds and pigs. The first infection of humans with an avian influenza virus occurred in Hong Kong in 1997. With signs of severe respiratory disease in 18 humans, of whom 6 died. Aetiology is because of close contact with live infected poultry. In February 2003, when an outbreak of H5 N1 avian influenza in Hong Kong, caused 2 cases in members of a family who had recently traveled to southern China.

An outbreak of highly pathogenic H7 N7 avian influenza, which began in Netherlands in February 2003. Caused one death & mild illness in 83 other humans. Mild cases of avian influenza H9 N2 in children occurred in Hong Kong in 1999 & mid December 2003.

Recently, cause for alarm occurred in January 2004 by H5 N1, avian influenza in Viet Nam with severe respiratory disease. H5 N1, are able to mutate rapidly and can cause severe disease in humans.

Influenza Pandemics; Can they be averted? Influenza pandemic can be expected. For example in the 20th century, influenza pandemic of 1918-1919, caused 40-50 million deaths world wide, followed by pandemics in 1957-1958 & 1968 – 1969. Based on historical pattern, pandemic can be expected to occur, on average, three times each century. Experts agree that another influenza pandemic is inevitable & possible imminent. The prompt culling of Hong Kong's entire poultry population 1997 probably averted a pandemic. Causal organism is H5 N1 avian influenza with symptoms of muscle pain, fever (38°C or more) sore throat, cough and respiratory distress. Severe respiratory distress (Pneumonia) cause death.

Antiviral drugs (Tamiflu / Oseltamivir) are expensive and supplies are limited. Some of which may be used for both treatment & prevention, are clinically effective against influenza A virus.

Very recently there is an outbreak of avian influenza in Turkey by H5 N2. There their health workers can manage the cases with requirements they have.

How will health workers from Burma manage the case if there is an outbreak in our country, Burma? Do we have any skillful persons and requirements ?

Washington Post said "[Burma has no skillful health workers and requirements]" (VOA news 17/1/06).

Our authorities hold stay away from democratic & democracy loving people policy. They are not flexible to UN, Global Fund, MSF (France) & many other NGOs. Even with ASEAN.

What about Bird flu in Burma? Is there any technician if there is an out break? Do we have medicine for management? Do we have any policy for such kind of communicable diseases?

Details of confirmed H5 N1 cases from WHO report (16/12/06)

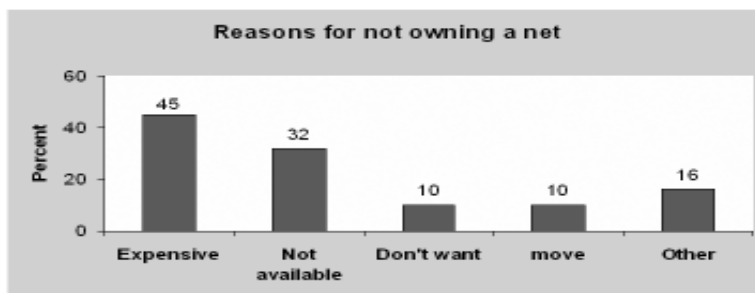
Year	Cambodia		China		Indonesia		Thailand		Viet num		Total	
	Cases	Death	Cases	Death	Cases	Death	Cases	Death	Cases	Death	Cases	Death
2003	0	0	0	0	0	0	0	0	3	3	3	3
2004	0	0	0	0	0	0	17	12	29	20	46	32
2005	4	4	6	2	14	9	5	2	61	19	90	36
Total	4	4	6	2	14	9	22	14	93	42	139	71

ITN use before MCP

- Net use = 45%
- 83% of those not owning a net want one

Treatment before MCP

- Low adherence to malaria therapy
 - Only ~50% finish all malaria medicines
 - 24% knew proper treatment duration for Quinine
 - Common reasons for not finishing anti-malarials:
- Felt better (34%) & Side effects (23%)



RDT: Diagnosis

- Rapid Diagnostic Tests (RDTs) in MHC & BPHWT areas
- Paracheck (Orchid Biomedical Systems, India)
 - 90% sensitive/specific
 - Inexpensive (\$0.62)
 - Border recognized (Burma Border Guidelines)
- Sensitivity/specificity of 85-90%

- % Paracheck Positive = 40-65%
- Cost effective (~50% presumptive don't actually have malaria)



Malaria Control Program

- EDT (Paracheck and ACTs)
- Vector Control (ITNs)
- Education
- Also:
 - Directly Observed Therapy (DOT)
 - Community Participation
 - Biannual population screening and treatment



Program: EDT

- Follow Burma Border treatment guidelines
- RDT
 - Paracheck Device (+) à ACT (MAS 3)
- Directly Observed Therapy (DOT)

Program: ITN

- Long Lasting Nets (Siamdutch, Thailand)
 - Deltamethrin (effective 3-5 years)
- Distributed 1 net/house first year
- Cost recovery started



Program: Malaria education

- Causes, Symptoms of Malaria
- EDT
 - symptoms - seek Rx
 - Adherence (full course)

- ITN
 - Nets Prevent bites/malaria
 - Treated = “medicine net”
 - Net use (when and how to use the net)
 - Net care (keep out of sun, wash once/month, do not use bleach)
- Environment
 - Cutting bushes around house
 - Filling water holes and cleaning up other water containers

Program: Monitoring

- Community Malaria Program Committee

- House visits
 - monitor net use
 - active surveillance
 - education



Malaria Control Program

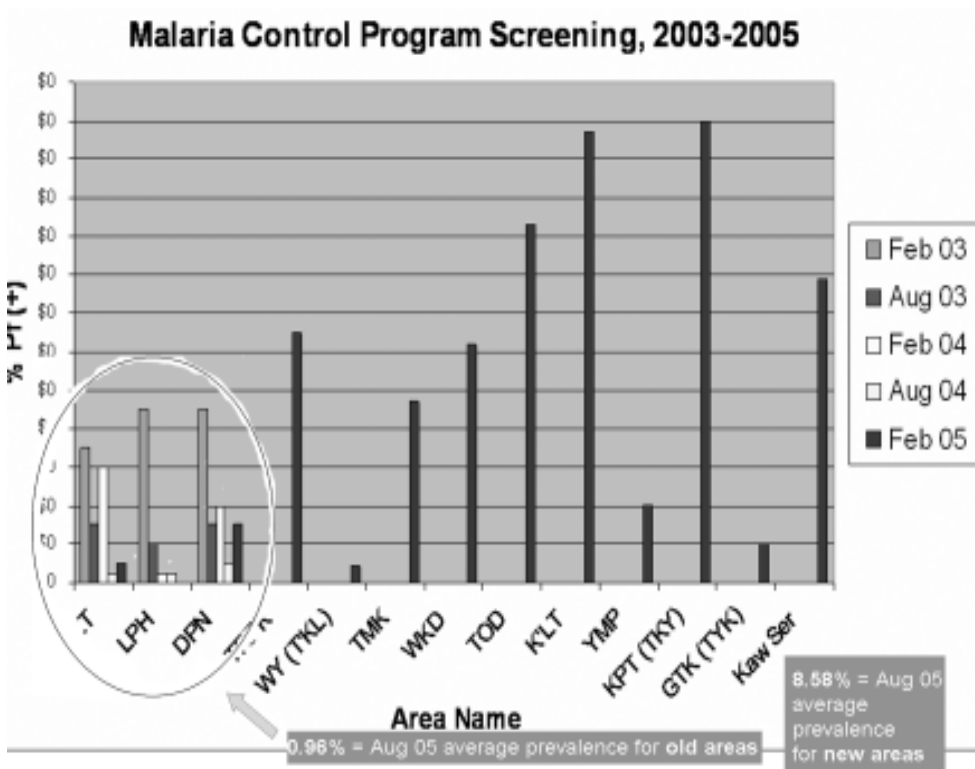
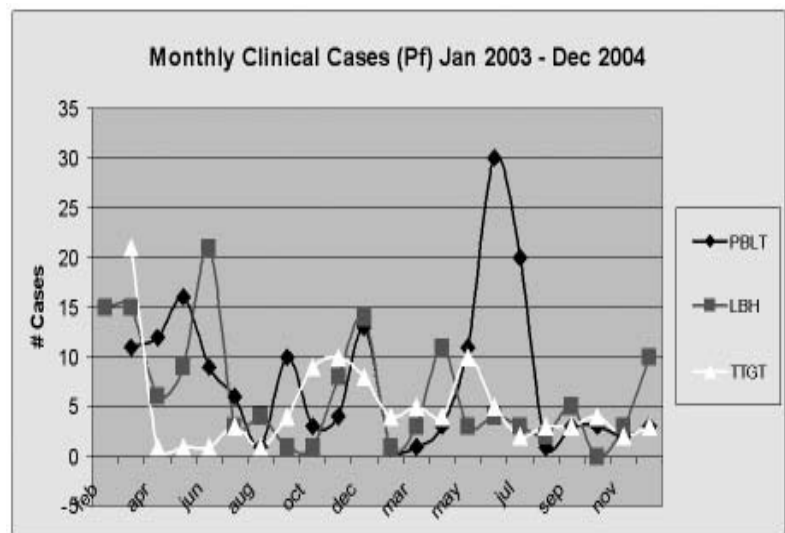
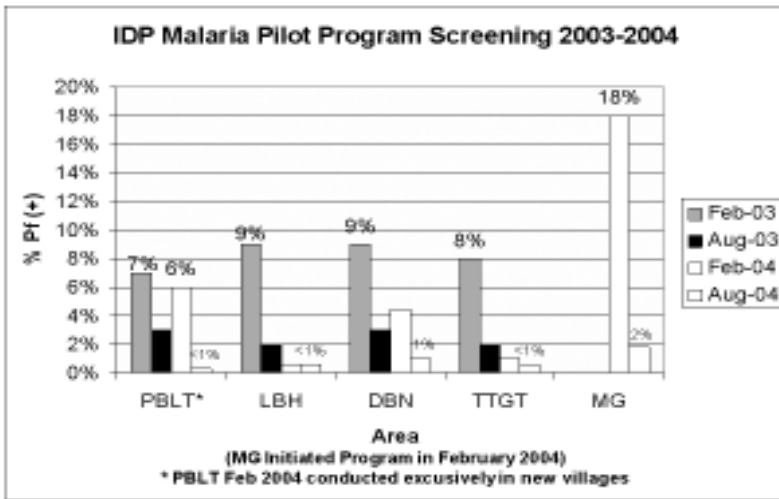
	2003	2004	2005
Villages	4	5	17
Population	1800	3460	9798
Option 1	Option 2	Option 3	
• Long Lasting ITNs	• Long Lasting ITNs	• Long Lasting ITNs	
• 100 sample screening	• Full screening	• 100 sample screening	
		• Early Detection and Treatment	

Monitoring- Bi-annual Population Screening and Treatment

- Test all villagers with RDT for Option 2
- Test 100 sample for Option 1 and 3
- Treat according to protocol
- Nets distributed, cost recovery for net
- Education

Evaluation: 3 most important indicators

- Net use
- Malaria monthly incidence rate
 - # Cases (Paracheck +) diagnosed at clinic
- “Point” prevalence of malaria parasitemia
 - % Paracheck positive during biannual screening



- >15,000 house visits = 1.2 /HH/mo
- 20-30% of HH members referred w/ fever

Vector Control: ITN coverage

- 1.7 nets/household
- <3 persons/net
- >90% sleep under net nightly



Education:

- all villages improved knowledge



Summary

- Malaria control is possible in an IDP setting
- IDP's can play prominent roles in program implementation, M&E & advocacy



Community Health Assessment in Selected Ethnic Areas of Burma

Baseline Mortality Findings PRELIMINARY RESULTS

Epidemiology Research Group (ERG)

The Community Health Assessment Project

Quality community health data collected by well trained health workers using appropriate tools will lead to better health resource allocation and better health program monitoring, which in turn will lead to healthier communities.

The Community Health Assessment Survey Tool

- Started with WHO/Hopkins/London manual
- Obtained sample tools from other mortality surveys and read many mortality research reports
- Consulted with CDC, various NGOs and individuals
- Extensive focus group assessments, practice, pre-testing, pilot testing and a full field test

Methodology

- Consistent in all surveys
- PPS Cluster Sampling
- Typically 20 clusters per survey
- 6 ethnic areas surveyed + 1 field test survey
- Presenting data for Arakan, Kachin, Karen, Karenni and Palaung – Shan data pending

Have you been living in this village since the last **Karen New Year**? **Yes / No**

Does any adult female in this house read (the local language)? **Yes / No**

Does your household have a latrine or toilet? **Yes / No** (if yes) ----->

Does your household have bed nets? **Yes / No** (if yes) ----->

How many times do children under age 5 eat in a day? **1 2 3 4+**

Do people in this house drink boiled water? **Always / Sometimes / Never**

When home, do adults use the latrine
Always / Sometimes / Never

Do all children under 5 use a bed net?
Yes / No
Do all adults use a bed net?
Yes / No

List everyone who was living in this household since first local holiday or last new year as instructed in training)

Person no.	Age (years)	Sex (circle one)	Current Status as of TODAY (circle one)	Died of which cause? (ask questions)	tick here if died in pregnancy or puerperian	In the past 2 wks, did anybody in this house have.... (tick all that apply) Diarhea? Malaria? Pneumonia?	Reported Disabilities (circle all that apply)	MUAC measurement from age 1 up to age 5
1		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
2		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
3		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
4		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
5		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
6		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
7		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
8		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
9		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G
10		M/F	1 2 3 4	1 2 3 4 5			1 2 3 4 5 6 7	R/O/Y/G

Current Status Codes
1 = alive (live in this household)
2 = alive (live some other place)
3 = died
4 = missing/unknown

Cause of Death Codes
1 = war related trauma
2 = other trauma/accident/injuries
3 = measles
4 = other illnesses/diseases
5 = unknown or not sure

Disability Codes
1 = missing leg/foot
2 = missing hand/arm
3 = blind
4 = deaf
5 = mentally retarded
6 = lame (can't walk)
7 = all others

checked by _____
verified by _____
entered by _____

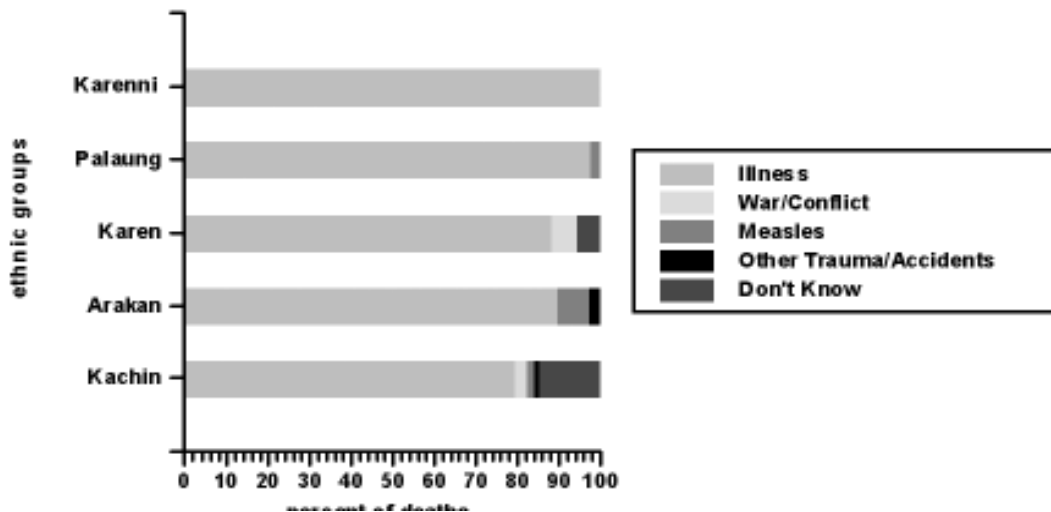
Ethnic Area	When Conducted	Recall Period	Population Assessed	Number of Deaths
Karenni	Oct 2004	298 days	1,709	6
Karen	Oct 2004	290 days	1,639	16
Palaung	Nov 2004	361 days	2,694	85
Kachin	Nov 2004	336 days	1,418	68
Arakan	Feb 2005	433 days	1,636	39

	Karenni	Karen	Palaung	Kachin	Arakan
CMR 1,000 year	4.35	12.63	33.19	54.42	20.75
CMR 10,000 day	0.12	0.35	0.91	1.49	0.57

Under 5 and Infant Mortality Rates

	Karenni	Karen	Palaung	Kachin	Arakan
U5MR 1,000 U5 year	5.77	42.58	100.0	189.44	50.476
IMR 1,000 births year	33.10	100.68	154.92	307.45	65.86

Causes of Mortality



Key Findings

- Over 10 fold increase in CMR, and 30 fold increase in U5MR seen in comparing selected locations.
- CMR in Kachin area qualifies as a public health emergency, Palaung area probably qualifies.
- Areas with established clinics have lower mortality rates.
- Most increases in mortality are in U5 and in infants.
- Beginning and/or improving MCH services should reduce IMR and U5MR which in turn will reduce CMR.
- Researchers returning from the field feel that HIV and/or TB are having an effect on mortality rates in Kachin and Palaung areas.
- These results are preliminary
- Additional results on mortality, recent illness and household behaviors will soon be available.
- Survey record now being used in additional studies in other ethnic areas

Field Survey Trip Photo



လူ့အခွင့်အရေးချိုးဖောက်မှုနှင့် ကျန်းမာရေးပြဿနာ
မန်း မန်းမန်း
နယ်လှည့်ကျောပိုးအိတ်ကျန်းမာရေးလုပ်သားအဖွဲ့

မြန်မာနိုင်ငံအတွင်း နှစ်ပေါင်း ၅၀-ကျော် ဖြစ်ရှိလျက်ရှိသော ပြည်တွင်းစစ်ကြောင့် သိန်းပေါင်းများစွာ သော တိုင်းရင်းသား ပြည်သူလူထုတို့သည် အတင်းအဓမ္မ ပြောင်းရွှေ့ခံရခြင်း၊ ရွှေ့ပြောင်းပုန်းအောင်း နေထိုင်ရ ခြင်း မိမိတိုင်းပြည်မှ စွန့်ခွာထွက်ပြေးခြင်း စသည့် အခြေအနေများ ဖြစ်ရှိနေပါသည်။ အထူးသဖြင့် အမျိုးသားထုတစ်ရပ်လုံး၏ အခြေခံလူ့အခွင့်အရေးဖြစ်သည့် ကျန်းမာရေး ဆိုင်ရာ အခွင့်အရေးများ နစ်နာဆုံးရှုံးခဲ့ပြီး ကျန်းမာရေးဆိုင်ရာ ပြဿနာများ ဖြစ်ရှိနေပါသည်။

နယ်လှည့်ကျောပိုးအိတ်ကျန်းမာရေးလုပ်သားအဖွဲ့၏ ကျန်းမာရေးစစ်တမ်းအရ ကျန်းမာရေးပြဿနာ များ ဖြစ်ပေါ်လာရသည့် အရင်းခံ ပြဿနာနှင့် ကျန်းမာရေးကဏ္ဍတွင် တိုးတက်မှုမရှိသည့် အဓိကအကြောင်းရင်းများထဲတွင် လူ့အခွင့်အရေး ချိုးဖောက်မှုကြောင့်သည်လည်း အဓိကအကြောင်းရင်းတစ်ခု ပါဝင်ကြောင်း တွေ့ရှိရပါသည်။ နယ်လှည့်ကျောပိုးအိတ် ကျန်းမာရေး လုပ်သားအဖွဲ့မှ ကျန်းမာရေးဆိုင်ရာ လေ့လာတွေ့ရှိ သုံးသပ်ချက်အရ မြန်မာနိုင်ငံတိုင်းရင်းသား နေထိုင်ရာဒေသများအတွင်း၌ လူဦးရေ ၁၀၀၀-တွင် တစ်နှစ်အတွင်း ၄၀-ယောက် မွေးဖွားပြီး ၂၅-ယောက် သေဆုံးကြောင်း တွေ့ရှိရပါသည်။ ကလေးအရှင်မွေး ၁၀၀၀-တွင် တစ်နှစ် အောက်ကလေး ၁၃၅-ယောက် သေဆုံးပြီး ၅-နှစ်အောက်ကလေး ၂၉၁-ယောက် သေဆုံးကြောင်း တွေ့ရှိရပါ သည်။ ကိုယ်ဝန်ဆောင်မိခင် သေဆုံးနှုန်းမှာလည်း ကလေးအရှင်မွေး တစ်သိန်းတွင် မိခင် ၁၂၀၀-ယောက် သေဆုံးသည်။ မြန်မာနိုင်ငံ တိုင်းရင်းသားများ ဒေသရွှေ့ပြောင်း ဒုက္ခသည်များအတွင်း သေဆုံးမှုနှုန်းသည် မြန်မာနိုင်ငံအတွင်း၌ ထုတ်ပြန်ကြေညာသော ကျန်းမာ ရေးဆိုင်ရာ အစီရင်ခံစာနှင့် နှိုင်းယှဉ်လျှင် ၁-နှစ်အောက် ကလေး သေဆုံးမှုနှုန်းနှင့် ၅-နှစ်အောက်ကလေး သေဆုံးမှုနှုန်းမှာ ၂-ဆ ကျော် မြင့်မားနေသည်ကို တွေ့ရှိရ သည်။ စစ်ဖြစ်သော အခြားနိုင်ငံများ ဖြစ်သည့် အာဖဂန်နစ္စတန်နှင့် အင်ဂိုလာ စသည့်နိုင်ငံများနှင့် နှိုင်းယှဉ်လျှင် ၅-နှစ် အောက်ကလေး သေဆုံးနှုန်းမှာ ထပ်တူမျှ ဖြစ်နေကြောင်း တွေ့ရပါသည်။ ၎င်းအပြင် နိုင်ငံတကာ မှတ်တမ်းတင် စံထားချက်အရ အာဖီယံနိုင်ငံများအတွင်း၌ ကမ္ဘာ့ဒီဇယ်နိုင်းထက် ၅-နှစ်အောက် ကလေးသေဆုံးမှုနှုန်းမှာ အမြင့်မားဆုံးဖြစ်သည် ဟု စံထားသတ်မှတ်ခဲ့သည်။ သို့သော် ၎င်းက ကမ္ဘာ့ဒီဇယ်နိုင်းထက် ပို၍မြင့်မားနေသည်ကို တွေ့ရှိရပါသည်။ ဤကဲ့သို့ ဆိုးဝါးနိမ့် ကျသော လူထုကျန်းမာရေး အခြေအနေသည် အဓိကအကြောင်း ရင်းများထဲမှ အခြေခံကျန်းမာရေးဆိုင်ရာ အခွင့်အရေး ဆုံးရှုံးခြင်း နှင့် လူ့အခွင့်အရေး ချိုးဖောက်ခံရခြင်းများ စသည့်အကြောင်းရင်းတို့ ဖြစ်နေသည်ကိုလည်း ထောက်ပြနေပါသည်။

လူ့အခွင့်အရေးချိုးဖောက်မှုအခြေအနေ

Region	Forced labour	Landmine injury/death	Forced displacement	Food destroyed/looted
1	47.7%	0.0%	0.0%	0.0%
2	5.7%	1.4%	45.4%	71.6%
3	0.0%	1.7%	60.5%	18.5%
4	33.8%	2.9%	0.0%	27.5%
5	36.2%	0.0%	4.1%	12.6%
6	74.1%	0.0%	0.0%	17.3%
7	11.9%	0.2%	0.6%	30.2%
8	37.3%	0.8%	14.2%	33.9%
Average	32.9%	0.7%	9.0%	25.7%

ပြည်သူလူထုများ အဓမ္မခိုင်းစေမှု ခံရခြင်းသည် ပေါ်တာဆွဲခြင်း၊ စစ်စခန်းဆောက်လုပ်ခြင်း၊ လမ်းများ၊ တံတားများ ဆောက်လုပ်ခြင်းတွင် အခမဲ့ခိုင်းစေခြင်းများဖြစ်သည်။ အထူးသဖြင့် နအဖထိန်းချုပ်သည့် နေရာများ၊ အပစ်အခတ်ရပ်စဲရေး လုပ်ထားသော နေရာများတွင် အခြားနေရာများထက် ပို၍ မြင့်မားနေသည်ကို တွေ့ရှိရပါသည်။ နအဖ ထိန်းချုပ်မှုမရှိသော (သို့) အနည်းငယ်ထိန်းချုပ်နိုင်သော နေရာများတွင် ရွှေ့ပြောင်းခံရသည့် အခြေအနေ ပို၍မြင့်မားပြန်နေသည်ကို တွေ့ရသည်။ ဒေသတစ်ခုလုံး၏ အိမ်ထောင်စုအလိုက် တစ်နှစ် အတွင်း အဓမ္မခိုင်းစေ ခံရခြင်း ၃၃ ခိုင်ရာနှုန်း၊ အဓမ္မပြောင်းရွှေ့ခံရခြင်း ၉ ရာခိုင်နှုန်းနှင့် အစားအစာပျက်ဆီးခံရ ခြင်း ၂၆ ရာခိုင်နှုန်း ရှိကြောင်းတွေ့ရသည်။

ကျန်းမာရေးပြဿနာအခြေအနေ

Cause of Death	Children under 5		Total Surveyed Population	
	Deaths	Percent of total	Deaths	Percent of total
Diarrhoea	16	22%	36	22%
Malaria	34	47%	67	42%
ARI	8	11%	20	12%
Landmine	0	0%	1	1%
Gunshot	0	0%	2	1%
Pregnancy	0	0%	1	1%
Other	15	20%	34	21%
TOTAL	73	100%	161	100%

နယ်လှည့်ကျေးပိုင်းအိတ်ကျန်းမာရေးလုပ်သားအဖွဲ့၏ ကျန်းမာရေးစစ်တမ်းဖော်ပြချက်အရ လူဦးရေ ၁၀၀၀-တွင် တစ်နှစ်အတွင်း ၂၅-ယောက် သေဆုံးကြောင်း တွေ့ရသည်။ ၅-နှစ်အောက်ကလေးများအတွင်း သေဆုံးရသည့် အဓိကအကြောင်းရင်းမှာ ၄၇% ရာခိုင်နှုန်း၊ ၄၇ ရာခိုင်နှုန်း၊ ၀မီးရောဂါကြောင့် ၂၂ ရာခိုင်နှုန်း၊ အသက်ရှူလမ်းကြောင်းရောဂါကြောင့် ၁၁ ရာခိုင်နှုန်းဖြစ်ကြောင်း တွေ့ရှိရပါသည်။ ၅-နှစ်အောက်ကလေး အာဟာရချို့တဲ့မှုလည်း ၁၄ ရာခိုင်နှုန်း ရှိနေသည်ကိုလည်း တွေ့ရသည်။ ၎င်းအပြင် ၄ ရာခိုင်နှုန်းမျှသာ သားဖွားမိခင်များအရေးပေါ် ပြုစုစောင့်ရှောက်မှုကို လက်ခံရရှိပါသည်။

လူ့အခွင့်အရေး ချိုးဖောက်မှုနှင့် ကျန်းမာရေးပြဿနာဆက်နွှယ်မှု

အထက်ဖော်ပြပါ လူ့အခွင့်အရေး ချိုးဖောက်ခံရသည့် အခြေအနေနှင့် ကျန်းမာရေးပြဿနာ ဖြစ်ရှိနေရသည့် အခြေအနေတို့ကို ဆက်စပ်နိုင်ယှဉ်ပါက အဓမ္မပြောင်းရွှေ့ခံရသည့် မိသားစုများသည် ပြောင်းရွှေ့မခံရသည့် မိသားစုများထက် သေဆုံးမှုနှုန်းမှာ ၂-ဆကျော် မြင့်မားနေပြီး အစားအစာ ဖျက်ဆီးခံရသည့် မိသားစုများသည် အဖျက်ဆီးမခံရသည့် မိသားစုများထက် ၄-ဆကျော် ၅-နှစ်အောက်ကလေး အာဟာရချို့တဲ့မှုနှုန်း မြင့်မားနေသည်ကို တွေ့ရသည်။

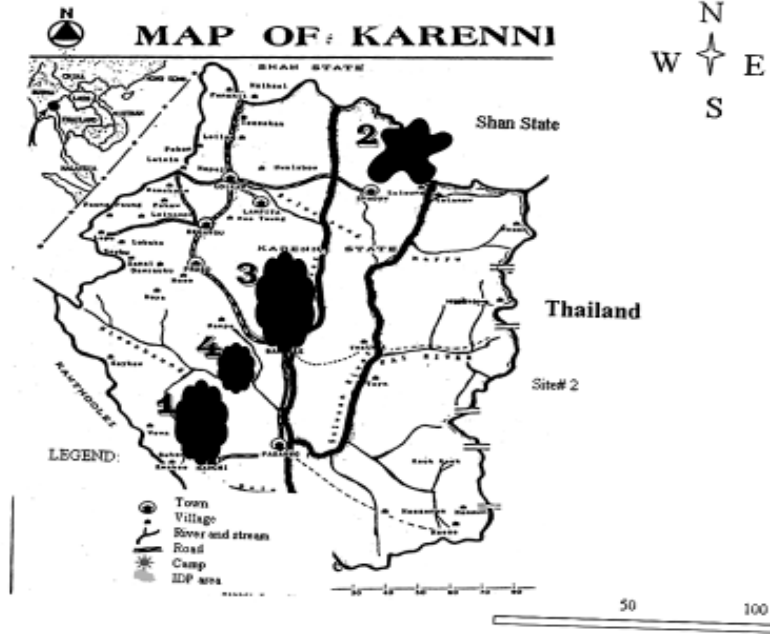
ဖော်ပြပါကျန်းမာရေး ပြဿနာများနှင့် လူ့အခွင့်အရေး ချိုးဖောက်မှု အခြေအနေများသည် လက်ရှိမြန်မာနိုင်ငံ တိုင်းရင်းသားဒေသများအတွင်း ဖြစ်ရှိနေသော ကျန်းမာရေးနိမ့်ကျမှု၊ ကျန်းမာရေးပြဿနာ ဖြစ်ရှိမှု များတို့သည် လူ့အခွင့်အရေး ချိုးဖောက်ခံရခြင်းနှင့် တိုက်ရိုက်သော်လည်းကောင်း၊ သွယ်ဝိုက်၍သော်လည်းကောင်း လုံးဝဆက်နွှယ်နေပါသည်။ ထို့ကြောင့် မြန်မာနိုင်ငံ တိုင်းရင်းသား ဒေသများအတွင်း ကျန်းမာရေး အဆင့်မြင့်မားရန် ဆောင်ရွက်မှု၊ ကျန်းမာရေးဝန်ဆောင်မှု လုပ်ငန်းများ ဆောင်ရွက်လုပ်ကိုင်ရာတွင် လူ့အခွင့်အရေး ချိုးဖောက်ခံရသည့် ပြဿနာများကိုပါ တပါတည်း ဖြေရှင်းဆောင်ရွက်နိုင်မှသာလျှင် ကျန်းမာရေး ပြဿနာများကို အောင်မြင်စွာ ဖြေရှင်းနိုင်မည်ဖြစ်သည်။ ယခုကဲ့သို့ လူ့အခွင့်အရေး ချိုးဖောက်မှုများ ဆက်လက်ဖြစ်ရှိနေပါက ဖြစ်ရှိနေသော ကျန်းမာရေးပြဿနာများကို အောင်မြင်ထိရောက်စွာ ဖြေရှင်းနိုင်မည် မဟုတ်ကြောင်း လေးစားစွာဖြင့် ဖော်ပြတင်သွင်းအပ်ပါသည်။

IDP and Refugee health situation

Luca

Karenni health department

ကရင်နီကျန်းမာရေးဌာန



စီမံကိန်းအကျဉ်း (Project Summary)

- ကရင်နီအမျိုးသားတိုးတက်ရေးပါတီ၏ ဌာနတစ်ခုဖြစ်သည်။
- ကရင်နီပြည်တွင်းရှိဌာနလက်လွှတ်ဒေသအတွင်း ကျန်းမာရေးပြုစောင့်ရှောက်မှုလုပ်ငန်းတွင် **Burmese Relief Centre (BRC)** နှင့် အမျိုးသားကျန်းမာရေးနှင့်ပညာရေးကော်မတီ (**NHEC**) တို့၏ထောက်ပံ့ကူညီမှုဖြင့် နယ်လှည့်ကျန်းမာရေးပြုစောင့်ရှောက်မှုစနစ်ဖြင့် ဒေသ(၄)ခုခွဲပြီး ဆောင်ရွက်နေပါသည်။
- ပြည်တွင်းဌာနလက်လွှတ်သူများလူဦး ရေ ခန့်မှန်ခြေမှာ ၄၅၀၀၀ ဦးခန့် ရှိပါသည်။
- ထိုင်းနိုင်ငံ အတွင်းရှိ ကရင်နီဒုက္ခသည် စခန်းများတွင်အပြည်ပြည်ဆိုင်ရာ ကယ်ဆယ်ရေးကော်မတီဖွဲ့ (**International Rescue Committee- IRC**)နှင့် ပူးတွဲဆောင်ရွက်လျက်ရှိပါသည်။
- ကရင်နီကျန်းမာရေးဌာနအနေဖြင့် ဝန်ထမ်းအုပ်ချုပ်ရေးနှင့်လုပ်ငန်းစီမံခန့်ခွဲမှုအပိုင်းကိုတာဝန်ယူပြီး အပြည်ပြည်ဆိုင်ရာ ကယ်ဆယ်ရေးကော်မတီဖွဲ့ကြေး၊ဆေးဝါးနှင့် နည်းပညာပံ့ပိုးခြင်းအပိုင်းကိုတာဝန်ယူနေပါသည်။ ကရင်နီဒုက္ခသည် စခန်းတွင် လူဦးရေ ၂၂၆၀၃ ဦးခန့် ရှိပါသည်။

စေစားချက်တာဝန် (Missions Statement)

ကရင်နီကျန်းမာရေးဌာနသည် ကရင်နီအမျိုးသားတိုးတက်ရေးပါတီ၏ ထောက်ခံအားပေးမှုကိုရရှိသည့်ပြင် ပြည်သူလူထုတို့မှ အားကိုးအားထားပြီးထိုင်း နိုင်ငံအတွင်းရှိ ကရင်နီဒုက္ခသည်များအား ပြီးပြည့်စုံသော ပဏာမကျန်းမာရေးစောင့်ရှောက်မှု လုပ်ငန်းများ ဝန်ဆောင်မှုပေးခြင်းနှင့် ကရင်နီပြည်တွင်းရှိ ဌာနလက်လွှတ်ပုဂ္ဂိုလ်များတို့အား (ဖြစ်နိုင်သည့်ဒေသများတွင်) နယ်လှည့်ကျန်းမာရေး စောင့်ရှောက်မှုလုပ်ငန်းဝန်ဆောင်မှုပေးခြင်း စသည့်အရည် အသွေးကောင်းမွန်သော ကျန်းမာရေး ပြုစောင့်ရှောက်မှုပေးခြင်းအားဖြင့် ၎င်းတို့၏ကျန်းမာရေးအဆင့်အတန်းကို မြင့်တင်ပေးသော အဖွဲ့အစည်းတစ်ခုဖြစ်သည်။

မျှော်မှန်းချက်တာဝန် (Vission Statement)

လူထု၏ပူးပေါင်းပါဝင်မှုဖြင့်ကျန်းမာခြင်းနှင့် ပြည့်စုံသော လူထုတရပ်အဖြစ်တည်ဆောက်နိုင်ရန် ကရင်နီကျန်းမာရေးဌာန

သည် ထိုင်းနိုင်ငံအတွင်းရှိ ကရင်နီဒုက္ခသည်များနှင့် ကရင်နီပြည်တွင်းရှိ ဌာနေလက်လွတ်ပုဂ္ဂိုလ်များတို့အား ပြီးပြည့်စုံသော ပဏာမ ကျန်းမာရေး ပြုစုစောင့်ရှောက်ပေးခြင်းဝန်ဆောင်မှုပေးခြင်းနှင့် သင့်တော် ကောင်းမွန်သော နယ်လှည့်ကျန်းမာရေးပြုစုစောင့်ရှောက်ခြင်း ဝန်ဆောင်မှုပေးခြင်းတို့ကို အကောင်းဆုံးဆောင်ရွက်သွားမည်။

လုပ်ငန်းပန်းတိုင်များ (Goals)

- ၁။ ပိုမိုတောင့်တင်းခိုင်မာပြီး အရည်အသွေးပြည့်မီသောကျန်းမာရေးဌာန(အဖွဲ့အစည်း) ဖြစ်လာစေရန်။
- ၂။ ကရင်နီပြည်တွင်းရှိ ဌာနေလက်လွတ်ဒေသအတွင်းတွင် နယ်လှည့်ကျန်းမာရေးပြုစုစောင့်ရှောက်ခြင်းများတိုးချဲ့ခြင်းကို ပြုလုပ်ခြင်း အားဖြင့် လူထုကျန်းမာရေးပြဿနာများကို လျော့ချသွားရန်။
- ၃။ ကရင်နီဒုက္ခသည်စခန်းအတွင်းတွင် အရည်အသွေးကောင်းမွန်သော ကျန်းမာရေးဝန်ဆောင်မှုလုပ်ငန်းများကို လုပ်ဆောင်သွား ခြင်းဖြင့် ပြည်သူလူထုများသည် ၎င်းတို့၏ကျန်းမာရေးပြဿနာများကို တတ်နိုင်သမျှကိုယ်တိုင်ဖြေရှင်း လာနိုင်စေရန်။

ရည်ရွယ်ချက်များ

- (၁) ၂၀၀၈ ခုနှစ်တွင်ကရင်နီကျန်းမာရေးဌာနတွင် ကောင်းမွန်လုံလောက်သည့် ကျန်းမာရေးမူဝါဒများ ပြည်စုံ၍ထိုမူဝါဒကို ကျင့်သုံး သည့်အဖွဲ့အစည်းဖြစ်လာစေရန်။
- (၂) ၂၀၀၈-ခုနှစ်တွင် ကရင်နီဌာနေလက်လွတ်လူထုများသည် တကိုယ်ရေနှင့်ပတ်ဝန်းကျင်သန့်ရှင်းရေး၊ အခြေခံကျန်းမာရေးမြင့် (အသက် ၁၂ နှစ်အထက်) တင်ခြင်းစသည့်အသိပညာများကို နားလည်သဘောပေါက်ပြီး အနဲဆုံးလူထု(၂၀)ရာခိုင်နှုန်းသည် ကိုယ်ထူကိုယ်ထ လုပ်ဆောင်ကျင့်သုံးလာစေရန်။
- (၃) ၂၀၀၈ ခုနှစ်တွင် ဌာနေလက်လွတ်ဒေသတွင် ရောဂါဖြစ်ပွားမှုနှုန်းနှင့် သေဆုံးမှုနှုန်းကို (၁၅) ရာခိုင်နှုန်းလျော့ချသွားရန်။
- (၄) ၂၀၀၈ ခုနှစ်တွင် ကရင်နီဒုက္ခသည်စခန်းအတွင်း အရွယ်ရောက်ပြီးသူ (၁၂)နှစ်အထက်)အနဲဆုံး (၆၀)ရာခိုင်နှုန်းသည် ကျန်းမာရေး နှင့်ညီညွတ်သော ဗဟုသုတ၊ အမူအကျင့်၊ လက်တွေ့လုပ်ဆောင်မှုများရှိလာပြီး လူထုအတွင်းတွင် အချင်းချင်းကျန်းမာရေး အသိပညာဖြန့်ဝေခြင်းများ ရှိလာစေရန်။
- (၅) ၂၀၀၈ ခုနှစ်တွင် ကရင်နီဒုက္ခသည်စခန်းအတွင်းရှိ ကုသရေးလုပ်ငန်းများတွင် အရည်အသွေးထိန်းသိမ်းရေးစနစ်များ ရေးဆွဲချမှတ် ကျင့်သုံးသွားရန်။
- (၆) ၂၀၀၈ ခုနှစ်တွင်ကရင်နီကျန်းမာရေးဌာနတွင် လူထုအတွက်လိုအပ်သည့် အရည်အချင်းပြည့်မီသည့်ဝန်ထမ်း (၈၀)ရာခိုင်နှုန်း အနဲဆုံးရှိလာစေရန်။

စီမံကိန်းနယ်မြေဒေသနှင့်ပစ်မှတ်လူဦးရေ

- ပြည်တွင်းကျန်းမာရေးပြုစုစောင့်ရှောက်မှုလုပ်ငန်းကိုနယ်မြေအခြေအနေအရ ဒေသ (၁) (၂) (၃) (၄) ခွဲထားပါသည်။ ၎င်းတို့မှာ
 - ✓ ကရင်နီပြည်တောင်ပိုင်း မော်ချီးဒေသအတွင်းရှိ နတ်တောင်တောင်ဘက်အခြမ်းဒေသ(၁)
 - ✓ ရှမ်းကရင်နီနယ်စပ်ဒေသ(၂)
 - ✓ ကရင်နီပြည်အလယ်ပိုင်းရှိ ဒီမောဆိုမြို့နယ်နှင့် ဖရူဆိုမြို့နယ်အတွင်းရှိကျေးရွာအချို့ဒေသ(၃)
 - ✓ အမှတ်(၃)ခရိုင်အရှေ့ဘက်ခြမ်းဒေသ(၄)တို့ ဖြစ်ပါသည်။
- ယင်းဒေသ(၄)ခုအတွင်းတွင် ခန့်မှန်းခြေလူဦးရေပေါင်း ၄၅၀၀၀ ဦးခန့်ရှိ ပါသည် (၁၉၉၆ ခုနှစ်ကရင်နီ IDPs ကော်မတီ စစ်တမ်းအရ) ။
- ထိုင်းနိုင်ငံအတွင်းတွင်ကရင်နီဒုက္ခသည်စခန်း အမှတ်(၁)နှင့်အမှတ်(၂)စခန်း ဟူ၍ (၂)ခုရှိပါသည်။
- ယင်းဒုက္ခသည်စခန်းနှစ်ခုတွင်ဒုက္ခသည်ပေါင်း ၂၂၆၀၃ ဦး ရှိပါသည်။ (၂၀၀၅-ခုနှစ်၊ ကရင်နီဒုက္ခသည်ကော်မတီ လူဦးရေစာရင်းအရ)

IDP ဒေသတွင်ဆောင်ရွက်ပေးသည့်လုပ်ငန်းများ

ပြည်တွင်းကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများ

- ဆေးကုသရေးလုပ်ငန်း
- ကျန်းမာရေးပညာပေးလုပ်ငန်း
- ကိုယ်ဝန်ဆောင်မိခင်များစောင့်ရှောက်မှုပေးခြင်း၊ ခလေးမွေးပေးခြင်း
- လူထုကျန်းမာရေးလုပ်သားနှင့် TBA သင်တန်းပေးခြင်း
- လူနာလွှဲပြောင်းပေးခြင်းစသည်တို့ကို ဆောင်ရွက်ပေးနေပါသည်
- လုံခြုံရေးနှင့်အခြားအခက်အခဲအမျိုးမျိုးကြောင့် လူထုအတွက်လိုအပ်သော ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်း အားလုံးကိုပြီးပြည့်စုံစွာ ဆောင်ရွက်နိုင်ပေးခြင်းမရှိသေးပါ။

ဒုက္ခသည်စခန်းအတွင်းရှိကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများ

(၁) ။ ဆေးကုသရေးလုပ်ငန်း

- (က) အပြင်လူနာဆေးကုဌာန
- (ခ) အတွင်းလူနာကုဌာန
- (ဂ) ဌာနဖျားနှင့်တီဘီထိန်းသိမ်းရေးဌာန
- (ဃ) အရေးပေါ်လူနာလွှဲပြောင်းကုသရေးလုပ်ငန်း

(၂) ။ ဓါတ်ခွဲခန်းလုပ်ငန်း

(၃) ။ မျိုးပွားခြင်းနှင့်ကလေးကျန်းမာရေးလုပ်ငန်း

- (က) ကိုယ်ဝန်ဆောင်မိခင်များနှင့်မီးဖွားပြီး မိခင်များပြုစုစောင့်ရှောက်ခြင်း
- (ခ) ကလေးမွေးဖွားပေးခြင်း
- (ဂ) ကာကွယ်ဆေးထိုးနှံခြင်း၊ အဟာရနှင့်ကလေးကြီးထွားမှုစောင့်ရှောက်လေ့လာခြင်း
- (င) အဟာရဖြည့်ဆည်းခြင်းလုပ်ငန်း
- (စ) မိသားစုစီမံကိန်း
- (ဆ) နှစ်သိမ့်အားပေးခြင်းလုပ်ငန်း
- (ဇ) မုဒိန်းကျင့်ခံရသူများအား ကူညီပံ့ပိုးခြင်းလုပ်ငန်း

(၄) ။ လူထုကျန်းမာရေးလုပ်ငန်း

- (က) အိမ်တိုင်ရာရောက်သွားရောက်လည်ပတ်ခြင်း
- (ခ) ကျောင်းကျန်းမာရေး
- (ဂ) ကျန်းမာရေးလုပ်ရားမှုများ
- (ဃ) ကျန်းမာရေးမြှင့်တင်ရေးလုပ်ငန်းများ
- (င) အပတ်စဉ်ယနေ့ကျန်းမာရေးအစီအစဉ် (စနေနေ့ တိုင်း)

(၅) ။ ဆေးဝါးစီမံခန့်ခွဲခြင်းလုပ်ငန်း

(၆) ။ ကျန်းမာရေးသတင်းအချက်အလက်ကောက်ယူ ဖြန့်ပေးခြင်းလုပ်ငန်း

(၇) ။ ကျန်းမာရေးသင်တန်းပေးခြင်း

(၈) ။ ငွေကြေးစီမံခန့်ခွဲခြင်းလုပ်ငန်း

(၉) ။ ဝန်ထမ်းအုပ်ချုပ်ရေးလုပ်ငန်း စသည်တို့ ပါဝင်သည်။

လုပ်ငန်းပြီးဆုံးအောင်မြင်မှုများ

- ပြည်တွင်းဌာနေလက်လွတ် ပုဂ္ဂိုလ်များတို့၏ ကျန်းမာရေးပြဿနာအတော်များများကို ကူညီဖြေရှင်းပေးနေပါသည်။
- ပြည်တွင်းဌာနေလက်လွတ်ပုဂ္ဂိုလ်များအတွက် ကျေးရွာကျန်းမာရေးလုပ်သားများအရပ်လက်သည်များ စသည့်စေတနာ့ ကျန်းမာရေးလုပ်သားတော်များများကိုမွေးထုတ်ပေးနိုင်ခဲ့ပါသည်။
- ပြည်တွင်းဌာနေလက်လွတ် ပုဂ္ဂိုလ်တို့၏ ကျန်းမာရေးလိုအပ်ချက်ကို တတ်အားသ၍ဖြည့်စည်းပေးခြင်းဖြင့် ကရင်နီ အမျိုး သားတိုးတက်ရေးပါတီအပေါ်ပြည်သူတို့၏ ထောက်ခံအားပေးမှုကို ပိုမိုရရှိ စေပါသည်။
- ထိုင်းနိုင်ငံအတွင်းရှိ ကရင်နီဒုက္ခသည်စခန်းအတွင်း၌IRCနှင့်ပူးတွဲပြီး ကျန်းမာရေးလုပ်ငန်းများဆောင်ရွက်ရာတွင် အောင် မြင်မှုများစွာ ရရှိခဲ့ပါသည်။
- စခန်းအတွင်းရှိ မိသားစုအားလုံးကို လူထုကျန်းမာရေးလုပ်သားများက လွှမ်းခြုံနိုင်သည့်အပြင်၊ မိသားစုတိုင်း တလလျှင် အနည်းဆုံး တကြိမ် ၊ လူထုကျန်းမာရေးလုပ်သားနှင့်တွေ့ဆုံခွင့်ရရှိခဲ့ပါသည်။
- ကိုယ်ဝန်ဆောင်မိခင် ၉၅ %သည်မိခင်နှင့်ကလေး ကျန်းမာရေး ပြုစုစောင့်ရှောက်ရေးဌာနကို အသုံးပြုပြီး ကိုယ်ဝန်ဆောင်မိခင် ၉၆%သည် သင်တန်းပေးထားသော ဝန်ထမ်းများဖြင့် ကလေးမွေးဖွားပေးနေပါသည်။
- ကာကွယ်ဆေးထိုးနှံခြင်းတွင်၁၀၀% လွှမ်းခြုံမှုပေးနိုင်ပါသည်။
- ဒုက္ခသည်စခန်းအတွင်း လူသေနှုန်းမှာ ထိုင်းနိုင်ငံ လူသေနှုန်းထက်နည်းပြီး မိခင်သေနှုန်းမှာ(၀)ဖြစ်နေပါသည်။
- ကျန်းမာရေး ဝန်ဆောင်မှုလုပ်ငန်းအပေါ် လူထုကျေနပ်မှုနှုန်းမှာ ၈၀% ကျော်ရှိပါသည်။

DATA ANALYSIS FORM: Health Status in Karenni Refugee Camps			
Comparing month of	Dec-05	Nov-05	
	<i>(This Month)</i>	<i>(Previous Month)</i>	
Table 1. Basic Health Indicators			
	2005	2005	2004
Health Indicators	December	November	December
Crude Birth Rate (CBR)- /1,000 Refugees/Month	3.0	2.9	4.2
Crude Mortality Rate (CMR)- /1,000 Refugees/Month	0.1	0.4	0.2
Under 5 Yr Mortality Rate (U5MR)--/1000 Childier			
Under five/month	0.0	0.0	0.3
Infant Mortality Rate (IMR)--/1,000 Live Birth/month	0.0	0.0	10.5
Low Birth Weight--(LBW)-- 100 live Birth/Month	7.6	1.6	7.4
Abortion Rate --/100 Live Birth/month.	3.0	7.8	3.2
Stillbirth Rate--/1,000 Live Birth/month.	0.0	0.0	0.0
Neonatal Mortality Rate--/1,000 Live births/month	0.0	0.0	0.0
Perinatal Mortality Rate (PMR)-/1000 Live birth/Month	0.0	0.0	0.0
Ratio of Complete TT2 in Pregnant Women -			
100 Live Birth/month.	93.9	96.9	95.8
Contraceptive Prevalence Rate (CPR)(Modern Methods)			
100 Reproductive Age Women(15-49 Yrs)	32.3	38.0	31.7
Ratio of Consultation per Health Worker	56.5	72.1	N/A

Health Status in Karenni state (IDP) Area (By regions)												
Regions	Region (1)				Region (2)			Region (3)		Region (4)		All
Field Worker Incharges Name	Htoo Bawe	Aung Aung	Ywa Hay	Philli	Johnathar	Meh Reh	Tee Reh	Htoo Htoo Gay	Hsae Wah	Law Reh		
Malaria (Presumptive) ခြံမိမိခေခြံခြံသေ သုတ်များ	179	133	197	179	95	93	29	42	34	96	1077	
Malaria by (Para Check or M/S)	0	0	0		0	91	14	0		0	105	
Pneumonia နှစ်နှိမ့်သား	21	142	241	73	84	244	29	26	24	126	1010	
Otitis Media & Externa အပြင်ဘက်အတွင်းနှုတ်ခွေခြံခြံ	11	108	63	12	25	89	17	48	36	23	432	
Skin Disease အခြေပြားရောင်	58	85	84	34	75	147	38	48	46	77	692	
Measles ဝတ်သက်ရောင်	0	0	0	0	0	4	0	0	0	0	4	
Meningitis နှစ်နှိမ့်သားရောင်	0	0	4	0	0	0	0	0	0	0	4	
Diarrhoea ဝမ်းချက်ဝမ်းရောင်	78	24	105	20	93	202	12	37	34	142	747	
Dysentery Amoebic, bacillary ဝမ်းချက်ရောင်	70	24	100	139	45	103	18	32	24	87	642	
Hypertitis အသေညှိရောင်ရောင်အေး	2	5	10	4	4	10	1	10	0	0	46	
Worms အစားအစာရောင်	73	67	157	29	102	69	218	80	61	65	921	
Landmine ချွတ်ပျက်ခြင်း	2	1	4	2	0	0	0	0	0	2	11	
Gun-shot အသေအစားအစာ	3	2	21	3	0	4	5	0	0	1	39	
Other injuries အခြားအဆိုးဆိုးခြင်းများ	19	19	12	25	36	59	0	20	19	15	224	
TB suspect ဝတ်သက်ရောင်	8	5	23	11	6	9	0	3	2	5	72	
Malnutrition (Y) အသေ ချွတ်ပျက်ခြင်း	5	10	10	7	8	14	7	13	10	15	99	
Malnutrition (R) အသေ ချွတ်ပျက်ခြင်း	0	4	3	8	2	4	1	2	3	7	34	
Vitamin A Deficiency စိတ်အဆိုးဆိုးခြင်း	8	9	41	12	11	37	5	10	7	12	152	
Vitamin B Deficiency စိတ်အဆိုးဆိုးခြင်း	21	12	45	46	11	72	28	32	17	13	297	
Anemia အသေအစားအစာ	25	10	50	44	20	32	16	42	13	23	275	
Pregnancy/Delivery-related problems									1			
ကိုယ်ဝန်ဆောင်မှု/မိသားစုဆိုင်ရာအသေအစားအစာ												
နာဆေးချက်/ချက်ခြင်းများပါသည့် septic abortion	6	2	8	9	0	1	1	4		0	31	
* Other (အသေ ကံဆိုးဆိုးဆိုးဆိုးခြင်းများ)	14	12	22	28	35	48	2	29	23	21	234	
Tonsillitis	14	3	8	5	4	15	7	12	5	28	101	
Eye problem	51	64	137	93	68	157	111	47	42	38	808	
Common cold	29	9	50	140	25	98	10	27	15	10	413	
UTI	22	30	131	33	51	72	34	59	42	72	546	
Bronchitis	10	9	36	17	13	17	8	14	8	14	146	
Severe pneumonia	14	10	23	15	27	44	5	10	7	20	175	
Abcess	168	85	53	223	72	64	430	117	48	97	1357	
Total (စုစုပေါင်း)	911	884	1638	1211	912	1799	1087	764	521	1009	10736	

Ranking																						
regions	Region (1)								Region (2)				Region (3)				Region (4)				Total	
Medics	Htoo Bawe		Aung Aung		Ywa Hay		Philli		Johnathar		Meh Reh		Tee Reh		Htoo Htoo Gay		Hsae Wah		Law Reh		Total	
Disease	cases	Rate	cases	Rate	cases	Rate	cases	Rate	cases	Rate	cases	Rate	cases	Rate	cases	Rate	cases	Rate	cases	Rate	cases	Rate
ARI	88	9.7	173	19.6	358	22	250	20.6	153	16.8	418	23.2	59	5.4	89	11.6	59	11.3	198	19.6	1845	17.2
Skin disease	226	24.8	170	19.2	137	8.4	257	21.2	147	16.1	211	11.7	468	43.1	165	21.6	94	18.0	174	17.2	1823	17.0
Diarrhoea	148	16.2	48	5.4	205	12.5	159	13.1	138	15.1	305	17.0	30	2.8	69	9.0	58	11.1	229	22.7	1389	12.9
Malaria	179	19.6	133	15.0	197	12.0	179	14.8	95	10.4	184	10.2	43	4.0	42	5.5	34	6.5	96	9.5	1182	11.0
Worms	73	8.0	67	7.6	157	9.6	29	2.4	102	11.2	69	3.8	218	20.1	80	10.5	61	11.7	65	6.4	921	8.6
Eye problem	51	5.6	64	7.2	137	8.4	93	7.7	68	7.5	157	8.7	111	10.2	47	6.2	42	8.1	28	2.8	747	7.0
Total Cases	911		884		1638		1211		912		1799		1087		764		521		1009		10736	

ALL CASES REPORT (ရောဂါဖြစ်ပွားမှုနှုန်း)

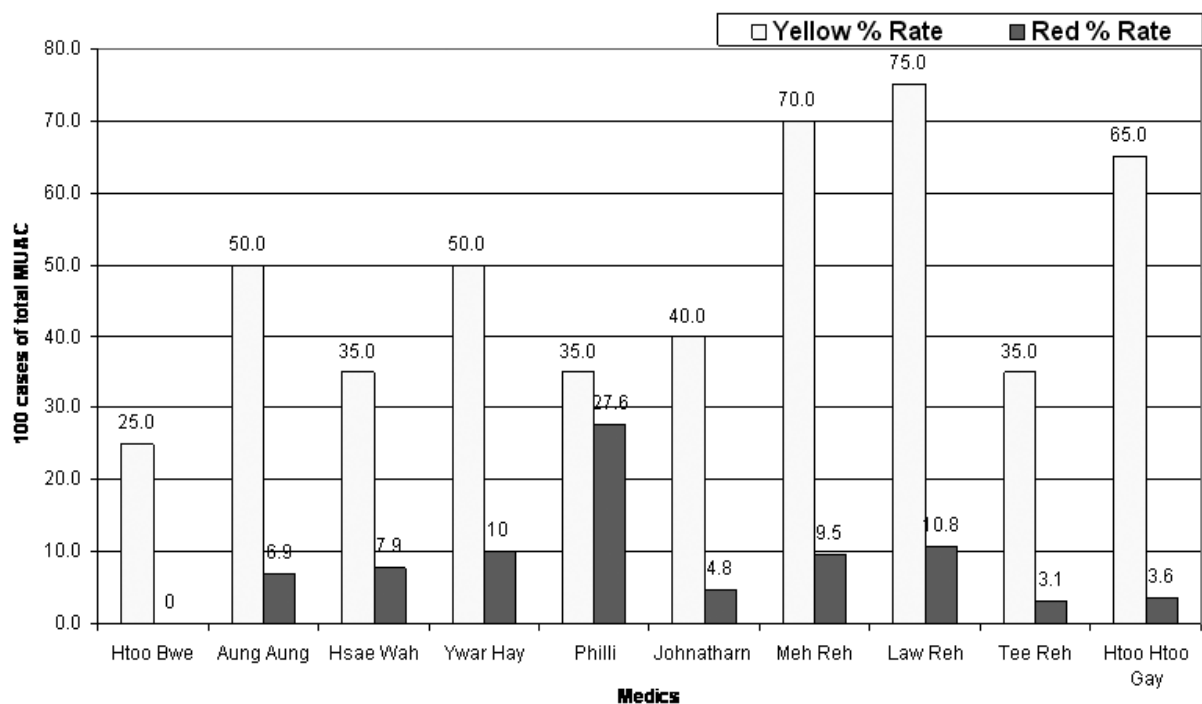
2005

District: 1,2,3

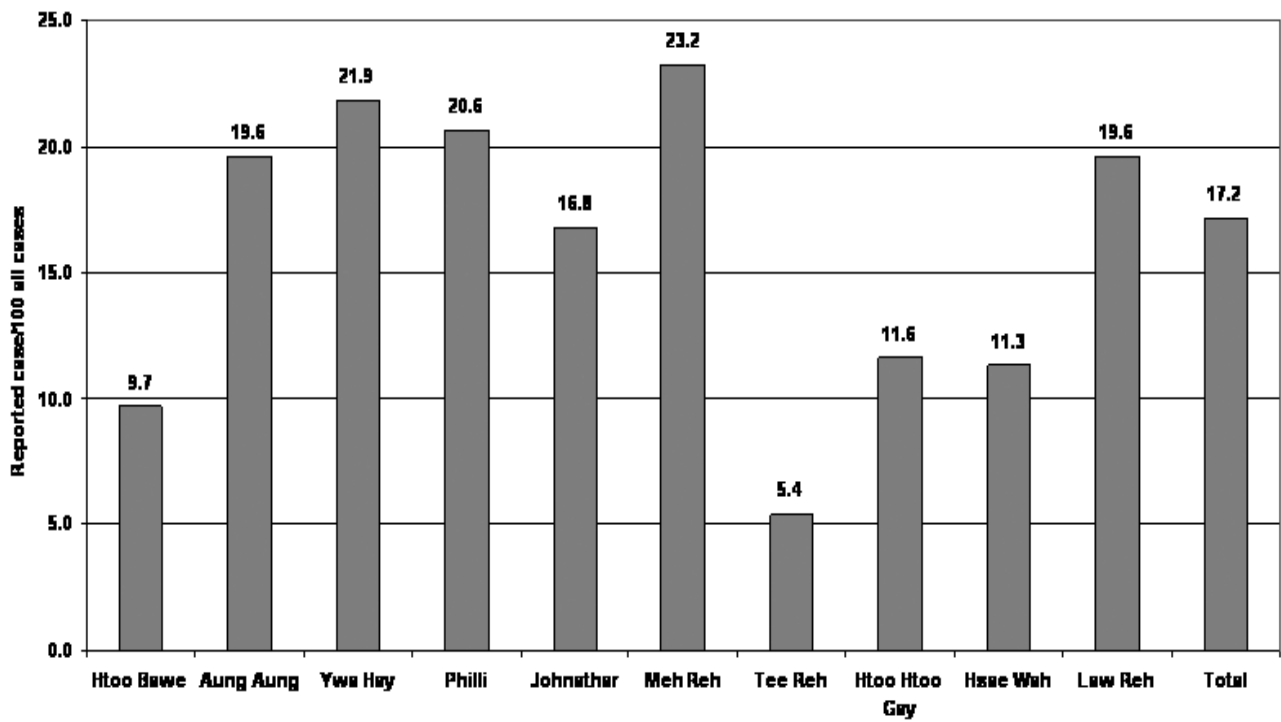
Region: 1,2,3,4

Condition (ရောဂါအခြေအနေ)	< 5 Years (၅နှစ်အောက်)		>5 Years (၅နှစ်အထက်)		Total (စုစုပေါင်း)		Total
	ကျား	မ	ကျား	မ	ကျား	မ	
	Malaria (Presumptive) မြစ်နင်းစစ်ချိန်ထောက်ရှာ	151	137	450	339	601	
Malaria by (Para Check or M/S)	15	12	46	32	61	44	105
Pneumonia နှစ်ဖို့ယား	259	240	250	261	509	501	1010
Otitis Media & Externa အပြင်နားအတွင်းနားရောင်ခြင်း	105	99	138	90	243	189	432
Skin Dis ease အရေပြားရောဂါ	161	169	195	167	356	336	692
Measles ဝက်သက်ရောဂါ	1	3	0	0	1	3	4
Meningitis ဦးနှောက်အမြှေးပါးရောင်	1	3	0	0	1	3	4
Diarrhoea ဝမ်းပျက်ဝမ်းလျှော့ရောဂါ	153	161	231	202	384	363	747
Dysentery Amoebic, bacillary ဝမ်းကွဲရောဂါ	128	118	212	184	340	302	642
Hypertitis အသက်ရောင်ရောဂါအသုံး	2	2	27	15	29	17	46
Worms သံကောင်ရောဂါ	286	274	189	172	475	446	921
Landmine မြေဖွပ်ဖို့ဒေါက်ရာ	0	0	11	0	11	0	11
Gun-shot စောနပ်ခဲကန်ရာ	0	4	29	6	29	10	39
Other injuries အခြားထိခိုက်ဒဏ်ရာများ	36	22	93	73	129	95	224
TB suspect ဝိသိဟုသံသယဖြစ်သူ	1	4	29	38	30	42	72
Malnutrition (Y) အဟာရချို့တဲ့လက်မောင်းအပတ်(ဂါ)	51	45	2	1	53	46	99
Malnutrition (R) အဟာရချို့တဲ့လက်မောင်းအပတ်(နီ)	9	21	2	2	11	23	34
Vitamin A Deficeincy မိသားစုအချို့တာပုံသူ	31	37	45	39	76	76	152
Vitamin B Deficeincy မိသားစုအချို့တာပုံသူ	17	14	103	163	120	177	297
Anemia သွေးအားနည်းရောဂါ	14	25	79	157	93	182	275
Pregnancy/Delivery-related problems ကိုယ်ဝန်ဆောင်မှု/မီးဖူသင့်ဆက်ခွယ်စေ ပြုသောနာကျင် ကလေးမျက်/မျက်စိရောင်များပါသော သံသယရှိ Septic abortion	0	0	0	31	0	31	31
Tonsilitis	48	37	67	82	115	119	234
Eye problem	12	20	30	39	42	59	101
Common cold	175	189	236	208	411	397	808
UTI	8	10	186	209	194	219	413
Bronchitis	95	95	170	186	265	281	546
Severe pneumonia	32	26	39	49	71	75	146
Ab cess	21	19	63	72	84	91	175
* Other(အထက်တွင်မပါစောသောခြားရောဂါ)	166	130	470	591	636	721	1357
Total (စုစုပေါင်း)	1994	1935	3392	3415	5386	5350	10736

% Rate Of MUAC

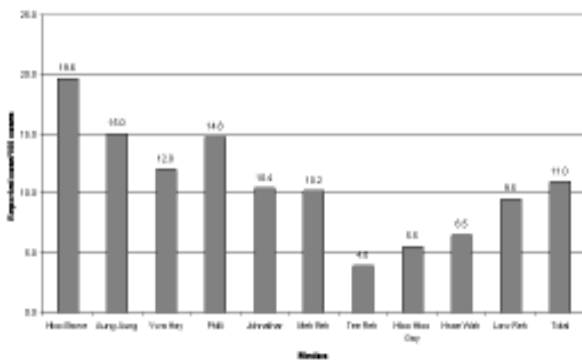


ARI Morbidity Rate in Kamni IDP Area(2005)

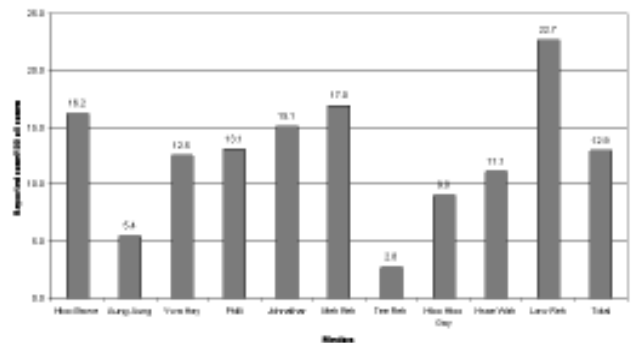


Medics

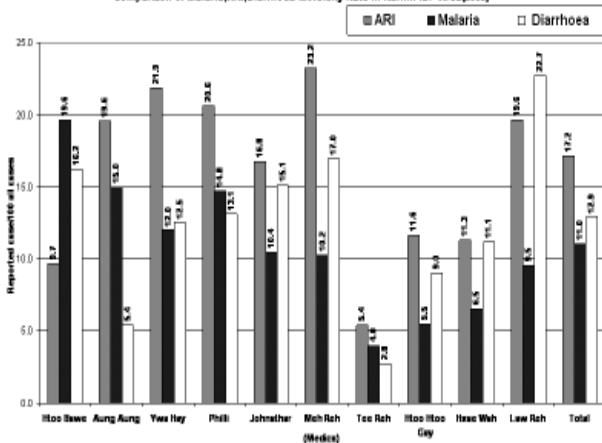
Malaria Morbidity Rate in Kamni IDP Area(2005)



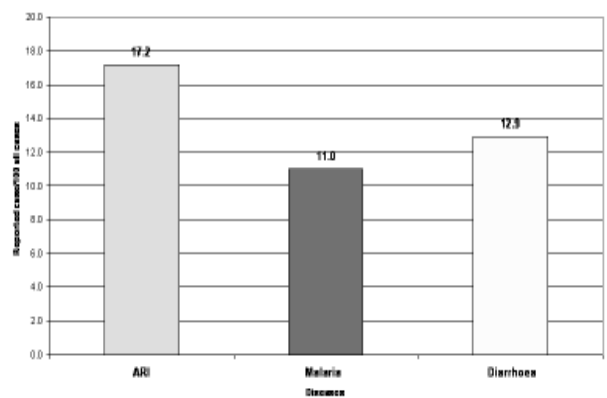
Diarrhoea Morbidity Rate in Kamni IDP Area(2005)



Comparison of Malaria,ARI,Diarrhoea Morbidity Rate in Kamni IDP Area(2005)



Comparison of ARI,Malaria,Diarrhoea Morbidity Rate in Kamni IDP Area(2005)





အမျိုးသားကျန်းမာရေးနှင့်ပညာရေးကော်မတီ နှင့် မြန်မာနိုင်ငံဆေးပညာရှင်များအသင်းတို့
ပူးပေါင်းကျင်းပသည့်
ကျန်းမာရေးစနစ်ဖွံ့ဖြိုးရေးဆိုင်ရာ နှီးနှောဖလှယ်ပွဲ (၂၀၀၆-ခုနှစ် ဇန်နဝါရီလ (၁၆-၁၈)ရက်) မှ
ရရှိခဲ့သော မူဝါဒ၊ အရည်အသွေးမြှင့်တင်ရေး၊ ပူးပေါင်းဆက်စပ်ဆောင်ရွက်ရေးဆိုင်ရာ သဘောတူချက်များ

လမ်းညွှန်မူပိုင်းဆိုင်ရာ စုစည်းချက်များ

၁။ ၂၀၀၀-ခုနှစ် ကျန်းမာရေးညီလာခံမှ ချမှတ်ခဲ့သော ကျန်းမာရေးမြှင့်တင်ရေးနှင့်လူမှုဖွံ့ဖြိုးရေးလုပ်ငန်းများတွင် လူထုအခြေပြု ကျန်းမာရေးလှုပ်ရှားမှုများ တိုးမြှင့်ဆောင်ရွက်နိုင်ရန် အောက်ပါမူဝါဒများကို လုပ်ငန်းလမ်းညွှန်အဖြစ် ဆက်လက်ကျင့်သုံးသွားရန်။

၁။ ပြောင်းလဲရမည့်ဦးတည်ချက်များ

- ရောဂါကုသရေးမှ ကျန်းမာရေးဘက်စုံဖွံ့ဖြိုးတိုးမြှင့်ရေးသို့ ဦးတည်ခြင်း။
- ကုသခြင်းမှ ကြိုတင်ကာကွယ်ရေးသို့ ဦးတည်ခြင်း။
- ကျန်းမာရေးကဏ္ဍတစ်ခုတည်းဆောင်ရွက်နေခြင်းမှ ကဏ္ဍပေါင်းစုံပူးပေါင်းညှိနှိုင်းဆောင်ရွက်မှုသို့ဦးတည်ခြင်း။

၂။ ဦးတည်သောချဉ်းကပ်မှုများ

- ကြိုတင်ပြင်ဆင်ခြင်း။
- ကာကွယ်စောင့်ရှောက်ခြင်း။
- အရည်အသွေးတိုးမြှင့်ခြင်း။

၂။ မြန်မာပြည်တွင် အဓမ္မနေရာပြောင်းရွှေ့ခံရသူများနှင့် နယ်စပ်ဒေသများတလျှောက်ရှိ တရားမဝင်လာရောက်နေထိုင်သူများ၊ ဒုက္ခသည်လူထုများ၏ ကျန်းမာရေးလိုအပ်ချက်နှင့် ဆိုးဝါးနိမ့်ကျသော ကျန်းမာရေးအခြေအနေကို မြှင့်တင်ရာတွင် ၂၀၀၀-ခုနှစ် ကျန်းမာရေးညီလာခံကြီးတွင် သဘောတူချမှတ်ခဲ့သော “ပဏာမကျန်းမာရေး စောင့်ရှောက်မှု” လုပ်ငန်းအမြင်ဖြင့် ချဉ်းကပ်၍ အကောင်အထည်ဖော်ဆောင်ရွက်ရန်ဆိုသည့် သဘောတူညီမှုကို ဆက်လက်အတည်ပြုဆောင်ရွက်သွားရန်။

၃။ ကျန်းမာရေးလုပ်ငန်းများဆောင်ရွက်မှုတစ်ခုလုံးနှင့်ပတ်သက်၍ အများသဘောတူညီသော ရေရှည်မျှော်မှန်းချက်တစ်ခု ရရှိရေးအတွက် ဆောင်ရွက်သွားရန်။

၃(က)။ ကျန်းမာရေးစီမံချက်များ ရေးဆွဲချမှတ်ရာတွင် သက်ဆိုင်ရာ လူထုဒေသအတွင်းရှိ အခြေအနေအရပ်ရပ် ဖြစ်သော အရင်းအမြစ်များ၊ ပညာရေး၊ စီးပွားရေးအခြေအနေများ၊ လုံခြုံရေး၊ လမ်းပန်းဆက်သွယ်ရေး၊ ရိုးရာယဉ်ကျေးမှု၊ ဓလေ့ထုံးစံ ယုံကြည်မှု စသည့်အခြေအနေ အချက်အလက်များအပေါ် အလေးအနက်ထား စဉ်းစားဆောင်ရွက်ရန်နှင့် ကျန်းမာရေးဝန်ထမ်းအဖြစ် တရားဝင် အသိအမှတ်ပြုခွင့် ရရှိစေရန် ဆောင်ရွက်သွားရန်။

၃(ခ)။ ဒေသအလိုက် မတူကွဲပြားသော အခြေအနေများ ရှိသော်ငြားလည်း ကျန်းမာရေးအခြေခံလိုအပ်ချက်များကို ဖြည့်ဆည်းရာတွင် လူအား၊ အတွေ့ အကြုံ၊ အသိပညာအတတ်ပညာများ၊ လုပ်ငန်းဖွဲ့စည်းဆောင်ရွက်မှုများကို ဖွံ့ဖြိုးတိုးတက်အောင် ဦးစားပေးလုပ်ဆောင်နိုင်ရန်လိုအပ်သည်။ ထိုလိုအပ်ချက်များကို ဖြည့်ဆည်းရန်အတွက် သက်ဆိုင်ရာတာဝန်ရှိသော နိုင်ငံရေး၊ ဖွံ့ဖြိုးရေး ဆိုင်ရာအဖွဲ့အစည်းအသီးသီးမှ မူဝါဒပိုင်းဆိုင်ရာအပါအဝင် လိုအပ်သောအခြားပံ့ပိုးမှုများဖြင့် လက်တွေ့ကျကျဆောင်ရွက်ပေးရန်။

၃(ဂ)။ ကျန်းမာရေး မူဝါဒချမှတ်ရာတွင် ဒေသဆိုင်ရာ ပြည်သူ့သဘောထားများကို အလေးထားစဉ်းစားလျက် လူ့အခွင့် အရေးစံညွှန်းများကို အခြေခံ၍ ချမှတ်ရန်။

၃ (ဃ)။ ကျန်းမာရေးဆိုင်ရာ သတင်းအချက်အလက်စနစ်နှင့်ပတ်သက်၍ ကျန်းမာရေးအဖွဲ့အစည်းများသာမက လူထု အခြေခံအဖွဲ့အစည်းများနှင့် နိုင်ငံရေးအဖွဲ့အစည်းများကိုပါ အကျိုးဝင်ရန်။

၄။ လူထုအခြေပြုကျန်းမာရေးလှုပ်ရှားမှုများ တိုးမြှင့်ဆောင်ရွက်ရာတွင် မျှတသော ကျန်းမာရေးစောင့်ရှောက်မှုရရှိရေး၊ လူထုကိုယ်တိုင် မိမိကိုယ်ကိုမိမိ အားကိုးမှုဖြင့် လုပ်ဆောင်နိုင်ရေးကို ဦးတည်ရန်။

၄(က)။ ကျန်းမာရေးလုပ်ငန်းများလုပ်ဆောင်ရာတွင် သက်ဆိုင်သောဒေသဆိုင်ရာ အဖွဲ့အစည်းများ၏ကဏ္ဍကို အသိအမှတ် ပြုလျက် လူထုအခြေစိုက် လုပ်ငန်းရပ်များ ဖော်ဆောင်နိုင်ရေးကို တွန်းအားပေးရန်။

၄ (ခ)။ လူထုအခြေပြုကျန်းမာရေးလှုပ်ရှားမှုများ တိုးမြှင့်ဆောင်ရွက်ရာတွင်လည်း ကျောင်းကျန်းမာရေးလုပ်ငန်းမှ ချဉ်းကပ် ဆောင်ရွက်မှုသည် ထိရောက်သော နည်းလမ်းတခုအဖြစ် အသိအမှတ်ပြုဆောင်ရွက်ရန်။

၅။ ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများကို ဆောင်ရွက်အကောင်အထည်ဖော်မှုများတွင် ဒီမိုကရေစီနှင့် တန်းတူညီမျှရေးကျင့်စဉ်ကို လိုက်နာကျင့်သုံးရန်။

၆။ ပြည်သူလူထုအနေဖြင့် ကျန်းမာရေးဆိုင်ရာအခွင့်အလမ်းများကို ထိရောက်စွာအသုံးပြုနိုင်ရေးအတွက် လူသားဆိုင်ရာလုံခြုံမှု (Human Security) ရရှိရေးအတွက် ဆောင်ရွက်ရန်။

၆(က)။ ရွှေ့ပြောင်းအလုပ်သမားများ၏ ကျန်းမာရေးစောင့်ရှောက်မှုဆိုင်ရာ အခွင့်အလမ်းများကို ဒေသတွင်းနှင့် နိုင်ငံတကာ ဥပဒေအရပြဌာန်းမှုများနှင့်အညီ ခံစားပိုင်ခွင့်ရရှိရေးအတွက် ဆောင်ရွက်ရန်။

၆ (ခ)။ မွေးစာရင်းမရှိသော မြန်မာပြည်သား ကလေးများအတွက် မွေးစာရင်း တရားဝင်ထုတ်ပေးရန်။

၆ (ဂ)။ ကျန်းမာရေးဝန်ထမ်းများ လူနေမှုဘဝတည်ငြိမ်မှုသည် ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းမြှင့်တင်ဆောင် ရွက်ရေး တွင် အဓိကကျသောအစိတ် အပိုင်းမှပါဝင်သည်။ သို့ဖြစ်ရာ ကျန်းမာရေးဝန်ထမ်းများ၏ ဘဝလုံခြုံမှုဆိုင်ရာကိစ္စရပ်များအပေါ် အလေး အနက်ထားစဉ်းစားဆောင်ရွက်ရန်လိုအပ်သည့်အပြင် ကျန်းမာရေးဝန်ထမ်းအဖြစ် တရားဝင်အသိအမှတ်ပြုခွင့် ရရှိစေရန် ဆောင်ရွက် သွားရန်။

၆ (ဃ)။ ရွှေ့ပြောင်းအလုပ်သမားများ၏ ကျန်းမာရေးဆိုင်ရာလိုအပ်မှုများကို ဆောင်ရွက်ရာတွင် အခြေအနေများကို စမ်းစစ် လေ့လာပြီး လုပ်ငန်းရှင်များနှင့် စုပေါင်းဆုံးဖြတ်ဆောင်ရွက်ရန်။

၇။ ကျန်းမာရေးဆိုင်ရာ သုတေသနပြုလုပ်ဆောင်ရွက်မှုများသည်၊ သုတေသနပြုလုပ်သည့်ဒေသနှင့် သက်ဆိုင်ရာပြည်သူလူထု၏ အကျိုးစီးပွားကို အဓိကရှေ့စေနိုင်ရန်အတွက် ဒေသခံများနှင့် နိုင်ငံတကာနှင့်ဒေသတွင်း သုတေသနပြုသူများအကြား အပြန် အလှန်အကျိုးဖြစ်သော ပူးပေါင်းဆောင်ရွက်မှု လိုအပ်သည်။ ထို့အပြင် သုတေသနပြုချက်များသည် ဒေသနှင့်သက်ဆိုင်ရာ ပြည်သူလူထု ၏ အကျိုးစီးပွားကို မထိစေရန်အတွက် သုတေသနပြုမှုများအပေါ် ကျင့်ဝတ်ထိမ်းကြောင်းပေးသည့် ကော်မတီတရပ်ကို ဖွဲ့စည်း ဆောင်ရွက်ရန်။

အရည်အသွေးမြှင့်တင်ရေးဆိုင်ရာ စုစည်းချက်

၁။ ကျန်းမာရေးမြှင့်တင်ရေးလုပ်ငန်းတွင် လုပ်ငန်းခွင်ဆိုင်ရာ ပေါ်လစီများ၊ နည်းဥပဒေများ၊ စီမံခန့်ခွဲမှုဆိုင်ရာ လမ်းညွှန်ချက်များကို ဖွံ့ဖြိုးစေအောင်ဆောင် ရွက်ရန်

၂။ လူထုကိုယ်တိုင် မိမိကိုယ်ကို မိမိအားကိုးမှုဖြင့် လုပ်ဆောင်နိုင်စေရန် လူထုအခြေပြု ကျန်းမာရေးပညာပေးမှုလုပ်ငန်းနှင့် ဆောင်ရွက်ရန်

၃။ လူထုအတွင်း ရောဂါကာကွယ်ရေး၊ ကျန်းမာရေးမြှင့်တင်ရေးအတွက် ကျန်းမာရေးဆိုင်ရာလုပ်ငန်းများကို ဆောင်ရွက်မည့် စေတနာ့ဝန်ထမ်း ကျန်းမာရေးလုပ်သားများကို ရိုးရှင်းထိရောက်သော နည်းစနစ်များဖြင့် အသုံးပြုလေ့ကျင့်ပေးရန်

၄။ ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းဌာနများတွင် ပို၍အရည်အသွေးပြည့်ဝသော ကျန်းမာရေးလုပ်သားများဖြင့် ဆောင်ရွက်နိုင်ရန်အတွက် လက်ရှိ ကျန်းမာရေးလုပ်သားများကို သင့်တော်လိုအပ်သော အတတ်ပညာနည်းပညာများကို ဖြည့်ဆည်းပေးရန်အပြင် ကျန်းမာရေးဝန်ထမ်းများ၏ အတွေးအခေါ်ဒီယူချက် (အမျိုးသားရေးတာဝန်)များကိုပါ တပါတည်းမြှင့်တင်ပေးရန်လိုအပ်သည်။

၅။ ကျန်းမာရေးလုပ်သားများအနေဖြင့် လုပ်ငန်းများကို ပိုမိုထိရောက်စွာအကောင်အထည်ဖော်ဆောင်ရွက်နိုင်ရန်အတွက် လိုအပ်သော ကျွမ်းကျင်မှု၊ လုပ်ငန်းတာဝန်လိုအပ်ချက်များနှင့်အညီ ကိုက်ညီမှုရှိစေရန် လက်ရှိဆောင်ရွက်နေသော သင်တန်းများ အကောင်အထည်ဖော်ဆောင်ရွက်မှုများကို ပြန်လည်လေ့လာသုံးသပ်ရန်

၆။ အရည်အသွေးပြည့်မီသည့် သင်တန်းများ ပြုလုပ်နိုင်ရန်အတွက် သင့်တော်သော စနစ်တစ်ခုထားရှိရန် (စံချိန်စံညွှန်းသတ်မှတ်ခြင်း၊ မွမ်းမံထိမ်းသိမ်းခြင်း၊ ကျွမ်းကျင်တတ်မြောက်မှုစစ်ဆေးခြင်း)

၇။ ကျန်းမာရေးလုပ်သားများ၏ အရည်အသွေးမြှင့်ဆောင်ရွက်ရာတွင်လည်း တရားဝင်အသိအမှတ်ပြုလက်မှတ်ထုတ်ပေးနိုင်သော သင်တန်းကျောင်းများ၊ ပညာရေးဆိုင်ရာအဖွဲ့အစည်း အသင်းအပင်းများနှင့်ဆက်စပ်၍ ဆောင်ရွက်သွားနိုင်ရန်အတွက် နည်းလမ်းများ ရှာဖွေသွားရန်။

၈။ အုပ်ချုပ်ရေးနှင့်စီမံခန့်ခွဲမှုဆိုင်ရာ လုပ်ငန်းဆောင်ရွက်သူများ၏ ကျွမ်းကျင်မှုအရည်အသွေးများကို မြှင့်တင်ပေးရန်။ (လုပ်ငန်းခွင်ကြီးကြပ်ကွပ်ကဲမှု၊ အသင်းအပင်းနှင့်ဆောင်ရွက်မှု၊ စီမံချက်စီမံခန့်ခွဲမှုအရည်အသွေးများ)

၉။ တာဝန်ပိုမိုရှိသောသူများ၏ ခေါင်းဆောင်မှု၊ ကျန်းမာရေးပေါ်လစီဖွံ့ဖြိုးရေး၊ လုပ်ငန်းမူဝါဒများကို အကောင်အထည်ဖော်မှု၊ အကောင်အထည်ဖော်မှုအပေါ် လေ့လာအကဲဖြတ်မှု၊ ဆိုင်ရာအရည်အသွေးများ မြှင့်တင်ပေးရန်။

၁၀။ လိုအပ်သော ဝန်ထမ်းများနှင့် ပံ့ပိုးမှုများမှတစ်ဆင့် ထိရောက်အကျိုးဖြစ်မှုရှိသော၊ တစ်ခုလုံးဆိုင်ရာပြောင်းလဲခြင်းဆိုင်ရာကို ဆောင်ရွက်ရန်

၁၁။ ကျန်းမာရေးဝန်ထမ်းများအတွက် လူထုဆက်သွယ်ရေး၊ လူမှုဆက်ဆံရေးနည်းပညာကျွမ်းကျင်မှုများကို မြှင့်တင်ပေးရန်

၁၂။ ကျန်းမာရေးဝန်ထမ်းများ၏ ကျင့်ဝတ်သိက္ခာပိုင်းကို ကြီးကြပ်မြှင့်တင်ပေးမှုကို ဆောင်ရွက်ရန်။

၁၃။ ကျန်းမာရေးလုပ်သားများအားလုံး လူ့အခွင့်အရေးကို သိရှိရန်နှင့် လေးစားလိုက်နာရန်အတွက် လုပ်ငန်းအစီအစဉ်များချမှတ်ရန်။

၁၄။ လူ့အခွင့်အရေး ချိုးဖောက်ခံရမှုနှင့် ပတ်သက်၍ မှတ်တမ်းပြုခြင်း၊ သုတေသနပြုခြင်း၊ အစီရင်ခံစာပြုစုခြင်း၊ နည်းပညာများကို လေ့လာသင်ကြားရန်။

၁၅။ လူထုကို လူ့အခွင့်အရေးများ သိရှိရန်နှင့် လေးစားလိုက်နာရန် ပညာပေးခြင်းကိုဆောင်ရွက်သွားရန်

၁၆။ သုတေသနလုပ်ငန်းနှင့် လိုက်နာရမည့် ကျင့်ဝတ်ဆိုင်ရာကိစ္စရပ်များနှင့်ပတ်သက်၍ ကျန်းမာရေးဝန်ထမ်းများသိရှိနားလည်ရန်အတွက် လေ့လာသင်ကြားမှုများပြုလုပ်ရန်။

ကျန်းမာရေးလုပ်ငန်းဆောင်ရွက်မှုအတွက် ကွန်ယက်ဖွဲ့စည်းမှုဆိုင်ရာ စုစည်းချက်များ

၁။ အမျိုးသားကျန်းမာရေးနှင့်ပညာရေးကော်မတီအနေဖြင့် လူထုအခြေပြုအဆင့်လုပ်ငန်းများအပါအဝင် ကျန်းမာရေးဆိုင်ရာမူဝါဒများ၊ သင်တန်းများနှင့် ပါတ်သက်၍ သက်ဆိုင်ရာဌာန၊ အဖွဲ့အစည်းများနှင့် ဆွေးနွေးညှိနှိုင်းမှုများကို ဆောင်ရွက်အကောင်အထည်ဖော်ရန်။

၂။ အမျိုးသားကျန်းမာရေးနှင့်ပညာရေးကော်မတီနှင့် အဖွဲ့အစည်းများအကြား ဆက်သွယ်မှုလမ်းကြောင်းကို စနစ်တကျ တည်ဆောက်ရန်နှင့် ဒေသအတွင်း အကောင်အထည်ဖော်နိုင်မှုအတွက် သက်ဆိုင်ရာဒေသတာဝန်ခံများအား ချဉ်းကပ်ရန်။

၃။ အမျိုးသားကျန်းမာရေးနှင့်ပညာရေးကော်မတီအနေဖြင့် ပေါ်လစီများလုပ်ငန်းများကို အောင်မြင်အောင်အကောင်အထည် ဖော်နိုင်ရန်အတွက် ကျွမ်းကျင်သူများ၊ လိုအပ်သောရံပုံငွေများ ရှာဖွေခြင်း၊ ကျွမ်းကျင်သူများနှင့် တိုင်ပင်ညှိနှိုင်းမှုများကို ဆောင်ရွက်ရန်

၄။ ပြည်တွင်းပြည်ပရှိ လူ့အခွင့်အရေး ကျန်းမာရေးအခွင့်အရေးများအတွက် တိုက်ပွဲဝင်နေကြသော အဖွဲ့အစည်းများနှင့် ဆက်စပ် လက်တွဲဆောင်ရွက်ရန်။

၅။ သက်ဆိုင်ရာ အဖွဲ့အစည်းအသီးသီး ညှိနှိုင်း၍ လူ့အခွင့်အရေးချိုးဖောက်မှုကြောင့် ဖြစ်ပေါ်လာသော ကျန်းမာရေးပြဿနာများကို လေ့လာမှတ်တမ်းတင်ခြင်း၊ လုံခြုံစွာထိန်းသိမ်းခြင်း၊ အစီရင်ခံစာများ ထုတ်ပြန်ခြင်း၊

၆။ ရွှေ့ပြောင်းအလုပ်သမားများ၏ ကျန်းမာရေးအခွင့်အလမ်းများအတွက် ပံ့ပိုးကူညီဆောင်ရွက်နေသောအဖွဲ့အစည်းများနှင့် ဆက်သွယ်ပူးပေါင်းဆောင်ရွက်ရန်၊

၇။ ရွှေ့ပြောင်းအလုပ်သမားများ၏ ကျန်းမာရေးအခွင့်အလမ်းများနှင့်ပါတ်သက်၍ လိုအပ်သောသတင်းအချက်အလက်၊ အသိပညာ၊ အတတ်ပညာများအတွက် တည်ဆောက်၊ ဖန်တီးပေးမှုများကို ဆောင်ရွက်ရန်။

“Health System Development Seminar 2006”
Statement released by National Health and Education Committee (NHEC) &
Burma Medical Association (BMA)

NHEC and BMA have jointly held a seminar on January 16-18, 2006 at Thai Burma Border Area. It was attended by more than 80 participants including academics, professionals and health workers from both local and international. The participants discussed reports on health situations from different border areas, reviewed research findings and outlined future plans.

Based on UNICEF and WHO, Infant and Under 5 mortality rates (IMR & U5MR) are of 76 and 107 per 1000 live-births respectively for the whole country. At least one third of the children are malnourished, while 67 % of the households do not have enough food. Major infectious diseases such as malaria, tuberculosis and HIV/AIDS are widespread and inadequately controlled. Less than 4 % of GDP is allocated for health and education whereas 45 % is for defense. Environmental degradation is at its worst. Therefore, it is not surprising that Burma is the second last in health systems performance amongst member countries (World Health Report 2000, WHO). Seminar delegates considered that the current health situation and human insecurity in Burma is a consequence of persistent and escalating human rights violations. Hence, the political instability, rampant corruption, mismanagement perpetrated by the military are the root causes of the present social crisis and poor health indicators.

According to Back Pack Health Worker Team (BPHWT) report, IMR and U5MR amongst IDP are of 135 and 291 per 1000 live-births respectively, similar to situations in Angola and Afghanistan. In other words, the military authority's human rights violations and forced relocations have subjected the populations to conditions similar to war-torn countries like Angola and Afghanistan. Maternal mortality ratio is also terribly high at 1200 per 100,000 live births. Therefore, it is time to intensify efforts to stop human rights abuses and promote human security for the improvement of health status and access to health services.

Moreover, the participants unanimously agreed on the followings:

- To work towards curbing human rights violations and promote health and welfare services of 2 million migrant workers in neighboring countries.
- To upgrade the social status and skills of health workers for better performance and quality assurance.
- To improve collaborative action among health departments, civil societies and political organizations in order to deal with health problems effectively.
- To promote coordination and cooperation amongst local and international organizations for improved health services including research.

Finally, all the seminar delegates decided to achieve the goal of 'Health for All' through Holistic Approach.

Date: January 18th 2006.

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၂၀၀၆ခုနှစ် ကျန်းမာရေးဆိုင်ရာ နှီးနှောဖလှယ်ပွဲ
အမျိုးသားကျန်းမာရေးနှင့် ပညာရေးကော်မတီ နှင့် မြန်မာနိုင်ငံ ဆေးပညာရှင်များအသင်း၏
ထုတ်ပြန်ကြေငြာချက်

အမျိုးသားကျန်းမာရေးနှင့်ပညာရေးကော်မတီနှင့် မြန်မာနိုင်ငံဆေးပညာရှင်များအသင်းကြီးနှစ်ခုမှ ပူးတွဲ၍ ကျန်းမာရေးဆိုင်ရာ နှီးနှောဖလှယ်ပွဲကြီးတစ်ခုကို ၂၀၀၆ခုနှစ် ဇန်နဝါရီလ ၁၆-၁၇-၁၈ ရက်တို့တွင် ထိုင်း-မြန်မာနယ်စပ်တွင် အောင်မြင်စွာ ကျင်းပပြုလုပ်ခဲ့သည်။

နှီးနှောဖလှယ်ပွဲသို့ ပြည်တွင်း၊ ပြည်ပရောက် ဆေးပညာရှင်များ၊ ကျန်းမာရေးလုပ်သားများ စုစုပေါင်း (၈၀)ကျော် တက်ရောက်ခဲ့ကြပြီး မြန်မာနိုင်ငံတွင် လက်ရှိဖြစ်ပေါ်နေသော ကျန်းမာရေးဆိုင်ရာ အခြေအနေများ၊ အစီရင်ခံစာများ၊ သုတေသန စာတမ်းများနှင့် ရှေ့လုပ်ငန်းစဉ်များကို ဆွေးနွေးချမှတ်ခဲ့ကြပါသည်။

ဤနှီးနှောဖလှယ်ပွဲကြီးသို့ တက်ရောက်လာသူများအားလုံးက လက်ရှိမြန်မာနိုင်ငံ၏ ကျန်းမာရေးအခြေအနေသည် လူမှုအထွေထွေအကြပ်အတည်းကြီး ရင်ဆိုင်နေရချိန်တွင် အဆိုးဝါးဆုံး၊ အောက်ဆုံး၊ နောက်ဆုံးအဆင့် ရောက်ရှိနေပြီး တိုင်းရင်းသားပြည်သူလူထုကြီးတစ်ခုလုံးမှာ ကျန်းမာရေးဆိုင်ရာ အခွင့်အရေးများ ဆုံးရှုံးနေ၍ တမျိုးသားလုံးအတွက် အင်မတန် စိုးရိမ်စရာ အခြေအနေအဖြစ် မှတ်ယူခဲ့ကြပါသည်။

ထို့ပြင် ညီလာခံသို့ တင်သွင်းခဲ့ကြသော လေ့လာဆန်းစစ်မှုစာတမ်းများအရ အရှင်မွေးကလေး ၁၀၀၀-တွင် တစ်နှစ်အောက်ကလေး သေဆုံးမှု ၇၆ ဦး၊ ၅နှစ်အောက်ကလေး သေဆုံးမှု ၁၀၇ ဦးရှိခြင်း၊ တစ်နိုင်ငံလုံး ကလေးဦးရေ၏ သုံးပုံတပုံမှာ အဟာရဓါတ်ချို့တဲ့နေခြင်း၊ ၆၇ ရာနှုန်းသော အိမ်ထောင်စုမှာ နေ့စဉ် အဟာရပြည့်ဝစွာ စားသုံးနိုင်မှုမရှိခြင်း၊ အိတ်ချ်အိုင်ဗီ-အေအိုင်ဒီအက်စ်၊ တီဘီ နှင့် ငှက်ဖျား စသောကူးစက်ရောဂါများ မထိန်းချုပ်နိုင်ခြင်း၊ ဆင်းရဲမွဲတေမှု၊ ကျန်းမာရေး၊ ပညာရေး အခြေခံပေါ်တွင် တွက်ချက်သော လူသားဖွံ့ဖြိုးမှုအဆင့်မှာ ၁၃၂ ဖြင့် ကမ္ဘာပေါ်တွင် အောက်ဆုံးတန်း၌ ရောက်ရှိနေခြင်း၊ ပညာရေး၊ ကျန်းမာရေး၊ လူမှုရေးဆိုင်ရာများတွင် အသုံးစားရိတ်မှာ ဂျီဒီပီ၏ ၄ ရာခိုင်နှုန်းအောက် ရှိသော်လည်း စစ်သုံးစားရိတ်မှာ ၄၅ ရာခိုင်နှုန်းကျော်ရှိခြင်း၊ သဘာဝပတ်ဝန်းကျင်ဆိုင်ရာပျက်စီးမှုတွင် အဆိုးဝါးဆုံးအဆင့်သို့ရောက်နေခြင်း စသည့်အချက်အလက်များက မြန်မာနိုင်ငံရှိ တိုင်းရင်းသားပြည်သူတစ်လုံး၏ ကျန်းမာရေးအခြေအနေ အဆိုးဝါးဆုံးရင်ဆိုင်နေရခြင်းကို အခိုင်အမာ ပြဆိုနေပါသည်။

တဆက်တည်းမှာပင် မြန်မာနိုင်ငံ၏ လက်ရှိနိုင်ငံရေးအခြေအနေ မတည်ငြိမ်မှု၊ စီမံခန့်ခွဲမှုညံ့ဖျင်းမှု၊ အစိုးရယန္တရားတစ်ခုလုံး ပျက်စီးချစားနေမှုများမှာလည်း လူမှုအထွေထွေအကြပ်အတည်းများကို ဆိုးဝါးစေသည့် အဓိကအခြေခံ အကြောင်းရင်းဖြစ်သလို အစိုးရ၏ အတင်းအဓမ္မရွှေ့ပြောင်းခံရသည့် ဒေသများ၊ အဓမ္မလုပ်အားပေးခိုင်းစေခြင်းခံရသည့် အခြေအနေများသည် ပြည်သူလူထု၏ စိတ်ပိုင်း၊ ရုပ်ပိုင်းကျန်းမာရေးအခြေအနေကို တိုက်ရိုက်ထိခိုက်စေပြီး တတိုင်းပြည်လုံး အခြေခံကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများ အမြန်ပြန်လည် ပြုပြင်တည်ဆောက်ရန် လိုအပ်နေကြောင်းကို ဖော်ပြနေပါသည်။

နယ်လှည့်ကျောပိုးအိတ် ကျန်းမာရေးလုပ်သားအဖွဲ့၏ အစီရင်ခံစာအရ တိုင်းရင်းသားဒေသများရှိ ဌာနေရွှေ့ပြောင်းဒုက္ခသည်များကြားတွင် လူဦးရေ ၁၀၀၀-တွင် တစ်နှစ်အတွင်း ၄၀ ယောက်မွေးဖွားပြီး ၂၅ ယောက် သေဆုံးကြောင်း၊ ကလေးအရှင်မွေး ၁၀၀၀-တွင် တစ်နှစ်အောက်ကလေး ၁၃၅ ယောက်သေဆုံးပြီး ၅ နှစ်အောက်ကလေး ၂၉၁-ယောက် သေဆုံးကြောင်း၊ ကိုယ်ဝန်ဆောင်မိခင်သေဆုံးနှုန်းမှာ ကလေးအရှင်မွေး ၁၀၀၀၀၀-တွင် မိခင်ဦးရေ ၁၂၀၀-သေဆုံးကြောင်းနှင့် ဌာနေတွင်း ပြောင်းရွှေ့ဒုက္ခသည်များအတွင်း သေဆုံးနှုန်းမှာ မြန်မာနိုင်ငံတွင်း၌ ထုတ်ပြန်သော ကျန်းမာရေးအစီရင်ခံစာနှင့်နှိုင်းယှဉ်ပါက တစ်နှစ်နှင့်ငါးနှစ်အောက်ကလေးသေဆုံးနှုန်းတို့မှာ ၂-ဆကျော် မြင့်မားနေခြင်းတို့ ရင်ဆိုင်နေရပါသည်။

ထို့ကြောင့် ကျန်းမာရေးအဆင့်အတန်း မြင့်မားရန်ဆောင်ရွက်ရေး၊ ကျန်းမာရေးဝန်ဆောင်မှုလုပ်ငန်းများ လုံခြုံမှုရှိရှိ လုပ်ဆောင်နိုင်ရေးတို့အတွက် လူ့အခွင့်အရေးချိုးဖောက်မှုများကိုပါ တပါတည်းဖြေရှင်းသွားရန်လိုအပ်နေပါသည်။

ထို့ပြင် အိမ်နီးချင်းနိုင်ငံများတွင်ရောက်ရှိနေကြသော ဒုက္ခသည်များနှင့် မြန်မာနိုင်ငံသားပြောင်းရွှေ့အလုပ်သမား ၂ သန်းကျော်တို့ ရင်ဆိုင်နေကြရသည့် လူ့အခွင့်အရေးချိုးဖောက်ခံရမှုများ၊ ကျန်းမာရေးနှင့် လူမှုရေးဆိုင်ရာ ကာကွယ်စောင့်ရှောက်မှုများ ကင်းမဲ့နေခြင်းကို ကြိုးစားဖြေရှင်းသွားရေး-

ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများကို လက်တွေ့လုပ်ဆောင်နေကြသော ကျန်းမာရေးလုပ်သားများ၏ လူနေမှုဘဝ အဆင့်အတန်းနှင့် အရည်အသွေး မြှင့်တင်ရေးလုပ်ငန်းများ အရှိန်မြှင့် လုပ်ဆောင်သွားရေး-

သေအသီးသီးတွင် တာဝန်ထမ်းဆောင်နေကြသော ကျန်းမာရေးလုပ်သားများကြား ပိုမိုပူးပေါင်းဆောင်ရွက်ရေးနှင့် ကျန်းမာရေးအဖွဲ့စည်းများ၊ လူထုအခြေပြုအဖွဲ့အစည်းများ၊ နိုင်ငံရေးအဖွဲ့အစည်းများကြား ကျန်းမာရေးပြဿနာများကို လက်တွဲပူးပေါင်းဖြေရှင်းသွားရေး-

ကျန်းမာရေးဆိုင်ရာ သုတေသနလုပ်ငန်းများအပါအဝင် ဒေသတွင်းနှင့် နိုင်ငံတကာရှိ လူမှုကယ်ဆယ်စောင့်ရှောက်ရေး အဖွဲ့အစည်းများနှင့် ဆက်စပ်၍ မြန်မာနိုင်ငံကျန်းမာရေးဆိုင်ရာ ပြဿနာများကို ပူးပေါင်းဖြေရှင်းသွားရေး- တို့ကို ရှေ့လုပ်ငန်းစဉ်များအဖြစ် တညီတညွတ်တည်း သဘောတူဆုံးဖြတ်ခဲ့ပါသည်။

၂၀၀၆ခုနှစ် ကျန်းမာရေးနီးနှောဖလှယ်ပွဲကြီးမှ လူတိုင်းကျန်းမာရေးစောင့်ရှောက်မှု ရရှိနိုင်ရန်နှင့် တိုင်းရင်းသား ပြည်သူများ အားလုံး၏ ကျန်းမာရေးအဆင့်အတန်းများ မြှင့်တင်သွားရန် ဘက်ပေါင်းစုံမှ လက်တွေ့ကျသည့် လုပ်ငန်းများဖြင့် အစွမ်းကုန် အားစိုက် လုပ်ဆောင်သွားကြရန် သန္နိဋ္ဌာန် ချမှတ်ခဲ့ကြောင်းထုတ်ပြန်ကြေငြာအပ်ပါသည်။

အမျိုးသားကျန်းမာရေးနှင့်ပညာရေးကော်မတီ နှင့် မြန်မာနိုင်ငံဆေးပညာရှင်များအသင်း နေ့စွဲ ။ ။ ၂၀၀၆ ခုနှစ် ဇန်နဝါရီလ (၁၈) ရက်

ပိုမိုသိရှိလိုပါက ။ ။ ဒေါက်တာစင်သီယာမောင် (၀၉၉၆၁၅၀၅၄)
ဒေါက်တာ ထော်ဖိုးဒီဂေး (၀၁၀၄၅၆၁၄၄)

HEALTH SEMINAR – OUTLINE OF DAILY ACTIVITIES**1st Day (16/1/06)**

Time	Items	Remarks
09.00 – 9.45 am	- Announce opening of seminar - Opening session: - Key note speeches (10 min. each)	Chairperson- U Aye Saung (1) NHEC Chair (2) BMA Chair (3) NCUB Rep. M.C- Min Min Oo
09.45 - 10.00	Introductions	Participants.
10.00 - 10.30	NCUB policy (Stand) on Humanitarian Assistance	U Myint Thein, NCUB Rep.
10.30 - 10.45	Tea break!	
10.45 - 11.15	FDB's view on Humanitarian Assistance	Min Naing, Forum for Democracy in Burma (FDB)
11.15 - 11.45	Health Policy	Dr. Tun Kyaw, NHEC
11.45 - 12.15	Listening to the grass-roots (Local Health Workshop)	Dr. Salai Pacin
12.15 - 13.15	LUNCH BREAK	
13.15 - 13.45	Rewards & Challenge of Health Workers at Thai-Burma Border	Lin Yone , MTC
13.45 - 14.30	Group discussion!	Participants
14.30 - 14.45	Tea Break!	
14.45 - 16.00	Report/Panel Discussion	Participants

Moderators of presenting sessions: Dr. Khin Saw Win & Aye Lwin.

For group discussion: Divide into 5 groups/Each group led by 2 chosen facilitator.

Group Facilitators:

- | | |
|------------------------------------|---------------------------------------------------------------|
| (1) Min Min Oo/Than Khal | - Recommendation of Local Health Workshop |
| (2) Dr. Thein Win/Sayar Ekalu | - Findings from Local Health Workshop (Issues and Challenges) |
| (3) Dr. Myint Cho /Dr Zin Min | - Approach to health policy, planning and implementation |
| (4) Dr. Myat Htoo /Dr D.G Htaw Soe | - Monitoring and evaluation of health policy |
| (5) Dr. Win Myint Than /Dr Cynthia | - Rewards and challenges of health workers |

2nd Day(17/1/06)

09.00 - 09.15	Recap	Dr. Khin Saw Win & Aye Lwin
09.15 - 09.45	Health & Human Rights	Dr Khin Saw WinMahn Mahn Mahn
09.45 - 10.15	Migrant's Health Rights	Dr Zin Min, MAP

10.15 - 10.45	Fundamentals of Australian Health System: A case study	Dr. Myint Cho
10.45 - 11.00	Tea Break!	
11.00 - 11.30	Research & Ethics	Dr. Chris Beyrer, John Hopkins University
11.30 - 12.00	Health Access & Utilization	Dr Cynthia, MTC
12.00 - 13.00	LUNCH	
13.00 - 14.00	Group discussion	Participants
14.00 - 14.15	Tea Break!	
14.15 - 16.00	Report and Panel Discussions	Participants

Moderators of presenting sessions: Min Min Oo & Dr. Tun Kyaw

For group discussion: Divide into 4 groups/Each group led by 2 chosen facilitator.

Group Facilitators:

- | | |
|------------------------------------|-------------------------------|
| (1) Dr Myint Cho/Dr. Thein Win | - Health and human rights |
| (2) Saya Ekalu/Aye Lwin | - Migrants' health right |
| (4) Dr. Myat Htoo/Than Khal | - Research & Ethics |
| (5) Dr. Salai Pacin /Dr Kyaw Nyunt | - Health Access & Utilization |

3rd Day(18/1/06)

09.00 - 9.15	Recap	Moderators: Min Min Oo & Dr. Tun Kyaw
09.15 - 09.45	Kangaroo Mother Care	Dr. Thein Win
09.45 - 10.15	Bird's Flu	Dr. Pho Thawda
10:15 - 10:45	IDP and Refugee health situation	Karenni Health Dept.
10.45 - 11.00	Tea Break!	
11.00 - 11.30	Malaria Control Program	Saya Ekalu
11.30 - 12.00	Community Health Assessment in selected areas of Burma	Epidemiology Research Group
12.00 - 13.00	LUNCH	
13.00 - 13.30	Group Discussion	Participants
13.30 - 14.30	Report and Panel discussion	Participants
14.30 - 14.45	Tea Break!	
14.45 - 16.00	- Recommendations - Closing ceremony	Chair: Dr. Htaw Soe MC: Min Min Oo

Moderators of presenting sessions: Dr Khin Saw Win & Aye Lwin

For group discussion: Divide into 3 groups/Each group led by 2 chosen facilitator

Group Facilitators:

- | | |
|-----------------------------------|----------------------------------------------------------|
| (3) Dr. Win Myint Than/Dr Cynthia | - IDP and Refugee health situation |
| (4) Dr. Salai Pacin./Dr Thein Win | - Malaria Control Program |
| (5) Dr Htaw Soe/ Dr. Myat Htoo | - Community Health Assessment in selected areas of Burma |

List of participants and organizations

No.	Name	M	F	Organization
1	Dr. D. G Htaw Soe	M		NHEC
2	Dr. Cynthia Mg		F	BMA
3	Dr. Khin Saw Win		F	BMA/ Canada U of A
4	Dr. Thein Win	M		BMA/South Africa
5	Dr. Myat Htoo Razak	M		BMA
6	Dr. Salai Pacin	M		BMA
7	Dr. Tun Kyaw	M		NHEC
8	Dr. Win Myint Than		F	BMA/ MOM
9	Dr. Po Thaw Da	M		BMA
10	Mahn Mahn Mahn	M		BMA
11	Dr. Myint Cho	M		BMA/ Australia
12	Ko Than Khe	M		BMA
13	U Aye Saung	M		NHEC
14	Dr. Kyaw Nyunt	M		PPF/BMA
15	Saya Lu Ca	M		KNPP
16	Nai Aye Lwin	M		BMA
17	Saw Chit Win	M		BPHWT
18	Ko Win Thint Han	M		ABSDF
19	Sai Sam Thip	M		SSA
20	Ko Sein Han	M		BMA
21	Ko Min Min Oo	M		NHEC
22	Khun Tet Lu	M		PPLO
23	Saw Moe Kel	M		MTC
24	Nai Naing Soe	M		NMSP
25	U Har Mid	M		ABMU
26	Saw Lin Young	M		MTC
27	Saw Mu Ni	M		MTC
28	Saw Eh Kalu Shwe Oo	M		KNU
29	Dr. Zin Min Than Oo		F	MAP
30	Nang Khan Thaw		F	SSPC
31	DD. AH Hkawn		F	KWAT
32	Mai Nay Lyum	M		PYNG
33	Na Mi Bo		F	BMA
34	Mi Ein Roi Chan		F	BMA
35	U Hla Tawng	M		KIO
36	Khu Htu Reh	M		KNPP
37	Tun Win	M		PLF
38	Dr. Lun Swe	M		Nightingale Journal/ BMA
39	Saw La Hser	M		KDHW/KNU
40	Tender		F	MTC
41	Phjoe		F	PPP

42	Khin Ma Ma		F	PPP
43	S' Htun Htun	M		KNPLF
44	Myint Thein	M		NCUB
45	Thaung Tan Cho	M		BMA
46	Saw Romel	M		BPHWT
47	Thar Win	M		MTC
48	Dr. Myo Win	M		NHEC
49	Dr. Thiha Maung	M		
50	Dr. May Thandar Khin		F	MTC
51	Mr. Jan Aung	M		SYCB
52	U Khong Hong	M		LDF
53	Ko Myint Aung	M		BPHWT
54	Elizabeth Eggers		F	Guest
55	Hla Aye	M		NCUB
56	Sitt Ko Naing	M		SYCB
57	Saw Thart Kler	M		KDHW/KNU
58	Hser Nay Blute	M		MTC
59	Saw Law Du	M		KNU/KDHW
60	Saw Ohn Mya	M		BMA
61	Aung Than Aye	M		BMA
62	Khaing Kyaw Lu	M		ALP
63	Lin Yone	M		MTC
64	Kyar Shen	M		LDF
64	Min Naing	M		FDB
66	Mai Khun Thein	M		PYNG
67	Nai Kyaw Htat	M		NHEC
68	Kyaw Moe	M		MLOB
69	Jo Nord		F	JHU
70	Tom Lee	M		GHAP
71	Janet Wells		F	GHAP
72	Suzanne Hammer		F	GHAP
73	Emily Whichard		F	Planetcare
74	Courtrey Bowe		F	Planetcare
75	Aaron Samuels	M		JHU
76	Varavit Suwanvavickkoj	M		JHU
77	Luke Muuany	M		GHAP/JHU
78	Chris Beyrer	M		JHU
Total		60	18	

Income and Expenditure for Health Seminar

Income			Expenditure		
No.	Description	Amount Baht	No.	Description	Amount Baht
1.	Funded by DBC	570,000	1.	International Travel	212,882
2.	Funded by BRC	300,000	2.	Local Travel	134,035
			3.	Food & Accommodation	197,972
			4.	Stationary & Supplies	23,027
			5.	Administration	20,110
			6.	Publication	34,000
				Total Expense	622,026
				Balance	247,974
				Total	870,000
				Transfer to BMA Conference Balance	250,000 - 2,026
	Total	870,000		Total	870,000

Photos





