



HUMANITARIAN AID RELIEF TRUST

VISIT TO HEALTH AND HOPE, LAILENPI, CHIN STATE, MYANMAR **(BURMA)**

February 8th -21st 2015



'Road' hacked out of the jungle by Dr SaSa and local villagers to reach Lailenpi

Background: Signs of Hope

After the elections in 2010, President Thein Sein promised to introduce reform, and we saw evidence of some genuine progress during our visit to the very remote location, Lailenpi, in Chin State.

Pre 2011

- Burma has experienced decades of oppression under military regimes during which many ethnic national civilians suffered from systematic violations of human rights, including military offensives (often on a shoot-to-kill basis), use of human minesweepers extra-judicial killings, forced labour, rape, theft of land and livestock.
- The Chin State Government signed a Peace Agreement with the Burmese Government in 2012. Therefore, the people here were not subjected to military offensives but suffered the challenges of occupation by the Burmese Army.
- With soldiers in every village, civilians were constantly in fear of arrest and other gross violations of human rights. Moreover, repressive policies were put in place such as prohibition of education beyond Grade 10 and of teaching in the local language. The citizens of Chin State are predominantly Christian who traditionally erect crosses on hilltops and other significant locations such as crossroads. During the years of oppression, many crosses were destroyed by the Army and, in some cases local civilians were forced to build pagodas in their place.
- Chin State is economically the poorest State in Burma, with minimal investment in development of infrastructure such as roads, education or health care.
- With steep mountains and thick jungle, access to many villages is inevitably difficult and the lack of investment or resources for development resulted in a situation where many villagers were totally bereft of health care, often with virtually no means of access to health care facilities. Consequently, there were high mortality and morbidity rates with many people suffering and dying from preventable or treatable diseases.
- A large part of Chin State has better communications with India than with the rest of Burma. Food, medical care, and building materials are accessed more easily from India. Culturally it is in ways more akin to neighbouring peoples in India.

Post 2011

We are encouraged to witness some significant improvements:

1. The reign of terror, with people living in constant fear of arrest, torture, forced labour and rape, no longer prevails. In the places we visited, people said they no longer lived in fear of the military or the police and relations between them and local communities have greatly improved. They also no longer live in fear of informers.
2. We saw massive investment in the building of roads: travelling in Chin State from Mindat to Matupi and beyond, many miles of road are under construction with scores of JCBs (bulldozers) at work, day and night, resembling herds of dinosaurs scattered over the steep mountainsides! We understand that this is being developed as a highway linking Burma to India and that there will be a road link to Lailenpi.
3. We were pleased to see a new hospital in Mindat, due to be opened by the President on February 20th. It appears to be well equipped including wards with curtains for privacy and facilities such as operating theatres and a pathology laboratory.
4. Local people expressed their appreciation of the introduction of free education at primary and middle school levels with the expectation that this will soon be extended to secondary schools.
5. There was deep concern over a case of rape, allegedly by a Burmese Army soldier, in Renzua in 2014. However, there was some reassurance in the fact that local women remonstrated and the culprit was brought to justice. On this occasion the victim had not been murdered as on so many occasions in previous years. It was said that this freedom to bring complaints and to publicly seek justice would not have been possible under the highly repressive regime before 2011.

Conclusion

- We are well aware of continuing problems in Kachin and northern Shan States including military offensives and violations of human rights with impunity. We have raised these concerns on many occasions and will continue to monitor these situations closely.
- However, we are encouraged by the improvements we witnessed in the areas of Chin State we visited: the greater freedom of speech and expression; improved relations with the Burmese Army and police; and economic investment in essential services, including health care and road construction which will open up previously inaccessible very remote locations. We are also very pleased that these improvements have enabled the 'Health and Hope' programme in the remote location of Lailenpi which we support to have achieved phenomenal success in the training programme for Community Health Workers and in their literally life-saving work in their villages.

Contents:

1. Background: Signs of Hope
2. Aims of the Visit
3. The Health and Hope Programme, Lailenpi
 - a. Origins
 - b. Achievements
4. Interviews with Community Health Workers from the first cohort who trained in 2009-2011
5. Interviews with new Community Health Workers
6. Programme of Cultural Celebrations and Events
7. The Mawta Famine
8. Support for Health and Hope
9. Acknowledgements
10. Appendices

[Burma: We use 'Burma' rather than 'Myanmar' as this is preferred by local people].

Explanation of Report

This is essentially a simple Project Report, but includes in addition reference to the background within Chin State, and lesser reference to other parts of Burma.

Aims of Visit

- 1) To visit, encourage and monitor the work of a HART project and partner: Health and Hope - Burma (H&H) and Dr. Maung Taing San (Sasa).
- 2) To obtain specific information regarding the work and efficacy of established Community Health Workers (CHWs), already trained, and regarding the training taking place at present.
- 3) To obtain specific information regarding the staff and structures for administration and financial accounting; also the provision, ease of supply and distribution of medicines.
- 4) To obtain information on the present and developing political situation within Chin State.

The Health and Hope Programme, Lailenpi.

Origins

The founder, Dr Maung Taing San, known as Dr. Sasa, was born and grew up in Lailenpi. Throughout his childhood, there was no provision of any form of health care in his village or any nearby location. Mortality rates were very high: when Sasa was a young boy, three of his school friends died in one day from diarrhoea. When he was a little older, his best friend succumbed to a respiratory tract infection. Sasa and other young men tried to carry their ill friend to a township for treatment (a 5-day walk over the mountains and through the jungle) but, crossing a swollen river, they slipped and their friend drowned. Due to the desperate need for healthcare, Sasa's family and all the villagers were determined to enable him to obtain a medical qualification in order to help his people. Thus began an arduous journey.

Sasa first travelled to Rangoon for high school education. A situation of abject poverty coupled with the need to first learn Burmese for studying purposes both served to make this exceptionally difficult. However, he managed persevere and complete this stage of education. Following this, villagers from Sasa's community took on a great sacrifice to raise enough money to enable Sasa to continue study in India for pre-clinical qualifications. This was a tough time for him as he had to juggle working to raise funds for study while learning Hindi and English, but yet again he succeeded. Next, Dr Sasa chose to study in Armenia where he could study medicine cheaper than in the UK or USA. Several more very tough years followed, learning Armenian, which includes a whole new script, and working to raise money for University studies. Due to his exceptional stamina and hard work, Dr Sasa qualified as a medical doctor with distinctions in medicine, surgery, obstetrics and gynaecology!

On completion of his medical qualification, Dr Sasa's vision was to establish a training programme for his people in the remote Hill Tribe regions of Chin state so that each village would have their own Community Health Workers (CHWs). This would provide essential health care and education in villages where there had been no such provision of any kind.

The programme entitled 'Health and Hope' was inaugurated on the India-Burma border, in Chapi, Mizoram State. Textbooks were brought from Yangon – by boat and then carried on foot on trails through the high mountains and across rivers. Messengers were sent to villages deep inside Chin State – some 5-7 days' walk away, inviting Village Councils to elect a man and a woman from each to come to train as CHWs. After months of building and preparation, the first training began in 2009 with 317 students from 153 villages.

Subsequently, the Chin State Government has allowed a Health and Hope Training Centre to be established in Lailenpi and this now serves as the main base for the training programme.

Achievements:



Dr SaSa standing with the local CHW at another Community Health and Education Centre, now being built with funding from Guernsey Overseas Aid Commission.

Numbers and Scope of Outreach of CHWs

As more cohorts of students have come in for training, the numbers have increased significantly:

- 681 have completed their training and are now working in their villages
- 157 just completed training, some of whom we were able to meet and interview in Lailenpi
- 473 villages now benefit from the activities of CHWs
- The geographical areas now served by CHWs have extended beyond Chin State: increasing numbers of trainee CHWs are now coming to the centre from Rakhine State as well.

Effectiveness of CHW contributions

Dr. Martin Panter of HART-Australia, a medical practitioner with especial interest in tropical diseases and medicine in developing countries, and long experience of Burma, along with the HART staff, interviewed a sample of the first cohort of newly qualified CHWs now working in their home villages. Dr. Panter, on a previous visit, had estimated that their knowledge would enable them to save the lives of 8 out of 10 people in their villages who would previously have died. Following the interviews on this visit he considered that this figure was confirmed.

(See below and Appendix 2 for transcripts of these interviews).

- In essence, their reports show a consistent pattern of reduction in avoidable disease and death compatible with the original estimate of approximately 80%.
- The interviews show a consistent pattern of activities and achievements undertaken by the CHWs in their villages as CHWs such as:
 - Establishment of Village Health Committees to support their work
 - Health education promoting:
 - Boiling water for drinking
 - Rehydration in response to illness, especially diarrhoea

- Appropriate use of malaria nets (many villagers had been using netting which had been provided for fishing instead of protection from mosquitos at night)
- Hygiene, including construction of latrines
- Control of animals to prevent unhygienic excretion
- Hand washing
- Cutting nails, especially for children to prevent infection from scratching with dirty nails
- The interviews also highlighted consistent accounts of challenges and problems encountered by CHWs and their requests for further support. These included:
 - 1) Pressure of combining responsibilities of a CHW with the need to work in order to make a living and support families.
 - 2) The need for refresher courses to provide clinical updating and personal support.
 - 3) Lack of supply of medicines.
 - Each newly qualified CHW is provided with an initial supply, but once this has been used, CHWs had to find resources to obtain more medicines.
 - Many undertake work to try to raise money to purchase further supplies but this is clearly difficult and shortage of medicines means that they are often unable to provide treatment. Some Village Health Committees do provide some funding.
 - This not only causes them frustration and disappointment but may reduce their standing in the local community.
 - 4) A request for supplies of dressings and sutures to treat minor injuries. Most of their communities are farm workers and many come as patients with lacerations caused by working with bamboo. The CHWs feel very inadequate as they have no equipment to treat these conditions. As a response, Dr Martin Panter has undertaken to try to raise resources from HART Australia to provide dressing and suture kits.

Four Examples of Interviews with CHWs from the first cohort who trained in 2009-2011

Several of the CHWs with Baroness Cox at Lailenpi.





Another CHW (right) standing with Khai Aye (left: Sasa's Chief Personal Assistant and Administrator) in Lailenpi, outside one of the dormitories, named after their strong Supporter Jersey Overseas Aid Commission (JOAC).

1. KhaiLau, 35, Lovai village Palewa Township. 56 homes and 300 people.

I trained Chapui, 2009.

As soon as I finished and returned to my village, I started with hygiene and health education campaign. The village had no WCs so we immediately dug a latrine in own home and demonstrated to villagers – this was a pit latrine with wood cover. All now have some WC; villagers teach each other; I then worked to obtain 80% use ceramic; 20% still wood.

We have introduced systematic arrangements for domestic animals, so they don't pollute the water in the village or rivers. Pigs were free but now are kept in pens; chickens in hen house but free; dogs are mostly killed because they spread disease, possibly rabies.

My second campaign was water. People don't know about water in their body; when I started teaching about drinking water, people realised it saved lives. Now they boil water and rehydrate when they have diarrhoea. I taught importance of boiling water especially through talking to churches and school to share the importance of rehydration. I even made a promise that if you die after drinking you can come back to haunt me! They measure sugar and salt and have enough I tell every family to keep sugar and salt as treatment and most do.

Hygiene: *most children don't cut nails and they are so dirty; I distribute clippers and all children now cut nails; I teach people to wash their hands every morning, evening and after using the toilet. People had used boiled water for faces, so we taught that washing hands is even more important.*

Diarrhoea and nausea have reduced. Before, people felt pressurised to do things which they thought were not necessary; but now they have become habits, so we have no need to continue to teach these practices. Pressure has become habit. These are some impacts:

- *70% reduction in G-I diseases.*
- *4-5 people died every year in previous years, from diarrhoea and respiratory problems. When at Chapui, I reflected why.*

I now point to the difference and so they are convinced. Church leaders pray for me and support me.

By God's grace, everyone listened to us. They come for meetings and are eager to listen.

We discuss that health is not medicine, health is YOU!

Main difficulties and Problems:

- *Time: I'm also a farmer with my own family so Health Care work is in addition and I need to divide time; as do the villagers.*
- *Women are better in health issues than men, who are finding it more difficult to change behaviour.*
- *Supply of medicines: I sell chickens and a pig to buy medicines in Palewa or Matupi; some are Chinese and some Indian; and I try to encourage villagers to pay but sometimes they have difficulty in repaying me. This is one of the most difficult issues. Paracetamol (c. 20kiats per tablet) is very cheap but antibiotics are very expensive and if they don't repay me, it is very difficult for me to do this.*
- *Community collection of money began but people who were healthy didn't want to give and stopped giving money. The Church helped but still it didn't work. So I sold my own animals and the problem remains. I explained that if I have to go to buy medicine I have to pay fare and more expensive. Sometimes we got oxytocin and hydrocortisone and some anti-biotic but they expired before I could use them, but I know I might need them. We don't have any pharmacy.*

Help required?

- *As we are in isolated village with no information, we need to refresh our knowledge, so we need clinical updating and would like refresher course as we have no access to information of any kind or contact with others.*
- *I need equipment for injuries, including suturing; and need wound dressings; when HandH gave medicine, we give it free, so some people think they can have all they want.*
- *People are impatient and want to recover immediately and we need to teach them to be patient; but they tell us we are lying. But people do respect me in my village so they do come and they give me time and respect.*
- *I drive a motor bike and I give a lot of my own resources because the church is poor. I know we need vitamins so I give Vitamin A out of my own pocket.*

2. Laisa 38, father of 4, Rari village, Palewa Township; 467 people, 62 households.

I trained in 2011.

Major illnesses:

- *As summer starts, because water is unclean there is a big problem with Diarrhoea and Vomiting. After we finished training, we taught people how to drink clean water and this has improved the situation.*
- *Many fevers, sometimes I consider it to be malaria but when tested, I find that it's not malaria so treat with malaria treatment and some get well.*
- *With babies I ask mothers to keep feeding and giving them water.*

I formed Village Health Committee with village leaders to support my work. With the committee, I started working for villagers holding monthly meetings for health education, Maternal and Child Health, hygiene and nutrition (including vegetables). With hygiene we look at water or waste. I also went to the Village Committee to open the education of school children in health care.

Also, with help from Chin National Front based in India, we were able to build toilets with running water from a hose pipe with one toilet per family.

We have a problem of scarcity of water and many people don't use it properly so we train to boil drinking water. This rehydration with boiled water is used for fever, not just diarrhoea.

4-5 people died the year before I came: 2 children. 2 adults 1 elderly.

Until today over past 3 years, there have been no deaths. Not only because of our work but because of God's grace.

Villagers had no water pipe and without this, it is impossible to have health care so I applied to the Government and NGOs and last year one NGO (SCF) - based in Palewa, programme of work gave cash for 1 month.

I also worked for road construction and with the money, we purchased a water pipe to fix water supply from the river to the village.

Main difficulties and Problems: *Health and Hope gave medicine when we qualified. When that was used, we tried to save money so people could repay, but many can't afford to do so. So we work with village council who collect money for us to purchase medicines. It is never enough but we struggle along.*

The next way to get medicine is that someone will buy and keep for emergency. We share medicines until today.

So we work with the village council who collect money for purchase of medicines; never enough but we struggle along

Help required?

We need enough medicines so we can treat anyone in need.

We have no equipment for injury. We need wound dressings, sutures.

One day, one man became very ill with Diarrhoea and Vomiting, and couldn't keep ORS down; but I had no medicine to treat him. I was very worried but as I had no medicine I cut down banana tree and made a drink and the patient recovered.

I would be very happy to learn updates of treatment and new knowledge re new diseases.

Are you Happy you became a CHW?

Yes, though we can't help everything, through this work I feel I and my family are improving our spiritual life and the villagers'.

3. Hunau, 36, Ralie village, Palewa Township (with 110 homes, 630 people)

Trained 2009-2011.

Achievements

Before I started as a CHW, 8-10 people died p.a.; in first year, no deaths; last year, 2 died from tree injury and tetanus another from diarrhoea (but I was away at the time).

Major illnesses:

- *Malaria,*
- *Hepatitis - I use a local medicine of crab soup- fastest way to treat it*
- *Kidney stone (pain) - use ciprofloxacin and encourage them to drink fluids and this helped*
- *Fever – I give them paracetamol*
- *Dysentery*
- *URTI*
- *Typhoid.*

Reasons for Success?

I teach hygiene which prevents infections and encourage people to bring ill children to us so we can treat and/or refer.

Main children's problems:

- Malaria
- Hepatitis.

I test degree of fever of malaria patient and give paracetamol and atemetal. If fever remains, pour cool water and open the door to keep cool.

Not every home has a toilet. I try to help them but some families move. There are only 2-3 homes without. Before I came, most homes had no toilet but didn't know how to use them properly and didn't appreciate the importance for health so we taught about this and this made a difference.

Main problems and difficulties: *One main problem is we have to purchase medicines by ourselves and we request repayment. Villagers often don't repay so we have no money left to purchase more medicines so when we see someone ill, we just feel sad and helpless.*

- *There are 2 types of people in the village: Mara and Matu. The Matu sometimes find it difficult to understand (not agree with us when we try to teach them, so they don't cooperate with our teaching because they are poor and only subsistence level existence so when church collects money for medicines, they can't contribute) so we find it difficult to raise money for medicines.*
- *Can collect money from Mara families and we need to use for all, so they don't want to give again.*
- *When I have some money, I buy some medicine and sell without much profit, but when they cannot repay, I have problems.*
- *As CHWs, many villagers trust us and come for help when injured working on the farms, but we don't have any equipment.*
- *We need childbirth delivery kit. Although I'm a man, I may get called for emergency and I need equipment. I know how to deliver a baby but I can't touch them; I give the woman instructions and stay with her.*
- *Sometimes, since we are working on the farm, we have no time to study so I need updating each year.*

Are you glad you became a CHW?

Very happy, because God blessed me to help some people when suffering from some illnesses and because of my help, some people get well and that makes me happy.

4. Ngohla, 36, Satu village, Matupi Township (with about 600 people in 115 homes)

Trained as CHW: 2009-2011.

Successes:

Happy about when CHW returned, she collected all the children and women's groups to teach them about hygiene and importance of health education, including the importance of drinking enough boiled water, washing hands, and importance of having a clean toilet with no flies.

After this, although I could not give much medicines, these healthy practices made a real difference.

Before came to Chapui for CHW training, every year, lost 4-5 children p.a. After I returned no deaths, except very old who did not die from preventable illness (one died from cancer and one elderly)

Last year, one child died because family did not seek help; another small girl aged 2 years died who was very disabled.

Main difficulties and Problems:

- *When we finished our training we returned to our village, many villagers became sick with Diarrhoea and Vomiting - this is a very common problem.*
- *We had no equipment for malaria tests. He was NGO member and I begged him to help with diagnosis and treatment and everyone recovered. Therefore we need equipment for diagnosis of emergency cases.*
- *One day a girl with cerebral malaria was unconscious, so I investigated to see if I could give Artesunate; but I had none. One man from neighbouring village came and said she had hepatitis, so family didn't want me to give Artesunate, so I didn't know what to do because if I gave this and she died, I would be in trouble with Government but then I insisted and she recovered.*

Help required?

- *I need help renewing medical training because we do not know new knowledge.*
- *Equipment for treating patients, especially injuries.*

Are you Happy you became a CHW?

Yes, because I can see how people are peaceful when they know I can help them and when people get well through my help with advice on nutrition, medicine – that makes me very happy.

(See Appendix 2 for further interviews and Appendix 3 for information on the Training Programme, including textbooks used, the curriculum, the preparation of resource handbook in local languages for the CHWs to take with them to their villages, and examples of imaginative teaching methods developed by Dr Sasa)

Interviews with New CHWs

While we were present in Lailenpi, the current cohort of CHW students were completing their training. We were interested to obtain information about their backgrounds: where they came from, how they heard about the programme, their reasons for wanting to become CHWs and their assessment of the course. *We include two examples below. Additional interviews are to be found in Appendix 1.*

Summary

The catchment area for students has expanded, with students coming from more distant locations in Chin State and also from Rakhine State.

The faith tradition of students has also diversified, with increasing numbers of Buddhists, traditional believers and also some Muslims. While Health and Hope was established by people with strong Christian convictions and the staff are Christian, there is no commitment or policy to encourage conversion to Christianity.

The students whom we interviewed seemed very satisfied with the course and eager to put their knowledge into practice.

- 1. Kyaw Hein, 28, Kyaut Chauwa village, Palewa, 58 homes, 219 people.**

Why did you become a CHW?

In my village there are no health workers and many illnesses. We are far from towns and hospitals, so with no medicines and no-one knowing how to help people, many people die. There is no hygiene, no health workers, so I wanted to help.

How were you chosen?

Nobody selected me. I really wanted to be a CHW and I don't have money or qualifications to train elsewhere. When I heard I could come without any qualifications I asked my older brother if I could come and he agreed so I came.

As I have no money, one of my teachers paid my travel expenses.

I'm very, very happy and satisfied.

No problems during my stay here.

2. Mayithanwin, 28, Bayngyaya village, Punakya Township, Rakhine State, Buddhist.

Why did you become a CHW?

One day, in my family 3 died because of diarrhoea – one girl and 2 boys, aged 16, 18, 19.

Because of this, I realised that we didn't have anyone to help us, we had nowhere to go, healthcare is very expensive, and so I wanted to train to help.

How did you hear of Health and Hope?

Someone came to our village and talked about Health and Hope. As I have no training I didn't feel it was possible, but villagers encouraged me to come, so I did and was accepted.

It took 10 days walking to come with 2 friends who wanted to train as CHWs.

I come from a very poor family but we have many costs here. Dr Sasa paid for my travel and costs are covered here. MEC met them halfway and gave them help.

From our village to where we get the boat, we walked for 3 days. From where the boat stopped it took 4 days to Lailenpi and MEC pastors walked with them. We sleep in villages on the way.

Are you Happy?

I really enjoy the course. I only know that Love is here in Health and Hope and I really enjoy being here.

I don't have any big problems with my study because I share with my friends and we help each other.

Do you have any problems?

Not here. But with my family because my father started to drink alcohol after the 3 died; and we often do not have enough food and we are very poor so this hurts my heart.

Programme of Community Cultural Celebrations and Events

Dramatic photo of Mr. AyeBee, Sasa's father and the local Chief, at the Opening Ceremonies.

In addition to the opportunity to examine the project and obtain information about the CHW Training and its effectiveness, the local community leaders also arranged a programme of significant social and cultural events for our visit:

The journey from Matupi took 18 hours, on extremely rough terrain. The sections from Renzua to Lailenpi had been cut through the jungle in preparation for our visit, with 60 villagers working to forge a very basic road up until 3 days before our arrival. The journey was therefore inevitably very slow and arduous, in a robust Indian 'Gypsy' jeep having to negotiate a route with steep gradients, sharp U-turn bends, rocks, trees and rivers.

Having left Matupi at 0800, we had to negotiate the final and most challenging part of this newly forged route through the jungle by night.

Despite our late arrival at villages en route, many villagers had prepared elaborate 'Welcome Ceremonies' to greet us, including construction of 'Welcome Gateways', singing, dancing and food. On eventual arrival at Lailenpi, at 2 o'clock in the morning, many hundreds of villagers had waited up, in the dark and cold to welcome us with a ceremony of singing and dancing and a candlelight 'Guard of Honour' stretching for at least a quarter of a mile down the mountainside. Over 2.5 thousand people had gathered at Lailenpei to celebrate our visit including man who had walked for several days from their villages. Some had brought very generous gifts such as cows, goats, chickens and eggs. As these are generally very poor communities living at subsistence level, these gifts represent generous sacrifices for the community celebrations.



Special events included:

1. The opening of an airstrip. Personnel from Mission Aviation Fellowship (MAF) have visited Lailenpi and, remarkably, given the steep mountainous terrain, identified a location suitable for the community to clear the jungle and prepare an airstrip. We were privileged to be invited to undertake the formal opening! Although it is likely to be a good six to nine months before there is the possibility of a plane landing.
2. The naming of a nearby mountain as 'Baroness Cox Mountain' and the road leading to the summit, marked by a cross.
3. Cultural celebrations, including two evening concerts with performances of traditional dance and singing by different village communities.
4. Sunday morning service attended by over 2,000 people.
5. Promotion of good relationships with local representatives of the Burmese Army, the police and Buddhist monks. A farewell dinner was hosted by the highly respected community leader, Mr AyeBee, to which 2 Burmese Army officers from the nearby Army camp, a Buddhist monk and the

senior police officer were invited – a happy gathering which would have been unthinkable before the recent reforms.

6. The placement of a ‘corridor’ of many mini-‘posters’ for 2 miles along the road as we departed with messages of appreciation and affection.

The Mawta Famine

One of the reasons for so many people from so many villages, with many villagers walking for several days to attend the huge gathering and warmth of the welcome was the gratitude for the help HART was able to provide when the region was afflicted by the ‘Mawta Famine’ in 2007-8. This crisis of severe food shortage occurs approximately every 50 years, when the bamboo flowers, encouraging the breeding of hundreds of thousands of rats who eat not only the bamboo flowers but all other food supplies.

In previous recurrences of the “Mawta”, local people were able to take pre-emptive measures to mitigate the harm, through the storing of supplies from previous years as well as the readiness to move within Burma as the flowering of the bamboo advanced over a period of 3-4 years across the country. Under the rule of the repressive regime at the time of this recent crisis, local people were unable to take such measures. Widespread suffering ensued, with families unable to obtain food, people having to scavenge and to dig deep into the ground for roots with little nutritional value, deaths from hunger-related illnesses, children unable to attend school because of hunger and the need to search for something to eat.

The World Food Programme (WFP) based in Yangon sent an exploratory mission to Chin State to assess the situation. However, the delegation visited locations where bamboo was not grown so concluded that there was no problem of food shortage.

Sasa requested HART to make an emergency visit and a group, accompanied by a BBC reporter, travelled to Mizoram to meet representatives of the affected communities. The reports were compelling; the BBC broadcast news of the crisis and HART made representations to DFID.

DFID responded with a grant of £650,000 for food aid to be distributed via WFP. In conjunction with a very efficient system of distribution established by local communities, the food was sent to communities in desperate need. Even very remote communities received supplies, sometimes carried by local people walking for several days to take the food to their otherwise inaccessible villages. The following year, DFID gave further funding of £250,000 to provide food for communities still in need.

During this visit, many people expressed their gratitude and we wish to record our appreciation, in this report, of DFID’s response to the ‘Mawta famine’ which alleviated severe and widespread suffering.

We also wish to record our admiration for the efficiency, resourcefulness and resilience of the local communities which established a sophisticated system of committees to co-ordinate distribution of food to the very remote communities which would otherwise have been deemed too inaccessible.

We also wish to place on record the appreciation of DFID-UK by indigenous Chin organizers of relief, who stated that they had found access to WFP inadequate. They claimed that, to their knowledge, it was DFID in Yangon who encouraged the WFP to meet with the indigenous organizers in order to hear from them the areas which were neglected by the provided aid and to discuss how to access them. As a result, they felt, people had been reached who, otherwise, would not have received any food.

Support for Health and Hope

Another reason for the warmth of the welcome and expressions of appreciation is due to the help HART provided in the establishment of the Health and Hope Training Programme, from the earliest days in 2008, and the continuing financial support provided by Jersey Overseas Aid Commission (JOAC) and Guernsey Overseas Aid Commission (GOAC).

In addition to the valuable information provided by the CHWs regarding the effectiveness of their work as well as the challenges, we were able to see two examples of the kind of buildings funded by GOAC to provide centres for the work of the CHWs as well as other community services such as education facilities for local children.

Various other supporters are now involved with Health and Hope, some mentioned below.

'Health and Hope - UK' (H&H-UK) is now established as an independent charitable organisation to coordinate funding within the UK (and internationally). H&H-UK also takes the lead in seeking to raise the efficiency of the administrative, financial and monitoring structures and procedures of H&H in both Burma and India, as well as improving the communication of information and news to donors and supporters. In all these areas it is accepted that further improvement is required. The NGO Mission East has now made three visits to improve the skills of H&H staff in administration and finance, as well as in strategic planning. The UK based NGO Birthlink, led by Kathy Mellor, has also now made several visits to assist in the training of CHWs and TBAs (Traditional Birth Attendants) in ante-natal, delivery and neo-natal skills; also, importantly, to assist the CHWs and coordinating staff in establishing some statistics that can be updated by properly maintained records for monitoring in the area of child and maternal health and mortality. The CHWs and TBAs already keep records but more use needs to be made of them. Also, both H&H-Burma and HART are conscious that increased practical support for the CHWs from their villages, led by the local Village Committees, could free them to give more time to keeping and reporting their records. The obvious support would be labour in their fields to assist them in the continuing support of their families.

HART itself continues to collaborate in many ways, including taking responsibility for accountability for the generous funding from JOAC and GOAC.

HART is glad to send this report to H.R.H. the Prince of Wales, as a most significant development of the past year has been His Royal Highness becoming the Patron of Health and Hope. This follows previous support from the Prince of Wales Trust for medical equipment.

Conclusions

This unique visit served several purposes:

- A focus for the local communities to accomplish some significant achievements, including clearing the jungle for a 'road' to enable vehicular access (apart from some workers from India who had come to assist with clearing the jungle, we were the first people ever to arrive by vehicle in Lailenpi) and the formal opening of the airstrip which will enable access by air with MAF.
- The opportunity to meet CHWs and to hear their reports of their achievements, challenges, problems and requests for further help to enable them to function even more effectively.

- An opportunity for the enhancement of positive relationships between local civilians, the Army, police and the representative of the Buddhist community.
- To re-engage with staff members of Health and Hope in location.

Acknowledgements

We wish to record our deep gratitude to the many people who made this visit possible, who welcomed us so warmly and who enabled us to achieve specific objectives with regard to obtaining information on the Health and Hope CHW programme.

In particular, we wish to thank:

- The Chief Minister of Chin State, Mr. Hun Ngai, for his generous hospitality in allowing us to stay overnight on our outward and return journeys in his residence in Matupi.
- His Excellency Mr. Andrew Patrick, the UK Ambassador, for his hospitality and time in Yangon.
- Dr Sasa, his parents and family for their welcome as well as for the phenomenal hard work in mobilising the team of 60 villagers in the clearing of the jungle to create the road for access by vehicle – work which was only just completed 3 days prior to our arrival!
- Vahnei and Khai Aye for their hard work and great efficiency in arranging all the complicated logistics and for being such excellent travelling companions on such arduous journeys.
- The Health and Hope staff and students for their welcome and assistance with our programme, including all who gave us interviews and the valuable information regarding the CHW training programme and clinical experiences.
- All the villagers who greeted us so warmly, including the warm welcoming ceremonies on our arrival in the cold, dark hours after midnight and those who gave such generous gifts, including the most valuable gift of cows.
- The community and church leaders who organised the ceremonies which will be remembered by the local people as events of historic significance.
- The police who provided security, especially the outstanding service by the senior police officer who accompanied us for many miles on his motor bicycle over the rough terrain.

We cannot mention every individual but we hope that our gratitude and appreciation were self-evident and that all involved will know that we will never forget their contributions to this unique visit.

Finally, we wish to record our appreciation of an event which occurred before we arrived and which may not be connected with our visit but which was warmly welcomed by the local community: the arrival of a military helicopter bringing a consignment of vaccines for children. This was received with great gratitude, both for the inherent value of the vaccines and for the gesture of goodwill which this signified.



CHW Dormitory funded by Guernsey Overseas Aid Commission (GOAC).

Monument Commemorating victims of the Mawta Famine.



Dr SaSa, Baroness Cox and a CHW standing in front of cabin built with funding from GOAC..

Appendices

Appendix 1

Map of Chin State containing villages (marked by white stickers) accessed by H&H-Burma and where there are CHWs trained in H&H .

The spread of white stickers, beyond the concentration in the South West, shows the gradual extending of the reach of Health and Hope in to new areas through its present total of 681 CHWs. What is not shown is that beyond the S.W. of Chin State, more and more trainees are coming from Rakhine State, supported by one of the Outreach Centres.



APPENDIX 2.

Additional Case Studies

CHW #1: Chit Maung 45 year old male from Tisi village (345 people), he has been there for three years.

He formed a village committee with six people soon after returning from training. The committee gave 22,000 Kyats in total to buy medicines. Each member of the committee would be responsible for 10 houses in the village.

Chit Maung taught villagers to build toilets, (initially pit latrines, but then with ceramic covers) which provide a clean and odour free environment and many now have them installed in their homes. The cost of a ceramic toilet is around 3500 Kyats (US\$3.50).

During the three years he has been there nobody has died except one boy who tragically died after being hit by a large falling branch in the forest. Prior to that time, between 6-7 people died in the village every year from illnesses such as Typhoid and diarrhoeal diseases. Water is now boiled and oral rehydration salts are given to every child and adult with Diarrhoea. He has also taught villagers when to make ORS using just boiled water salt and sugar.

The challenges he faces are that he has four children to support, and is limited in the time he can give as a CHW. He said there's not really sufficient food for his family if he does not work. Many have motorbikes in the village, but they have no suture material for lacerations or dressings for wounds. Most villagers want their drugs for nothing and say that they will pay him back later so he provides them from his own pocket. He said 'we love' so we cannot force them to give.

CWH #2: Aye San Da Maung 20 years old, male. He finished training in 2013 his village is Hrin Hang (688 people).

He is the only CHW in the village; after training he was given some drugs by Dr SaSa, particularly paracetamol and amoxicillin.

He taught the villagers basics in personal cleanliness and washing. They have a water pipe in the village but it is very small, is divided into four supplies, and often breaks down. He treats headaches with Panadol, and said there is a lot of diarrhoea which he treats with metronidazole.

His challenges are that many patients come at the same time to see him in his home and he only does home visits, either at his home or the patients' home.

Most of them now have toilets, and he has taught them how to build a toilet but there is a shortage of water in the village.

He sometimes buys medicines for the people but he also gives his own money. He also often works breaking rocks on the road for 3500 Kyats a day, working at 8.30 in the morning and 3.30 in the afternoon.

His wish list consisted of two things, one to have a clinic in the village, and secondly to have a kitchen garden where he could grow vegetables for himself and family and also for people in the village. There is a UNDP government medic in the town who can sometimes provide suture material and local anaesthetic for his needs.

He also wished for more regular and sustained supply of water for the village.

CHW #3: 33 years old works in Taubo Village East of Lailenpi. There is an old part of the village with 465 people in and a new part of the village, with 150 people.

There are two CHW's in the village and she has been there 3 years, and it is five years since she started her training.

In the last three years since 2012 she realised that many villagers were having respiratory problems and diarrhoea. Thus following her training she taught them to drink only boiled water, to wash themselves and to cut the children's nails.

At first only very few believed that it was important!

Before training, about five people died every year from Diarrhoeal diseases and respiratory diseases, but only three people have died in three years since she has been there and these were for conditions that were untreatable in a village setting i.e. cancer and accidents.

In other words, an over 80% reduction in unnecessary deaths. She either sees patients in the home or does home visits.

She will often buy medicines and charge patients plus a small amount for the costs of purchasing them in Matupi and carrying them back to his village. Most of the villagers are farmers and they often get wounds and she has no means of treating these wounds or suturing lacerations. She also has problems getting catheters for use prior to delivery, as although there are midwives in the village they do not have access to either catheters or other medicines.

CHW#4 San Yor, Male of 45 years old he works at Hlo Mo village (275 people).

He has worked there for three years. He said a minimum of five or six children were dying each year, mainly from pneumonia prior to him starting work there, however in the last three years only three have died one died from asthma whilst he was away, a two-year-old boy from the severe respiratory infection and 78-year-old female heavy smoker died following a cough and respiratory problems.

As soon as he returned from Training he formed a village health committee with 7 members.

He told the villages to use water to clean themselves and to keep their houses clean.

Before training, very few had toilets, now more than 60% of the village have ceramic toilets and there is sufficient water, with a pipe supplying the village, however it often breaks and leaks.

For the challenges, he says that most villagers are farmers and many get wounds but he has no dressings or suture packs.

CHW #5: Vanabre 32-year-old male working at Heimata village which is close to Lailanpi (180 people).

He has been at the village for three years and as soon as he returned from training he formed a village health committee and helped people to provide clean boiled water. He encouraged all of them to wash their hands after using the toilet. He encouraged villages to get rid of rubbish around their homes, to always boil water before drinking and to wash themselves daily.

He taught them how to build latrines and keep themselves clean.

He said that there were mostly wooden houses in this village.

Pregnant women are encouraged to drink plenty fluids, but many of them say they get too fat from drinking water!

The main challenge is that he has three children and when working he is often called back for patients, which means he does not have time to spend on his farm to grow sufficient rice for his family. Many farmers cut themselves and he has nothing to suture them with or dressings to put over their wounds.

His Wish List is that he would love some suturing instruments and dressing packs he said he has difficulty supporting himself as patients cannot pay him back most of the time. He gives ORS for Diarrhoea and dehydration and recently had a shoulder presentation of the baby and he had to cut the arms off in order for the baby to be delivered. The mother also almost died but recently returned home from hospital in Sittway healthy and well.

CHW #6: Na Nao 29 years old from Chai Khai village (470 people).

Has 2 CHWs both female and she has been there for two years. She encourages people to clean around the houses and also to sweep the area around to keep it nice and clean. Many key pigs lived outside and she has encouraged them to use pigpens and contain them within them rather than wondering round the houses, she has also taught the children cut the nails and to wash.

Most of the villagers now have ceramic toilets in their homes. During the last 2 years only two people died both of them elderly and of stomach cancer.

Prior to her working at least five died annually usually children and it was usually from respiratory or diarrhoeal diseases. Many of the villages have motorbikes and get wounds from falling off or from working in the forest and she has nothing with which to suture any wounds.

Her wish list would be for suture packs and dressings. She is self sufficient in her village lives with her parents. She only has minimal living expenses but said her patients usually cannot pay so she usually buys the drugs and some pay her back later that many don't. She said that she is always telling the villagers to drink lots of boiled water.

New Trainee CHWs

New recruit number 1: Maw Maw Tin, 22 years old female from Kya Maung Village in Rahkine state (389 people), travelled 10 days in total to reach Lailenpi. The journey consisted of three days on foot, two days on a boat, one day in a vehicle and a further four days walking. She came of her own accord as she had heard from church leaders about the training program on the CHWs in Lalilenpi. In her village many children die unnecessarily and women have died in childbirth. She has spent six months in training and all the people in the village are Christians.

New recruit number 2: Chid Wai, 33-year-old from Man Yaer Gon village in Rahkine state (310 people) is presently undergoing training of having completed six months so far. The journey was four days by boat, two days walking and one day in a vehicle. The village has no CHWs and he heard about the training and just decided to come. He is married with four children has a garden to grow vegetables which he has lent to

others who pay a small rent which will help keep his family alive and fed while he is studying in Lailenpi. He has two more weeks here and then he will go back to his village.

New recruit number 3: Myint Hla Aung, 25 years old, works in Topui village (271 people) and has been in training for six months. The last CHW went to Malaysia in 2013 and the village elders selected him for training. They had in the village another lady who wanted to come but her mother was ill and so she was unable to commit to the training. It took him two days by boat and one day walking to reach Lailenpi, and said he's learned a lot from the training would love to have a clinic in the village, all the people in his village are Christians.

APPENDIX 3.

Aspects of Dr. Sasa's teaching programme:

Dr SaSa's teaching.

1. 4 tutors

2. 5 textbooks: 'Where there is no doctor'; Ted Lancaster: 'Community Health'; Burmese textbook for Health Workers, with especial focus on Pathology and Physiology; Burmese Border Guidelines, Dr. Cynthia Maung; Community Health Education Source book with advice on the establishment of Village Health Committees; psychology, leadership and administration.

3. Books written by students in their own languages to take with them covering the core curriculum.

4. Curriculum

Diseases:

- Pathology
- Diagnosis including differential diagnosis – see below
- Prevention
- Covers 200+ diseases.
- Symptoms
- Treatment
- Discussion and health education for villagers.
- Aetiology

Themes according to Body Systems with Alimentary Tract as one example

- Alimentary Tract:
- Throat
- Stomach
- Duodenum
- Small and large intestine
- Dental and oral pathology
- Oesophagus
- Liver E.g. Cirrhosis;
- Pancreas
- Rectal and anal

Teaching using this 'systems' model includes pathology and differential diagnosis, e.g. Vomiting and Diarrhoeal diseases (e.g. Watery, like rice water; bloody; frothy); cholera with rice water stools, bacillary dysentery or bloody diarrhoea; amoebic dysentery with frothy diarrhoea.

Other systems/themes:

- | | |
|--------------------------------|--|
| 1. Respiratory | 2. Cardiovascular System and blood |
| 3. Urinary Tract | 4. Musculoskeletal |
| 5. Neurological | 6. Reproductive system including STDs, HIV and Family Planning |
| 7. ENT | 8. Immune system |
| 9. Maternal and Child Health | 10. Skin |
| 11. Nutrition and malnutrition | 12. Mental health |
| 13. Health Education | |

5. Teaching aids and examples:

- a) Family Planning: Menstrual cycle: red and green beads for number of days when safe to have intercourse and when likely to conceive: days of menstrual cycle = red; 15-22 – 'high probability to conceive = blue; 5-14 and 22-28 = green when relatively 'safe'.
- b) Differential Diagnoses and probability of different diseases: story of mother with 5 children and a banana she was keeping for her husband when he returned from work.
The banana disappeared; she had to assess which child was the most likely to have taken it.
The oldest child was at school all day
Then next oldest spent the day with his aunt
3rd was with father in the field all day
4th was disabled; spent day at home;
5th was at nursery school and returned home early for the afternoon.
Assessment: the 4th and 5th options are the most probable but the disabled child couldn't reach the banana, so the 5th was the most probable culprit!
Lesson: always assess probability of a diagnosis with the most common being the most likely.