From Rice Cooker to Autoclave at Dr. Cynthia’s

MAE TAO CLINIC
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MAE TAO CLINIC
From Rice Cooker to Autoclave at Dr. Cynthia’s Mae Tao Clinic: Twenty Years of Health, Human Rights and Community Development in the Midst of War

Written and published by Mae Tao Clinic
February 2010

Front cover photo: Dr. Cynthia with a Mobile Medical Team in Dooplaya district treating a child, 1994. [photo: MTC]

The Mae Tao Clinic (MTC), founded and directed by Dr. Cynthia Maung, provides free health care for refugees, migrant workers, and other individuals who cross the border from Burma to Thailand. People of all ethnicities and religions are welcome at the clinic.

Visit: www.maetaoclinic.org

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ACKNOWLEDGMENTS

Mae Tao Clinic presents this book about our 20-year history as a gift to our supporters, donors, and community. The intention of this book is to honor those contributions and support with which the success of the clinic today would not have been possible.

There are many donors, supporters, volunteers, partners, organizations and individuals who may not have been specifically mentioned. We take this opportunity to recognize and appreciate all of your efforts and support over the years.

The text of the book was compiled from the oral history of the clinic as related by clinic staff and by Dr. Cynthia Maung. If it contains any inaccuracies or omissions, it is surely the fault of the editors. If you feel something is incorrect or incomplete, we welcome your stories and facts which will help us to fill out the history of the clinic for future website updates.

Our first priority was to hear the voice of the clinic staff and Dr. Cynthia Maung, and to reflect that to you, the reader. We thank the Mae Tao Clinic staff who took time out from their daily workload to relate stories and facts for the book. Finally, we thank Dr. Cynthia Maung for patiently relating stories and facts from the past. She did this during the quiet hours of the early morning before the Clinic’s day began and during holidays when she could afford the extra hours. We were fortunate that Dr. Cynthia’s memory appears to be as strong as it was 20 years ago when the clinic began.
“We will surely get to our destination if we join hands.”

Aung San Suu Kyi
**LIST OF ABBREVIATIONS**

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ABSDF</td>
<td>All Burma Students Democratic Front</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ARHN</td>
<td>Adolescent Reproductive Health Network</td>
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<td>Anti Retroviral Treatment</td>
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<td>BBG</td>
<td>Burma Border Guidelines</td>
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<td>BCH</td>
<td>Bamboo Children’s Home</td>
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<td>BAMF</td>
<td>Burma Adult Medical Fund</td>
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<td>BCMF</td>
<td>Burma Children Medical Fund</td>
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<td>BMA</td>
<td>Burma Medical Association</td>
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<td>BMWEC</td>
<td>Burmese Migrant Workers Education Committee</td>
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<td>BPHWT</td>
<td>Backpack Health Worker Team</td>
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<td>CBOs</td>
<td>Community Based Organizations</td>
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<td>CDC</td>
<td>Children’s Development Centre</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CMH</td>
<td>Chiang Mai Hospital</td>
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<td>CPPCR</td>
<td>Committee for the Protection and Promotion of Child Rights</td>
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<td>CTDCE</td>
<td>Coordination Team for Displaced Children’s Education</td>
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<td>DKBA</td>
<td>Democratic Karen Buddhist Army</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>GHAP</td>
<td>Global Health Access Program</td>
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<td>HBC</td>
<td>Home-Based Care Program (for HIV)</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HIS</td>
<td>Health Information Systems</td>
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<td>ICRC</td>
<td>International Committee of the Red Cross</td>
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<td>IDPs</td>
<td>Internally Displaced Persons</td>
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<td>INGOs</td>
<td>International Non-Governmental Organizations</td>
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<tr>
<td>IPD</td>
<td>Inpatient Department</td>
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<td>IPU</td>
<td>Infection Prevention Unit</td>
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<td>IRC</td>
<td>International Rescue Committee</td>
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<tr>
<td>KAP</td>
<td>Knowledge and Practices Survey</td>
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<td>KNU</td>
<td>Karen National Union</td>
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<tr>
<td>KWO</td>
<td>Karen Women’s Organization</td>
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<td>KYO</td>
<td>Karen Youth Organization</td>
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<td>KHWA</td>
<td>Karenni Health Worker Association</td>
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<td>MAP</td>
<td>Migrant Assistance Program</td>
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<td>MMT</td>
<td>Mobile Medical Teams</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>MOE</td>
<td>Ministry of Education (Thai)</td>
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<td>MOH</td>
<td>Ministry of Health (Thai)</td>
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<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>MSH</td>
<td>Mae Sot Hospital</td>
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<td>MTC</td>
<td>Mae Tao Clinic</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<tr>
<td>NHEC</td>
<td>National Health and Education Committee</td>
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<td>NLD</td>
<td>National League for Democracy</td>
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<tr>
<td>OPD</td>
<td>Outpatient Department</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care (training)</td>
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<td>PHPT</td>
<td>Perinatal HIV Prevention Trial</td>
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<tr>
<td>PMTCT</td>
<td>Preventing Mother to Child Transmission (of HIV)</td>
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<td>PRC</td>
<td>Public Relations Center</td>
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<td>RH</td>
<td>Reproductive Health Department</td>
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<td>SAW</td>
<td>Social Action for Women</td>
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<td>SHC</td>
<td>Shan Health Committee</td>
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<tr>
<td>SLORC</td>
<td>State Law and Order Restoration Council</td>
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<tr>
<td>SMRU</td>
<td>Shoklo Malaria Research Unit</td>
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<tr>
<td>SPDC</td>
<td>State Peace and Development Council</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendants</td>
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<tr>
<td>TBBC</td>
<td>Thai Burma Border Consortium</td>
</tr>
<tr>
<td>TDH</td>
<td>Terre Des Hommes</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing (for HIV and STIs)</td>
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<tr>
<td>WEAVE</td>
<td>Women’s Education for Advancement and Empowerment</td>
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LETTER FROM DR. CYNTHIA MAUNG

THE ROLE OF HEALTH workers is much more than doing medical things. They need to rebuild the community as well…learn to work together, negotiate, build trust and empower the people. We want the young people to feel that they are the people who can make change. They are the people who can mobilize their community to know basic health rights. We especially hope the younger generation will get involved—as leaders.

When I look at the clinic, I see people working very hard. Sometimes, there’s a lot of pressure both psychologically and financially. Staff have been away from their family for many years, and they always hope to go back home. The people we serve have the same feelings. I think everybody has sad feelings: When can we go back to our homeland?

But the problems in Burma cannot be solved quickly. Even if the SPDC collapses or the political opposition wins the election, the country is still traumatized by landmines, prostitution, street children, broken families. People have lost their dignity and identity. Health services and education are not accessible to the people. All this cannot be fixed within a few years.

So we will expand as long as we need to provide health services for people from Burma. Wherever and whenever there are poor people in the community, we will continue to serve.

We at the Mae Tao Clinic invite you to join us in providing health care and building the community on the Thai-Burma border or wherever there is a need in the world. We hope you feel empowered by the clinic’s successes, rather than impressed or overwhelmed. We want you to understand that you, too, can take on such projects. The key is to start small and grow.

We leave you with lessons we’ve learned over the past 20 years in hopes that our shared experiences may be helpful as you go forward to serve.

Dr. Cynthia Maung
and the Founders of the Mae Tao Clinic
1. **No matter how bad the situation, you can always find ways to make it better.** First, identify existing resources. Start with the people already working as community-resource providers - teachers, religious leaders, village heads, midwives, medics, grandmothers - or the neighbor everyone looks to for help and advice. Take time to listen, show respect, and learn from their experiences. Work with them to identify needs and plan solutions using existing resources.

2. **Try to understand rather than to judge.** If you judge people’s beliefs or practices, it’s harder to work as partners. For example, don’t fault a family for refusing to boil their drinking water if they only have one pot and it’s needed for cooking. Instead, try to provide another pot or find a more appropriate method for purifying their water. Understand people’s resources, emotions, and culture before you try to change their behavior.

3. **You can’t improve the health of the people without improving their community.** Use a comprehensive, sustainable approach: nutrition, sanitation, clean water, medical care, and education. If people understand health and human rights, they’ll have the keys to building a healthy stable community. Then, if those rights are ever taken away, they’ll work to get them back. If the people aren’t educated, if they don’t have jobs, if they’re depressed - they won’t be able to care for themselves or their children. They will starve, get sick, and have accidents. Some daughters will enter brothels and some sons will join the army. They will have no choice.

4. **Train and use local people to work in their own community whenever possible instead of bringing in outsiders to provide services.** Locals have a better understanding of a given political and social situation, geography and culture, and can move around more easily and safely. And since they’re from the area, they’re more likely to stay and network with other local leaders to improve the community.

5. **Wherever you go or whatever you do, reach out.** Don’t isolate yourself. Learn the language and culture of your neighbors and host country. Work together with humble farmers, university professors, large NGOs, small community-based organizations. “Community is not based on ethnicity or country of origin,” Dr. Cynthia says. “It’s based on human rights, human dignity and security.”

6. **Rise above rumors, suspicion and fear.** These are the regime’s most powerful weapons. They turn people against each other, erode the community, and destroy the heart.

7. **Don’t give up, even when things get really bad.** “You can look back over your shoulder, and then they win,” Dr. Cynthia says, “Or you can look forward, and you win.”
IN FEBRUARY 1989, five months after fleeing a brutal military crackdown in Burma, Dr. Cynthia Maung and a small group of students opened a makeshift medical clinic in a rickety wooden house on the dusty outskirts of Mae Sot, Thailand. In the beginning, the clinic had virtually no supplies, no money, and (except for Dr. Cynthia) no staff formally trained in medicine. Other factors compounded their problems; they were in Thailand illegally, and didn’t speak the language.

All of the clinic’s medical instruments fit into the woven bag that Dr. Cynthia had slung over her shoulder during the ten-night trek to escape through the jungle of Burma’s eastern border region. There was a stethoscope, a pair of scissors, two pairs of forceps, a thermometer, a blood pressure cuff, one medical textbook, and a few packets of basic medications. With these limited tools and a commitment to care for all who fled war and oppression in Burma, the Mae Tao Clinic was born.

The clinic’s young founders anticipated returning to Burma within months of their arrival on the border, ideally hoping international pressure would force the junta into peace negotiations with pro-democracy groups and ethnic minorities. “We didn’t expect to be here 20 years,” Dr. Cynthia says. While the fledgling group was establishing what was to become the Mae Tao clinic in Mae Sot, inside Myanmar the civil conflict worsened and the military dictatorship tightened its grip over the country. So instead of returning to reform their homeland, the group continued to work at the humble clinic with limited available resources, using medicine, education, and outreach to relieve human suffering and heal broken communities.

TWO DECADES LATER, the Mae Tao Clinic (MTC) has grown into a comprehensive community health center and a hub for regional health training with more than 1,000 graduates serving clinics, schools, villages, factories, camps and peri-urban slums along both sides of the Thai-Burma border. In some remote areas inside Myanmar, the clinic’s former students have become the only sources of medical care.

With an estimated 2009 budget of 99,413,550 baht (US$2.9 million), the clinic now shoulders an annual caseload of about 90,000 patients; somehow squeezes as many as 200 patients on its 150 beds; runs a jungle field clinic; and feeds 2,000 school children, patients, staff and their families every day. Currently, just over half of the clinic’s patients are from the local Burmese migrant community, with the rest traveling from inside Burma to seek healthcare.

The clinic’s health services have to cope with both acute and chronic medical problems. Staff members treat everything from minor maladies to malaria, tuberculosis (TB), HIV/AIDS, malnutrition, pneumonia, acute diarrheal diseases, diabetes, epilepsy, thyroid disease, cancer and mental illness. The surgical department repairs hernias, drains abscesses, performs vasectomies and treats minor wounds, burns and injuries. The reproductive health department provides family planning, antenatal care, normal (and some complicated) labor and delivery, neonatal care, post abortion care and gynecological services.

The clinic’s eye program provides vision screening, corrective lenses and cataract surgery. A dental program handles fillings, root canals and extrac-
tions. Its prosthetics program fabricates and fits artificial legs, teaches patients to walk on their new limbs and trains survivors for jobs in prosthetics and other vocations.

MTC’s pediatrics department cares for children with acute and chronic illnesses; provides routine immunizations, screens for malnutrition, and distributes de-worming medication, Vitamin A, and supplementary food. MTC also runs thriving health and dental program for 58 migrant schools; and operates a school in Mae Sot for over 1,000 students (including 440 boarders) as well as a Bamboo Children’s Home boarding house in Umpium Mai Refugee Camp for 154 unaccompanied minors.

The clinic’s support services include a lab that processes thousands of malaria smears each year and conducts rapid HIV testing; a rigorous infection control team; a central pharmacy; a health information team that manages the clinic’s registration, patient records, integrated database and financial systems; a community relations team that provides around-the-clock social support for patients and their families, helps locate missing people, arranges funerals, and responds to the needs of those escaping from brothels and immigration raids.

MTC has set up safe houses for abused women and abandoned children; counselling and home-based treatment for HIV/AIDS patients; a mobile medic program to train and equip health workers in war torn areas of Burma and an education and advocacy program to protect thousands of children (many without parents) from malnutrition, child trafficking and labor exploitation.

The clinic also provides emergency food, shelter and medical care in the wake of crises such as Cyclone Nargis, the Saffron Revolution and relentless military attacks in eastern Burma.

In recognition of the clinic’s role in alleviating human suffering, Dr. Cynthia and the Mae Tao Clinic have been honored with many international humanitarian awards, and Dr. Cynthia has been nominated for the Nobel Peace Prize (see Annex: Awards). MTC represents a model for community-based health care, and as such it has received many visits from health and human rights leaders who have shared their support and experiences. Last year, the clinic hosted a delegation of Nobel Peace laureates and the then U.S. First Lady Laura Bush.

Today, surveying the clinic’s array of accomplishments and its sprawl of simple, sturdy concrete buildings, it is remarkable to think that the clinic started with just a few medical instruments stuffed into a woven shoulder bag.

IN THE BEGINNING, there was no blueprint for the Mae Tao Clinic, no comprehensive plan. Instead, the clinic evolved as Dr. Cynthia and the students learned as the needs of the communities and individuals around them. The founding members of the clinic comprised a group of 14 people who fled to the Thai-Burma border in September 1988, traveling mostly at night to hide from the Burmese army, walking single-file to avoid stepping on landmines. Naw Htoo, now a leader in the reproductive health department recalls, “I was 20. I had never been in the jungle before, we were very afraid.”
made a powerful impression on the fleeing students. Initially, many Burmese students distrusted the Karen peoples, a side-effect of a youth spent absorbing the military’s propaganda about “ethnic insurgents.” Such is the power of the military’s propaganda machine that these young students were not then aware that the junta had torched, displaced and abused thousands in ethnic areas, a situation that continues today. The villagers in the ethnic rural areas were likewise wary of the students; due to their isolation they hadn’t heard of the democracy movement or the turmoil that had recently shaken the capital.

“On the border, for the first time, opposition groups eventually began to cooperate and, for the most part, trust each other.

From the chaos and instability of these early years emerged the keystones that would guide the clinic for the next two decades: Dialogue. Cooperation. Generosity. Trust. Training.

When she first arrived in Thailand, Dr. Cynthia and her friends stopped at Mae La1 opposite Beh Klaw refugee camp in the Tha Song Yang district. Here Dr. Cynthia worked at a small hospital treating those fleeing the border, assessing the healthcare situation and distributing donated paracetamol and quinine for malaria. Later, Dr Cynthia cared for malaria patients in the home of a Karen leader, but the house could not accommodate the numbers and soon became overcrowded.

In February 1989, a Karen family offered Dr Cynthia and her associates a dilapidated wooden stilt-house on the outskirts of Mae Sot as a possible location for treating patients. Dr. Cynthia and five students moved into the run down building. Sein Hein, one of the founders, recalls, “When we arrived at the new place for cleaning, I was really in despair, seeing the old building all the democratic movement and the ethnic revolution met,” Dr. Cynthia says. The ethnic groups talked of autonomy; the students spoke of democracy and human rights. The arrival of democracy advocates in the traditionally ethnic strongholds of eastern Burma fomented a political awakening for both students and civilians, as well as those seeking greater autonomy and rights for the ethnic regions. The two groups’ widely disparate political aims however, initially created distrust. There was also massive confusion in the aftermath of the crushed revolution as thousands of people tried to find their friends and families, flee the cities and organize resistance groups. Despite the chaos resulting from the military crackdown, fighting. Diseases were rampant: diarrhea, pneumonia and malaria among them. In addition to the dangers of a life on the run in jungles, many were afflicted by homesickness and a longing for loved ones who were left behind in the disorganized flight. Some tried to return to Myanmar; others decided to stay.

After a month or so, Dr. Cynthia’s group moved to Hway Ka Loke refugee camp and there they made contact with Karen leaders responsible for student affairs and with local Thai authorities and church groups who were sympathetic to the people’s plight. Together, they tried to organize, prioritize and organize treatment for patients. Dr. Cynthia visited five student camps most falling down in decay with a lot of spider webs, dirty with charcoal and surrounded by bush forest.” Naw Htoo, another member of the original group, remembers, “We had nothing! No mosquito net, no blanket, no food! I said: Give me 5,000 baht! And I went out and bought 20 pillows and blankets” and other basics with which the group set up their clinic.

The first two years were driven by a motivation to help fellow refugees and was made possible by the creative ability to adapt and optimize limited resources. The group cared for students recovering from severe malaria, delivered food to those who were hospitalized, and nursed them back to health after they had been treated. The group

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1 Mae La is also known as ‘Beh Klaw’ in Karen, which means ‘cotton field’ due to the agricultural activities for which Karen leaders first negotiated permission for refugees to cross into the area in 1984.
solicited medicine and food from Catholic relief workers and other donors.

At this time the group lacked an autoclave, so Dr. Cynthia improvised by sterilizing her few precious instruments in a rice cooker, an innovation inspired by necessity.

Since nobody else in the group had medical training, Dr. Cynthia began holding informal two hour “discussions” at night to teach some of the students practical medical skills. Over the years, the trainings became more extensive, evolving from a week-long seminar, to maternal/child health training, and finally into comprehensive primary health care training.

Today, in partnership with the Burma Medical Association (BMA) and volunteer professionals, the clinic offers a six-month community health worker course that can be upgraded with an additional ten months of medical training. The clinic also offers specialized training in obstetric emergencies, pediatrics, eye and dental health, counselling, laboratory work, prosthetics and minor surgery, field medicine for backpack health workers and reproductive health for traditional birth attendants. Backpack health workers provide basic mobile medical care to village communities inside Burma, and traditional birth attendants (similar to midwives) integrate western medicine with traditional medicine to assist in childbirth.

IN 1990, DR. CYNTHIA WAS in Papun in Karen State with a mobile medical team when she heard a radio report about Burma’s election results: Aung San Suu Kyi’s party, the National League of Democracy, had won 92 percent of the vote with 98 percent turnout! But she simultaneously heard gunfire in the jungle as Karen troops and the junta continued to battle. She realized freedom would not come overnight to Burma.

In 1991, the clinic expanded its services, and began to open regularly from 9 to 12 in the morning to treat an increasing number of patients with malaria, respiratory diseases and diarrhea as well as gunshot wounds and land-mine injuries. The clinic was still functioning without a microscope, so patients with symptoms of fever, chills and severe shaking chills (rigor) were presumed to have malaria unless the medics could find other causes. Later that year, Médecins Sans Frontières trained Chit Wen and Poo Hjoo to detect malaria in slides of patients’ blood using a microscope that had been donated to the clinic.

Around this time, battles raged at Wang Ka, a Karen stronghold near Mae Sot, and this unrest precipitated an increase in clinic staff. Many of the adolescent students from the Karen areas were sent to the clinic for safety. When Wang Ka ultimately fell to junta forces, many of the young students made the clinic their new home, trained as medics and became an integral part of the staff.

In the refugee and IDP camps, the older students began to marry and start families. When mothers-to-be were ready to deliver their babies, they came to the clinic and slept in the adjacent room to Dr. Cynthia and Naw Htoo. For the babies who came at night, Dr. Cynthia and Naw Htoo were right there to help the mothers through their labor and delivery.

In 1995, in response to growing need, the clinic set up a maternal child health program with a Saturday morning vaccination clinic, antenatal care, family planning, reproductive health services and a separate delivery room. The following year, 156 babies were born at the clinic. By the year 2008, the number of women giving birth at the clinic had risen to 2,500 per year.

Pregnant women who were severely anemic from malaria had to be referred to Mae Sot Hospital for blood transfusions. As a way of providing in-house blood transfusions for these women, the clinic decided to set up its own blood lab, complete with HIV testing. The lab was also equipped to screen pregnant women for HIV, hepatitis B and syphilis. Aside from the refugee camp hospitals, this was the first time that the migrant and displaced populations effectively had access to these tests. Most would never be able to afford these tests in Thai or Burmese hospitals.

When MTC first began antenatal screening, the HIV prevalence among pregnant women was 0.8 percent. By 2003, it had more than doubled. Rising HIV rates prompted the clinic to take a more proactive approach to the increasing risk of infection. To augment its previous program of general HIV education in factories, clinic staff set up a voluntary counseling and testing program to target people at risk for HIV. People who identified themselves as HIV positive were invited to join a support network and become peer educators or home-based health workers for other HIV patients. Today, in an effort to decrease HIV transmission from mother to child, the clinic collaborates with Mae Sot Hospital to provide antiretroviral treatment to pregnant HIV-positive women and newborns. Currently, 13 HIV-positive patients are treated with anti-retroviral drugs and the clinic continues to work with Mae Sot Hospital to increase the number of patients eligible for treatment.

While the clinic was focused primarily on the medical needs of those on the Thai side of the border, as well as those who could make the cross-border journey to receive health care, it simultaneously continued to expand its outreach in Karen State. Typically, mobile medic teams traveled to remote locations on foot, carrying supplies in back packs or woven bags braced by their foreheads. During the few days that these teams stayed in each location, their mobile clinics were crowded with patients from distant villages that in normal circumstances had no access to health care. The need was so great that Dr. Cynthia worked with village leaders to set up satellite field clinics in Dooplaya and Chogali villages in 1992 and later in the villages of Sa Khan Thit, Pa Hite, Mawkee and Mae La Po Hta.

The field clinics took a holistic, community-based approach, providing basic medical care plus latrines, nursery schools, nutrition, immunizations,
vitamins, deworming, simple clean-water systems and training in safe delivery techniques for traditional birth attendants. Unfortunately, within five years the military had attacked and destroyed every field clinic except one. Today, only Pa Hite survives; it is a remote jungle clinic which from Mae Sot involves a journey of six hours by road, another six hours by boat and finally a six or more hour walk.

In 1998, the year after the clinics in Chogali and Sukhundit were destroyed, Mae Tao Clinic worked with medical partners from Karen, Karenni and Mon States to organize the Back Pack Health Worker Team (BPHWT). The group’s mission is to provide primary health care in rural and ethnic armed conflict areas where medical care is scarce or non-existent. Initially there were 32 backpack teams with 120 health workers. Currently, 80 teams, with three to five members each, deliver health services and education to more than 160,000 displaced people in territory including Arakan, Pa O, Shan and Lahu areas. Back pack health work is crucial, but dangerous. The risks include capture, imprisonment, injury from landmines, rape and death.

In the past decade, seven Back Pack health workers and a traditional birth attendant have been killed and six arrested while delivering health care inside Burma. Four remain in prison.

Over the years, local health providers have proven themselves to be the safest, most effective and sustainable way to provide health care in remote rural areas affected by armed conflict. The Back Pack model utilizes local capacity and knowledge by training local people and sending them back to work in their own communities. Typically, Back Pack teams journey to headquarters in Mae Sot every six months for more supplies and training.

When Chogali and Sukhundit fell in 1997, the field clinics’ medics fled to Mae Sot with the nursery school teacher and a dozen young students. Dr. Cynthia built an open-air bamboo school for the children in the fields behind the clinic; later they moved to Hway Kaloke refugee camp where they were able to attend an established school and live in a treehouse dormitory known as the Bamboo Children’s Home. After Hway Kaloke was torched multiple times, the children moved to Umpium Mai Refugee camp where they now attend school and are cared for by clinic staff. Today, the Bamboo Children’s Home in Umpium Mai houses 154 unaccompanied children.

Apart from the Bamboo Children’s Home, the clinic also runs a day school for 1,200 students (children of migrant workers and clinic staff). The school accommodates 440 boarders, and coordinates a health, vision and dental program for 58 local migrant schools. Last year, the clinic also provided emergency funds for food and shelter for 1,440 unaccompanied displaced children in migrant areas of Thailand and 295 children displaced in war zones inside Burma.

An unprecedented number of Burmese migrant and refugee families have poured over the border into Thailand since the increased military offensives of 2007 began in the eastern ethnic areas of Burma. They have come seeking safety, jobs and medical care as the Myanmar military steps up attacks in conflict zones, destroys villages, rice fields and food stores, terrorizes women, and deprives people of basic human rights, including the right to livelihood.

The Saffron Revolution in September 2007 as well as Cyclone Nargis in May 2008 also forced more children to seek safety and education across the border. After the September uprising in which more than 100,000 monks and unarmed citizens demonstrated against the military dictatorship, the government closed many monastery schools, a traditional source of education for the children of families who cannot afford the moribund state education system in Burma. Although the
education system is technically free, the bribes and the financial burden of providing textbooks and contributing to teachers' salaries, for example, make even basic education untenable for many impoverished families in Burma.

All of these factors - war, poverty, displaced families, torn communities, lack of rights – force children into vulnerable situations. Children face exploitation in factories, farms, brothels and dysfunctional families on both sides of the border. In response, the Mae Tao Clinic and several community-based organizations set up the Committee for the Protection and Promotion of Child Rights (CPPCR), as well as a safe house for abused and abandoned children. CPPCR has held workshops which teach vulnerable communities how to avoid predatory employers, and is working on a Child Protection Policy and minimum standard of care for children in boarding houses.

In 2008, the clinic worked with Thai authorities to develop a delivery certificate to issue to all babies born at the clinic, enabling their parents to later obtain a Thai birth certificate for their child. The certificate does not give Thai nationality or citizenship, but does give the stateless children a recognized birthplace and the right to attend Thai schools providing that fees are paid.

CPPCR is set to publish a report documenting the violence, poverty and exploitation faced by migrant children. The goal of the report is to raise awareness among the children themselves as to what their rights are, and to learn how to speak out and seek help. It will also be used as an advocacy tool to lobby for legal protection for these vulnerable children.

The Mae Tao Clinic, in partnership with community groups and academic researchers, is also conducting research this year on the health of migrant school children and quality of care for Burmese migrant women who have had miscarriages or self-abortions.

Why research? In Burma, the State Peace and Development Council (SPDC) tightly controls information and much of what it relates to the public through state-controlled media and government ministries is propaganda. “Research provides accurate information,” Dr. Cynthia says, so the community can advocate for causes based on real numbers and choose how to respond to health care needs in an ethical and appropriate way. Research can identify barriers to health care, gaps in service provision and can show which services should be improved.

Looking ahead, the Clinic plans to work with community groups and Thai supporters to develop the Suwan Nimit Foundation (which translates as “Golden Dreams”). This new Thai-registered NGO will work on issues related to migrant schools, community education, health outreach and child protection. The MTC also hopes to establish a community training center for Burmese organizations in the Mae Sot area.

Across the border in Burma, the health care and economic system continue to deteriorate, forcing more and more people to leave their homeland to survive. It has commonly been reported that patients in Burmese hospitals have had to pay special fees merely to receive an adequate level of medical attention in a system where doctors receive low salaries and are infrequently paid, as is common in the Burmese civil service. Meanwhile, access to healthcare in the rural areas affected by conflict is close to non-existent.

Nearly half of the patients at Mae Tao Clinic are “medical migrants” who cross the border seeking health care that is normally unavailable to them in their own country. “When I look at the clinic, I see people working very hard,” Dr. Cynthia says. “Sometimes, there’s a lot of pressure both psychologically and financially. [Staff have] been away from their family for many years, and they always hope to go back home. The people we serve have the same feelings. I think everybody has sad feelings: When can we go back to our homeland? But the problems in Burma cannot be solved quickly. Even if the SPDC collapses, or the political opposition wins the election, the country is still traumatized by landmines, prostitution, street children, broken families. People have lost their dignity and identity. Health services and education are not accessible to the people. All this cannot be fixed within a few years. So we will expand as long as we need to provide health services for people from Burma. Wherever there are poor in the community, we will continue to serve.”
The first wave of Burmese refugees arrived in Thailand in 1984 when a major Burmese Army offensive broke through front the front lines of the Karen National Liberation Army (KNLA) forces, opposite the Tak Province of Thailand. This first group of 10,000 refugees remained in Thailand after the Burmese Army was able to maintain the territory it had gained. The Karen National Union (KNU) and its armed wing the KNLA, has been in rebellion since the late-1940’s, with aspirations of independence from the Burmese state. The Burmese Army sought to strengthen its position in Karen State from 1984 to 1994, and followed this with the sacking of Manerplaw, the KNU headquarters in 1995. After the fall of Manerplaw, the SPDC army forces began a campaign of assimilating the ethnic areas through forced relocations. With each escalation of conflict, refugees and migrant workers have streamed across the border to Thailand either as a result of conflict, forced relocation, or general economic hardship. Nearly 3,000 ethnic villages have been destroyed since 1996 affecting over one million people. It is likely that more than 300,000 have fled to Thailand as refugees (the majority of those being Shan and not recognized by the Thai government). In 2008 there were estimated to be over 500,000 internally displaced persons (IDPs) in the eastern states and divisions of Burma bordering Thailand.

In a parallel development to the subjugation of the rural ethnic minority areas, the democracy movement crystallized in 1988 when students and monks participated in mass demonstrations against the military. When the uprising was violently suppressed on September 18th, about 10,000 ‘student’ activists fled to the Thailand-Burma border. While the students aspired to a democratic state, the ethnic groups aspired to independence from the Burmese state. An uneasy partnership began with the students establishing offices at the Karen National Union (KNU) headquarters at Manerplaw, and also setting up about 30 of their own ‘student’ camps.

Throughout this book, camps are mentioned in three contexts;

Refugee camps in Thailand comprised (at least initially), of border ethnic minorities fleeing conflict, the first of which was established in 1984. At the end of 2008 the population in refugee camps in Thailand was estimated at around 150,000, including many unregistered people.

‘Student’ camps comprised of the pro-democracy activist groups who had fled mainly from Rangoon to take refuge in ethnic controlled areas. The ‘student’ camp numbers declined quickly from 10,000 in 1988 to 3,000 in 1989. By 1997, the Burmese Army took control of the border area which pushed the remaining ‘student’ camps into Thailand. At this time, most of their numbers were integrated into refugee camps. The term ‘student’ is used, although the groups consisted of students, teachers, university professors, young professionals, monks, and other activists.

IDP camps comprised of those forced to relocate internally in Burma since 1996. This population includes approximately 224,000 people currently in temporary settlements of ceasefire areas administered by ethnic nationalities authorities.

Mae Tao Clinic’s current patient

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2 For further detail on the border conflict, refer to TBBC 2008 Report, Appendix F.
population, listed below, comes from an overlapping constellation of groups, each facing different challenges in health care prevention, education and treatment:

- Migrant workers and their families living in Thailand, population estimated at 2 million.
- Unaccompanied or orphaned children living in Thailand.
- Refugees in camps in Thailand (est. 150,000).
- Cross-border patients from civil society unable to obtain or afford health care in Burma.
- Internally displaced persons (IDPs) living in camps or in temporary locations in Burma (estimated to be between 500,000 and 2 million).6

Even though the migrant population is difficult to quantify, it represents an enormous group with unmet health care needs. The Burmese migrant population is typically estimated at about 2 million, most of whom have little access to health care, are exposed to tropical and infectious diseases, and have little access to pre-natal care and overall preventative care. Moreover, many migrant workers do not possess legal residency in Thailand; therefore they have difficulty travelling to a health care provider without fear of arrest, harassment, or deportation, and don’t have legal access to Thai health providers. On the positive side, CBOs can often access these populations in their places of employment, such as in factories, for health and reproductive education initiatives.

Children of migrant populations at times reside in boarding houses or other informal living arrangements which are often overcrowded. There are usually very few adults present which results in the older children caring for younger children. This makes early identification of health problems difficult. Even after identification, there is typically little funding available for transport or treatment expenses.

Refugee camps in Thailand administered and managed by INGOs and CBOs have clinics and/or hospitals onsite. At times however, their patients are referred to MTC either due to a special patient need or preference. Additionally, cross border patients seek health care at MTC for a variety of reasons. They may not have access to health care in Burma due to their security situation or political status. If they do have access and can afford associated costs, patients report that care is expensive and of poor quality. Many patients are forced to make the journey to the MTC because of a lack of service provision or prohibitive costs in Burma. This can sometimes entail a journey of thousands of kilometers. These cross-border patients come from both civil and IDP populations. Although difficult to confirm or qualify, research suggests that: “Burma’s healthcare system is the most discriminatory in the ASEAN region, with responsiveness likely to depend upon an individual’s ethnic group, income level, or civilian versus military status. The health problems are exacerbated by the ongoing armed conflict, which disproportionately affects the ethnic groups.”7

Naturally, any other patient who ‘falls through the cracks’ may seek care at Mae Tao Clinic. For example, members of the non-state armed groups, military, government in exile, monks, and others from all states of Burma also seek care at MTC.

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## CLINIC STAFF

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Today the clinic’s staff spans a range of age, experience, and ethnicity. A visitor to the clinic might hear three or four languages being used at any given moment as the staff go about their work. Medics volley in conversation, jumping between Burmese, English and their own ethnic languages. Of course, the original founders of the clinic were from the Karen and Burman ethnic groups, however, this was due mainly to the proximity of the clinic to Karen State, and the linguistic needs of the majority of patients. Despite the traditionally large contingent of Karen speaking staff, recent years have shown a growing diversity in the languages used in the daily running of the clinic’s operations. An example of this diversity is the clinic’s small community of Arkanese speaking medics from Arakan State in western Burma. In their case, the journey to the clinic was long and treacherous, crossing the entire breadth of the country. If a visitor takes the time to sit under one of the shade trees at the clinic and listen to their story, they will proudly explain that they came to Mae Tao Clinic to receive training, to hope for change in Burma, and that they hope to return someday to help their people. They explain that there are few such opportunities for them to gain the training and experience necessary to assist their people in Arakan State equal to the ones that they receive at the clinic.

While in the clinic, the medics wear uniforms and identification badges and are respected authorities, however, they dare not travel far from the clinic, since most do not have legal status in Thailand. Whilst this is restrictive, the limitations have led to a lively social scene in and around the clinic. Births, weddings, deaths, and festivals are celebrated within the clinic society, with staff quarters centered around the clinic grounds. When Dr. Cynthia remarks, “This is not only a clinic, it is also a village”, one can see that this applies to both patients and staff.
A COMMUNITY OF ORGANIZATIONS

Mae Tao Clinic has evolved from a service provider into a network of organizations. Some organizations are part of the clinic umbrella, such as the Children’s Development Center, while others which remain technically separate are tightly woven into the fabric of the clinic, such as Karen Women’s Organization. When a meeting is held at the clinic, one can observe how a tight community, a little chaos, a lot of mobile phone calls and text messages, a few bicycles and motorbikes and a few rides hitched from a friend all make the process work. Sometimes there is too much chaos and not enough coordination and communication; other times, things seem to magically come together. As Mahn Mahn from Backpack Health Worker Team exclaims, “There is never enough communication and coordination!” With the clinic’s work a constant struggle between tight resources, high demand and a multicultural staff of varying experience, this is hardly surprising.

Throughout the book, many of the organizations within the clinic’s network are highlighted. The reader will begin to realize that the community-based organization and collaboration has been increasing exponentially during the last ten years. The clinic’s shift from service provider to advocacy, prevention, and child protection has been one element that has precipitated this change. The other element has been the expanding border and migrant populations; community based organizations are their only source of health care and education. One element that is frequently overlooked in the success of these collaborations is the spirit of the Burmese, Karen, and multiple other ethnic groups; a spirit that allows these diverse groups to help themselves and each other and has led to a flourishing of community-based activities.

Any reader of this book will also be interested to learn about the following MTC CBO partners, who are recognized here for their efforts throughout the years:

- Adolescent Reproductive Health Network (ARHN)
- Assistance Association for Political Prisoners (Burma)
- All Burma Student Democratic Front (ABSDF)
- Back Pack Health Worker Team (BPHWT)
- Burma Labour Solidarity Organisation
- Burma Medical Association (BMA)
- Burmese Lawyers’ Council (BLC)
- Burmese Migrant Workers Education Committee (BMWEC)
- Burmese Women’s Union (BWU)
- Care Villa
- Committee for the Protection and Promotion of Child Rights (CPPCR)
- Coordination Team for the Displaced and Promotion of Child Rights (CTDCE)
- Human Rights Education Institute of Burma (HREIB)
- Kachin Women’s Association Thailand (KWAT)
- Karen Department of Health and Welfare (KDHW)
- Karen Education Department (KED)
- Karen Refugee Committee
- Karen Student Network Group (KSNG)
- Karen Teacher Working Group
- Karen Women’s Organisation (KWO)
- Karen Youth Organisation (KYO)
- Karenni Health Worker Association (KHWA)
- Lahu Women’s Organisation (LWO)
- Migrant Assistance Program (MAP)
- National Health and Education Committee (NHEC)
- Palaung Women’s Organisation (PWO)
- Shan Health Committee (SHC)
- Shan Women’s Action Network
- Social Action for Women (SAW)
- Student Youth Congress of Burma (SYCB)
- Women’s League of Burma (WLB)
- Yaung Chi Oo Workers Association
1989 – 1994:
THE BEGINNING

MTC in 1989 - 1990
REFERRAL PROGRAM

MANY PEOPLE DON’T REALIZE that the Referral Program is the longest running program at Mae Tao Clinic. Before the staff of the clinic had the supplies and capacity to treat many of the patients that they saw, they were referring them to Mae Sot Hospital (MSH). In 1988, student camps were established along the border, mainly by students who had come from central Burma, and were not from Karen State or border areas. In the beginning, the cases that couldn’t be treated in the student camps were referred to MSH through coordination at MTC. At this time, MTC was more like a patient house, sending 20-25 cases per month to Mae Sot Hospital. Today the clinic is able to treat malaria cases, and deal with more severe injuries, but there are still patients that require services beyond the clinic’s capacity.

The majority of the patients that enter the Referral Program have crossed the border from Burma for medical services. They are seeking services that are either not available in Burma, or that they cannot afford; the journey to Mae Tao Clinic however, means free health care services. Some of the most common cases seen for referral are congenital heart disease and severe fractures in children, and myoma, uterine prolapse and ovarian cysts in adult cases.

Less than 1% of cases are referred to hospital, but require 15% of the clinic’s budget.

The referral team consists of 10 staff, managed by Saw Tin Shwe. The role of the staff is to be in regular contact with the clinic departments, coordinating the travel of referral patients to Mae Sot Hospital and then acting as translator and social support for patients during their visit to the hospital. For this reason, it is necessary that these staff members speak several languages each, possibly including Burmese, Pwo Karen, Sgaw Karen, Thai, and English, and to possess a Thai identification card allowing them to travel freely in Mae Sot without threat of arrest. Each morning the referral patients are gathered at 8:00 am for transfer (an often tricky task in the torrential downpours of rainy season, as the Referral Program does not actually have a specified office or covered area for patients to meet). Each patient is assigned to a member of the referral staff. Along with the patients, blood samples are taken to the hospital for testing of renal function, liver function, thyroid function, and all blood donor samples are sent for screening, and some biopsy for testing. MTC also supplies 40 baht per patient per day for food while at the Mae Sot Hospital. The referral team provides all transportation, as it offers security which helps patients avoid being arrested.

The referral staff speaks several languages... Burmese, Pwo Karen, Sgaw Karen, Thai, English, and others.

Of course not all cases that go beyond the services of the clinic will actually enter the Referral Program. Mae Tao Clinic allocates a monthly budget which is used to pay for treatment at larger service providers such as Mae Sot Hospital. Emergency and the most severe cases get referred first, but non-emergency cases do not often get referred. Most referred cases are surgical cases, as medical cases can be treated at the clinic, with exceptions being chronic diabetes cases, and HIV positive pregnant women.

MTC does not handle all patient referrals alone. Since 2004, the International Committee of the Red Cross (ICRC) has been supporting all landmine and gunshot wound cases for the first visit to MSH. For follow-up vis-
TB patients to a Médecins Sans Frontières (MSF) program in Mae Sot for comprehensive treatment. However, with MSF discontinuing this program, MTC isn’t able to refer most TB patients for treatment. Beginning in 2008, World Vision has established a less comprehensive TB treatment program in Mae Sot that does not include cross border patients.

The manager of the Referral Program, Saw Tin Shwe, is saddened and frustrated about the patients who still go untreated. He suggests that even if patients are presented with the opportunity of entering one of these referral programs and go to Chiang Mai Hospital for treatment, they do not always take the offer. From his experiences at the clinic, Saw Tin Shwe provides a variety of reasons as to why this happens: a patient or patient’s parents may lack general health knowledge and fail to understand the severity of the illness, the patients and their family fear traveling to Chiang Mai where they do not speak the language, and do not possess official documentation beyond the referral notice from MSH, or the patients or patients’ parents need to return home to care for other children or return to work to support the rest of the family. When asked what he wishes for the Referral Program Saw Tin Shwe easily responds, “more money.” With a larger budget there would never be a question of which patient takes precedence, or who is more severely ill. At this point, non-emergency cases do not get referred, but with a larger budget patients suffering from a wider array of conditions could also receive treatment.

Emergency obstetrical care comprised of 12% referral cases in late 2008, 22% emergency medical cases, and 25% general surgical cases in late 2008. Two imposing challenges are chronic budget limitations at Mae Tao Clinic to refer more patients, and capacity at Mae Sot Hospital to handle the ever increasing caseload.

MTC sees many neonatal complications. Along the border, most deliveries still occur at home. As a result, patients come to MTC after serious problems arise such as premature labor, infection or hemorrhage. When these cases have to be referred, the costs involved are quite high, so the clinic continues to upgrade it’s neonatal and delivery skill set.

Besides an unlimited budget, Saw Tin Shwe expresses a few other wishes for the program: as the only referral team member with a medical background, it is nearly impossible for Saw Tin Shwe to take a day off. He hopes that in the near future the Referral Program gains 2 or 3 new staff members with a medical background, although this poses a greater challenge than one might think. Saw Tin Shwe explains that not many medically trained staff are interested in working with the referral team, as they do not actually practice medicine, but rather facilitate the opportunity for patients to receive medical care elsewhere. Moreover, even if a medic were interested, the likelihood that they also speak Burmese, Karen, and Thai, and possess a Thai identification card is unlikely. Individuals who have strong language skills and possess a Thai identification card are understood to be very valuable assets to any organization, making them highly employable. Many of these skilled individuals are already employed by INGOs, and receive a salary much larger than most CBOs can offer, thereby depriving CBOs of a much needed resource.

Still, Saw Tin Shwe has hope; he hopes that more staff will understand the benefits of working with the Referral Program. Because the Referral Program coordinates closely with so many of the clinic departments, it provides employees a unique opportunity to learn about and understand the functioning of the clinic on a much larger scale than if working as a medic in only one department. Also, to be part of the referral team means providing invaluable support to the patients: providing security in transportation, providing comforting support to sick patients who are in a very unfamiliar environment, and acting as a translator and to ensure illnesses aren’t mistreated or go untreated all together.
It is common for many to assume that the trauma department was the first program in Mae Tao Clinic, however, this is not the case. While the original intention behind establishing the clinic was to provide referral and recovery services, there was still a need for Dr. Cynthia and her team to take care of burns, abscesses, and minor work injuries. Today, one might be more likely to encounter complex operations such as hernia surgery, bladder stone removal or a vasectomy. What is now known as the Dressing and Surgical Department was originally known simply as “Dressings”, and later, “Trauma”, and was part of the single department of the original clinic facility. The staff tended to skin infections such as cellulitis, as well as abscesses, some burns, and minor work injuries like lacerations and nail punctures. Originally there was one room with two beds – one for medical patients and one for dressing (trauma) patients. The current Surgery Department continues to treat trauma cases, but has transformed into a surgery and recovery department with an increased focus on medical cases. The medics note that the changing functions of the department are not just a matter of a bigger caseload, but also a question of seeing a broader and more complex range of ailments.

Initially trauma had one separate room, mostly for dressing and stitching. Starting in 1999, Norwegian trained medics (Trauma Care Foundation) trained local medics over the course of three years; these local medics were working in the jungle, doing war casualty management. This intensive training made more services available and upgraded surgical procedures. Naturally, the team of health workers who received training was very eager to upgrade the surgical facility.

These trainings facilitated changes from 2002 when the number of surgeries began to increase. In 2001 the dressing services moved to a separate building with more space for tending to traumas. Surgical procedures were introduced in 2002, under the instruction and supervision of international volunteer doctors. Department Manager Saw Law Kwa recalls how he first observed and assisted the visiting doctor, but after about 15 patients the roles changed and he was performing his first hernia operation.

The first surgical space was small and dark, with the staff quarters later added on the floor above it. The medics living above were always careful to walk quietly so as not to disturb operations going on below. A new operating theatre was built in 2004, offering a much larger and brighter air-condi-
tioned space with improved equipment, allowing staff to more comfortably perform a variety of surgeries, including hernia operations, hydrocele, vasectomy, skin grafts after burns or cellulitis, amputation, bladder stone removal, and penile repair after infection resulting from penile enhancement (coconut oil is injected into the penis to increase size and rigidity).

Burns are a very common type of trauma treated at the clinic. Some of the most preventable traumas are the accidental burns of children. Called fire-pit burns, children come in with major burns to the feet and legs, as a result of running through the ash of fires thought to have gone out. Fires are often built under stilt houses as a way to ward off mosquitoes during the night, so if children are up in the morning before their parents, or the parents are already working and cannot tend to the children, the results can be devastating. The clinic is never without one of these fire-pit burn cases.

For severe cases that cannot be treated at MTC, patients are referred to Mae Sot Hospital. The most common referral cases are severe fractures (open or closed), abdominal injury, head injury, landmine injuries, and severe burns. After being treated at the hospital, patients return to MTC for post-operative care. If the patient has the ability to walk they will stay in the Patient House at the back of the clinic property; if not, they will stay in the Trauma and Surgery Department. These patients receive daily dressing changes, and rehabilitation support for as long as necessary, which could be anywhere from one to six months, or even longer if there are post-operative complications. Patients with severe fractures usually require the longest rehabilitation time.

Law Kwa explains that they often have patients who want to continue staying at the clinic after their treatment is finished. This is understandable, as the clinic provides a safe environment, with free shelter and food; a much easier existence than what many will have to face after leaving the clinic. Unfortunately the clinic cannot allow these patients to stay; they must make space for the many patients coming in behind them. There are exceptions to every rule though. Law Kwa recalls the story of Khun Myo Myat, a previous patient who is now a staff member in the department. At the end of 2006, Khun Myo Myat had an accident while working at a construction site in Bangkok. He fell from a tower, severely fracturing a leg and his jawbone. Not long after this, he was arrested by police, and sent back to the border crossing in Mae Sot. Khun Myo Myat was still suffering from his injuries and did not know what to do; he certainly didn’t want to cross the border back into Burma. Luckily, a kind stranger at the border brought Khun Myo Myat to the clinic. When he first arrived at the clinic he could not speak to anyone, and was thus unable to explain his story. Regardless, the staff tended to his wounds and waited for his jaw to heal. Once the wounds had healed, about four months later, Khun Myo Myat was faced with the decision of what to do and where to go. He had left Burma nearly 20 years earlier, his parents were dead, and he didn’t know where his sister was; he didn’t know where to go. The department staff spoke with Dr. Cynthia, and it was decided that Khun Myo Myat could stay on as a cleaner in the surgical department. When asked why Khun Myo Myat was an exception to the rule, Law Kwa responds, “He is from Shan Dying a burn.
state...a long distance to travel. We can also say that he is lucky.” Lucky indeed.

Law Kwa would like to reduce the need for patient referrals to MSH, saving the clinic money and patients undue stress. Currently, the clinic is fortunate to have volunteer doctors that come for short-term visits and perform very specialized services, such as talipes surgeries, but the department would like a more sustainable solution and to be able to further develop the skills of the staff. Adding new procedures to the list already performed by the department would, however, require a great amount of training in new skills and knowledge, and most importantly, regular ongoing support from trained professionals. Because it is difficult for international doctors to visit for extended periods of time, and the clinic cannot offer financial support to volunteers, the likelihood of this seems distant, but the staff continues to hope.

The staff also expresses a wish to work more closely with the local Thai community, to establish more partnerships and relationships, to better know and understand the community that they now call ‘home’.

The surgical department shares the challenge of psychosocial issues with the Inpatient Departments. The department takes a pragmatic approach, which revolves around patient education. First, they try to learn as much about the patient as possible in order to gain an understanding of the broader circumstances faced by the patient. They then educate the patient through confidential conversations, supplemented by educational pamphlets in Burmese language. Educating the patient yields multiple returns – the medics report that patients tend to talk to other patients about their experience at the clinic once they have returned home, thereby acting as conduits of knowledge in their communities. The medics even educate patients about the health implications of smoking, drinking and risky sexual behaviors. The counseling center is a relatively new addition to the clinic, but already enjoys a strong partnership with the surgical department. While the medics feel it is an integral part of their job to manage the psychosocial issues, they also appreciate the need for more extensive support for the patient and work to ensure appropriate referrals.

The medics themselves suffer from psychosocial problems as well. When patients tell medics about their experiences whilst seeking health care in Burma, they feel disappointed and sometimes hopeless for the future of their homeland. The patients’ stories relating the cause of their visit to the clinic lead to mental and emotional challenges for the medics who deal with victims of trauma on a daily basis. There are also many positives associated with this type of work as well however; when asked what was the most satisfying part of their job, the medics said it was the satisfaction derived from treating a patient successfully and helping them get back to their families and jobs.
REPRODUCTIVE HEALTH

The Reproductive Health Program’s goals are to keep mothers strong and give all children a healthy start. These themes have been central to MTC’s mission since 1990, when Dr. Cynthia delivered a student’s baby on the floor of the dilapidated house where she lived and cared for patients recovering from malaria. Mothers and children are the future, she told graduating students at the first primary health-care training in 1996. “For a good future, do something good for mothers and children.” Young medics took the message to heart, emblazoning the slogan on their shirts.

Today, the Reproductive Health Department is located in a breezy light-filled concrete building with a shaded porch where mothers often cuddle swaddled newborns while staff members sit in a circle, assembling safe birth kits and rolling cotton hanks into swabs. The Reproductive Health Department’s inpatient and outpatient sections provide comprehensive women’s services including family planning, gynecology, normal and complicated labor and delivery, neonatal care, and post-abortion care. Its antenatal care program offers screening for malaria, HIV, sexually transmitted infections and anemia.

The clinic provides in-depth training in obstetrics and obstetric emergencies to medics and midwives; it has also trained hundreds of back pack health workers and traditional birth attendants in safe birth techniques and provided them with life-saving birth kits and supplies for use in remote villages and ethnic conflict areas. In the jungle, something as simple as cutting an umbilical cord can be a matter of life and death; doing so with a traditional sliver of bamboo risks neonatal tetanus, a terrible disease that can be prevented by using a sterilized razor blade instead.

The need for reproductive health services at the clinic was identified in late 1989, when expectant mothers began coming to the clinic to deliver their babies at all hours of the day and night, and to receive care from Dr. Cynthia and Naw Htoo, who now leads the Reproductive Health Outpatient Depart-
Naw Htoo, who started out with no medical training, recalls feeling fascinated, sympathetic and scared the first time she watched Dr. Cynthia deliver a baby. Since she was the only other woman on the clinic’s small staff, she realized she had to watch and learn; what if a woman went into labor when Dr. Cynthia was not available?

Maternal mortality rates are over 1,000 per 100,000 live births in the Eastern Burma conflict zones. This compares to 360 in the rest of Burma and 44 per 100,000 live births in Thailand.8

Back then, the facilities for expectant mothers were basic and women in labor had to climb a ladder to get to the delivery room, where they gave birth and then recovered as Dr. Cynthia and Naw Htoo cleaned up around them. In 1995, the clinic set up a maternal child health program with a separate ground-floor delivery room. It offered a Saturday morning vaccination clinic, family planning, reproductive health care, gynecological services and antenatal care. Pregnant women went home from their antenatal visit carrying small bundles of chicken eggs - a high iron food to help prevent anemia. The following year, 156 babies were born at the clinic. As the number of deliveries increased, the clinic added a second delivery room. Naw Sophia, who now leads the Reproductive Health Inpatient department, recalls that the delivery rooms in those days were narrow, dark and they stank; suffering as they did from their proximity to nearby toilets. In 2001, the clinic built a new, bright and airy building for reproductive health with support from the Women’s Commission for Refugee Women and Children, as part of the Averting Maternal Death and Disability Program. The clinic added programs for safe motherhood, sexually transmitted infections and HIV/AIDS, adolescent health care and gender-based violence prevention.

A recent challenge has been finding resources to care for cancer patients who come for pain treatment at the clinic and stay until they die because they have no money and nowhere else to go. The department often runs out of much needed pain medication; finding more is high on their wish list. Another huge challenge comes in the form of small swaddled bundles - the 10 or so newborns orphaned and abandoned at the clinic every year. Some mothers now manage prolonged labor, handle obstetric emergencies, do vacuum extractions and prevent most post-partum hemorrhages and manage those that do occur.

The Inpatient department now has 25 beds, but Naw Sophia laments, “It’s still not enough!” Even though the clinic has expanded its capacity in this respect, the need for quality reproductive health care continues to grow as more and more patients come to the clinic for obstetric and gynecologic care.

8 Chronic Emergency: Health and Human Rights in Eastern Burma, report by Backpack Healthworker Team.
Patient Food Program: 400-500 patients per day are provided with 3 meals, at a cost of 700 baht per person per month.

Staff and Families: 800 staff and family members are provided with 700 baht per month.

Supplementary Food for HIV Patients: over 200 HIV positive individuals are provided monthly food rations at 350 baht per month.

Boarding House Staff and Children: about 600 teachers, staff and boarding children are provided dry food rations.

Department Supplementary Food: a monthly budget of 20,000 baht is provided to inpatient departments working 24 hours per day, who also provide for patients who cannot eat rice (noodle soup).

Mae Sot Hospital Patients: approximately 80 patients per month are provided with 30 baht per day.

Eye Surgery Program: 3 daily meals are provided to the 400-500 extra patients that arrive four times per year for a 2-week period.

Milk Powder Program: OPD, Mother to Child transmission prevention, RH inpatient, (twin, abandoned, etc) Child OPD, supplementary program (HIV, abandoned baby, etc) with a constantly increasing budget needs.

Even before it was providing health care services, the staff of Mae Tao Clinic was providing food services to patients. In the very early stages of the clinic, before the necessary medical supplies were available, patients were referred to Mae Sot Hospital (MSH) for treatment. MSH provides food for patients but not their attendants. Mae Tao Clinic began by providing food for the patient and their attendants during their hospital stay and through their recovery in the clinic’s patient house. The food was prepared at the clinic, and then staff would walk the three kilometers everyday to the hospital to deliver food to patients who were in Mae Sot Hospital. Either they walked in the hot sun or monsoon rains, or with some luck got a free ride - a motorcycle taxi was an unaffordable luxury.

The average Burmese family spends 70% of their income on food. In contrast, in the United States, only 6% of household income is needed for food.9

Starting in 1989, a monthly ration from Catholic Relief Organization was an enormous help in meeting the clinic's food provision needs, allowing the clinic staff to pick up large sacks of rice and beans to distribute to dependents. The initial program at MTC supported 50 staff and patients, on a budget of 6 baht per person per day. This six baht per day only covered rice, with cooking oil donated from time to time. It wasn’t much, but there were no complaints.

When it was established, MTC had 8 rai 10 of land, where staff grew vegetables and raised some chickens, ducks and pigs. As MTC grew however, the land was needed for buildings rather than this small cottage industry of farming. Dr. Cynthia muses, “Growing vegetables was always a problem for us. We are not very skilled in agriculture, and the water bill seemed to be more than the cost of just buying the vegetables.” For the first two years the clinic had no separate kitchen. In time though, the clinic received donated timber to build a separate kitchen which the staff and students construct.


3.2 acres or 1.3 hectare
ed on their own. Eventually this separate kitchen became once again incorporated into the clinic facility, as the health service departments continued to expand around it in response to the ever-growing number of patients. Having the kitchen so close to the health services was not appropriate however, with both staff and patients complaining of the smell. In 1999, a large patient kitchen and dining hall was built at the back of the clinic compound and a new staff kitchen was built next to this in 2007.

“This is not only a clinic; it is a village.” – Dr. Cynthia

Food Program Manager, Naw Htoo, comments on the daily challenges of managing the various food programs, “The funds are fixed, but the prices and the number of patients is not. It is difficult.” Adjusting for the growing number of staff and patients, as well as regular food price increases has always been a challenge and this was drastically augmented by the 2008 global food crisis. With high prices and a fixed budget, the first items eliminated are the fresh foods – meat and vegetables. Naw Htoo explains having to sometimes buy food supplies on loan, “All the shop keepers know me, so I will go and get food in advance when the money is not there. They trust me. I keep my word. We have worked with them for a long time. This is okay for dry food, but not meat and vegetables…they have sympathy for us.” Naw Htoo has managed the Food Program since 1989, and her passion is still evident, despite the pressing challenges posed by funding shortfalls. Despite these, and other obstacles faced over the last 20 years, the Food Program has grown from a service for 50 staff and patients to a comprehensive program serving over 100,000 patients, staff, family members, and school children each year, and remains successful. The plans for the future are the same as those of the past – to make sure everyone who ‘passes through the doors’ of Mae Tao Clinic is fed.

MOBILE MEDICAL TEAMS

Following the 1988 uprisings in Burma the displaced population living along the Thailand-Burma border grew quickly, with people struggling to survive. Some individuals were able to find food, shelter, medical services, and relative safety either in student camps that were set up in the stable areas of Karen State, or on the Thai side of the border. For many people unfortunately, neither of these options was feasible, and instead they struggled for survival in the highly unstable and dangerous regions of Karen State. The term internally displaced persons (IDPs) was not yet being used to describe this population of people, and there were no coordinated efforts to assist them. The need was obvious, and there was the desire to assist, but in the period immediately after the uprisings no one had the resources or stability to offer this assistance. By 1991 though, three years after the uprisings, MTC was well enough established to begin providing health services to the people still inside Karen State. The Mobile Medical Team (MMT) was established, with health workers from MTC making 6-8 week trips inside Karen State to bring health care to people who had no access to services. The health workers would carry their medical supplies, and travel deep into the jungle on foot.


Before the MMT could begin these trips though, they had to gain permission from the local authorities to travel and work throughout the areas of Karen state. This wasn’t easy. The rapidly growing population of pro-democracy students arriving on the border was not yet well known, understood, or trusted by the people living in the area. The MMT had to first gain the trust of the local authorities, and then together they discussed which areas needed the most help and which were actually safe enough to travel in. Not only did the MMT need permission from the local authorities; they also needed the assistance of the local people. MMT health worker Sein Han puts it simply, “The most important thing was to have local health workers go with us.” Wherever the MMT traveled, the local health workers would join the team, forming a group 10-15 people at any given time. The local health workers knew the area and the
terrain, knew where it was safest to travel and how to avoid landmines and fighting. The local health workers also helped to gain the trust of the people they encountered on their trips into the jungle, who would then provide the MMT health workers with food and shelter. Local people would also help the teams to carry their medical supplies. At all times during these forays, the group was accompanied by soldiers from the area. The MMT health workers would live with, work with, and treat the same people.

MMT health worker Nay Htoo recalls how gaining the trust of the people was a challenge— it was understandable that they would be suspicious of strangers during this very unsafe and unsettling time. Furthermore, many of the people that the MMT assisted had no experience or understanding of western medicine, and so the MMT had to introduce new ideas that contradicted traditional thoughts and practices. Nay Htoo remembers the challenge of treating patients who had measles. It was very difficult to convince patients that they needed to clean their skin with boiled water, and then allow the skin to cool off and be exposed to the air. This was in total contradiction to their traditional understanding, which was to protect the skin and not aggravate it, by not washing it and keeping it wrapped under many blankets.

MMT health worker Nay Htoo says that the trips with the MMT were a practical test that made him a more active student.

Not only were they required to have sharp minds, but the members of the MMT were also required to be physically strong and healthy. They had to be strong, as they traveled on foot over mountains and across rivers, carrying all necessary equipment with them. They also had to be strong because, inevitably, they would get sick themselves. Sein Han explains that if people living in the village had dysentery, so did members of the MMT— they ate what the villagers ate. “Every time you returned from the jungle you brought back malaria,” says Sein Han, but “we didn’t worry about it. We got used to it.” When the MMT would return to MTC, they would take about a month of rest, which was seen as an opportunity to recover from their own illnesses before returning to the jungle for another trip.

These MMT trips continued until 1997, at which point the program ended. Security was getting tighter, movement was more difficult, and the MMT couldn’t grow fast enough to meet the needs of the people; unfortunately the MTC didn’t have the necessary resources. A re-coordinated effort was made to address the needs of this displaced population of people, and in 1998 MTC helped to establish the Back Pack Health Worker Team (BPHWT).

It takes a certain understanding and perspective to succeed in the role of a mobile health worker. Besides being strong both mentally and physically, these individuals require the characteristics of the teacher, the student, and the leader. It is a role that demands someone who truly understands the invaluable effects of their efforts. In comparison to health care services on the Thai side of the border, which by western standards are still basic and resource limited, Sein Han explains that, “over there, there is nothing. To work over there is meaningful for us. To have rain in the ocean? No, to have rain in the dessert is more meaningful.”
CIVIL CLINICS

Cho Gali, the first of the civil clinics, provided the framework for the subsequent clinics. It was constructed by the local villagers using bamboo and leaves. It provided services to people from approximately eight surrounding villages with both outpatient and inpatient services, and ran three main programs that were integrated with the medical services: maternal health care, school health, and water and sanitation.

MTC did not have the resources to provide a salary for the medics. Each staff member received food and board, and 2 longyis and 2 shirts a year. Each month the clinic as a whole received 1 bar of soap, 1 tube of toothpaste, and a ½ kilo of washing powder, as well as menstrual pads for women.

Between 1992 and 1994 five clinics were established in the Karen State. Due to military attacks, none remain in their original locations. One was re-established in Pa Hite and still operates today.

The idea of establishing civil clinics in Karen State came to fruition in 1992 when one of the Mae Tao Clinic’s mobile medical health workers working in Dooplaya came to Dr. Cynthia and asked her to set up a clinic in the area. The medic introduced her to the local health authority, and after several discussions, they agreed to set up Cho Gali clinic. MTC eventually established five civil clinics in Karen State, and helped to facilitate the establishment of clinics in other ethnic areas as well. When the clinics were established, they treated common illnesses such as malaria and diarrhea. A prominent feature of these clinics was their cooperation with local midwives, or traditional birth attendants (TBAs), who were the frontline health service providers of maternal health care in isolated areas. The clinics worked with TBAs to enhance safe practices for birth - including identifying the signs of danger during pregnancy and labour - and on introducing safe hygiene practices.

Education was another defining feature of the civil clinics, which were supported by local teachers in the area who could see the benefits of the clinics first-hand in the children they were teaching. Both health workers and teachers would work together to develop school health programs. In addition, according to Dr. Cynthia, the clinics became the centre of many communities. As the community, including women’s groups, teachers and village leaders, became more closely involved and worked with the clinic for the benefit of their communities, the role of the clinics within these communities expanded.

Over the years, more health workers trained by MTC, who came from diverse ethnic backgrounds (including Karenni, Shan, Chin, Arakan and P’Loung) were keen to set up clinics in their places of origin. These MTC alumni approached Dr Cynthia and asked if MTC would facilitate the establishment of these clinics. MTC agreed and worked to set up clinics inside Burma in ethnic areas, and on the Thai border area where groups of refugees were concentrated.

MTC has an admirable record of collaboration with partners to coordinate and manage the health worker clinics, and this has enabled them to improve the running of those clinics. Partners have cooperated with MTC on the maintenance of the clinics, such as the upgrading of equipment and facilities, and in the monitoring and evaluation of the civil clinics. Below, three medics recall their experiences working with civil clinics established by MTC.

CHO GALI CLINIC:

Cho Gali was the first clinic established by MTC. Initially, villagers were skeptical of the clinic and continued to use traditional medicines. Eventually, as the services proved effective, villagers came to trust the clinic and to use it. According to Say Hae, a teacher who worked in the area for many years before and after the clinic was set up; the clinic had a positive effect, particularly on the community’s view of education. She says that parents in the community started to send their children to school in much greater numbers. Say Hae remembers one family in particular. The father was arrested by the SPDC and subsequently disappeared, presumed dead. The mother became very ill soon after and was diagnosed with breast cancer. She soon died, leaving behind two children. The clinic staff cared for these two children and provided them with an education in the village. They then attended one of the migrant schools on the Thai side of the border, and recently they were resettled in the USA.

In 1997, the SPDC attacked Cho
traditional beliefs are still incorporated into community attitudes toward health. Pa Lae Paw remembers that some villagers had come to the clinic to get help for a pregnant woman who had been sick for a week. Staff from the clinic made the trip out to her village to render assistance. They explained that she needed to go to the clinic for treatment or she would die. Before she would go, she wanted to consult the spirits in the jungle. Knowing she would die if she did not go, a medic hid in the jungle and, posing as a spirit, told her that she must go. When she got to the clinic, she was treated for malaria and given two blood transfusions. The baby was born safe and well and they are both still alive today.

These days, the training for community health workers creates a formal integration of the two practices. For example, certain traditional beliefs regarding prevention and hygiene can be effective and are highlighted. The health workers learn how to complement the services of traditional healers and work side by side with them.

According to May Soe, a Mae Tao Clinic medic who began working at Sa Khan Thit in 1995, this clinic mainly treated pregnant women and patients with malaria. In addition, there was a refugee camp nearby on the Thai side of the border that had no clinic, and so staff would often travel there to treat people. May Soe says that many children were abandoned at the clinic and she remembers one case in particular; a young boy who came to the clinic who had no parents. Clinic staff cared for him and sent him to school, and he now works for MTC.

The same day that Cho Gali was attacked, Sa Khan Thit was also attacked by SPDC forces, but unlike Cho Gali, clinic staff had prior warning and were able to flee to Thailand before fighting began. When they moved, they had to take the 11 abandoned children they were caring for with them. They spent three nights on the Thai side of the border, near Sa Khan Thit, and then made the journey to Mae Tao Clinic. May Soe has not been back to Sa Khan Thit since, but says that she has heard that all the equipment and buildings are abandoned and destroyed.

**PA HITE:**

The clinic that is now based in Pa Hite, in Karen State, has had many incarnations. Prior to being located in Pa Hite, it was at different locations in the surrounding area, but was attacked by the SPDC several times, and medics and villagers were forced to flee. Each time the clinics were attacked they had prior warning and were able to save most of their supplies by hiding them in the jungle - although sometimes they were destroyed by elephants or other animals in the area.

Prior to the establishment of the clinic in the area, traditional beliefs regarding medical practices were prevalent; beliefs which were sometimes at odds with western practices. The community now regards western health care in a more positive light; however, traditional beliefs are still incorporated into community attitudes toward health. Pa Lae Paw remembers that some villagers had come to the clinic to get help for a pregnant woman who had been sick for a week. Staff from the clinic made the trip out to her village to render assistance. They explained that she needed to go to the clinic for treatment or she would die. Before she would go, she wanted to consult the spirits in the jungle. Knowing she would die if she did not go, a medic hid in the jungle and, posing as a spirit, told her that she must go. When she got to the clinic, she was treated for malaria and given two blood transfusions. The baby was born safe and well and they are both still alive today.

These days, the training for community health workers creates a formal integration of the two practices. For example, certain traditional beliefs regarding prevention and hygiene can be effective and are highlighted. The health workers learn how to complement the services of traditional healers and work side by side with them.

Pa Lae Paw says that she is unsure about the future of Pa Hite clinic, she says that, at least for now, the situation is stable. Back in 2001 the SPDC attacked the area and the medics had to flee, but Pa Lae Paw asserts that they were merely lucky that time as the KNLA protected the area and saved the clinic, adding that the security situation and the isolation of the clinic are some of the most difficult challenges they face.
MEDICAL OUTPATIENT DEPARTMENT

In the beginning all of the medical services available at Mae Tao Clinic were provided under one roof. Patients came to have a wide variety of ailments treated, ranging from treatment for malaria, to having wounds dressed to the delivery of babies. Although many of these patients stayed overnight, this is still considered the origin of the Medical Outpatient Department (OPD). The equipment and medical supplies at this time were scarce and food was limited and very simple. Despite the limited resources of the clinic, no one was ever turned away.

Although the space was small, an effort was made to keep trauma and maternal health patients separate. The original space was an old house, with various improvements added as time and supplies allowed. Originally the clinic was only open from 9:00 a.m. until noon, but increased patient loads necessitated an expansion of operating hours to a timetable of 8:30 am until 4:00 p.m, Monday to Saturday. Of course emergency patients were also admitted on Sundays.

As time went on, the number of patients and scope of services continued to increase, with the number of patients requiring specialized services such as minor surgeries, obstetric and delivery services, and child services beginning to overwhelm a single Medical OPD. In 1999 therefore, the MTC expanded to allow for the establishment of separate departments, ultimately leading to better, standardized treatment of patients and the adoption of established protocols. After the expansion, the Medical OPD had a larger space with four separate exams rooms; three for seeing patients and one for administering medication. A mere six medics completed all of the renovation work.

In 2000, the Medical OPD moved into a new building with six exam rooms, four for general care, one for chronic disease patients, and one for malaria cases. It is currently staffed by 12 full-time medics, but staff may number up to 35 when there are students doing their practical training. Two medics work together in each exam room, normally seeing only one patient at a time, but sometimes seeing two at a time if the department is overwhelmed with patients.

In the first half of 2008, 81% of malaria patients with the most deadly strain (P. Falciparum) came from Burma. A separate space to treat malaria patients has always been necessary at MTC, but a separate exam room to treat patients with chronic disease is a newer development. The patient demographic is changing considerably, with more and more patients crossing
the border for health services as the state of health care continues to decline in Burma. Moreover, as word of mouth continues to spread regarding the wide variety of free services at MTC, more people are willing to risk the journey in order to receive the potentially lifesaving services.

At this point, MTC cannot fully treat most of the chronic disease cases that are presented such as diabetes, heart disease, and hypertension. Both the lack of resources and infrastructure to support the health care needs of long-term patients are issues yet to be overcome. Moreover, medics are not yet fully trained to cope with these illnesses, although they continually strive for that knowledge and work to gain it through weekly case studies, and upgrade training programs. It is a frustration and a challenge for the medics when they cannot provide the proper treatment for a patient, but it is also a challenge when they can.

The staff of the Medical OPD continually works to ensure that patients take their prescribed medicines properly. Unlike the other clinic departments, where patients receive their medication directly from the medic caring for them, in the Medical OPD the pharmacy is a separate unit. Therefore, the medics and the pharmacy staff have to maintain high levels of communication and ensure that communication with patients is also strong. When patients speak a variety of different languages, and often cannot read or write, this presents considerable obstacles. In 2005, new medicine distribution bags were created in order to eliminate the need for a patient to be able to read. Since the implementation of these bags, the dosages and schedule for taking the medicines are depicted through pictures, making it much easier for the patient. Not counting solely on this method though, the pharmacy is always staffed with 3-4 people who can speak a variety of languages, ensuring that patients are also be given the instructions verbally.

Language barriers and illiteracy have also been a challenge when it comes to educating patients about their illnesses. With Medical OPD continually getting busier, the medics can only spend a small amount of time with each patient, and so the hope is to produce more printed education materials to give to patients. These printed materials however, need to be produced in more languages and also need to take into account patients who cannot read.

The staff of Medical OPD recognizes that until there are radical changes in the political situation in Burma, MTC will continue to see an increase in patients; the staff hopes for the necessary developments to be able to serve these patients. They need a larger waiting area, more exam rooms, more medics, further training and greater resources to be able to recognize and treat the greater variety of illnesses coming through the door.

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**Mae Tao Clinic Caseload**

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LABORATORY AND BLOOD BANK

Since its inception in 1989, malaria has been the most common illness presented at Mae Tao Clinic; thus it made sense for the clinic to have laboratory facilities with the ability to perform malaria screening, rather than relying on an external laboratory. Laboratory work first began at MTC in 1992, with a staff of approximately four tucked away in a small corner with 2 microscopes, and a freezer. The staff performed malaria screening, hemoglobin testing for anemia, and blood typing.

In 1995, the clinic began blood donor screening on a case-by-case basis, but there was no storage facility for donations. In 1996, there were 36 transfusions, still using case-by-case screening, using mainly clinic staff as the donors. If there were no donors available, blood was purchased from MSH. In 1997 MTC began collecting blood from factory workers in order to keep sufficient inventory and stored it in Mae Sot Hospital. This wasn’t a sustainable or cost-effective approach, so in 2000, MTC with the support of MSH, set up a blood donation centre and blood bank for the blood transfusions performed at the clinic. Since then, MTC has performed blood transfusions, as they have been necessary for the large numbers of patients arriving at the clinic with anemia due to malaria, tuberculosis, nutritional deficiency, chronic disease or blood loss due to complications of childbirth or surgery.

Beginning in 2004, malaria and hemoglobin screening was provided for all pregnant women as well as children under 12 years old suffering from malnutrition. In the border area, malaria is one of the biggest health threats, with high prevalence, transmission rates and drug resistance. The border population tends to be very mobile in areas without permanent health care centers or electricity for laboratories. Where treatment did occur in these areas, it was through self-diagnosis or without any diagnosis.

As the patient population grew so did the need for further laboratory services.

Today the laboratory services include:

- screening for malaria and hepatitis
- blood typing
- cross-matching for blood transfusions
- urine analysis for glucose levels
- HIV rapid tests.

HIV screening began in 2001, as an antenatal care service for pregnant women in collaboration with Mae Sot Hospital (MSH) on their Prevention of
Mother to Child Transmission (PMTCT) program. In 2003, the Voluntary Counseling and Testing (VCT) services began. In 2008, the PMTCT screening was ‘insourced’ to MTC which provided quicker results for improved post-test counseling and follow-up care, as well as lower costs. This led to the expansion into two lab rooms, along with separate HIV and malaria rooms. MTC Laboratory staff was given the opportunity to tour the MSH lab, blood donation centre, and blood bank facilities, learning the policies and procedures being utilized there, and receiving training for cross-matching donors to recipients.

**BLOOD DONATION CENTER**

The Blood Donation Center service at MTC now encompasses the collection, screening, storage and administration of over 1,000 units of blood each year. All donors are unpaid volunteers, with the safety of the blood supply ensured through the universal screening (by MSH) of donated blood for hepatitis B and C, HIV, syphilis and malaria. Most often donors are factory workers that come as a group to donate. This poses a challenge, as factory workers have very limited free time, with the entire process of risk assessment and donation by up to 100 people having to be completed in a few hours. This is also seen simultaneously as a valuable opportunity to provide donors with health education about transmissible diseases, in particular, HIV and hepatitis.

Laboratory Manager, Hsa K’Paw goes to great lengths to ensure the quality of the lab work. There are rigorous quality control protocols, with regular internal and external controls performed. Hsa K’Paw greatly appreciates and understands the benefits of these collaborations, “We stand by our protocol, but sometimes we need ideas from others. We have to share with other people and learn from other people.” He also works to ensure that the other laboratory staff understand this, “I want them to understand everything, to be able to do all the work in the lab, and know who to contact if they have a problem. To contact MSF, MSH, SMRU….I want the next generation to know members of other organizations.”

Hsa K’Paw views the Laboratory Training program as an opportunity to share this information and insight beyond the clinic. Laboratory training participants come from various ethnic groups inside Burma and then return to their communities once the training is complete. Saw Hsa K’Paw lets the trainees know that he is available to help even after they finish the program, “They contact me if they have a problem. I am able to give them help, and ideas. I am proud to affect all of the regions of Burma.” It is this attitude that contributes to the lab having a much greater impact on border communities, making the many tests run each day only a small part of the contribution.
In the early years of Mae Tao Clinic, access to water was a major obstacle to the safe and efficient running of the clinic. In addition, there was often overflow of waste water from the toilets. In the monsoon season, this overflow was particularly problematic as it contaminated fresh water sites. In the dry season, Mae Sot suffered severe water shortages and many households in the local population had built water tanks in their homes to deal with this problem. The clinic however, could not build permanent structures on the site and thus had no water supply during the day. The clinic water supply would flow only in the evenings, and this was when clinic staff did all their cleaning; this included cleaning the medical instruments, having showers, and cleaning clothes. This was usually done around midnight.

One of the difficulties involved in running a water and sanitation program in the civil clinic areas is that the pipelines can be trampled by elephants!

In these nascent years of MTC, as the number of staff, staff families, and patients attending the clinic was steadily increasing, the lack of toilet facilities became a major problem. The existing toilets were over-used and often would overflow. It was a health hazard, and there was a fear that the local authority would shut down the clinic if the problem was not addressed. Prior to the establishment of the Water and Sanitation Department at MTC, water and sanitation was a feature of the civil clinics run by MTC inside Karen State. When the first civil clinic, Cho Gali, was set up, there were no toilets and the area did not have a water supply; as a result, many of the children had worms. The clinic worked to build infrastructure for the local population, as well as to educate them about how to use toilets and employ safe hygiene practices. They also built school toilets and trained the children to use toilets with water.

The continued increase in awareness of water and sanitation issues lead to the establishment of the Water and Sanitation Department at MTC in 2000. Tin Htun, the department manager, has been in charge of the program since its commencement. Beginning with six staff members, the first major effort was to increase the fresh water supply to the clinic. Even with rain water run-off, one deep water well and a Thai pipe-line, there was not enough water for the effective running of the clinic. The clinic, in conjunction with the clinic’s landlord, applied to the Thai government and was granted permission for a larger pipe-line to go through the clinic. After the water supply issues had been addressed they began to work on drainage, cleaning and the toilets; these were the first priorities of the newly established department.

In 2002, it was identified that MTC needed to improve existing waste-water management systems. The local community had been complaining about the run off from the clinic, and MTC wanted to maintain a positive relationship with the local authorities and community. Therefore, the construction and stabilization of ponds for waste water was undertaken. The clinic also concentrated on the reduction of vectors (mosquitoes) and vector-borne diseases by introducing vector eating fish into the pond, thus decreasing contamination in local ponds. These improved methods of waste water disposal proved valuable in enhancing the relationship between the clinic and the local community.

Today, with the continuing expansion of the clinic, the role of the department has grown, with responsibilities that include:• building maintenance (building and repairing),• cleaning and repairing drains,• cleaning toilets,• building additional toilets,• sweeping and cleaning all outside areas,• maintaining the horticultural aspects of the clinic,• controlling the clinic’s water supply,• recycling waste water to use in the toilet and for cleaning the clinic’s vehicles.

Tin Htun says that there have been many challenges involved in running the department. In the past it has been a problem to build permanent structures on land that is only rented by the clinic. Tin Htun adds that his staff often faces blockages in the toilets, as many of the clinic’s patients are from rural areas, and have had no experience using toilets. He says that they find sticks or plastic blocking the toilets, and sometimes patients go to the toilet in the drains. When asked what he is most proud of regarding his work in the water and sanitation department, Tin Htun says that his greatest achievement is implementing water recycling because it is so useful to the clinic and saves the clinic money.
When the MTC founders arrived in Mae Sot, they had no money, equipment, supplies, nor accommodation. Thankfully, a number of local kind-hearted souls stepped in to help. Father Manat Supalak of the Mae Sot Catholic Church, and Monty Morris of Christ Church Thailand assisted in arranging safe accommodation, medicine, and food. They also assisting in fundraising, advocacy, and helping set up initial partnerships and connections with Mae Sot Hospital. Starting in 1992, Médecins Sans Frontières provided crucial in-kind donations of medicine which continued until 1997, along with assistance in setting up the laboratory.

**PLANET CARE/GLOBAL HEALTH ACCESS PROGRAM**

MTC has continued to strike a balance for many years between receiving assistance from outside and maintaining itself as a sustainable independent community managed organization. One of the first outside supporters of the clinic was Ben Brown, who found Dr. Cynthia with the help of a map sketched on a napkin in 1989. Staff recall, “He helped Dr. Cynthia who had recently fled Burma herself, treat sick villagers in a small wooden building with dirt floors, without medical books or diagnostic tools except a thermometer, a blood pressure cuff and a stethoscope. With a small cadre of refugee medics Ben went on mobile missions into border villages cut off from access to medical care by the war. Ben continued to go back to Mae Tao Clinic twice each year, bringing supplies and teaching valuable skills.”

Bob Condon was motivated by Ben’s involvement and commitment and got involved himself. He raised money for the clinic, and recalls, “Thanks to many generous people there was enough money to pay for the make-shift lab in an old two-story barn in Mae Sot. That same barn still stands at the entrance of the Mae Tao Clinic where Dr. Cynthia Maung continues to...
run the clinic, offering free medical services to thousands of displaced Burmese”.

“Ben [Brown] told me about Burmese refugees who fled over the border to a safe haven in Mae Sot, Thailand. Ben was headed back to Mae Sot with microscopes, textbooks, and medical supplies so his Burmese friends could set up a temporary clinic to provide medical care to other refugees. Ben’s passion to help inspired me to get involved in my own way – which was to call friends and ask for money”. – Bob Condon reflecting on his history with the clinic.

For many years, Planet Care worked side by side with Global Health and Access Program (GHAP). Planet Care brought medical teams of doctors and nurses who travelled along with medics to civil clinics, and conducted training for medics. Planet Care provided the first international volunteer administrator. This was the first time that international volunteers with critical skill sets were identified and supported by a stipend so that they could stay for long periods of time. In 2006 GHAP and Planet Care merged, and continue to work today as an important partner of the clinic.

BURMESE RELIEF CENTER

Similar to Planet Care, Burmese Relief Center is a partnership which spans the history of the clinic. The Burmese Relief Center (BRC) was set up, in a similar fashion to MTC, as a response to the thousands of Burmese students who had fled the crackdown on the 1988 nationwide democracy uprising and were staying in camps all along the Thai-Burma border. BRC began to collect and distribute food, medicine and clothing to the refugees along the border. BRC staff recall, “My first memory of the clinic is of a dingy wooden shack with rows of Burmese students in longyis lying on the floor with intravenous drips in their arms”. BRC was the first organisation to provide ongoing grants to MTC in 1994, which were used for monthly running costs. BRC also assisted in setting up the financial and administration system for the clinic, which they collaborated with Planet Care. BRC and InterPares set up an exchange with Philippines (psychosocial, health and human rights, reproductive rights) and Guatemala (women’s change). BRC provided crucial assistance in building the advocacy capabilities of the clinic – which are now a cornerstone of the clinic’s work.

BRC also supported the first clinical internship program in 2002. Their view was that MTC could not solve the health problems on the border alone, and the ethnic health workers needed to be trained and empowered to work inside Burma. This internship program continues today, with a high demand for seats in the course. Dr. Chris Beyer and team conducted the first external evaluation of the clinic, which was facilitated by BRC. They looked at clinical capacity, public health needs, pharmacy system, and clinic protocols.

While BRC has supported the physical needs of many refugees through the years, they were instrumental in fostering the community based organizations activities. They have played an important role in advocacy and community building activities. BRC promotes the development of civil society organizations that will provide the foundation of a democratic future in Burma. InterPares explains, “In these ways, BRC is helping to define what is possible for a future in Burma that is just, democratic and peaceful.”

ALL BURMA STUDENTS DEMOCRATIC FRONT

ABSDF was formed in 1988 as a response to the military crackdown in Burma, and worked in partnerships (albeit sometimes uneasy) with the ethnic resistance groups. ABSDF worked in partnership with the clinic to deliver training and coordinate support to civil clinics. When Chogali and the other civil clinics were established, ABSDF students were pressed into service as medics. Whether they were previously medical students, doctors, or had no prior experience, the students learned on the job.

KAREN DEPARTMENT OF HEALTH AND WELFARE

When villages in Karen State were attacked or natural disasters occurred, the Karen Department of Health and Welfare (KDHW) has provided relief inside Burma. KDHW has worked in partnership with MTC since the early years, for example conducting the first midwife training for mobile medics. In Dooplaya district, KDHW established a civil clinic, has been an MTC civil clinic partner in other areas, and works in Burma through its own Mobile Medical Teams.

The first formal training conducted by MTC was a midwife course taught in collaboration with BMA and KDHW. Naw Ree was the first trainee participant and still works in MTC’s reproductive health department today. This training was conducted in Ah Zin

BRACKETT REFUGEE EDUCATION FUND

Although the Brackett Refugee Education Fund (Brackett) was founded in 1997, the staff had been personally involved in the clinic since January 1992. For example, Brackett produced the first annual report of the clinic in 1995, and provided English language and computer training for staff. One Brackett staff member recalls, “At that time it was a very small, poor place. I can remember bringing a small bag of oranges to share with the people”. After Brackett was founded, they started the school for Dr. Cynthia’s children and children of the staff. Brackett is understandably proud of this accomplishment – the original school has evolved to be the CDC today, with 1,000 students, from kindergarten through to Grade 12. Today, Brackett continues to provide support for schools, medics, scholarships and other areas of need for the internally displaced populations in Burma.

“One day I sought a driver to take me from Mae Sot to the Clinic. My Thai was not good enough to explain where I wanted to go. So we negotiated a price that he was willing to take in payment for a very long ride. It was much more than the short drive was worth, but I was willing to pay because I had to get there. When the driver found out where I was actually going, he gave me all the money back and refused to accept any money for his service. I like to think of that as a testimony of the truly fine work Dr. Cynthia and her staff has done from the very beginning, and of the appreciation of some Thai for her merit”.

–Brackett staff member

Dr. Cynthia and ABSDF students.

KDHW’s first health information seminar in Jungle.
Village (Dooplaya district) in 1992 at Paw Taw Moo Hospital with 50 participants. Since that time, KDHW worked in collaboration on relief programs, such as the flood in 1993 in Kyai Dom. When Ah Zin village was attacked by Burmese military in 1994, MTC and KDHW joined forces to assist. KDHW worked with MTC to set up mobile medical teams and clinics which are described in more detail in subsequent chapters of this book.

KDHW has been a key partner of MTC in supporting IDP populations inside Burma. In 1996, MTC and KDHW organized the first Health Information Management Seminar in Karen state. This seminar covered service delivery methods, establishing standards of care, and fostering community participation. KDHW invited CBOs and INGOs to coordinate health programs in Karen state.

BURMA MEDICAL ASSOCIATION

How does it happen that a small community-formed organization, initially with no funding, is eventually cited in medical journals?12 The BMA was founded in Karen State, Burma in June 1991 by a group of medical professionals led by Dr. H. M. Singh from Burma. Although formed in the Karen state, BMA was a collaboration of many ethnic groups who were represented in the Manerplaw stronghold. The National Coalition Government of the Union of Burma took the initiative to coordinate and join forces across ethnic groups to create BMA and to improve health care coordination in the ethnic areas. The organization serves as a leading body in the coordination of public health policy and promotion of health care among refugees, migrants and IDPs from Burma. Since its inception, the BMA has provided medical and first aid teaching to community health workers, mobile medical teams, community health education workshops, HIV prevention education, and health education materials in appropriate languages.

In 2000, Dr. Cynthia became Chairperson of the BMA, which formalized her and MTC’s role as a mentor and technical advisor to the group, providing training and technical assistance for BMA. Starting in 2007, the ‘push’ of improved funding and resources coupled with the ‘pull’ of the ever-increasing health needs of the IDP community in Burma, led to an ongoing evolution of BMA towards becoming a more rigorous and far reaching organization. Although Dr. H. M. Singh passed away in 2000, his legacy lives on in the passionate desire of those working for the BMA to provide public health infrastructure in Burma. To this end, the BMA has been the key partner in an innovative pilot program in the border area, Mobile Obstetric Maternal Health Workers (MOM) Project. The project involves collaboration between Johns Hopkins Center for Public Health and Human Rights (USA), Mae Tao Clinic, Global Health Access Program (USA), and local Burmese Health Organizations. The goals of the project include: improving access to essential maternal health interventions among vulnerable communities in eastern Burma, capacity building, delivering evidence-based maternal and newborn health care and providing information to inform service delivery strategies in similar settings. The target population for the pilot study was 60,000.13

These days, BMA is supporting over 30 clinics, serving approximately 200,000 people across six states in Burma. BMA serves eight different ethnic areas in Burma, with a footprint spanning the Thailand, India and China borders. The distance in kilometres is not necessarily the challenge, but rather, crossing through various security checkpoints and unstable areas to reach the patient populations.

The BMA, in coordination with MTC, Ethnic Health Organization and the Back Pack Health Worker Team, has coordinated a wide variety of services including; training and curriculum development for maternal and child health, training for traditional birth attendants, school health, hygiene practices in medical settings, water and sanitation, malaria management, solar panel installation and maintenance, emergency obstetric care, health information and documentation and health policy and systems development activities.13


ties along the Thai-Burma border. These activities have been ongoing for over five years in an effort to reduce maternal mortality and morbidity rates among women as well as to decrease prevalence of communicable diseases such as malaria and gastrointestinal tract infection for populations living along the Thai-Burma border. Since 2005, BMA has been running several projects on Reproductive and Child Health and has partnered with migrant and ethnic health organizations to increase access to reproductive health (RH) services and information.

BMA’s work is not only focused on IDP areas in Burma. BMA one of the first partners with MTC for school health promotion and HIV prevention education in the migrant areas of Thailand. This collaboration began in 1999, with MTC and Doctors of the World to improve migrant health. This migrant outreach program has grown, with other CBO’s complementing these efforts through collaboration. It is also notable that this was the first of many collaborations with the Thai Ministry of Health.

BMA also began publishing the Nightingale Health Journal in 2003, which aims to promote an exchange of health-related knowledge among internally displaced, migrant and refugee communities in border areas, with a monthly circulation of 2,000.

BMA has evolved since its inception. Initially, the goals were focused on coordination and friendship among the health care workers and service providers in Burma. After a conference in 2000, the goals became more focused on specific public health goals; improving health information, delivery and standards across ethnic areas. The future challenges for BMA include: securing long term funding, attempting to keep up with the growing and unmet health care needs of their patient population, and managing the security of health workers. BMA hopes to achieve increased access to maternal and child health services and reproductive health information and services. BMA will continue to collaborate with MTC to work towards international advocacy to improve cross-border health care.

MAE SOT HOSPITAL

MSH has continued to provide invaluable support to the clinic – not only providing medical treatment and standardized records, but also training staff, donating supplies, and aiding with laboratory quality control.

The medical referral program that started in 1989 was initiated and supported by Father Manat Supalak and local Catholic Church organizations. This included patient transfer and food support. The most common referrals in the beginning were severe malaria cases which required transfusions. Today the clinic is able to treat malaria cases, although if the patients progress to renal failure they are referred. These days, there are still approximately 60 patient referral admissions per month that go to MSH for a variety of treatments, including various surgical procedures and caesarean delivery. For each of those patients there might be twenty hospital visits, so the referral staff and Mae Sot Hospital can be very busy!

In 1995, the clinic introduced a blood transfusion program. MSH helped with the development and necessary training of staff, and also screened the donor blood that was collected by MTC, collected the blood of some donors that the clinic arranged to go directly to MSH, and even provided blood if the clinic did not have enough. The clinic stored blood at MSH from 1996 until 1998. Today the clinic receives enough blood donations, but
premature babies, and home-based care kits. MTC appointed a Migrant Health Coordinator to work with the MoH. This resulted in an increase in out-reach services for MTC, including HIV education, and a School Health program. A Traditional Midwife Training program was started, which yielded a greatly improved home-delivery service and strengthened the emergency obstetric referral system.

HIV is one example of a public health issue best addressed by utilizing partnerships. As discussed in greater detail in the HIV chapter, MTC has been working with MSH since 2001 in the HIV area. In 2001, MTC joined as a partner in the Perinatal HIV Prevention trial. This subsequently developed into the Preventing Mother to Child Transmission (PMTCT) programme at the conclusion of the trial. As part of this program, the clinic conducts HIV counselling and testing, and if the mother tests positive she delivers her baby at MSH, with all appropriate medication for transmission prevention supplied. Both MSH and MTC then provide ongoing support until the baby is 18 months, with support including milk powder, psychosocial support, and home-based care kits.

The Medical Waste Disposal partnership between MTC and MSH began in 2001. Previously the clinic had buried placentas and discarded blood at the back of the clinic property, but with more and more patients the clinic simply lacked the capacity to continue this method of disposal. Now, all needles, syringes, human tissues, expired blood, and infected blood are taken to MSH at 6:00 am every morning. In 2007 MTC began collaborating with MSH in implementing expanded access to Antiretroviral treatment. MTC provides the initial counselling and testing service, and then if a patient is identified as positive the MSH can provide ARV. The patient must meet a list of criteria, with the clinic guaranteeing compliance. Patients who live in Burma or don’t satisfy certain clinical criteria do not enter the program, which currently has 48 patients.

In response to research on post-abortion services for migrant women, conducted at both MTC and MSH, the two health care facilities began working together on the Post-Abortion Care Quality Improvement project, in coordination with Darwin University, Australia. Due to language and cultural barriers it was decided that the clinic would have three staff members work at MSH to provide counselling and education on abortions. Currently, any Burmese women admitted to MSH for post-abortion care, even when not referred by MTC, receive counselling and follow-up care by MTC staff. Services and procedures were also upgraded at both facilities, with manual vacuum aspirations introduced at MSH, due to the fact that they are less painful and incorporate less risk for patients (these have been conducted at MTC since 2004).

Considering that MTC is not a legally recognized establishment in Thailand, the level of support it has received from MSH and the MoH is remarkable. The local support provides a certain amount of stability, and thus the ability to work effectively. The support goes beyond MTC, to include...
many other health CBOs in the area, allowing those organizations to provide greater community outreach services. This support from the local Thai community has helped strengthen partnerships between the local health organizations, and in particular, has resulted in improved access to the Thai health system.

Inside Burma it is impossible to form this type of relationship; CBOs not sanctioned by the junta simply do not exist, resulting in a major gap in health services. When the junta introduces a major health campaign, such as the 3-Disease Fund, which provides free medications for malaria, tuberculosis, and HIV, the campaign usually only supports the medication but not the social services (counselling) or diagnostic costs, such as diagnostic x-rays, blood tests or sputum tests. Due to the fact that these costs are not supported by the junta, the financial burden falls on the patients. Further there is no community support system for these patients whereas in Thailand the Thai Ministry of Health fosters social support services delivery for these patients. Therefore, the vast majority of the civilian population inside Burma who cannot afford to cover these costs goes untreated. Many of these untreated patients eventually arrive at Mae Tao Clinic, adding to the already burgeoning caseload.

In Mae Sot, effective public-private partnerships between Mae Tao Clinic and Mae Sot Hospital, among others, is in stark contrast to the situation in Burma and has allowed for treatment for many patients unable to access the Burmese public health care system. MTC is able to support these patients with counselling, testing, and follow-up support while the MSH supports the medications; the two complement each other very well. Dr. Cynthia sees the relationship between Mae Tao Clinic and Mae Sot Hospital as a paradigm, “This is a model for how a migrant or vulnerable population can be supported. This is the example of the relationship that should exist between the government and CBOs. It improve[s] coordination and improve[s] access to health care service.” Dr. Cynthia hopes that the international community will learn from this example and that health practitioners are able to glean a better understanding of the role of CBOs and how to work effectively with them.
1995 – 1999:
GETTING ORGANIZED

Medic checks a pregnant woman’s blood pressure at Reproductive Health OPD (photo: James Mackay, www.enigmaimages.net)
I HAD VISITED Chogali village so often, in stray moments, it sometimes seemed I never left. In reality, almost a year had passed since my husband and I volunteered in medical clinics along the Thai-Burma border.

We took many snapshots, but I didn't need them to travel back -- down the rutted elephant trail, across the steppingstones in the stream, past the black pig in the bamboo pen, along the path lined with white star flowers that smell like magic.

This is how I liked to remember Chogali, as a place of little girls and orchids, of peace and hope.

Actually, Chogali was -- and is -- in the middle of a war.

On one side is a military dictatorship that in the past 35 years has killed, tortured and displaced millions. On the other are ethnic tribes who want autonomy and dissidents who want democracy.

The military is winning. Burma's people have lost just about everything that makes life decent. And every year, things get worse.

In this country of chaos, Chogali was an oasis. The village was nurtured by a remarkable woman known along the border as "Dr. Cynthia." She ran a clinic there, took in orphans and trained medics to care for hill-tribe people who had no other access to modern health care.

That such a gentle community could exist in the middle of war became my antidote to the world's horrors.

After we came home to Seattle last summer, I kept returning, in my mind, to Chogali. To escape from the blur of news of war, of genocide, of rape, of hunger and hate . . . .

I'd hear a snippet, read a headline, then drift away to be with the little orchid girls, mixing mud and rain in coconut shells -- playing pretend within a game of pretend.

Then Chogali fell.

The message came over the Internet one morning last February, a few sips into my first cup of tea:

"Burmese Relief Center -- Japan has just received information SLORC (the Burmese military) occupied Chogali yesterday morning."

As I read it, the little girls appeared again, shoulders hunched, scared. I wandered around the newsroom, unsure if I could finish writing an article on mutual funds.

Suddenly, I was back in Chogali. This time, I was surrounded by artillery, exploding bamboo, snakes wriggling in the heat, ash settling on empty huts. At least I hoped they were empty. I hoped the village people had all escaped, scattered into the jungle. I recalled a human-rights documentary in which a former Burmese soldier, in tears, admitted raping village girls.

I thought I saw the little orchid girls hiding in a grove of banana fronds. I felt relieved they were malnourished, too light to crunch the bamboo leaves underfoot.

I hoped they were together. I hoped the soldiers would not find them. I wondered if they were cold.

I wondered what I could do.

I turned to the only thing I know how to do: I dug out my passport and went back to the Thai-Burma border, this time as a reporter.

I realized the war in Burma might seem as distant to most readers in Seattle as it once did to me -- just another of the many confounding "ethnic conflicts" smoldering around the globe as the century closes. Bosnia, Rwanda, Chechnya, Congo, Cambodia -- news
we struggle to understand, news we struggle to ignore.

The problem isn't that we don't care. We're rarely given the chance.

Most of our news about war is dominated by quotes from pundits, debate about economic sanctions, dispatches on the latest counteroffensive. But war is not only about weaponry and economics and aging generals grasping for more power. War is about little girls playing in a village.

I returned to the Thai-Burma border as a journalist, but I wanted to write a story of the heart.

I longed to find those two little orchid girls. They were real. They haunted me. I needed to know what war had done to them, what it was doing to me, what it can do to us all.

Secretly, I hoped I might save them.

WE HAD FIRST HEARD about Cynthia Maung at a party on a rainy Seattle night in fall 1995. A public-radio reporter had told us about a young Burmese doctor, herself a refugee, who ran clinics on the Thai-Burma border.

Mother Teresa to Burmese refugees... in her 30s... fled Burma after the 1988 military crackdown... main clinic in Thailand... several thatched-hut clinics in rebel-controlled Burma... Everybody calls her, simply, Dr. Cynthia.

My husband, Tao, had finished his pediatric residency -- four years of life as a tired blur -- and we wanted to have an adventure, do something hands-on. In March 1996, we landed at Dr. Cynthia's main clinic in Mae Sot, Thailand, a dusty town about a 20-minute jog from the Burma border. For the next three months, Tao would see patients and teach pediatrics, while I would peal mountains of garlic, lead a dawn aerobics class and type Dr. Cynthia's field reports and grant applications.

The tin-roof clinic sits on the edge of parched rice paddies in Thailand's hottest province. The air smelled of blood and iodine, sewage and steaming rice. Everywhere, there were fuzzy chicks, sucking kittens, nursing moms. The place oozed with fertility. This was not what I had expected.

I had imagined, before we arrived, that we would see battle wounds like in "M*A*S*H," when the theme music plays and the choppers swoop down and the medics crouch low under rotor blades, carrying moaning men on stretchers. I had expected cowboy surgeons extracting shrapnel, nurses holding gauze over land-mine stumps, legions of muddy army boots. This was war, wasn't it?

In the slow heat of the first morning, I kept waiting for the arrival of bloody soldiers but kept seeing more and more women. Pregnant women. Women shivering with malaria. Women coughing from tuberculosis. Women bent over from diarrhea. Factory girls with ugly rashes on their legs and gashes on their hands. Emaciated ladies with glazed yellow eyes.

Every so often, a rickety blue pickup loaded with garlic and bananas skittered off the road where the pavement crumbled into dirt. Out jumped children, their scrawny brown legs covered with mosquito bites. Then a small parade of tired women unfolded from the back of the truck and shuffled into the clinic, leaving flip-flops at the door. By noon, the concrete stool was covered with flip-flops, mismatched, dusty, smudged under the toes. No army boots.

Finally, I realized, this was it. This was war: waged by men, dumped in the laps of women.

"I didn't have much idea about war before I came here," Dr. Cynthia told me, "but everywhere I see the men go off to fight or get captured, and the women and children suffer most."

Dr. Cynthia has done much to reduce that suffering. In addition to the main clinic at Mae Sot, she ran a half-dozen smaller field clinics in jungle villages across the border in Burma -- including Chogali.

When we visited last year, Chogali had 29 babies, 56 other children, 148 adults, 60 bamboo houses, five elephants, one microscope, no electricity and no cars.

Gurgling blue PVC pipes Dr. Cynthia had installed to divert clean water from upstream meant the women didn't have to spend three hours a day hauling water in oil cans while the men were gone.

The teak-leaf nursery school she had built fed the children one good meal a day, monitored their vision and growth, screened for worms, immunized.

The latex squat latrines she had installed helped dry up dysentery and cholera. The training she gave midwives meant fewer mothers and babies died from infection. Her clinic treated malaria and malnutrition and snake bites.

The little orchid girls had seemed safe, playing with tiny white blossoms.

I do not mean to romanticize what was, essentially, a harsh subsistence. I just want you to know what was lost.

by: Paula Bock, Seattle Times 1997
CHILD PROTECTION SERVICES

MTC opened one of the first day care centres in the Mae Sot Area in 1995. As the children continued to grow, the next obvious step was the development of a primary school; thus began MTC’s Children’s Development Center in 1998, one of the many migrant schools that would open in the Mae Sot area.

Burma ranks fifth worst in the world on education spending at 1.2% of GDP. 15

Some parents also wished to send their children to Thai schools, but were faced with difficulties when they couldn’t provide supporting birth registration documents for their children. In response to this, as well as to address the issues of statelessness, teachers, health workers, and other concerned individuals worked on raising awareness and assisted with establishing documentation for migrant children.

Until 2000 there were no formal meetings between the migrant schools, but in April 2000 that changed when thirteen schools came together to form the Burmese Migrant Education Working Group, through which there were regular meetings revolving around information sharing and capacity building programs for migrant teachers. In July 2000 the group changed its name to the Burmese Migrant Workers Education Committee (BMWEC), and the group began working tirelessly on fundraising, advocacy, capacity building, and curriculum development. The increased level of coordination and standardization of services has lead to stronger programming, with the community showing a greater sense of ownership in the education system.

There have certainly been challenges; work continues in standardizing the curriculum used among the migrant schools, a very difficult task when a community of people from such diverse ethnic, political and historical backgrounds comes together. Furthermore, although progress has been made, it is estimated that less the 30% of the migrant children between ages 5-18 are actually attending school. Efforts are being undertaken to make education even more accessible, with some organizations trying to introduce a night school program for students who are forced to work throughout the day, most often in agricultural work. There are also current initiatives to make the Thai education system more accessible to migrant school kids and to achieve closer integration between the Thai and migrant programs. The Thai Ministry of Education is working with BMWEC on an inclusive education program with activities including standardizing curriculum for primary schools, training teachers and research on improving access to the Thai education system.

Even children who cross the border with their parents often end up in boarding facilities. The parents often do not find full time employment, and even if they do, the wages are so low that they can barely afford to feed their family let alone send their children to school. If the parent is lucky enough to find full time employment it often means that they stay at the factory or farm where they are working, with the boss requiring the children to begin working as soon as they are able. Parents realize that sending their children to a boarding facility will ensure access to an education as well as three meals a day for their child and safety

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from child labor.

In response to major increases in the number of boarding children, the organizations working with education and boarding facilities in the Mae Sot area began a collaborative response through the development of the Coordination Team for Displaced Children’s Education (CTDCE). With three working groups: the Boarding House Working Group, the Education Working Group, and the School Health Working Group, the CTCDE works to provide emergency food assistance to boarding houses, as well as develop a registration system for boarding children, child protection policies, and standards of care for boarding houses.

With so many concerned individuals and organizations coming together to address the challenges of child rights, education and security, progress can certainly be seen, but challenges still lie ahead. Many of the children suffer from psychosocial illness—they have come from conflict zones and have often witnessed or experienced great violence and human rights abuses. Work is being done to support these children, to provide them with tools for stress management and to appropriately deal with conflict, helping them to be part of a diverse community and to participate in the healing of the community.

The diversity of the border population is certainly a celebrated concept at MTC, with the slogan “unity in diversity” seen throughout the community, on posters and the backs of t-shirts, but this diversity also imposes challenges. Curriculum development for such a diverse collection of ethnic groups living in a Thai community has been a particularly difficult challenge. It is a community that that wishes to be integrated into whilst simultaneously maintaining a sense of identity and culture. The curriculum providers have also been faced with the problems of which languages should be taught, what history, which political views? Moreover, there is the challenge of finding a balance between the strong academic focus of the Thai education system, and providing students with the necessary life-skills to prosper within the community (as the majority of students will not have the opportunity to attend formal post-secondary education). With so many disparate considerations, the development of a standardized curriculum has been far from easy.

The diversity of the teacher population is also a challenge; these are individuals with various levels of training, who come from different ethnic groups, political backgrounds, upbringings and ultimately, with different understandings of the situation in Burma. Furthermore, these individuals have come to the border with different goals; some have come to stay, some have come as a stop-over before resetting in a third country. Staff turnover continues to be a major problem among the migrant schools.

Of course, none of these challenges will put a stop to the tremendous efforts being made by the community; it is a community of people which seeks to foster strength, hope, and knowledge in the future generations. Dr. Cynthia puts it simply, “working on child protection is a collaborative effort,” and this strong partnership between the Thai and Burmese communities means that work will continue towards ensuring the rights, safety, growth and development of the children on the border.
DELIVERY CERTIFICATES AND CHILD DOCUMENTATION

“In the beginning, we didn’t think about the delivery certificate and just helped [patients] deliver here, because we had never thought that we would be here for that long. After a few years, when these children entered the schools, the problem started and the responsibility was put on our shoulders,” says Naw Htoo, one of the clinic’s founders. Naw Htoo refers here to the problem Burmese children faced when trying to access the Thai education system; in order to attend school they needed a birth certificate showing that they had been born in Thailand. In 1994 MTC began issuing delivery certificates to all children born at the clinic in an attempt to address this problem. Although not official birth certificates, they provide enough information and authority for children to access the schools. The cards were also part of an attempt to address the issues stemming from the statelessness of children who were not officially recognized by any government. An update to the delivery certificates was made in 2001 after it was decided that the information provided in the 1994 delivery certificate lacked sufficient detail.

In 2003 MTC collaborated in the establishment of the Committee for the Protection and Promotion of Child Rights (CPPCR). Collaborative meetings were then held with CPPCR, other CBOs, Burma Lawyers Council, and the Thai Lawyers Society, to further discuss the documentation of the Burmese children. The results came in the form of two types of documentation for children: the Birth Registration Record, for children who already have a delivery certificate from any hospital (whether in Thailand or Burma) and babies who are presented to CPPCR within 15 days of birth. The second type is the Child Record, for all children under 15 years of age who do not possess any form of documentation.

Today CPPCR works not only on registration, but also on child rights advocacy, coordinating and participating in many child rights and child protection campaign activities, such as the World Children’s Prize for the Rights of the Child voting events, and International Children’s Day.

MTC continued to issue its own delivery certificates until July 2008, at which point a new collaboration was established with the Thai Ministry of Health; the staff of MTC are now authorized to record births in the ‘Maternal and Child Health Booklet’ distributed by the Thai government. This booklet is a record of all the mother’s maternal health care visits. Although the use of these booklets is a more involved process, the benefits are worth it. Not only do the booklets provide a more complete record of the health care that a woman has received throughout pregnancy, they also allow Burmese migrants, for the first time, to apply for official Thai Birth Registration Certificates for their children born in Thailand. The RH-IPD hopes to train more staff in the processes of applying for the Thai Birth Registration Certificates, as well as implement a follow-up program to determine how many families successfully acquire the certificates. With no immediate change foreseen in Burma, the importance of these certificates only increases, especially considering the significant rise in the annual number of births at MTC – from less than 20 deliveries in 1989 to nearly 2,400 in 2008.

BAMBOO CHILDREN’S HOME

MTC has responded not only to the needs of the children living on the Thai side of the border, but also to those of the children living inside Burma. At MTC’s civil clinics in Sah Khan Tit and Cho Gali, the staff often saw children who had been orphaned by war or illness, and thus, health workers and teachers often ended up caring for these children, with the clinic also functioning as a boarding facility. When these clinics were attacked and evacuated in 1997, 10-20 children from each clinic were brought to Thailand under the continued care of the staff. The children spent a brief period at MTC, and were then moved to Kway Kaloke refugee camp where they were cared for by MTC staff in the Bamboo Children’s Home (BCH). BCH has since been moved to Umpiem refugee camp, but continues to be supported by MTC.

BCH began with 3 staff and 49
children, all of whom were Karen; by 2008 there were 16 staff members, and 154 children from various ethnic groups. The boarding house continues to see an increase in the number of unaccompanied adolescents coming from Burma in order to access education beyond the primary level. Each year, many children complete their studies and leave the BCH to pursue their chosen careers; some examples have included those working as medics, as administrators at MTC, or as teachers at the CDC. The satisfaction, former boarding house master Tin Htun says, is seeing the children finish their studies at the BCH and then go on to contribute to the peace and development of their community.

Like so many boarding facilities, BCH struggles with enforcing rules among its students; when a student breaks policy, showing little interest in education and failing tests, the policy is to remove them from the boarding house, making room for another student that would greatly benefit from the support and access to education. Win Tin explains that this is always harder done than said, as often the children have no parents and nowhere else to go. For the students who do have one or more living parents, BCH tries to arrange monthly visitations at BCH, allowing parents to see their children as well as meet with the BCH staff and discuss any concerns they may have. Although these students are fortunate to meet with their family members, it is still incredibly difficult on their emotional and mental health; this is a recognized problem and to this end the BCH works hard to provide strong psychosocial support to all of its students.

Like the other migrant workers in the Mae Sot area who were settling and starting families, by 1995 the staff of MTC also found themselves needing day-care services for their own children. As a solution the MTC Nursery Care program was started, initially caring for approximately 20 children. The next logical step was a primary school and so the Children’s Development Center was established in 1997, with 5 staff members. This was located in a house across the highway from the clinic, providing more space for both work and play for the students. Although not official in the beginning, the CDC was already acting as a boarding facility as well, caring for 10 children by 1999.

The next major challenge came as these children completed primary level schooling, and thus a separate high school was established in 2005, with 2009 seeing the first grade 12 graduating class. In 2009, a new school facility was inaugurated with all the children from primary to grade 12 in the same facility. The 2009/2010 academic year has nearly 1,000 students enrolled, with approximately 50% of students being cared for in boarding facilities. Between the school and the boarding facilities there are 80 staff members performing all duties. Currently the CDC offers a wide variety of classes including: Thai, Burmese, English, Mathematics, Chemistry, Physics,
Economics, Geography, History, Social Studies, Community Development and Computer Skills. Coordination will continue with the BMWEC and the Thai Ministry of Education to continually evaluate the curriculum, making sure it continues to be the most relevant and beneficial one available for the students.

**EMERGENCY DRY FOOD PROGRAM**

<table>
<thead>
<tr>
<th>Monthly Food Rations: per one child</th>
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</thead>
<tbody>
<tr>
<td>Rice 12 kilo</td>
</tr>
<tr>
<td>Cooking oil 1 liter</td>
</tr>
<tr>
<td>Salt 1 pack</td>
</tr>
<tr>
<td>Sardines 2 tins</td>
</tr>
<tr>
<td>Dried beans 0.5 kilo</td>
</tr>
<tr>
<td>Total cost: 350 baht, $10</td>
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Food security is a major threat to the health and safety of the population living along the border, especially for children whose parents cannot afford to feed them. In migrant schools it was noticed that children were often absent from school as their parents were unable to supply them with a boxed-lunch, or were providing lunch but no breakfast, and so children were eating the lunches before coming to school. Work began in an effort to ensure that no student was missing school due to a lack of food.

The Emergency Dry Food Program is one of the CTDCE Boarding House Working Group’s programs, responding to the food crisis at boarding houses not only in the Mae Sot area but also in IDP areas and refugee camps. Although it is understood that meat and vegetables are required for a healthy diet, the drastic increase in the number of children in boarding facilities means that, at this point, the food program budget can only cover the cost of dry food rations.

The immediate focus for the Boarding House Working Group is further fund raising to ensure that they can meet the needs of the growing student population. In the interim at least, the dry food is a viable option as a long-term food program, even though it is not an optimal solution. The working group will also work to develop stronger monitoring and evaluation processes for the program. BHWC member and CDC teacher Eh Moo Paw highlights the ongoing dilemma facing the community; although boarding facilities have reached their limits, one cannot simply close one’s eyes and ears to the children that continue to cross the border unaccompanied in order to access an education.
Since the mid-1990s, the Mae Tao Eye Clinic has:

- Facilitated more than 2,000 eye surgeries to restore sight lost mostly due to cataracts and glaucoma, the world’s leading causes of blindness
- Trained almost 1,000 health workers in basic eye care and eyeglass refraction
- Conducted periodic eye screenings for more than 5,500 children in 58 migrant schools and provided vitamin-A in conjunction with the Mae Tao Clinic School Health Program.
  - Dispensed more than 60,000 pairs of eyeglasses
  - Dispensed 30 artificial prosthetic eyeballs for patients blinded by eye infections and landmine-related eye injuries

The Mae Tao Eye Clinic started in 1995 in an open-air bamboo shed. There, the first group of three eye care medics began doing eye exams, managing basic eye diseases, and refracting and dispensing donated eyeglasses after being trained by the Border Eye Program. It was a modest beginning, with the medics initially seeing three to five patients a day. They worked with few instruments and were often short of glasses with optical power high enough for patients with poor vision, according to Aung Phy, one of the original eye medics. The team persevered however, and by the end of 1996, the eye care medics saw more than 30 patients daily and started an outreach program in Karen State (later discontinued for security reasons).

Over the next 14 years, the Eye Clinic’s services expanded significantly. In addition to its original services the Eye Clinic now facilitates eye surgery for cataracts and glaucoma; conducts eye screenings and eye-health training for teachers in migrant schools; treats eye infections such as trachoma (the leading infectious cause of blindness in the world), and runs mobile eye-health outreach in Thailand’s Mae La District.

The Mae Tao Eye clinic has also become a base for eye training. It facilitates eye health training as well as primary eye care training for nurses, interns, health assistants, backpack medics, teachers and community health workers who see patients in clinics, schools, villages, and camps in Thailand and across the border in Burma. In total, the eye clinic has trained nearly 1,000 health care workers who can be found working in all refugee camps and in nearly all ethnic states inside Burma.

As part of the health outreach work done at MTC, the Eye Clinic promotes prevention methods throughout the migrant schools. On the Thailand-Burma border, as in many developing countries, vitamin-A deficiency from malnutrition is the number one cause of blindness in children. Periodic vitamin-A supplements not only help prevent blindness, they also enable children to better resist lower respiratory infections.

- Approximately 87% of visually impaired people live in developing countries.
- Globally, about 85% of visual impairment and 75% of blindness could be prevented or cured.17

In 1997, the Eye Clinic began facilitating on-site eye surgery in partnership with the KarenAid surgical team from the United Kingdom under the auspices of the International Rescue Committee. Initially, the team visited the clinic for one week each year, performing at least 10 surgeries per visit. Now, the team visits the clinic three times a year and performs 400 to 500 surgeries annually, mostly for glaucoma and cataracts. These surgeries are invaluable; many blind people arrive for surgery almost totally reliant on others, and come out of surgery with their independence restored. “If you are blind,” says Aung Phy, “the only way of life is staying home, only eating and sleeping. You cannot do anything, you cannot go anywhere by yourself.”

The patients come from nearby factories, farms and refugee camps as well as from inside Burma, from mountain villages and cities as far away as Mandalay. Most have cataracts or glaucoma, but others have been blinded by accidents; landmines, illness, infection or inappropriate applications of tradi-

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tional medicines. In 2007, 87.5 percent of the more than 500 surgeries were for cataracts, and 72.5 percent of patients came from Burma, mostly from Karen State. The incredible impact that these surgeries have on the patients is evident in the fact that simply through word of mouth, each round of surgeries sees a longer queue of patients.

Weeks before the surgery team arrives at MTC, hundreds of visually impaired patients begin arriving at the clinic grounds. Many require the assistance of a family member or friend; all are hopeful of receiving surgery that could restore their vision. Although the surgery is provided free to the patients, it can still pose financial difficulty. Most of the patients or their families must borrow the money or sell an animal to pay for transportation to the clinic. In recent years, so many people have come seeking surgery that the clinic hasn’t had enough space to house everyone. Patients and their families have had to sleep in storage rooms, the janitor’s closet, and outside under trees. For a few weeks, the grounds are crowded, yet friendly, as if the clinic were hosting a convention; two free meals are provided per day and the sightless are able to share conversation and experiences.

Unfortunately, some must go away disappointed. Last year more than 800 people arrived for surgery; the surgical team only had enough time to operate on approximately two thirds of them. Patients journey from so far and have so much at stake, the eye medics say, that it’s heartbreaking to see their hopes dashed.

Unfortunately not all patients can be helped. Their vision loss may have been caused by untreatable genetic diseases, or scratched corneas requiring expensive corneal replacement, an advanced procedure the clinic does not perform.

Currently, the Mae Tao Eye Clinic has twelve full-time eye medics, one eye clinic program manager, one clinical supervisor, one optometrist, and several community health workers and community health volunteers. As in other departments, the resettlement of senior eye medics to other countries continues to be a challenge. Their years of training and experience are difficult to replace.

The Eye Clinic must serve this large community with very basic instruments, limited supplies of eyeglasses, and limited space to manage high volumes of patients during surgical events. Most of the Eye Clinic’s challenges though, revolve around access; it’s difficult for many patients to get to the clinic because of high transportation costs, risk of arrest, and inability of family or friends to leave work to accompany them. That makes it hard for the clinic to do follow up care and to assess long-term success rates. It also means that some glaucoma patients are forced to delay their treatment until it is too late, after high eye pressures have already permanently damaged their vision.

La La is 40 years old and has recently had eye surgery at Mae Tao Clinic (MTC), and sadly was not able to regain her vision. She is from Pago Division, Shwe Kynn Township in Burma, but has been working in the Mae Sot area for four years with her husband and family.

La La is married with two children, a boy aged 6 and a girl aged 12. When they lived in Burma, three of her cousins and three of her uncles were murdered by the SPDC. Her husband moved to Thailand first, and she followed later with the children. They did farm work in the Pho Pra area when they first arrived. She says her children do not go to school in Burma as they were living in a conflict area, and in Thailand they do not go as her family has to move around to find work. She says her husband is also injured and in pain with a hernia, and they cannot do strenuous work. They water plants and help planting beans on farms but she is worried that it will become increasingly difficult for them to work and earn money. At the moment, her husband is still working even though he is in pain, and he earns about 2,000 baht a month and one tin of rice for the family.

La La says that she had heard about MTC from many people in her area. However, it is bitter-sweet for her as she came here to get better, and has still lost her eye. She says that in normal circumstances when her family is sick with, for example, malaria, they would not come to the clinic as it is too difficult for them to travel. She says that they will only make the journey when they are really desperate.
TRAINING PROGRAMS

Health workers, doctors, or medical students arriving on the border in 1989, no matter their specialty, were all responding to the same emergency – Malaria. Residents in student camps with some type of clinic facility were the lucky ones. For the rest, illness meant long periods of travel, often on foot and by boat to seek medical care; there were simply not enough medical facilities to attend to the continual flow of new arrivals to the border. Eventually, each camp established its own health care facility, but staffed with only a few doctors and senior medics it was not enough. After about a year on the border, the health workers of the different camps began to discuss providing coordinated medical trainings, which led to the first formal medical trainings in the student camps.

At this point MTC was focused on offering referral services to patients, with Dr. Cynthia providing informal medical ‘discussions’ in the evenings as a means of training, with visiting doctors helping when they were there. Dr. Cynthia recalls, “We didn’t have manuals, textbooks, or a curriculum. We just started with the basics, physiology… malaria.” These informal trainings went on for over a year. After a couple years on the border, with acute treatment fairly well established, it was identified that lacking not only at the clinic, but all along the border were maternal and child health care services. As the students started to marry and have children, these services became essential.

Dr. Cynthia met with Women’s Education for Advancement and Education (WEAVE) to discuss the need for maternal and child health care training, which resulted in a 6-week program. This training, the first formal training conducted by Dr. Cynthia, was conducted in 1991 inside Burma as it was identified that the services were most desperately needed in the IDP areas. The training focused on maternal health, especially safe motherhood and family planning. After this first training, some of the trainees who had come from different villages along the border decided to return to MTC, where a more comprehensive maternal and child health care training would be conducted. The training was run in 1992 and 1993 with a 3-month theory and a 3-month practical portion. Most of the participants of these first two years had previous health care training and so this acted as a specialized upgrade training. By 1994 this was no longer sufficient; there was a great demand for more basic health care workers, and so the program was expanded to 4-month theoretical, 4-month practical segments, covering basic health care so that individuals without any previous training could join the program. The increases still were not providing adequate training for these new participants however, so the first 10-month Primary Health Care Training was offered in 1995/96. This training was conducted for five consecutive years, with trainees from other ethnic groups and various camps along the border joining in.

In 2001, Burma Medical Association and the National Health Education Committee held a joint conference where the decision was made to begin coordinating the training programs offered on the border, and to develop standardized curriculums for these programs. It was concluded that all health organizations should be providing two levels of training: a 6-month Community Health Worker (CHW) Training, and a 2-year Health Assistant (HA) Training. MTC, BMA, BPHWT and NHEC began collaboration to develop standardized training curriculums. A commitment was made to ongoing Laboratory Training, as well as to stan-
standardize a Traditional Birth Attendant (TBA) training curriculum.

The growth and development of training programs continued in this fashion – an organic response to the continually changing needs of the growing population on the border. The MTC Training Program has grown to include trainings in: Prosthetics, Eye Care, Dental, and Comprehensive Reproductive Health, as well as an Internship Program for previously trained health care workers to come for upgrade training. There are frequent short workshops available on topics such as: Leadership Training, Gender-based Violence, Community Management, Human Rights, and Environmental Health.

MTC is viewed as an excellent training facility as it offers skilled trainers, including Burmese doctors, senior medics, and international professionals. Due to the clinic’s high patient load, it also offers extensive practical training. Although travel from inside Burma to the clinic is expensive and difficult, involving passage through areas of conflict and the passing of security checkpoints both in Burma and Thailand, participants come from all over Burma to attend trainings at MTC. The Thai Ministry of Health also recognizes the strength of the training and has MTC health workers assist in the TBA trainings offered by the MoH. MTC is only able to support a small portion of travel cost for participants, but does provide full support for food, shelter, training materials including stationery, and a small stipend for pocket money. Although the clinic always finds a way to support the trainees, there are always challenges; it is often difficult to find training space, teaching materials, and knowledgeable, skilled trainers that are able to commit the time needed. Fortunately, participants from large NGOs are frequently sponsored through their own organizations, relieving MTC of the financial burden in these instances.

Although the trainings are incredibly beneficial to the populations living both inside Burma and along its many borders, the fact that such a diverse group of individuals come to MTC for the trainings also poses one of the biggest challenges – that is to say, training a group of individuals from various social, cultural and political backgrounds, with different education and skill levels. A further problem is student retention, which can be as challenging as staff retention; although it is required that participants of the training program have not applied for resettlement before beginning the training, this is not always the only problem and some students end up leaving the program due to other obligations.

One of the Training Program managers, Eh Thwa, speaks of the benefits of these programs, “We are able to train more young people. After they finish school they have the opportunity for further education. We do the training so that people can take new skills back to their community.” These training programs not only benefit MTC and the patients that access the clinic; these are community development programs, where the capacity of the border community is supported and encouraged.
CHILD OUTPATIENT DEPARTMENT

Although the Child OPD officially opened in 1998, its vaccination program began as early as 1995. As part of Maternal and Child Health services, every Saturday the vaccination program was run. For two days each week, sessions were held for antenatal care and family planning. In 1997, the nutrition program was upgraded to include growth monitoring, a feeding program for the malnourished, nutrition education, Vitamin A supplements, deworming, and the development of a child health record.

Prior to establishing the department, adults and children had been treated together, but as numbers of patients and staff rose, Child OPD was separated, whereupon staff became more specialized. When it first opened, the department had only 5 staff members and saw 30-40 patients a day. It was housed in an open area with a roof, which had only concrete floors and limited equipment. May Soe, the department manager since 2002, and Dixie, a medic in the department since 2000, like to say it was a roof with no building. Now they have a building with tiled floors, see about 100 patients per day, have electricity, a fan, a refrigerator and storage space. They have their own pharmacy too, as well as desks and a computer.

According to May Soe and Dixie, in the first few years after the department opened, it serviced mainly children of migrant workers from Burma, who already lived in Thailand, but as the clinic has expanded and more people became aware of its services, they have increasingly seen cross-border patients. Their demographic is now about 50% from the Mae Sot area and 50% from inside Burma.

The department maintains its original focus on curative care, immunization, growth monitoring, nutrition assessment and malnutrition, and is committed to treating the common illnesses it sees, such as malaria, pneumonia, diarrhea, and acute respiratory infections. However, the department has now added education as one of its main priorities, so that when patients leave they will be better informed on health issues. For example, the staff will tell the parents what food is best for a malnourished child, or for a breastfeeding mother. Or when a child is immunized, they will tell patients alternate places to get immunized if they can’t follow up at MTC. Ideally, patients will take this information back with them to their communities.

In 2002, School Health outreach was established mainly to provide Vitamin A and de-worming, and in 2004 the Integrated Management of Childhood Illness Program brought a more holistic approach to improving clinic services for children under five.

Data gathered from the immunization program and curative care records goes into reports, which help with funding, and provides a picture of the population serviced to aid research. Child OPD also shares information with Thai Public Health, which provides it with vaccines.

The program has expanded to cover referrals for patients to Mae Sot Hospital and Chiang Mai Hospital for cases that the clinic cannot treat. This has mainly been facilitated through the Burma Children Medical Fund (BCMF). This fund was set up through the Burma Children Medical Fund (BCMF). This fund was set up through the clinic to finance the treatment of children externally. BCMF organizes transfers for children, and a few adults.
to Thai hospitals, where they can get the life saving surgery they need. These surgeries are often relatively simple and cheap, but without BCMF they would be beyond the means of most patients.

May Soe and Daisy maintain that the feeding program carried out on immunization days is a very important aspect of the work they do. This program provides milk powder to families with twins, children with cleft palates, and children with no mothers or HIV positive mothers. May Soe and Daisy also say that the most common illnesses the department sees are malaria, pneumonia, diarrhea, acute respiratory infections and malnutrition. There have been many challenges for May Soe and Daisy in the daily running of their department. One of the most trying occurrences is when parents leave their children at the clinic and never return, which has happened three times so far. Also, like the clinic as a whole, the department is continually growing, and there is still a great need for more space.

Nevertheless, there have been many uplifting experiences within the department. For instance, staff often see young patients with heart disease, whose parents usually do not know what is wrong. They can’t get treatment or even diagnosis in Burma, and this is highly stressful for them. May Soe remembers one such case where the mother had become so distraught prior to coming to the clinic that she had contemplated giving up her child. The staff at Child OPD was able to properly diagnose the child as having a congenital heart condition, which was subsequently treated with funding from BCMF. May Soe related that the mother was very happy and relieved at not being forced to give up her child.

May Soe and Daisy have many aspirations for the future of their department. They hope one day to expand into two departments, Curative Care and the Immunization and Feeding Program. They would also like to have more space to build a play area for the children who come to the clinic.

The Mae Tao Clinic library grew out of the idea that providing books to staff and patients would relieve stress and tension, while at the same time providing information and education. The aim of the library is to provide relief from boredom, as well as serving an educational tool. This is reflected in the array of books the library now offers to its patrons. These range from medical texts and literature on human rights and politics to love stories and novels.

Dr. Shee Sho was very active in establishing and organizing the library services and KWO members helped with the numbering and registering system. Hla Thein, the library manager, says that the library has changed dramatically since its original incarnation as a box of books at the clinic that staff shared and swapped with each other before 1994. The library now has approximately 100 visitors daily and over 5,000 books. The library officially opened in 2001 when it was decided to turn the expanding collection of books into a proper library. When Hla Thein took over the running of the library in 2003, he was the only staff member; now there are seven staff members on the team running the library from 8am-9pm daily.

Despite the expected challenges of obtaining more books and retrieving them from borrowers, Hla Thein is proud of the library. He is most proud of the fact that more and more people are coming to borrow books. He says that patients and staff now often request books from him, which shows him that people are engaging with literature and the library’s services. Hla Thein would like to see the library develop in the future. He hopes that one day he can get the medical texts translated into Burmese from English, since currently it is only possible to get them in English. In addition, he would like to see the library have an exclusive space that is not interrupted by meetings.
Displaced already, they fear getting split up by circumstances if they don’t travel together. For example, in the case of arrest or deportation, they could have great difficulty finding one another again. The family may not have the resources to travel back and forth to the clinic every day, or have difficulty travelling freely due to security. Sometimes, the family members will search for some work in Mae Sot while attending to a sick family member.

One might be tempted to declare victory when a patient’s condition has improved and is able to go back home. However, for many patients, this merely heralds the beginning of the next set of challenges. They may not have money to get back home, face security and travel challenges, and their old job may no longer be waiting for them even if they do complete the journey without incident.

In other cases, the whole family travels to the clinic together. They may live far away and are unfamiliar with Mae Sot. If the family is migrant or challenged for the medics is to manage the psychosocial aspects. While the death rate is very high, the community spirit of the patients is unbreakable. The HIV/AIDS patients stay in the clinic for a long time, become a close-knit community, and take care of each other.

Unfortunately, there is no space in the ward for relaxation or recreation for long-term patients, and many don’t have sufficient clothing, blankets or basic necessities. One byproduct is that the visual impact for visitors can be a shock. Desperately poor patients arrive with few basic necessities and after long travel. The patients often leave with blankets, meaning that the clinic is constantly in short supply, some patients are accompanied by an entire family who may sleep under their bed, and they can be very dirty due to travelling and sleeping on the floor. While they may receive good care and treatment, there may be visual shock at the patient’s physical appearance in the crowded and disorganized ward. Dr. Cynthia stresses the importance of looking past the initial appearance, avoiding judgment, and looking more closely at the most important elements – quality of care and strength of the community.

Under the misnomer of a “clinic”, Mae Tao Clinic also functions as a hospital facility, with several inpatient departments (IPD). Until 1999 there was only one inpatient department, treating medical, trauma, reproductive health, and child inpatients all in the same space. In 1999, the continually growing patient population led to the expansion of the clinic and separation of departments, eventually resulting in the Medical, Children’s, Reproductive Health, and Trauma/Surgery IPDs that exist today.

Established in 1999, the Medical IPD was a combined service for both...
adults and children. The most common cases seen continue to be malaria, acute respiratory infection, and diarrhea, with a continuing increase in the number of chronic cases being seen at the clinic, including cancer, sclerosis, hypertension, nephritic syndrome, and heart disease. Among children, malnutrition is also a common case, and this was one of the leading reasons for the development of a separate Children’s IPD in 2005; children with weakened immune systems needed to be separated from patients with contagious illnesses.

Beyond the regular patient caseload, staff of MTC must be prepared for the unexpected, such as the cholera outbreak in 2007, or other effects of extreme weather seen in tropical climates. The rainy season from May to September for example, always brings an increase in the number of patients arriving with malaria. Also, the further word spreads of the services of MTC, the more chronic cases are presented at the clinic. Even in a well-equipped, modern hospital setting, these cases would be an extreme challenge.

For severe cases that cannot be treated at MTC, the referral program to Mae Sot Hospital (MSH) becomes a possibility. Department Manager, Saw Muni, and the staff of the Medical IPDs are charged with the unenviable task of deciding who will be referred for treatment and who will not be. There are procedures and protocol to follow, but this does not make it easier. Staff must first consider the potential survival rate of the patient, and then the cost of treatment, referring only the patients that require a one-time visit to the hospital, and not ongoing hospital visits. Of course these decisions are made in developed countries, but not to this extent, and not on a daily basis. Frustration and sadness is evident when talking with Saw Muni. “I am sad because we cannot treat all of the patients, we don’t have enough facilities or enough money to refer the patients. If I see sick patients, and I can’t do anything for them, I feel very sad. And when the patients die…we see a lot of death.”

The Medical IPDs are also plagued with the challenge of staff retention. Saw Muni summarizes the plight well, “If we look for our strong points…we have trained a lot of medics. If we look for the weak points…we have trained a lot of medics that have left.” With the introduction of a resettlement program in 2004, the clinic has suffered extensive loss of staff, but Saw Muni expresses the understanding and acceptance for those that choose to resettle in a third country, “We are human beings. We want to improve our lives. If we are just living, with nothing to hope for…people don’t want to live like this.”

There is hope that the future will see the training of more long-term staff, especially as there are more plans for expansions in Medical IPD. As an example of possible future development, the department still requires better isolation of patients with communicable diseases, especially now that there is no longer an external Tuberculosis program to send patients to. There is also the hope for greater coordination and partnership with other health organizations, Mae Sot Hospital, and the Thai community. Communicable illnesses such as TB quickly become devastating public health issues that don’t recognize borders. The increase in cross-border patients requires greater collaboration in the community to battle health issues.

The IPD cannot alone solve the problem of cross-border tuberculosis, malnutrition, lack of health care inside Burma, or the extreme social and economic challenges of the patients. The IPD aspires to treat the patients with the best care possible with its resources, utilizing strong collaboration with other clinic departments as well as other organizations to address the broader issues that result in its high caseloads.
Prior to 1992, medical supplies were donated, and the clinic survived using various donations-in-kind. Fortunately, there were regular monthly and quarterly donations from organizations such as Médecins Sans Frontières of rice and medicine. If patients were referred for treatment at Mae Sot Hospital, supportive church groups would pay the hospital directly. From 1993 onwards, funding for running costs was donated by organizations such as the Burmese Relief Center. This provided funding for basic necessities of the staff, phone bills, and other administrative costs. Fortunately, other groups began to provide funding as well for running costs.

In parallel, there was a need to develop the medical administration. For example, there was initially only one medical record and log book format which was used by all departments. Separate antenatal care, family planning, and delivery records format were developed in 1994. In 1995 the first annual report was published, but until 1999 there wasn’t a dedicated staff of professional administrative staff. Until 1999 a small office team managed to reply to correspondence or requests to the clinic. However, 1999 marked the beginning of building out the administrative and finance backbone of the clinic. The first clinic administrator and accountant were appointed, and the first audit conducted. For many years MTC didn’t keep its own records – all receipts and records were sent back to the donors and MTC didn’t have its own finance system. Therefore, financial audits were done within the donor organizations. In 1999 the clinic started to keep its own receipts and financial records which could be audited.

The other change from 1999 was the method of ordering supplies and medicine. From 1989 – 1999 there was a central ordering system, but increased grants with specific purposes caused MTC to begin catering to specific donor requirements. More staff was required to monitor supply and medicine expenses and to match those to donor requirements, and the ordering system needed to be decentralized. This development allowed each department’s program manager to independently manage logistics, staffing and expenses. Furthermore, although each department was able to send requests to the central pharmacy, they also kept a separate pharmacy storage area, and in this way individual departments operated like tiny hospitals.

Throughout the early years, MSF had been providing quarterly medicine donations-in-kind, but this eventually proved insufficient for the clinic’s caseload. From 1999 onwards, donors began providing grants that were used for quarterly medicine orders through a local supplier. Terre Des Hommes (TDH), for example, supported specific areas in the clinic. Due to growing donor requirements, the clinic needed to change the ordering system. More people were needed to monitor medicine expenses and to ensure these matched donor requirements. As the clinical space grew and began to sprawl across the grounds into new buildings, more coordination was needed. After 1999, departments were established as decentralized entities with some central coordination. Each department now has a program manager who manages logistics, staff issues, budget and supplies. There is also a clinical supervisor, and shift leaders for the inpatient departments. In each department one person manages the pharmacy - if there is enough staff, this is a separate person, but many times the program manager does this in addition to their other duties.

When a new department is created, a new logbook and report format is created. At the outset, however, there was no consistency or complete data across the reporting formats which made it difficult to consolidate information into an annual report. In 2002 a data coordinator was appointed to oversee logbooks, data entry, and data quality. This coordinator trained clinical staff to do data entry, but their clinical skill set was not suitable, and this resulted in staff turnover. When the data department was finally established...
and data entry staff was hired, the data quality improved. (For further discussion see the Health Information Systems chapter) From that time on, data quality has continually improved and obtaining consolidated figures across the clinic and reporting to donors has become easier and more accurate.

In addition to the establishment of the data department, a concomitant driving factor behind administrative developments in the clinic was the increasing role of MTC as a refugee advocate and social service provider and coordinator. From 2000 onwards, the increasing population of migrants and health problems, gave rise to more NGOs working with migrants. MTC decided to appoint its first migrant health coordinator. Until then, the clinic had restricted its activities to providing services, referring patients to other NGO services, and recording case counts. However, there was no system to monitor the quality of services provided. The Migrant Health Coordinator set out to monitor care in the migrant community, but this was just the beginning of a broader advocacy role the clinic would begin to play both locally and internationally.

On the clinical side, in 2001 a program in collaboration with the Women’s Commission for Refugee Women and Children (WCRWC) brought improvements to the Reproductive Health areas. The support of the WCRWC for two years enabled revision and improvement of the logbook format, establishment of a data collection system, revised medical reports, and a facility checklist. An important facet of current clinic operations also began – the exit interview. This has enabled MTC to better understand patient illnesses, situations, and satisfaction. The program also introduced quality assurance measures such as updated clinical protocols and medical case audits. This project was the beginning of MTC’s monitoring and managing of health care delivery quality.

Once MTC had set up the accounting system, changes and require-processes continues to this day. To support this initiative full time finance manager was appointed in 2005. While the title might mislead one to thinking the role was mainly related to “bean-counting” or tallying the financial figures, the role encompasses fund raising, auditing, reporting, and process improvements to ensure clear reporting. In 2007, a procurement team was established, which set a policy as well as managed the procurement and logistics of the clinic. Recognizing the importance of dialogue with donors, the first meeting inviting all donors to discuss clinic issues was held in 2007. These annual meetings cover issues such as funding needs, standardization and schedule issues.

Prior to the appointment of the clinic administrator, public relations duties were shared by clinic staff. The frequency of visits from donors, universities, media and civil society began to increase with the clinic’s notoriety from 2000. Finally in 2008, an international volunteer was appointed to lead Public Relations. This led to clear guidelines for media tours, referring visitors to departments, and visitor protocols. This role has now been transitioned to local staff. These days, the local staff continues to increase its ranks of young, multi-lingual, educated and polished members who are capable of taking the lead in this area.
STABILITY AND SECURITY FOR MAE TAO CLINIC

With 20 years of service under its belt, the Mae Tao Clinic offers its community a sense of stability and security. In a region which continues to endure ongoing conflict and volatility, it is reassuring to know that there is a community-based organization such as the Mae Tao Clinic which has been able to offer hope for the future for over two decades. Yet, there have been times in the last 20 years when the services and the existence of the Clinic were questioned, possibly even threatened. Dr. Cynthia explains, “In the late 1990’s, the attacks came across the border into Mae Sot. At that time, all the clinic staff slept together in one building. There was a woman brought to MTC for care since she was terribly traumatized who would wake up in the middle of the night screaming. One night when attacks were not uncommon, she woke up screaming. By the time I saw what was happening, wondering if there was an attack, the whole staff had already fled. I noticed they each grabbed a bag and ran out the door. It was only at that moment I realized that everyone slept with their belongings packed, ready to go, ready to flee at any moment.”

As the Clinic has continued to grow, its visibility has increased - certainly in the eyes of international supporters, and even among the host community where the Clinic maintains as low a profile as possible to avoid unnecessary tensions with the local community. Being without official recognition as a Thai-registered organization, the Clinic has operated discreetly, giving importance to the kind understanding of the host community leaders and taking care to engage in full cooperation with local authorities. Even then, there have been times when MTC faced challenges, for example, due to changes in the interpretation of the work permit rules.

Each time the Clinic has come under pressure, Thai senators empathetic to the situation along the Thai-Burma border, and other prominent international supporters, have come to the rescue and have helped to forge deeper ties between the Clinic and concerned parties so that discussions could continue. Situated in the complex reality of competing politics and economics, the Mae Tao Clinic has had to work hard at balancing the needs of its people – both patients and staff, against the turmoil that surrounds it. Each day may bring a new crisis to its door, each year a larger clientele to treat and heal. Even after 20 years, the sense of stability and security that the Clinic will be there for those who need it is continually challenged by the changing landscape of the local context.

Long term funding security is a constant challenge. The events of 2004, for instance, resulted in one of the more severe crises in the clinic’s history, when a large influx of cross border patients came at a time when there were no new increases in funding. There are still some fundamental concerns that keep the Clinic on its toes besides funding issues – such as not being able to own the land that the Clinic stands on, not being able to secure long-term documentation and residency in Thailand for its staff, and not being able to own assets in its name. Lamentably, these issues sometimes negatively affect the operations of the Clinic, and thus the Clinic strives to ensure greater security and stability as opportunities arise. In the end, it is clear that recognition and support at all levels - locally, nationally, and globally - are essential elements in ensuring that the Clinic can continue to serve its community and provide hope for the day when a democratic Burma can emerge.
BACK PACK HEALTH WORKER TEAM

- In 2007, Back Pack Health Worker Team (BPHWT) distributed de-worming medicine, vitamin-A tablets, latrines, soap and health education to 21,962 students and 1,009 teachers in 353 schools.

In the IDP areas, BPHWT addresses three areas: medical, public health promotion prevention, maternal and child health.

- The medical program treats malaria, diarrhea, acute respiratory infections (ARI), anemia, worm infestation and war injuries. Malaria is the most common disease, followed by ARI, worm infestation, anemia, diarrhea and dysentery.

- Tuberculosis is a growing major health problem among internally displaced people. In 2007, back pack teams identified 430 suspected cases of TB. Back pack health workers are not equipped to treat the disease; instead, they educate patients about TB and refer them to other service providers for treatment.

- In the past 11 years, seven back pack health workers and one traditional birth attendant have been killed while delivering health care. One health worker, imprisoned in 2005, and three village health volunteers remain in prison. Two health workers captured in 2007 were released after payment of “fines.” The junta regularly steals medical supplies.

The Back Pack Health Worker Team began in 1998 with 32 teams in the Karenni, Karen and Mon areas. Today, there are 80 teams which have expanded their territory, also reaching into Arakan, Chin and Shan areas. In the Shan areas, there are Lahu, Pao and Shan teams. These teams each have two to five members, and overall serve about 160,000 people displaced by civil war in Burma. Back Pack Teams, laden with 100 kilograms of supplies, often walk more than 1,000 kilometres to deliver health care in ethnic conflict areas.

The focus of the Back Pack model has been to train local people in primary health care and some specialties so they can serve their own communities. Typically, Back Pack teams visit Mae Sot every six months where they re-supply and attend training. Each team then shoulders 100 kilograms of provisions and heads back over the border, traveling mostly on foot through mountainous jungle terrain. Their destinations are the rural and ethnic armed conflict areas where medical care is scarce or non-existent. Walking as far as 1,000 kilometres in a single trip, the teams provide a range of medical care along with community health education and prevention, and maternal and child healthcare services. In bamboo classrooms and simple encampments, health workers teach villagers sanitation and hygiene, how to breastfeed, nutrition, and how to prevent landmine injuries, malaria, diarrhea, avian influenza and HIV/AIDS.

BPHWT’s maternal/child health program includes family planning and breastfeeding education. In a place where one out of 12 women dies in pregnancy or childbirth, BPHWT has trained 720 traditional birth attendants.
in safe birth techniques and provided them with life-saving birth kits and supplies. BPHWT’s mission is to equip people with the skills and knowledge necessary to manage and address their own health problems, while working towards long-term sustainable development. “Human rights violations have commonly been reported by rights organizations, but the association between violations and health indicators has not been quantified” prior BPHWT’s work in this area. A study was undertaken in collaboration with Johns Hopkins University in 200418 Which used epidemiologic methods to demonstrate links between human rights abuses and adverse health outcomes. The report found that children who had been forcibly relocated in the last 12 months had double the chance of dying, and triple the chance of becoming malnourished. In the 12 months after being forcibly relocated, the study found a five-fold increase in the risk of landmine injury for both children and adults.19 Destruction of families’ food supplies and crops not only increases malnutrition, but also increases the chance of landmine injury and malaria as people are forced to forage in the jungle and sleep in beds lacking mosquito nets. This is a particularly important statistic providing that at any given time, 12 percent of the displaced population is infected with Plasmodium falciparum, the most deadly form of malaria.

With limited resources and such high rates of disease, it’s always a challenge to prioritize: should efforts be focused on treating the ill, or should resources be directed at teaching vital statistics?18 Prior BPHWT work in this area. A study was undertaken in collaboration with Johns Hopkins University in 2004 Which used epidemiologic methods to demonstrate links between human rights abuses and adverse health outcomes.

The Karenni Nationalities Health Worker Organization has set up clinics in the Karenni state, with medics attending training at MTC and MTC medics travelling to the clinic to assist the set-up. Staff exchanges were done to facilitate knowledge transfer across the organizations. After attending prosthetic training at MTC they are now able to build their own prosthetics since 2008.

After the massive forced relocation of over 300,000 Shan people in 1998, the Shan Health Committee (SHC) established Tin Tad Clinic on the Thai side of the border, which still operates today in Fang. MTC helped to establish this clinic, which has now been officially recognized as a Thai health post. Today, this clinic in Fang is recognized by the Thai Ministry of Health as a model clinic for migrant workers in Thailand.

In staff exchanges similar to those done by the Karenni Nationalities Health Worker Organization, SHC sent their medics to MTC for training and did staff exchanges and knowledge transfer. They also work with the Burmese Medical Association to the same end. SHC also worked in partnership with MTC and set up a prosthetics workshop, and conducted their own community health worker and laboratory training. SHC is an example of partnerships creating an empowered community.

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KAREN WOMEN’S ORGANISATION (KWO)

After the December 1996 attacks in Dooplaya and February 1997 attacks in Hway Kaloke, KWO stepped in to support the affected women and children. MTC has been working in partnership with KWO ever since; initially on emergency relief and later on to set up community projects. KWO has set up libraries, nursery schools and income generation projects in the refugee and IDP camps. Starting in 1999 KWO worked together with MTC to write funding proposals and to build of the capacity of both organizations. Over the years, KWO has worked alongside MTC to further advocacy and community development. These days, MTC and KWO work together on programs for Traditional Birth Attendants, Maternal Health, adolescent reproductive health, and Child Protection.

KARENNI NATIONALITIES HEALTH WORKER ORGANIZATION

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SHAN HEALTH COMMITTEE

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2000 – 2004: BUILDING CAPACITY

A child patient at Child IPD (photo: James mackay, www.enigmaimages.net)
Dr. Cynthia Maung, the 43-year-old founder of Mae Tao clinic in the Thai border town of Mae Sot, is an abscounder, an insurgent and an opium-smuggling terrorist. Any attempt to deny this is as futile as covering the rotting carcass of an elephant with a goat hide.

That, at any rate, is the opinion of Burma’s ruling military junta, as published on its reliably absurd and malicious website. The generals have every reason to despise “Dr. Cynthia,” as her patients call her. In 1989, equipped with medicines scrounged from foreign relief workers and instruments she had sterilized in a rice cooker, she transformed a dilapidated barn in Mae Sot into a clinic to provide free treatment for the sick and wounded fleeing Burma’s oppressive regime. Today, thanks to her preternatural drive and optimism, up to 200 patients—mostly migrant workers and refugees from across the border—pass through her clinic every day. Its five doctors and 120 other medical staff treat everything from diarrhea to gunshot wounds, all for a patient registration fee of just 25¢. Maung has won a slew of international prizes, most recently a Ramon Magsaysay Award for community leadership, and remains among her own people the likeliest candidate for sainthood after the leader of Burma’s pro-democracy movement herself, Aung San Suu Kyi. If you were a Burmese general, you’d hate Maung, too.

“When I first arrived in Thailand I thought I’d be here for only three months or so,” recalls Maung, a handsome, soft-spoken woman who emanates serenity even in less-than-serene circumstances—in this case, with dozens of infants howling from immunization jabs in her clinic’s child-health center. “Then I thought I would go back in three years. Then five years. I always thought the political situation in Burma would improve.” Instead, it got worse, creating an ever-growing caseload for Maung and her staff. While the clinic hasn’t lost its make-shift feel—the beds in its 49-bed inpatient ward are wooden trestles covered with floor linoleum—it has expanded to include a trauma department, blood and eye labs, and a prosthetics department for land-mine victims. The clinic also serves as a training center for the famous “backpack medics”—teams of doctors who make perilous treks deep into the Burmese jungle to treat people with no access to medicine. The physicians occasionally have to resort to jungle amputations to save lives.

Maung understands what it’s like to be a refugee—she’s one, too. Born into a Karen family in Rangoon, her work as a young doctor at a tiny rural clinic in Karen state enabled her to witness firsthand the poverty and disease endemic under Burmese military rule. She was among the euphoric millions who joined nationwide antigovernment protests in 1988—and, a few months later, one of thousands who fled over the border into Thailand to escape a savage crackdown. Traveling at night to evade army hit squads, Maung and 14 colleagues trekked through the jungle for seven days, stopping only to treat the sick and injured they came across with the few supplies they had carried. Although she has now lived in exile in Thailand for 15 years, Maung has no official papers and is effectively stateless. The clinic is her country now. Private and unassuming, she lives in a modest house at its gates, along with her husband and three children, the last a baby girl adopted after being abandoned by her mother at the clinic.

Maung places enormous faith in her medical staff despite their lack of formal training, and they return this faith with fierce loyalty. “For Dr. Cynthia, nothing is impossible,” says Tara Sullivan, an American reproductive-health expert who has worked alongside her for two years. “She has a great sense of humor and a great sense of purpose.” Clinic administrator Rae Svarnas says, “She’s an incredibly hard worker. She never asks anyone to do something she wouldn’t. And in two years I’ve never seen her angry. Never.” With her medical qualifications and experience, Maung could easily claim asylum in a third country. Has she ever been tempted? “Work abroad?” she asks, as if I’ve just suggested we tango through the inpatient ward. “I’ve never thought about it. The West has enough doctors.” Which is a relief to hear, because as tens of thousands of her patients would attest, impoverished and benighted Burma needs all the doctors it can get—and all the heroes, too.

Dr. Cynthia Maung has undergone a dramatic transformation. Once a rural Burmese doctor, she became a victim of war, then a refugee and exile, and is now a world-renowned human rights leader helping thousands of desperate people from her country.

Known universally as Dr. Cynthia, she was working as a doctor in a rural clinic in Myanmar in 1988 when political turmoil and conflict forced her to flee to neighbouring Thailand. There she established the Mae Tao Clinic in Mae Sot, Tak Province.

The Clinic has grown from a small, makeshift operation in 1989, with a few volunteer staff assisting approximately 1,700 patients, to become one of the leading organizations on the Thai-Myanmar border. Today, more than 250 staff and volunteers provide critically needed and culturally appropriate health care to thousands of ethnic Burmese and migrant workers living in desperately poor circumstances in Thailand, as well as internally displaced persons in Myanmar who undertake the dangerous, illegal trip across the border to Thailand to obtain health care at the Clinic. The Clinic also provides health services for thousands of internally displaced persons at two satellite clinics in Myanmar. In 2003, the Clinic provided for over 80,000 patient visits to its facilities.

In addition to the Clinic’s comprehensive inpatient and outpatient services, Dr. Cynthia and the Clinic’s volunteer staff support education and social services, including two schools for orphaned children. The Clinic also hosts regular extensive training programmes for health workers, who then work in migrant communities along the border, among the internally displaced in Myanmar or with international organizations in one of the refugee camps in Thailand.

Dr. Cynthia has trained some 70 backpack health worker teams, each composed of two medical assistant and a traditional birth attendant. The teams provide health services to internally displaced people at great peril to their own lives, risking possible landmine injuries and military attacks, in area of Myanmar where government services are not available and international non-governmental organizations are not allowed to go.

In 2000, Dr. Cynthia helped to found Social Action for Women, which established a ten-bed temporary safe house for abandoned infants and young girls who have suffered gender-based violence or who are seeking to escape commercial sex work or forced prostitution. The organization provides information on HIV/AIDS and other reproductive health issues, helps young girls attend school and offers job skills training. The increasing numbers of abandoned infants at the Mae Tao Clinic and the district hospital reflect the critical problem of unwanted pregnancy and the need for family planning among internally displaced women in Myanmar and others living in refugee-like circumstances.

Dr. Cynthia has lived in exile for 15 years and effectively stateless, at constant risk of being deported along with the 150 volunteer staff who work with her. She lives in a house at the Clinic’s gates, along with her husband and three children, including a baby girl adopted after she was abandoned by her mother.

Dr. Cynthia’s humane and fearless work truly embodies the spirit of Security Council resolution 1325. Under her direction, the Clinic has received numerous international accolades - including the Jonathan Mann Health and Human Rights Award, the John Humphries Award and the prestigious Magsaysay Award - for its compassionate and courageous work in addressing the health and human rights of ethnic Burmese people in Thailand and the internally displaced in Myanmar.

(Faces, Women as Partners in Peace and Security 2004, Office of the Special Adviser on Gender Issue and Advancement of Women (OSAGI), Department of Economic and Social Affairs, United Nations Department of Public Information.)
PROSTHETICS DEPARTMENT

- Burma is second only to Afghanistan in the number of new landmine victims each year.
- 95% of the program’s clients come from Burma

From the outside, the prosthetics department looks like another plain, heavy concrete cinderblock building - one among the many that form Mae Tao Clinic’s maze of structures. Inside the bland façade however, is a workshop that gives hope to landmine victims – hope in the form of prosthetic limbs, food and shelter, social support, and the knowledge and expertise of staff that know firsthand the difficult journey that landmine survivors have made.

Saw Maw Kel is a sturdy Karen gentleman who founded the Mae Tao Clinic’s prosthetics program at the end of 2000 and has been a driving force in its development ever since. A landmine survivor himself, Maw Kel experienced the psychological wounds that accompany the physical injury – a wound that takes more than an artificial leg to heal. “In our culture, the man is the leader of the family and more responsible for taking care of the family,” says Saw Maw Kel. Many landmine survivors suffer humiliation and shame when their injury makes them dependent on the loved ones they are supposed to provide for and protect. “I have seen that most [landmine survivor] patients have little confidence in themselves after they get their prosthetic, including me,” he says. “They got injured not only physically but mentally...some don’t even listen when they are told how to take care of themselves after their amputation. I understand how they feel, because I was also feeling the same way a long time ago.”

Dr. Cynthia helped Saw Maw Kel set up the prosthetics shop at the Mae Tao Clinic after a workshop he started with Dr. Cynthia’s support at the Mae La Poh Htah IDP camp was burned to the ground. Less than a year later, Saw Maw Kel and his staff of one, Moe Khar, had treated 30 patients from Burma. Year by year, the shop grew from a simple room with no power tools into a modern prosthetics production facility. Lamination was the primary method of making artificial limbs. In 2005, with the support of Clear Path International, the monolimb was introduced. Light and partly vacuum-formed, the monolimb promises faster production and easier delivery to IDP areas, but requires complex and precise techniques. Today the shop’s crew of 6 can make more than 200 limbs a year, using both lamination and monolimb methods.

Throughout the program’s histo-
ry, most of the prosthetics trainees have been landmine survivors themselves. Ninety-five percent of the Mae Tao Clinic’s Prosthetics Program’s clients come from inside Burma. Moe Khar, now the prosthetics department manager, says that 17 out of 20 patients that come each month have lost their limbs to landmines. Accidents, disease, and congenital defects make up the remaining 15%. The vast majority need lower limbs. When a client needs an upper limb, a sponsor is sought to purchase and deliver the materials for an artificial arm.

The Mae Tao Clinic refers newly-injured landmine and gunshot wound victims to Mae Sot Hospital for stabilization and initial surgery. In 2004, the ICRC began supporting the referral program by paying for patients’ initial medical expenses and conducting assessment interviews. After their amputations, landmine survivors begin a long journey of rehabilitation. At the Mae Tao Clinic, in addition to prosthetic limbs, patients receive food and housing, and social support services. They also get gait training – in essence, relearning how to walk. The clinic began offering mental health counselling specifically for prosthetic patients in 1998. Today prosthetics patients can get help at the clinic’s counselling center that opened in 2006.

In addition to the successes, the program faces hurdles that are beyond the clinic’s control. The supply of artificial feet, ordered from Cambodia by Handicap International, often cannot keep up with the demand. It is difficult to find local people willing and able to give physical therapy and limb massage to patients, and lastly, with such a small staff, the shop acutely feels the loss of experience and knowledge when a technician resettles overseas. Fortunately however, the program’s financial future seems secure, as an Italian community organization has guaranteed the clinic’s prosthetics program long-term support. Eventually the clinic hopes to produce artificial feet in-house to reduce the reliance on supply from the outside.

The legacy of the Mae Tao Clinic’s program will not only be the landmine survivors it has served, but the many technicians that have graduated from the program’s prosthetics workshop training. Some from ethnic minorities have returned to their communities inside Burma to apply what they learned in Mae Sot, bringing hope to landmine survivors who are unable to make the arduous trek to the border. For Saw Maw Kel, the satisfaction comes from seeing amputees make the mental journey from victim to survivor. Though the prosthetic limbs are an imperfect replacement for what was physically lost, they are pivotal to recovering a wholeness of being. “I am happy and proud,” Maw Kel says, “to see those who have lost parts of their body like me, regain confidence and struggle for life without giving up.”
HEALTH INFORMATION SYSTEMS

Getting accurate information on time is the mission of the health information systems department (HISD). How many cases of a certain disease has the clinic seen? What is the percentage of female patients? Where do the clinic’s patients come from? These are the types of questions that the HISD seeks to answer, but before the development of an electronic health information system, answering such basic questions was laborious. It meant flipping through pages and pages of clinic logbooks to get each patient’s name and diagnosis, retrieving cardboard medical charts from a filing cabinet, interpreting the sometimes messy handwriting of busy medics, and recording the information in another logbook to be added, divided, and analyzed. Not only was each step of this process time-consuming to do by hand but was prone to error as well. A line in a thick logbook might be overlooked, a name misspelled, a diagnosis missing from the chart, or numbers added incorrectly.

Of course, even without the numbers, the basic work of the clinic can continue. Medics can still see patients, pharmacists can still dispense the proper medications, and babies are still delivered. Without these numbers however, planning, a crucial element in the development of the clinic and the services it provides, is impossible. How can you know how many anti-malarial pills to order for July unless you know the number of patients with malaria you saw this June or last July? How can you know how much money to budget for medications and supplies for the Trauma and Surgery Department unless you know the numbers of different surgical procedures that were done? In the mid-1990’s the clinic started recording this information in computerized spreadsheets using Microsoft Excel. The information that was stored at first was basic: name, age, gender, and diagnosis. While Excel is good for mathematical analysis, it is not so good for storing information. The clinic started using an electronic database program for its medical inpatient department in 2000. By 2004, almost all of the clinic’s departments were entering information into their own Microsoft Access databases, which were then combined into a central database that the clinic could use for planning, budgeting, and reporting to donors.

Thanks to the generosity of foreign donors, getting computer hardware and software has not been the main challenge. Rather, the biggest obstacles are developing staff with database skills and knowledge, keeping the system going as experienced staff leave and new staff come on board, and educating clinical staff on the importance and value of information.

Some of the best examples of the system at work are in communicable disease public health. As tuberculosis emerged in recent years on the Thai-Burma border, the clinic used its health information system to determine the proportion of cases coming from Burma. In 2003-2004, Tak Public Health conducted a pilot project with MTC, helping the clinic improve its database’s ability to monitor 19 infectious diseases of public health importance. During a cholera outbreak on the border in 2007, the information in the clinic’s database was used to conduct surveillance for the deadly diarrheal disease.

In 1995, MTC had only two computers— one for Administration, another for a DOS learn-to-type program. Today HIS has 24 desktop computers and 11 laptops spread across 12 departments.

The next big step planned for the clinic’s health information system is to introduce a fully centralized database. Today, to update the clinic’s main database, staff members have to copy the data entered on the computers of each of the clinic’s twelve departments onto memory stick “pen drives,” walk to the health information system office, plug the drives into the office’s main computer, and import the data into the central database. After 2009, the data entered by each department will immediately travel via a computer network to be stored in a single modern SQL server database. This will decrease the errors associated with manual information transfer, and allow the main database to be updated more quickly.
REGISTRATION / MEDICAL RECORDS DEPARTMENT

The function of the Registration/Medical Records Department is to create, file and be able to quickly retrieve any one of more than 100,000 medical records. Every person coming to Mae Tao Clinic first goes to the Registration Department where they are given a unique registration number that will follow them for all subsequent visits. In addition to serving as the medical record for the patient, records are the source for quality assurance and case reviews. Being able to retrieve the patient records of those who, for example, had fatal outcomes from malaria or came from a specific area of Burma, entails identifying the patients through the Health Information Systems and then reviewing the care they received.

There are formidable constraints in the Medical Records Department that are unique to a health care facility that serves migrants and displaced persons. Due to security concerns, some patients may give a different name or address on successive visits in order to remain anonymous. Others feel it is necessary to throw away their registration card before returning to Burma so as to not have any incriminating evidence of their visit to Mae Tao Clinic; for others it may be that they actually do not know their date of birth or even the name of their village. For Moe Oo, head of the Medical Records Department, and his staff, the difficulties then lie in translating the information from Burmese or one of the many ethnic languages into English, which leaves room for many different spelling variations.

Beginning in mid-2007 new patient registrations were directly entered into the HIS database. In less than 2 years, the Registration/Medical Records Department has entered more than 130,000 patients into the HIS database and is adding patients at a rate of 40,000 to 50,000 each year.
1992:
- Mae Tao Clinic medics trained to recognize the signs and symptoms of HIV/AIDS
- More patients admitted to the Inpatient Department with the complications resulting from AIDS.

1995:
- HIV testing introduced with the beginning of the blood donation/transfusion program.
- Rapid tests for HIV, Hepatitis B and C, and syphilis performed at the MTC Laboratory.
- MTC begins working with HIV cases and referring antenatal care cases to Mae Sot Hospital.

1998:
- HIV testing for pregnant women receiving antenatal care begins.
- Between 1998 and 2001, some financial support for the testing program received, significantly boosting participation to approximately 75 percent. Women’s Commission’s support for the Reproductive Health project facilitates beginning of testing for all pregnant women.

2003:
- Home Based Care (HBC) begins – 15 to 40 PMTCT clients in program
- Cotri for prophylaxis begins
- Monthly meetings of PLWA (people living with aids) support group begins
- MTC enters agreement with Family Health International (FHI) to provide voluntary counselling and testing and to expand perinatal services for HIV positive women. Expands services for post delivery, home visits, follow-up care, and opportunistic infection.

2004:
- All testing for the Blood Transfusion Program sent to the laboratory at Mae Sot Hospital.

Prior to 1999 the clinic staff had a reasonably good understanding of prevalence via blood donors, antenatal and other testing; what staff members lacked however, was a good understanding of what information migrant workers had about the disease. Since condom use was and continues to be stigmatized, high school drop out rates are high, and the population is very mobile, the staff feared a high level of misconceptions. Even if the misconceptions were addressed, condom availability was limited due to constant economic pressure on the community.

Condoms were outlawed in Burma until 1992.21

Facing this confluence of public health dangers, in 2000 MTC, Thai Public Health authorities, and Burma Medical Association conducted the HIV/AIDS KAP (knowledge and practices) Survey. This was the first time this type of survey focusing on migrant workers had been conducted. The results showed that the community had poor knowledge of the disease – typical misconceptions included the ideas that antibiotics could prevent HIV, and that transmission wasn’t possible with only one exposure, and community leaders and teachers were typically reluctant to have the sensitive discus-

From 2001 to 2003, MTC joined the Perinatal HIV Prevention Trial (PHPT), a collaborative pilot project that provided no-cost testing for all antenatal care patients. Blood samples were sent to the laboratory at Mae Sot Hospital and then combined with data from three other sites in Thailand. Anti-retroviral medications were given to those testing positive in order to prevent mother-to-child transmission. Both mother and infant received follow up visits, and milk formula was provided to replace breast milk. Whilst 22 UNFPA, “United Nations Population Fund Proposed Projects and Programs: Recommendations by the Executive Director; Proposed Special Assistance to Myanmar”, 13 July 2001. UN Doc DP/FPA/MMR.

constituting a positive step forward in preventing mother-to-child transmission, this program didn’t include treatment of opportunistic infections, home based-care, or nutritional support.

The voluntary counselling and testing (VCT) program began in 2003. It is a free, confidential and anonymous HIV/AIDS counselling and testing service offered six days a week at the clinic. Partners of all positive clients are also encouraged to go to the VCT center. VCT is a rapid test which produces results in thirty minutes, so the clinic can offer pre and post-test counselling. VCT clients have a higher prevalence of HIV infection than the general population since the majority of them present with symptoms of a sexually transmitted disease, indicating a higher risk for exposure to the virus.

Before the HBC program, patients were often lost to follow-up since there was no organized means of contacting them. This was especially problematic for pregnant women who tested positive. The idea of HBC is that by providing home visits, the clinic can ensure continuity of care while increasing opportunities for counseling on risk reduction, personal care and health education. The home-based care staff is generally persons living with HIV who have decided they want to help others. They carry the most convincing messages since new clients can identify with them.

Currently, one of the major venues for HIV testing is the blood donation center, with most donors being factory workers. Every year the clinic conducts an HIV education and counselling workshop for this section of the migrant population. The factories work with MTC both on education as well as providing blood donors. Twice a year MTC provides HIV counselling and testing for factory workers. Ultimately, the factory delegates become HIV education supporters, as well as coordinators for blood donation.

Clearly though, the migrant and cross-border communities are not composed solely of the factory workers. In recognition of the complex demographics of these communities, MTC has tried to enable a peer support network for the migrant community, as a means of taking advantage of opportunities to network, provide HIV prevention education, and raise awareness. This happens through both community collaboration as well as medical collaboration, for example with Mae Sot Hospital.

Some people come Thailand to avoid the stigmatization they would be subjected to, were they to be treated in Burma. At MTC, patients feel they have a safe and accepting environment for treatment. MTC achieves this by
providing a comprehensive approach including home-based care, nutrition support, and psycho-social services.

Three medics working with the HIV/AIDS program, Naw Shwe of the Blood Transfusion Program, Naw Ree of the PMTCT program and Saw Than Lwin of the VCT and Home-based Care Programs have worked for several years on their programs and are justifiably proud of the progress that has been made. As a result of education and peer support, patients are now more receptive to health education counselling and are less afraid to ask about their risk of HIV exposure. They are proud that the patients living with the HIV virus have a better quality of life than before. The peer-group meetings run by the HIV program have helped patients deal collectively with issues of stigmatization and isolation and have increased exposure to education and support.

Saw Than Lwin says that when the VCT program started there were only about 10 people tested per month, now there are approximately 100 people tested monthly. News has spread by word of mouth through the factories and housing areas, that at MTC, one can get a free anonymous HIV test and straight answers to questions. The role the program plays in educating the community is very important, and it has been highly successful in getting information about HIV to the migrant community.

However, there are significant challenges for the program. Patient and staff security is a problem, particularly for home-based care workers. Peer counselors do not have work permits in Thailand so when they are making home visits they face the threat of arrest and detention by police; security issues are even greater for clients coming to the clinic, especially from cross-border areas. Moreover, many HIV/AIDS patients cannot work and therefore do not have an income. Social stigmatization of HIV/AIDS patients is also a problem in the workplace and in the community.

An ongoing challenge is managing pregnant women and mothers with HIV. MTC provides milk powder, but HIV peer counselors need to explain how to prepare and use the milk powder. This might seem like a simple task, but when the mother’s living environment may be transient, without electricity, clean water, and clean cooking vessels, it becomes a challenge. Thanks to the perseverance of the HIV peer counselors though, there has been some measureable success - testing of babies between 12 and 18 months after delivery was negative for all 12 babies in 2004, and for 21 of 22 tested in 2005.

The HIV program in the clinic has become integrated across departments, rather than existing as a completely separate department. It is conducted across blood donors in the blood bank, via antenatal testing in the reproductive health departments, family planning and counselling. Family planning issues relevant to HIV patients are addressed in the Reproductive Health Outpatient Department.

Aside from addressing HIV across the clinic’s programs, MTC aims to provide a comprehensive and proactive approach to HIV. This approach has stemmed from the clinic’s institutional knowledge that instead of focusing on a specific element of HIV (such as testing), what is needed is a comprehensive approach that encompasses the empowerment of people living with HIV, education of the community as well as working with women, health workers and community based organizations. It is an approach which cuts across all of the clinic’s departments as well as partner organizations.

The voice of experience: HIV Peer Counselor

Khin Lay Thwe learned that she was HIV+ in early 2004, due a test done by MTC. By the middle of 2004, she became a peer counselor, in order to help out fellow HIV patients. She explains that she gets the most satisfaction from being able to talk to HIV patients when they are sick and from ensuring the patients and caregiver share the same outlook and approach. She travels around the Mae Sot and Cross Border area to visit her patients who may have many other problems aside from their illness.

When asked about how she deals with the depressing parts of her job, Khin Lay Thwe explains her approach, “I keep in mind that everyone will die. When we do, we will be released from the suffering in this life”. She tries to explain and share this gentle acceptance with her patients and their caregivers to bring serenity and dignity to their situation.

Khin Lay Thwe typically goes by bicycle to visit her patients, up to a 30 kilometer round trip over the dilapidated roads into Burma. However, she doesn’t find this the difficult part. Rather, trying to find patients who live in jungle or unsafe areas who may be transient is the challenge. For these cases, she takes a male friend to accompany her and ensure her safety. The other issue that troubled her was that many patients have difficulty accessing ARV (anti retroviral therapy).

Peer counselors also provide coordination between patient and hospital. The patient may not remember what the doctor has instructed, or miss appointments. The peer counselors follow up with the patients to ensure they comply with doctors’ instructions, treatment, and appointment schedules.

Challenges which the peer counselors cannot always address are domestic violence, family problems and financial problems, but they do their best to advise and console. While most patients are polite and cooperative, there are always a few who are difficult to manage.

Khin Lay Thwe plans to continue work as a peer counselor, with good health on her side for now.
The School Health Program started in 2003, teaching hygiene and basic nutrition to 1,500 children in 13 schools. By 2008, it expanded to serve nearly 10,000 children and train 92 teachers in 58 schools in Mae Sot, Poh Pra and Mae Ramat. Services now include vision screening, water/sanitation assessment and monitoring, first-aid supplies, polio vaccination, and prophylactic de-worming and vitamin A supplementation.

School Health Teams teach age and culturally appropriate lessons on child trafficking, child rights, HIV/AIDS, and adolescent health, and environmental health. The teams train student leaders, and refer abuse cases or emergency cases to MTC; trafficking cases are referred other organizations such as Social Action for Women (SAW).

In 2003, the Mae Tao Clinic started a School Health Program (SHP) to prevent disease and improve health among an increasing number of children displaced by war and economic migration. Teachers in newly formed migrant schools noticed students coming to class with rashes, abscesses, fever, and asked medics to start making school visits. “Here was an opportunity to prevent disease, rather than just treat children after they were already sick”, says Thar Win, manager of the SHP.

“The main problems seen in migrant children by health workers are malnutrition, acute respiratory tract and other infections, malaria, diarrhea, worms, deformities, skin diseases and anemia. Malnutrition is a significant problem and teachers report that at least 50% of children are weak because of lack of food”23

Early on, while visiting Naung Bo Del, a bamboo school near the Moei River along the border, Thar Win saw two little boys playing with chickens in the dirt by the kitchen. The children were filthy. No pants, no shoes and no underwear, just shirts - and laughter. “You could see the faces, their smiles,” he says, “but the risk around them was too much.” Watching them, Thar Win worried about worm infestation, scabies and other skin diseases; tetanus from cuts and respiratory infections from inhaling dust. He wondered whether the children were malnourished - a special problem that affects developing brains and bodies because it can cause IQ loss and physical damage. He was also concerned about the spread of diarrheal diseases, since the boys had bare bottoms and played near pots of rice and curry. Furthermore, they were playing with live chickens, exposing them to the risk of avian flu.

“Who are their parents?” he asked the teacher. Like so many others, the teacher said the parents lived in Thailand illegally, had little education, and

worked until late at night for low wages, barely surviving. They lived in crowded, damp and dirty housing without enough latrines, a bad water supply, and not enough money for food.

In order to combat these types of situations, the SHP began partnering with community-based organizations to identify and improve access to clean water and latrines. The teams started annual height and weight screenings at each school and semi-annual de-worming and vitamin A supplementation. They taught children about global warming, and how to plant a garden, recycle, compost, clean toilets, pick up trash, and reduce electricity use. They trained student leaders to organize children, identify problems and work together on solutions.

Has there been progress? Yes and no. As school health workers spent more time in schools and communities, they heard of more problems: rape, domestic abuse, HIV/AIDS, child trafficking, abuse of child labourers, children forced to porter illegal drugs, work with toxic chemicals and dangerous machinery, labor long factory hours for little or no pay, or work in brothels as prostitutes. In response, the SHP expanded their network of partner organizations, referring complicated cases to related organizations that deal with child trafficking and abused and orphaned children, among others. With input from families and communities, they began teaching an age appropriate and culturally sensitive HIV/AIDS curriculum, along with lessons about how to protect against pregnancy and sexually transmitted diseases.

In 2006, the School Health Program joined the Burma Anti-Child Trafficking Network to train factory workers, school staff and families about child rights and brainstorm ways to prevent abuse of children. One of the most creative lessons plans they developed is an interactive drama. Acting from a script, the children pretend to collect garbage for which they earn a few small coins. One day, a friendly man comes by and gives them treats to eat and drink. This makes the children happy, and they come to trust the man. Eventually, he promises them a job if they’ll go with him. Then he forces some to beg or sell flowers on the street, giving him whatever they earn. Others have to work in a factory for low or no wages. Still others are forced into sex work. This drama teaches the children to identify and avoid these dangerous situations.

The key to living in this challenging environment, Thar Win says, is to learn from the children themselves. “Even if they don’t have facilities, they find a way to play. Buddhist, Christian, Karen, Burmese, Mon...it doesn’t matter the religion or ethnicity, they’ll play together because their goal is to find happiness.” Of course, children have conflicts as well, but they solve them face-to-face in the moment. Adults take too long to solve conflicts, allowing them to escalate; they focus on wants instead of happiness, he says.

In the short term, the School Health Program plans to expand its network of partner organizations to combat child-trafficking and work on other health issues. Long term, Thar Win says, people need to follow the children’s example and work together to stop human rights violations in Burma. Until that happens, problems will continue spilling over the border and into children’s lives.
PUBLIC RELATIONS

By the late 1990’s, MTC had bloomed into something more than a small medical clinic. The MTC umbrella began to provide various social services, education, and community oriented services. The medical staff began to spend more time providing direction to patients on non-clinical issues, drawing their focus away from their clinical work. At the same time, there were a growing number of young people who had either arrived from Burma, migrant communities or refugee camps. These young people were articulate, energetic, and in search of opportunities to contribute. It was a natural to apply the skills of these young people to form a Public Relations Centre (PRC); but who could train them and be a leader? It proved difficult to find an appropriate leader for the undertaking, since only senior members in the clinic had a good understanding of security issues, how partner organizations worked, and how the various departments in the clinic functioned. The leader would need good communication and organization skills.

Fortunately an ABSDF (All Burma Students Democratic Front) leader who had plans to resettle agreed to lead the effort to set up the centre until his relocation. He coordinated with the various departments in the clinic, as well as with CBOs and trained a diverse staff. Staff diversity in the PRC was essential in order to communicate in all the ethnic languages used at the clinic, as well as to have staff with backgrounds ranging from migrant communities to refugee camps. The PRC was formed in 2003 in order to efficiently communicate information to the many patients coming to Mae Tao Clinic. Previously, patients who needed information would simply ask the closest person to them, often a medic. This resulted in medics being distracted from the job at hand while they clarified something for the patient. It was decided that MTC needed a public relations service to ensure effective dissemination of information and free up the medics to concentrate on their work. When it started, the PRC consisted of a tin roof over a concrete floor. It was responsible for taking care of emergency patients and others who needed assistance, and for providing directions and information to patients.

The name, “Public Relations Centre” might be misleading, since the PRC has a much broader role which includes social services coordination. These services include: providing in-
formation to clinic patients, keeping records of vehicle traffic at the clinic for security reasons, assisting patients who are frail or cannot walk and caring for long-term patients, such as the mentally ill and the elderly. It also runs the clinic’s patient house and funeral service. Many who visit the clinic describe it as a “little village” – the PRC ensures that the environment is clean, organizes festival events, and works to make the clinic a safe and culturally rich place where patients can recover. The PRC is also frequently the first point of contact for emergency medical patients arriving in the clinic, or those requiring referrals to other social services.

Today, the PRC has a small office added onto the original enclosure, and has a plethora of new responsibilities. In addition to providing information, they now also take care of MTC security. This involves recording the number plates of cars that come through the clinic, both for security reasons and to keep track of who has come in with patients in case of emergency. The PRC also has stretchers to tend to patients who are frail and cannot walk, as well as emergency patients, and it brings food to patients in IPD and Child IPD who cannot get their own. Another of the PRC’s responsibilities is the care of patients who are at the clinic long-term, such as the mentally ill, the elderly, and the disabled. The PRC also organizes the distribution of the clinic’s mail to the appropriate departments.

U Tin Shwe, the head of Public Relations, says there are many challenges for the department. For instance, they often have to help migrant workers whose bosses have simply dropped them off at the clinic with no means of returning to their place of employment. The PRC will try to get in touch with the employer, and if that fails they will give the patient money for transport. U Tin Shwe says that despite obstacles, there are also many uplifting moments and his proudest achievement is helping patients everyday. If he could have anything for the department that he wished, it would be an ambulance like the Thai hospitals have. He would like to drive it around to pick up patients who are too ill to travel and need transport to Mae Tao Clinic.

**Patient House:** The Mae Tao Clinic patient house was built in 2004 to address an increasing need to house patients who were awaiting follow-ups or referrals to a Thai hospital, such as Mae Sot Hospital or Chiang Mai Hospital. Patients were failing to follow-up because they had traveled back home and could not afford, or did not have the time, to return to the clinic. It was decided that housing them at the clinic would increase the likelihood of patients staying and thus receiving better health care.

**Funeral Service:** Mae Tao Clinic organizes funeral services for patients whose families cannot afford the service, cannot be contacted, or cannot make the journey to Mae Sot to claim the body. Most services are either Buddhist or Christian, and involve either cremation or burial.

U Tin Shwe is always sad to see patients who have died with no family around. He recalls one particular patient who had an impact on him, a 28-year-old man who was HIV positive. He often came to the clinic for treatment, and one time he was admitted to IPD with severe malaria. The clinic tried to contact his family, but could not get in touch with anyone before the patient died. Although U Tin Shwe finds such situations challenging, he is happy that he can at least offer some dignity in death to patients like this.
What to do if your molars ache, gums swell and the shooting pain in your jaw keeps you awake at night? If you’re poor and from Burma, you head for the Mae Tao Dental Clinic (MTDC), where trained dental workers examine, diagnose and, when necessary, drill and fill cavities, scrape away plaque, perform root canals and extract infected teeth - for free.

Dental Clinic saw about 4,000 patients in 2008, and extracted 1,907 teeth in the first half the year alone.

The Mae Tao Dental Clinic started in 2001, opening three days a week as an adjunct to the clinic’s surgery department. At first, the clinic had only one syringe and a handful of dental mirrors and tools for extractions. The surgical medics, who had attended a dental training in Bili Htoo, saw three to five patients a day. Patients came to the clinic complaining of tooth pain, jaw swelling and abscesses. Sometimes the medics couldn’t figure out what caused the problems, but they could treat the symptoms by cleaning teeth, giving antibiotics, draining abscesses, and, when needed, extracting teeth.

Today, the dental clinic is a separate department in a newly constructed concrete suite that has three donated chairs and high-speed pneumatic dental drills. Led by clinical supervisor Dr. Kyaw Zayar, a dentist from Burma, and clinic manager Gay Moo, the 6-person staff is specially trained in dentistry and sees 20 to 30 patients daily, resulting in the treatment of approximately 4,000 patients in 2008. In the first half of 2008, the dental clinic performed 1,907 tooth extractions, 26 root canals, 87 scalings, 289 resin fillings and treated 18 oral cancer patients for pain.

Almost all the patients seeking dental care at the Mae Tao Clinic have never before visited a dentist. In addition to their primary complaint, eight out of 10 patients also have cavities they aren’t aware of. The problem, dental medics say, is that most patients have little education and don’t understand the importance of oral hygiene. “Dental care is very important,” says medic Lawkwa. “It is a part of health. Before, people didn’t understand. They only (associate) malaria and diseases like that with health. [A tooth infection] starts because of lack of knowledge about how to clean and take care of the mouth. It gets worse, sometimes turning into an abscess if you do not get appropriate treatment. Lots of suffering, pain, fever. It can cause osteomyelitis, an infection of the bone.”

For impoverished patients, it’s common to delay treatment until an infection rages out of control. Patients say they’d be forced to spend their life savings if they went to a doctor or dentist in Burma, so they wait, hoping the infection will clear up by itself. “It’s not a problem for the rich man,” Lakwa
says, “but it’s a BIG problem for the daily workers and the poor people.” When the dental medics ask why patients didn’t come earlier, “Most of the patients say they can’t leave their work, they have no transportation, they have no money. So the dental problem gets worse and worse,” according to Lawkwa. The medics recall the sad story of a 9-year-old girl whose father brought her from Burma with a fever and swollen face caused by an infected tooth. The dental medics wanted to admit her to the pediatric ward, but her father needed to return Burma to farm. So they gave the family antibiotics and asked them to come back for follow-up. By the time the girl finally returned, the bacteria had spread to her bloodstream. They sent her to Mae Sot Hospital, but it was too late; she died of septicemia.

People struggling to earn enough to feed themselves can’t risk losing their jobs. Yet many employers demand long hours from their workers, giving them only one day off every 60 days. This makes it nearly impossible to go to the dentist when necessary. An example is a young woman who came to the dental clinic during the holidays with a toothache so painful she could not eat or sleep, causing exhaustion and weight loss. The medics found a very deep cavity. They performed a root canal, cleaned the area with calcium hydroxide, and put in a temporary filling. They asked her to return in a week for the permanent filling - enough time for the calcium hydroxide to kill bacteria and for the swelling to decrease. But she didn’t have another day off for two months. If she left work to return before then, she risked losing her job and getting arrested without a worker I.D. (which her employer held). There was nothing to do but wait two months and hope for the best.

The dental medics know prevention is the best treatment. They hope to improve oral health by teaching children the importance of brushing their teeth and avoiding sweet foods. Through the School Health Program in 58 migrant schools, the medics tour schools with colorful posters showing healthy food (fish, vegetables, fruits) and unhealthy food (candy, ice cream, Coke) choices. They warn children not to chew betel because doing so chronically increases risk of oral cancer, a painful disease that causes swelling and ulcers inside the mouth and can lead to death. In 2007, the dental clinic diagnosed more than 20 cases of oral cancer, but because treatment is beyond the clinic’s resources, it could offer these patients only pain medication.

Over the years, the Clinic developed its dental services with support, technical training and donations from generous volunteers, including Dr. Michael Travis from Colorado, who has visited the clinic annually since 2004 and donated much of the machinery, filling materials and instruments; and Dr. Bo-im from Korea, who trained the medics to clean and scale teeth and perform root canals in 2008. The dental medics dream of offering x-rays and dentures at the clinic someday. Their short-term wish list is for small dental instruments, an atlas color endodontic book and a dental surgery book so they can learn more and provide better care.
PARTNERSHIPS: 2000 - 2004

BURMESE MIGRANT WORKERS EDUCATION COMMITTEE (BMWEC)

Starting about ten years ago, community based organizations started to collaborate and work together along the border areas. BMWEC is a reflection of that strong community engagement, an umbrella organisation of 45 schools. Each school is represented by their headmaster in BMWEC, giving a voice to all in the community.

BMWC continues to work to strengthen both education as well as overall situation of migrant and IDP children. One example is a pilot project with the Thai Ministry of Education, which aims for providing accreditation of migrant schools by the Thai government. Other important areas include advocacy and the creation of a child protection policy.

COMMITTEE FOR THE PROTECTION AND PROMOTION OF CHILD RIGHTS

A major issue for migrant children is statelessness. In some countries, migrant children are migrant with identity in their home countries. The situation is more complicated when children do not have identity in any country, which denies them access to the Thai education system in this case. As elaborated in the Child Protection chapter of this book, CPPCR created an innovative program to create delivery certificates and birth records. This work has been done in the true spirit of public-private partnership, with the Thai government, community based organizations, and MTC.

ADOLESCENT REPRODUCTIVE HEALTH NETWORK

ARHN is also a reflection of the strong collaboration among community-based organizations along the border. The first collaboration began in 2000 with Social Action for Women (SAW), Karen Women’s Organization (KWO) and MTC. ARHN is now a network of organizations including, but not limited to Karen Women’s Organization (KWO), Social Action for Women (SAW), Palaung Women’s Organisation, Karen Youth Organisation (KYO), Burmese Women’s Union, and NLD Women.

Usually the health organizations develop maternal and child services which are clinic based. Unfortunately, this approach doesn’t integrate with youth, men or other members of society. Therefore, the ARHN has developed effective outreach to all parts of society. Cultural and reproductive rights information is provided to a broad population base in a culturally appropriate manner. In the past, accessing reproductive information for young people was, at best stigmatized.
displaced women from Burma who are in crisis situations after having fled to Mae Sot, Thailand. SAW is based in Mae Sot and was established to support women facing difficulties through the provision of shelter, health education, rights awareness, counselling, and vocational training for unskilled women.

In addition to working in partnership on health education, SAW steps in to assist when babies are abandoned at the clinic. SAW arranges for safe accommodation and care for these children in their facilities.

**BURMA CHILDREN MEDICAL FUND**

Since 2006, the BCMF program has helped 300 patients.

The largest number of cases referred involves those with congenital heart problems.

Patients need from one to as many as five referral trips, depending on the severity of their illness and the number of surgeries they require.

At Mae Tao Clinic, there are patients whose needs go beyond the available services. Many of these cases are curable and if treated, would have life-changing or life-saving results for the patients. The necessary surgeries or treatments are inexpensive by western standards, but are often too complex and expensive for Mae Tao Clinic to support. In recent years, visiting doctors to the clinic would often find outside support for children requiring extensive treatment either at Mae Sot Hospital (MSH) or at Chiang Mai Hospital (CMH). This was helpful, but was done on an ad hoc basis, and the needs of many of the child patients went unmet – sick children had to be sent away without the treatments they needed to live.

In 2003, a volunteer critical care nurse, Kanchana Thornton’s first case while working with this fledgling referral program, known as Burma Children Medical Fund (BCMF), was a 5-month old baby who had been born with an imperforated anus. Mae Sot Hospital had done a colostomy on him at birth, the first of three surgeries necessary to repair the problem. However, the boy’s family could not afford the second or third surgery needed to operate on his anus and remove the colostomy. Without the surgeries the boy’s life would be difficult, needing to continually manage a colostomy bag in less than sterile conditions. The boy needed to go to CMH for surgery and Kanchana made sure that he received the necessary treatment.

The BCMF referral program depended on the support of volunteer doctors, so as the doctors’ began finishing their placements at MTC more and more children’s needs for surgery went unmet. In 2006, Kanchana, now faced with an increased demand for surgery and the withdrawal of volunteer medical assistance, decided to find donors and get commitment from Thai hospitals that would ensure the long-term sustainability of the BCMF program. Kanchana revitalized the BCMF program, restructuring its management, and creating a more sustainable system. The result was a fund that covered all complex children’s cases, ensuring these children received the life-saving treatment they needed – heralding a new beginning for the BCMF.

BCMF has been successful in supporting 300 complex medical cases...
since 2006, with approximately 140 still active cases. In 2008 the program also began supporting treatment for special adult patients. BCMF supports these patients all the way through their medical treatment, and provides counseling and social welfare assistance to make sure patients get back on their feet. BCMF also provides medication and equipment, in the form of wheelchairs, special footwear, and mattresses to maintain and improve patient’s quality of life. In the unfortunate event that a patient dies, BCMF supports the family, helping to organize burial or cremation services. With a focus on respect and dignity, BCMF ensures that the patients’ right to health - a basic human right - is fulfilled.

To get the program to where it is today has not been easy. The process of coordinating a patients’ referral to a medical specialist can be complicated. Although some treatments can be done in the nearby Mae Sot Hospital, the majority of treatments need to be done at Chiang Mai Hospital, 400 kilometres from Mae Sot. Coordinating the referral of Burmese patients to a Thai hospital requires not only the goodwill of Thai authorities but also a coordinated, cooperative effort from MTC and BCMF staff to ensure patients make it to specialist appointments, and are able to return for follow-up care.

Additionally, transporting patients to CMH is not easy. Most of the patients are in Thailand illegally and do not have the proper documents to travel through the various Thai security checkpoints between Mae Sot and Chiang Mai. Most of MTC staff also lack the necessary paperwork to escort patients to Chiang Mai. Before the formation of BCMF, MTC was dependant on INGOs for patient transfers to Chiang Mai. This however, did not result in a reliable or sustainable option.

Kanchana negotiated with the Thai authorities to create a system between MTC and the relevant Thai security forces, allowing for BCMF to organize, prepare and coordinate the appropriate paperwork for the transfer of patients to Chiang Mai. Without this generous support and understanding of the Thai authorities, especially local police and the military, the referral program would not be possible. As regional and local politics change, it is essential to maintain regular contact with authorities to ensure the future of the BCMF program.

In late 2008, an INGO called Child’s Dream began supporting the complex cases at MTC’s for patients under the age of twelve. As a result, BCMF has turned its attention to securing funding for treatment of those patients over twelve years of age. In 2009 work continues to further develop an adult referral program under the name of the Burma Adult Medical Fund (BAMF). Kanchana says that all of the challenges have been worth it. “If you put in a little effort for the kids, the rewards are amazing.” To be able to give a child a future, to see the energy restored to their bodies, to see the look in the eyes of grateful parents – it is all worth it, she says. The patients’ families do not have the money to pay for the services, yet they find ways to thank the BCMF program for saving their children. Saw Win, the father of the young patient with the colostomy calls twice a year to give an update on how well his son is doing and to say thank you once again.

The future aims of BCMF and the BAMF are simple – to secure more funding in order to provide more lifesaving and life-changing treatments for the people coming to Mae Tao Clinic for help.

San Nyein Aung (Sam), was 13 months old when he came to Mae Tao Clinic in early 2006 with a heart problem. His heart was twice the size it should be and he only weighed a fraction more than the average newborn. His mum was 22 and she had spent most of the last year looking after her child when he was unwell and could not work. His father was 23 and he stayed at home in their village in Burma. The family is from Nyinaung, a small village of only 700 houses, where there is not much work; often his father had to leave the village for days at a time to find work. Without surgery San Nyein Aung would have died.

San Nyein Aung finished his final surgery in November, 2008. His grandmother accompanied him for his final treatment as his parents needed to keep working to support the family. Thanks to the operation, he has much more energy and is very playful. His grandmother says that he is now full of chatter and talks a lot. The family plans to send him to school next year and hope that he will now go on to get an education and eventually go to high school. Their main wish however, is that he will grow up healthy so that he can do whatever he wants when he is older. His grandmother expressed her deep gratitude to the donors who made his surgery possible, as well as to the clinic and BCMF. When the staff asked San Nyein Aung how he feels now that he has had surgery he starts to sing! What could express it more perfectly than that……

While San Nyein Aung’s story is that of just one boy, it is also in a way, the story of every patient that has been treated, and who has come through Mae Tao Clinic. BCMF has treated many patients whose stories, while all individual, have a common thread; which is that without the BCMF’s support these kids would have surely died, or lived severely diminished lives, as there is no way their families could afford their much needed surgery, let alone navigate the plethora of security issues they would have had to overcome to get to Chiang Mai Hospital for their surgery.

Mae Tao Clinic today.
Thousands of people flee Burma each year, escaping poverty, oppression, and civil war. The nearest escape for most is Thailand, where they experience both despair and hope. Burmese refugee, Dr. Cynthia Maung, runs a small, modest public health clinic near the border in Thailand, and is making a difference in her community by providing essential services not available to most residents of the poor region.

Mothers line up with children, waiting for immunizations. In another line, couples with newborns wait for documents certifying their children were born in Thailand. The documents take the place of birth certificates Thailand refuses to issue. These people are refugees, and in the eyes of Thailand’s authorities, they do not exist.

But to Dr. Cynthia Maung, they do matter. Dr. Cynthia is a Burmese physician and a refugee herself. She makes a difference for thousands of her fellow refugees in Thailand and for many more inside Burma. For example, the Burmese physician founded the Mae Tao Clinic, a safe haven where miracles happen every day.

Dr. Cynthia fled Burma in 1988 following an army crackdown on those who demonstrated for democracy and justice.

“I joined with the demonstration group and then when the military seized power, people started disappearing, or missing, or fled to the border. I myself also decided to come to the border to continue struggling or working for political change,” she says.

The clinic trains volunteer medics who fan out into the ethnic Karen and other isolated areas of Burma. Some of the volunteers are former patients who, once desperate for help, are now the ones helping. It is they who can, pay under a dollar.

Dr. Cynthia lives in modest quarters next to the clinic. She could have immigrated to the West and be making a huge salary. But for Dr. Cynthia, this is a greater calling.

“When we live here, we are not only treating illnesses, we can also educate young people who can go back and work in their community and who are very willing to promote the health activities in their village. So it is a very good opportunity for young people to give education and to give more hope,” she says.

The Burmese physician says young people should be taught “not to feel as victims.” Instead, she says, they should see themselves as “people who can change or improve the situation.”

Dr. Cynthia is reviled by Burma’s military government. To the generals, she is a terrorist and an insurgent. To the thousands she treats and trains, she is a saint.

VOA News, 2008 (photos: P. Laput)
The people of Burma are used to suffering. Burma has the worst health record in Southeast Asia. Yet the regime is not without money. It siphons billions of dollars earned from natural energy resources into offshore accounts while its citizens are forced to seek health care in neighboring countries.

It's mid-morning on the Thai-Burma border and amid the constant flow of people pouring into Mae Tao Clinic looking for health care is a barefoot girl carrying a feverish infant, half her own height.

The girl, Choo, shuffles and pushes her way to the front of the long queue that stops in front of a white-coated medic in the Children's Outpatient Department.

May Soe, the senior medic and manager of the department, looks up and asks: "Where's your mother?"

Choo hitches the slipping child onto her hip before saying: "Ma's died, I'm mother now."

May Soe was shocked by Choo's response, but did not have time to take it further, as the infant needed urgent medical assistance.

"Choo's baby sister, Wai, was very sick with malaria, she was dehydrated and also anemic. She urgently needed a blood transfusion and we had to get her onto a saline drip."

May Soe is concerned about the welfare of both children.

"I'm worried they have no mother. I'm worried that a 12-year-old, carrying a seriously sick infant, had to travel so far without the protection of an adult."

May Soe says getting to the clinic from inside Burma is difficult for adults at the best of times.

"It took the kids at least six hours to get here from their home. There are many army checkpoints to get around. There are many people who take advantage of children. Choo had no money and no one to help. The kids arrived with only the clothes they were wearing."

Choo explained to Spectrum why she came to the Mae Tao Clinic: "Wai was sick for five days. She was hot, crying all the time. There was no money to get medicine. I was worried, I was scared, I thought she would die like Ma did if I didn't take her to Thailand. Many people in the village told me to take her to Dr Cynthia's."

When Choo left home it was still early morning.

"It was dark, no lights, the sun was sleeping."

Choo tells how scared she was when her mother died two years ago.

"Wai was six months old. Ma was sick, she went to the toilet all the time. She couldn't get better. She took medicine, but nothing worked. She died."

May Soe said Choo's mother probably died from complications related to dysentery.

"If she could have got treatment, it would have been preventable."

Dr Voravit Suwanvanichkij, a research associate at the John Hopkins Center for Public Health and Human Rights, and one of the authors of the report The Gathering Storm: infectious disease and human rights in Burma, not only agrees with May Soe, but also condemns the Burmese military regime for failing to protect and provide the Burmese people with access to basic health care.

"It's not just a tragedy - I would go further and call it a crime. The mother's death was preventable."

The Mae Tao Clinic was set up by Dr Cynthia Maung in 1989 to treat Burmese people along the border, and each year its caseload increases.

In 2006 the clinic saw 107,137 people who needed help.

In 2008 this had jumped to 140,937. May Soe says the 13,438 children seen by Child Health in 2008 were mainly the result of acute respiratory infections, malaria and anemia.

In spite of the increased numbers
coming to the clinic in search of health care, Dr Cynthia says she expects to have less money in 2010 due to donors pulling out.

"We estimated a shortfall of about US$350,000 (11.6 million baht) in 2009 and US$750,000 in 2010. We've always been funded year by year. This short-term funding only allows you to breathe for a short while."

Dr Cynthia says her ever-increasing patient caseload is dictated by poverty, military oppression and the lack of human rights in Burma.

"The poor in Burma are getting poorer. We are not only treating migrants and refugees, but people from the cities and deep inside Burma. Over the past 20 years I have never seen the patient caseload decrease.

"I worry for next year - at the moment we don't have enough money for medicine, food, child protection or training."

Dr Cynthia says all groups working on Burma's problems face the same challenge - getting the regime to embrace change.

"I don't expect to see any noticeable change in Burma in the near future."

Meanwhile, in recent months, the Burmese regime, in an attempt to get international trade sanctions lifted and their hands on large sums of aid money, has pointed international governments, humanitarian agencies and non-government organisations to their self-lauded, but much-criticised National Constitution, as proof that they are serious about building a fairer society.

Enshrined in the constitution, under State Fundamental Principles, clause 17 (a) is this passage: "The state shall earnestly strive to improve education and health of the people."

But the constitution principle rings hollow when subjected to closer scrutiny.

Dr Voravit says Burma's health indicators are amongst the worse in the region.

"Burmese people are coming to Thailand for basic health care. People in Burma are dying because there is no significant investment in health infrastructure, no access to the most basic, cost-effective health interventions that should be available at home. Over 7% of Burmese children don't survive to their first birthday and 10% will die before their fifth."

Dr Voravit says these statistics are proof of years of neglect, and contrary to the regime's claims, clearly demonstrating how Burma's health system has failed its people.

According to a health report, Chronic Emergency, by the Backpack Health Workers Team, an organisation that delivers medical assistance to displaced Burmese people, the situation in eastern Burma is more dire. There, one in 10 children will die before age one, and more than one in five before their fifth birthday, and one in 12 women will lose their lives from complications of pregnancy and childbirth.

Dr Voravit says these figures are comparable to disasters in such places as Rwanda, Democratic Republic of Congo and Somalia.

Dr Voravit's damning facts are supported by an overwhelming number of international reports, including those from the United Nations and the World Health Organisation.

The UN's Development Programme's Human Development Index ranked Burma 130 out of 177 countries. The World Health Organisation placed Burma's health system as the world's second worst out of 191 countries. Burma's official spending on health per capita is estimated to be $0.74 (24 baht) compared with its Thailand, which invests $89 (2,955 baht) per capita.

A John Hopkins School Of Public Health report, The Gathering Storm, estimates that the Burmese regime spends as little as "3% of national expenditure on health, while the military, with a standing army of over 400,000 troops, consumes 40%".

Dr Sean Turnell from Macquarie University in Sydney, in a report, Burma after Nargis, accuses the regime of squirrelling away revenue earned by the sale of national resources such as oil and gas to off-shore bank accounts for their own use.

"Burma currently receives between $1 and $2 billion a year from its sales of natural gas to Thailand, but these funds are kept far from the country's public accounts."

Dr Turnell says the funds are moved off-shore and accessible only to the top leadership lurking in the shadows of the regime's State Peace and Development Council.

"Burma's gas earnings are today employed in constructing the country's new jungle capital of Naypyidaw, in buying military equipment from China, and in funding other schemes and proclivities that have long characterised the often bizarre aspects of the country's policy-making processes."

Matthew Smith from Earth Rights International says Burma earns billions from its natural resources.

"Since 2000 the Yandana gas project has generated $7 billion in revenue. But a massive $4.83 billion bypassed the rightful beneficiaries, the Burmese people, and ended up under the control of the military."
While the regime plunders money rightfully belonging to the Burmese people, Choo's father, a daily labourer when he can find work, earns 3,000 kyat a day, or less than $3. UN agencies say 73% of the average Burmese household budget is spent on food alone, making Burma one of the worst food-insecure countries in the world and one third of Burmese children suffer from malnutrition.

Dr Voravit says: "A result of this is that for most Burmese families, basic health care becomes an unaffordable luxury."

But it is not only wage earners in Burma who are paying the price for the regime's military-inspired policies. Since her mother's death two years ago, Choo has not attended school, she now has to look after five children younger than herself and manage the household for her father and stepmother.

"When everyone is at work I look after five children. I also cook for everyone. I get up when it is still dark to light the fire and fetch water for cooking."

Choo cooks six kilogrammes of rice a day. She has to split the cooking into three sessions as the combined weight of water, pot and rice are too heavy for her to lift. "I'm not strong. I look after all the other kids until after six at night when Pa and the older ones get home. I have to get the evening meal ready."

"Sometimes I get sick and I need to rest. If the others have time they help me. When I have free time I like to play."

Choo says she misses school. "I had to stop when Ma died, but I miss Ma more. When Ma was here, life was easy. If Ma was here, I would be able to go to school and play. I miss her cuddles and kisses."

"I like to play and read when I have time. I love all my brothers and sisters, but I fight with my new [step] brothers and sisters."

"I'm happy here at the clinic, plenty of people help me, May Soe gave me and Wai clothes." Choo runs around trying to help older women carry their food trays and pulls funny faces to make the other children in the ward laugh.

May Soe, a mother of three, says Choo is not shy. "She's liked by the other patients, she helps where she can. I look at my 11-year-old daughter and I can't imagine her doing this. I'm happy she only has to think about playing."

"Choo's very good, but she's vulnerable, she's a baby looking after a baby."

by: Phil Thornton, Bangkok Post 2009
For the displaced Burmese populations living along the Thailand-Burma border the ongoing experiences of socio-economic struggle, physical and psychological trauma, endless human rights abuses, chronic illness, exploitation as migrant workers, and being targeted for human trafficking have resulted in many psychosocial challenges. As the population living along the Thailand-Burma border quickly grew throughout the 1990s, it became evident to Dr. Cynthia and other community leaders that psychosocial support was needed for this population.

In 1999, a Mental Health Counselling Training was coordinated through the assistance of international organizations, for 32 participants including MTC medics and schoolteachers, as well as individuals from other local organizations. This was an introduction to the basic concepts and techniques of mental health care. The following year, a Child Psycho-Social Training was conducted, for 32 participants from MTC and other local organizations, focusing on basic principles of childhood behaviour and development, children’s rights, and program development to enhance children’s mental health. The introduction of these mental health care skills to the organizations working along the border was certainly beneficial, but with the population of displaced Burmese people continuing to grow, and more and more people accessing health care at MTC, more needed to be done to address the increasing psychosocial needs. Both staff and patients of the clinic needed greater psychosocial support – they needed confidential counselling, in a private space, from counselors with more advanced skills. In response, preparations began in 2004 for the development of a separate Counselling Centre at MTC.

A new building was constructed, providing a space for the Counselling Centre as well as the HIV Voluntary Counselling and Testing Program. Further training sessions were conducted, providing basic knowledge and skills in mental health care, as well as tools for specifically addressing the now endemic psychological trauma. In 2006, mental health services became part of the primary health care offered at Mae Tao clinic, with December 6th marking not only Dr. Cynthia’s birthday, but also the official opening of the Counselling Centre. Program Manager, Saw Than Lwin recalls that the first six months were very slow, as neither patients nor staff had a strong understanding about what counselling services were, who should be accessing them, and the incredible benefits that they could have. Also, there was the challenge of staffing the centre, as the newly trained counselling staff continued their work in other departments of the clinic, which were often busier and seen as a priority.

These challenges instigated the development of the Department Awareness Program, wherein staff members from other clinic departments are invited to the Counselling Centre for one-hour information sessions. The counselling staff explains the services available at the centre, the great benefits of these services, how and when to refer patients, and when staff should visit the centre themselves. The counselling staff continues to run the Department Awareness Program, which has successfully led to the continual increase in the number of patients accessing the Counselling Centre.

For those requiring psychosocial assistance, the Counselling Centre provides incredible support, but at times, due to insurmountable obstacles, the outcomes sought by both patients and counselors are not always attainable. Saw Than Lwin explains the challenges and frustrations of not always being able to help all of the patients they see, “Some patients come with social problems related to natural disasters or chronic diseases, where their community no longer accepts them. We cannot provide social services, like finding work and places to stay.” He also recalled the story of a patient who had been suffering from stress and depression as a result of not being paid by the factory owner he worked for. “How are patients supposed to address problems like this when a complaint to the authorities is risking arrest and deportation back to Burma?” In these cases, the counselling staff rely on their community networks, referring patients to other organizations such as the Migrant Assistance Program (MAP) for labour issues, or Social Action for Women.
(SAW), for women and children escaping abusive environments, who need a safe place to stay and access to income generation and education opportunities.

In the future the Counselling Centre hopes to further expand these invaluable community networks. There are plans to conduct regular Community Awareness workshops, where other organizations providing social services will be invited to learn about the services of the Counselling Centre, and to share information about their own services. Saw Than Lwin views this as an opportunity to ultimately help more patients, by either referring them to the appropriate organizations or eventually offering services that are not already provided by another organization in the community. As the Counselling Centre is still a relatively young program, the immediate future will also involve further skills training and capacity building. International volunteers, of various mental health backgrounds, have played a large role in the development of the center, providing regular mental health training programs that have been tailored to the specific needs and requests of the counselling staff. The local staff is eager to further develop their skills, to understand how other countries work to support citizens who are suffering psychosocial problems, and to transfer their gained knowledge to supporting fellow Burmese people.

Even though the staff express a need for further training, they are able to celebrate the positive effects already seen at the Counselling Centre; Saw Than Lwin says that, “We are very proud of our experiences. Some patients are completely better after their treatment. It makes us very happy to work through their problems, to understand their feelings.” To further develop this department will increase the invaluable psychosocial support being provided to the displaced people of Burma, giving them counselling, coping techniques, and possibly a renewal of hope.

RESEARCH

Research at MTC is a reflection of the evolution of MTC as a whole, evolving from service provider into program manager, community organizer and advocate. Initially, there was only medical action-oriented research, focused on medical treatment outcomes. Today, the goals of research touch upon program development and assessment, resource allocation, performance monitoring and broad-based understanding of community health care needs.

Since the clinic patient population is predominated by migrant workers in Thailand and IDP populations in Burma, it is important to understand these populations for the purpose of effective program design. However, as noted by the European Union, “Whether internal or cross-border, both forced and voluntary (economic) migrations occur on a relatively substantial scale. However, data collection on the different types of migration is almost non-existent…. Economic migration is a difficult phenomenon to grasp in Burma/Myanmar, due to large inaccessible parts of the country and migrants’ fear to tell their story”.25

Initially, research was done when external organizations were able to provide resources and expertise. However, MTC has been increasing the proportion of internally based research projects with the aspiration to improve areas such as program design and policy. Over the years, clinic staff was able to learn from others who conducted research as partners. Research was first introduced in the clinic in 2001 through the reproductive health monitoring evaluation project. This project helped the clinic staff to develop an understanding of how to conduct research and to utilize the findings. The benefits included improved clinical assessment skills, facilitating peer supervision through case review, an increased ability to demonstrate program effectiveness, ability to promote cultural exchange through enhanced counselling skills and increased issue awareness for adolescent health, sexual health, gender based violence and mental health. The success of this research encouraged collaboration on future Reproductive Health projects.

When MTC did begin doing internal research the areas of most importance were communication, Sexual and Gender Based Violence, and clinic

staff. For the Mae Tao Clinic, research is an opportunity to gain accurate information about the health situation on the Thailand-Burma border. Unable to rely on the Burmese military junta for accurate information, the clinic has taken it upon itself to retrieve it. Twenty years on, the two main reasons for participation in research remain: to learn about the health situation of persons living along the border, and to better evaluate and improve the services of the clinic.

The first internal MTC research was in 2005, and there have certainly been many subsequent challenges along the way. For staff to work in the community conducting surveys and interviews, there is a constant security threat, as they may not have the proper identification papers. It has also taken extensive training to introduce research skills and concepts to staff, and this has to be re-taught often in response to a high staff turnover. A lack of knowledge surrounding research, its procedures and its benefits among the target population are further problems. Whether research is done within the community or among staff at the clinic, a general lack of understanding of the goals and benefits of a research project can lead to poor participation. Thus, the information is not as informative as is sometimes hoped. Research Coordinator, Saw Aung Than Wai laments this situation, “They just don’t know how useful the information could be.”

MTC participates in many collaborative research projects done in partnership with other local and international organizations and institutions. These collaborative efforts lead to a better understanding of the border community on a whole, exposing the real situation that this population is faced with. This research allows the organizations involved to undertake more effective advocacy for the people, especially in the global arena. These collaborations have also lead to better coordination between local organizations, as well as between these organizations and the local community.

As the research has begun to incorporate more topics revolving around health impacts and community assessment, MTC faces typical research challenges. Qualitative research is easier to understand when data and facts can be collected, but MTC finds that anecdotal evidence must inform data interpretation. The accuracy and quality of the data collected should be constantly challenged, especially in the context of trying to understand social rather than technical measures. The more straightforward areas include monitoring prevalence of illnesses and quality improvement, in which case consistent and accurate monitoring over longer periods of time is required. The less straightforward areas include monitoring complex reasons behind patient decisions regarding how and when to obtain health care, along with cultural norms.

As the Research Program is still relatively new at the clinic, with the majority of research activity happening in the last couple years, the program still has some major developments ahead of it. The hope is to develop a research working group, first within the clinic, and then among the CBO community. The working group would function to develop general policies and procedures, especially addressing issues of ethical research. With a strong background in research work, Saw Aung Than Wai understands the benefits of research, but also voices a strong concern for ethical and psychosocial considerations when working with the vulnerable population living along the border. Even now, there is very little research conducted inside Burma, with legal, security and logistical challenges continuing to create obstacles. With about 50% of the clinic patients coming from Burma, MTC staff struggle to understand the patient situations, health care options, and outcomes.
In the earliest stages, a rice cooker was used to clean one set of instruments. Since there were five to ten procedures a day, it took time to do so many sterilizations. The clinic worked for nearly two years with one rice cooker until an autoclave was donated.

Infection Prevention Unit was not officially established until 2008, but as with so many sections of Mae Tao Clinic, the activities of the Infection Prevention program started long before there was an official title for them. For example, the Laboratory was the first department to formalize safety procedures. Staff received training and procedures for specialized blood withdrawal techniques, sample handling, and sharps disposal. The growing clinic required universal precaution procedures to maintain quality of service and in 1994, a universal precaution workshop was held, highlighting needle holding techniques and medical waste disposal.

All health care related trainings conducted by MTC over the years have contained a universal precautions module, with staff learning basic infection prevention techniques such as hand washing and using protective barriers such as gloves, but there was not always a monitoring and evaluation system within the departments to ensure these actions were being performed. In 2000, the blood transfusion, HIV prevention programs, and medical waste disposal programs were upgraded and Mae Sot Hospital staff came to the clinic to demonstrate appropriate techniques for labeling and separation of medical waste.

The Reproductive Health Monitoring and Evaluation Project initiated in 2002 was a two year project, implemented to improve quality of Reproductive Health services. The post-abortion care training within this project included an “infection control” section within the monitoring and evaluation training component. The staff began using a monitoring and evaluation checklist that included such things as: hand washing, using gloves correctly, and using barriers such as masks or gloves. This was an opportunity to ensure that infection prevention procedures were being followed. Training included sterilization techniques, via either boiling or the use of reagents. Room safety and sterilization was also addressed. As this training program finished in the RH department, it was clear that all the departments of the clinic would benefit from incorporating a similar infection control aspect into their monitoring and evaluation program. In order to make this possible, more training was needed. An upgrade training was provided for all current medics to ensure that they received the new information, and all health care training curriculums were permanently changed, and to implement this, a 3 to 4 day infection prevention component was added to the monitoring and evaluation module.

Working independently of each other, with some departments finding greater success than others; in 2006 it was decided to move towards more standardized protocol. An infection prevention working group was brought together with its first task being to evaluate the current procedures of each department. From this initial evaluation it became apparent that external factors were playing a major role in medics not properly adhering to the procedures. Therefore, the second task of the working group was to focus on improving supplies and logistics; how could a person be expected to wash their hands if sinks weren’t always working properly or there wasn’t any soap? Facilities were improved, and changes were made to the management of supplies, including ordering and storage, resulting in improved availability of soap and other sterilization products. These improvements to supply management and logistics certainly lead to enhancements in medics’ infection prevention behaviors, but they were not the only influencing factors to consider.

Another external factor influencing adherence to infection prevention procedures was a lack of knowledge; even though all medics were receiving training on the topic during their initial health care training, it was decided that this was not enough: upgrade trainings were needed. In 2008 a new Infection
Prevention Unit (IPU) was established, with ongoing upgrade trainings incorporated as one of the responsibilities of the staff in this unit. An added responsibility of the IPU is the sterilization of medical equipment and the preparation of bandaging materials, such as gauze, for the clinic departments.

It has also been identified that external monitoring and evaluation is a necessary practice for each department, and may also lead to improved behaviors. The hope is to begin regular external evaluations, both external to the department, and external to the clinic. Before this happens though, the working group and staff of the IPU continue to work towards updating, improving, and standardizing a checklist for use throughout the clinic departments.

One of the departments that the IPU works closely with is the Water and Sanitation Department. Together, they are currently working on improving medical waste management, with changes to handling procedures, and future plans to address storage procedures as well.

New challenges are presented in relation to the broadening range of services provided by the clinic, and by the wider range of illnesses treated. This combination increases threats and necessitates continually improving techniques. Each department appoints a person who looks after infection prevention; however, further steps need to be taken to ensure new staff members are trained, and that supplies are always available. Today, the ‘wish list’ of the IPU is a new autoclave. The clinic has already outgrown the current autoclave, and it cannot sterilize some instruments. The desire of Sandy and the IPU team is clear; to reduce the risk of infection, both for the staff and patients. With the dedicated staff continuing to work as they have done, it is only a matter of time before this will happen.

Originally, MTC didn’t have a cash budget to purchase medicine, and the Catholic Church, supported by Father Manat Supalak, donated medicine and supplies for the first two years of the clinic’s existence. Each week, the staff would go to a supplier in Mae Sot and collect the supplies, choosing what was needed; items such as quinine, tetracycline, paracetemol, gauze, and spirits. Visitors donated any other medicine. From 1992 until 1997, Médecins Sans Frontières (MSF) donated medicines on a monthly basis, comprised of twenty medications on an essential drug list. The MTC pharmacy also acted as the distribution center for five other student camps along the border for a few years, until they began to work directly with their donors. Whilst there has been direct donation of medical supplies, customs duty charges have hindered pharmaceutical companies from making direct donations.

Just as in any health care setting, there is a challenge in ensuring patient understanding of their medication and treatment. After the clinic had identified difficulties with the patients’ understanding of both their ailments and treatments, a protocol was established whereby the medic who sees the patient also prescribes and explains the medications. The Communication and Language Assessment Research Project launched in 2005 provided insight that lead to improvements. The research revealed that patients usually understand their diagnosis, but mix up doses of their medications. This led to establishment of a new system which created medicine bags marked with dosage and time of day indicated in pictorial form. Staff with additional language skills was also added at this time to avoid language barriers. Pharmacy staff members need to speak various languages – the estimated breakdown of patient languages is 52% Burmese, 34% Karen, with the remainder speaking other ethnic languages. Further, about 20% of patients have never been to school, and only 37% of those who had attended reached grade 4.

The first medical supplies and medications that Mae Tao Clinic used to treat patients were donated from sympathetic supporters in the Mae Sot area. As the patient population grew, and the donations no longer met the increasing need, the clinic began purchasing medical supplies from local markets and pharmacies. It quickly be-
came apparent that this was not very cost-effective and so, in 1998, through the assistance of Mae Sot Hospital, the clinic began ordering supplies from medical companies in Bangkok.

Until 2008, all pharmacy services were conducted out of a pharmacy attached to the Medical Outpatient Department, with a small storeroom supplying medications to the rest of the clinic departments on an “as needed” basis. Each department had their own small pharmacy area to store their inventory, with each department placing a quarterly order. In 2008, an old kitchen space was renovated, providing an office and large storage space for a new Central Pharmacy. A networked computer system was developed which now allows for each department to order medications from the Central Pharmacy on a weekly basis, resulting in efficient and accurate delivery of supplies to each department. This also means a more accurate inventory system and simplified quarterly supply orders to wholesalers in Bangkok. This system helps to save money and prevent the medication shortages that occurred frequently in the past; shortages which required expensive emergency medication purchases to be made from pharmacies in Mae Sot.

MTC now stocks over 470 items.

The medications used at the clinic follow the Burma Border Guidelines (BBG), a publication put together by the health organizations working along the Thailand-Burma border in a move to standardize care offered along the border.

Much donated-in-kind medicine must be thrown away, either spoiled or expired.

All of this work is coordinated by a dedicated group of medics who have all been trained in pharmacy management. They are responsible for keeping track of inventory levels, ensuring the medications are of good quality, and verifying that the medications are used for the proper illness, in the proper doses. The staff of the Central Pharmacy is in a unique position because, unlike the other clinic departments, which work relatively independent of each other on a day-to-day basis, the pharmacy is linked to nearly every department. The pharmacy staff can be looked to as a valuable source of medication information; they are always willing to discuss how a medication is properly used and any precautions that should be observed. The hope for the future is that more medics will utilize this valuable support.

Naw Klo explains that plans for the future incorporate continued developments with the new networked computer system. As more and more inventory and patient information is stored electronically, work can be done to cross-reference pharmacy records directly to patient records, specifically data on the medications prescribed. This will allow for even further efficiency and cost-effective work to be done in the Central Pharmacy. A sentiment expressed time and time again at Mae Tao Clinic is the desire to improve; the Central Pharmacy is no exception. Naw Klo echoes the wish to continually learn and develop, “We are always willing to learn, if others want to give us more information, [or] make suggestions.”
PARTNERSHIPS: 2005 - 2009

INTERNATIONAL PARTNERSHIPS

As mentioned in the Research Chapter, MTC began to conduct more research in recent years. International partners facilitating MTC staff learning more about how to conduct research, and more importantly, to leverage the results for service improvements and advocacy.

The School Health Team at Mae Tao Clinic collaborated with Tokyo University and other CBO partners (BMWEC, Burmese Migrant Teachers Association, SAW) on a research project regarding school health assessment and evaluation for all migrant schools which have students grade 1-4. The results of the baseline survey provide a basis to engage the teachers in dialogue about future planning for environmental health in their schools.

Maternal and Child health is another area which has benefitted from international research partners. The RAISE project aims to improve cross-border reproductive health care through the upgrading of clinics and health worker skills inside Burma. Through this project, facility checklists, data collection, standardization of care, community assessment and the training curriculum were upgraded. This project created a more standardized training curriculum and ongoing process of improving data collection and health services.

The Mobile Obstetric Maternal Health Workers (MOM) Project employs a unique approach to addressing the dire neonatal and maternal health situation among internally displaced persons (IDPs) living in eastern Burma. In partnership—the Global Health Access Program (GHAP), the Mae Tao Clinic, the Back Pack Health Worker Team and Mobile Clinic ethnic groups—have been able to establish a network of 12 mobile health centers inside Burma that serve as capacity building sites for 33 maternal health workers, 147 health workers, 350 traditional birth attendants and other community participants.

Although the long-term objective of the project is to reduce maternal and neonatal morbidity and mortality among IDPs within eastern Burma, the primary aim is to increase access to proven antenatal interventions and to basic emergency obstetric care. The centers provide proven and appropriate antenatal, peripartum and postpartum newborn and maternal health interventions, and are sites for standardized collection of program indicators, as well as referral centers for specialized emergency obstetrical care.

LOCAL COLLABORATION CONTINUES TO GROW

As noted previously, MTC was established purely as a service provider. These days, MTC plays a much broader role in areas such as program management, policy development, and collaboration. MTC’s nascent understanding of these areas has developed quickly and its partner engagement has evolved along with this role accordingly. These days, the wide scope of programmatic areas in which MTC’s partners operate is a reflection of the evolution of the clinic’s role. MTC’s partnerships with the Thai Ministry of Health and other stakeholders testifies to this changing dynamic and increased responsibility.

In 2008 a strategic planning meeting on migrant health was held to discuss challenges and opportunities to collaborate. This was coordinated by the Thai Ministry of Health and resulted in a Strategy Paper. Subsequently, each participating organization was obliged to include the recommendations in their approach. These included ensuring migrant workers’ access to the Thai public health system, managing health insurance for migrant workers, increasing effectiveness of community health volunteers, increased funding, and increased collaboration.

The last five years were not so much characterized by new partnerships, but rather gaining important traction in the existing partnerships and collaborations. An important example is the Coordinating Team for the Displaced Children’s Education (CTDCE), which was formed to intervene in the current crisis of education and protection for Burmese children in September 2007. The team is comprised of Burmese community leaders, teachers and health workers who are committed to assist displaced children. MTC has been involved with CTDCE for the Emergency Dry Food Program, securing emergency food supplies for boarding facilities, as well as developing Child Protection policies and Standards of Care for boarding facilities.

This type of collaboration is very powerful if it can be implemented effectively. Of course, there are many challenges ahead, but the engaged approach of the Thai Ministry of Health coupled with the tenacity and dedication of the community-based organizations should provide opportunity for much improvement in the coming years.
DR. CYNTHIA’S THOUGHTS: LOOKING TO THE FUTURE

With every year, it seems that the border population’s needs grow in scale and complexity. While MTC was founded to manage referrals and minor medical problems, the MTC of the future must prepare to face complex cross border public health, social and medical issues. Drug resistant tuberculosis along the border, for example, poses a large public health challenge which MTC cannot solve alone. The increasing population along the border creates education and social issues which cannot be solved in isolation.

MTC is looking to the future with a view to stronger partnerships with local and international organizations. MTC will continue to train and groom medical professionals to increase the expertise in the community. The umbrella of social services which address psychosocial and education issues continues to expand.

MTC also looks to the future of the community. In the past, ethnic groups inside Burma had strong civil societies which fostered support for health, education and social support. This has been dismantled by militarization. It was not through active fighting that this occurred – it was through the systematic control of resources such as land. Forced relocations, loss of livelihood opportunity, and military conscription are among the tools which have led to communities separated and without identity.

The way forward will require education, social change, and collaboration between community groups and CBOs. If civil society and community is strengthened in the border area, this will provide the ability to rebuild civil society inside Burma when it is finally possible.

Everyone should raise their voices. Not just politicians, but women, children, workers, and every individual.

Finally, the younger generation is our future leadership. Some might think that the legacy of Mae Tao Clinic will be hundreds of thousands of patients treated and comforted. Mae Tao Clinic hopes that our legacy will be a stronger civil society, and a generation of young leaders who have been trained, encouraged and groomed to lead.

Dr. Cynthia Maung
DONORS

To every donor over our 20 year history: Thank you!

To the travelers stumbling upon the clinic in Mae Sot and donating some used clothing, to those who have never visited the clinic yet raise money at home in their communities, those who have donated online, donated medicine in-kind, volunteered their time, or spread the word about the plight of the Burmese through advocacy: Thank you.

We wish to thank all of the individuals, organizations, and companies who have donated much-needed supplies in-kind over the years. This includes blankets, medicine, medical equipment, building supplies, food, school supplies and books, clothing, and toys among other things.

We wish we could mention every individual, every baht donated, and every effort made on our behalf since it has made the work of the clinic possible over 20 years. Over the years, regrettably this is not possible -- please accept the writing of this book as tribute to your efforts and support.

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- Actions Birmanie
- Aide Medicale International (France)
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- American Jewish World Service (USA)
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- Australian People for Health Education and Development Abroad (APHEDA - Australia)
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- Burma Relief Centre (Japan)
- Burma Relief Centre (Thailand)
- Burma Relief Centre (USA)
- Burma Volunteer Project (Thailand)
- Burma Youth Volunteer Association (Japan)
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- Department for International Development (UK-DFID)
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- Direct Relief International (USA)
- Doctors of the World (USA)
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- General Direction for Development, Cooperation and Humanitarian...
ian Action
- Global Health Access Program (USA)
- Global Health Conference (USA)
- Global Health Council (USA)
- GreaterGood.org (USA)
- HelpAge International
- Help Without Frontiers (Italy)
- HMK Organisation
- Ida Monzon
- Interchurch Organisation for Development Co-operation (ICCO - Netherlands)
- International Health Partners
- International Center for Human Rights and Democratic Development
- International Committee of the Red Cross (Switzerland)
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- Karen Aid (UK)
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- Karen Refugee Camp Women’s Development Group (Scotland)
- Kedron State High School
- Kurt & Cathy Bradner
- Larry Mueller (USA)
- Leo and Family (Australia)
- Lonely Planet (Australia)
- Mary Knoll
- Mae Sot Hospital (Thailand)
- Mahidhol University (Thailand)
- Maltesers International (Germany/Thailand)
- Mariposa Foundation (USA)
- Matriona (France)
- Medical Aid for Children (Korea)
- Medical Mercy Canada (Canada)
- Médecins Sans Frontières (France)
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- National Endowment for Democracy (USA)
- Network for Good (USA)
- New York Trust Foundation (USA)
- New Zealand Embassy
- Nonna Gabriella (Italy)
- Norwegian Church Aid (Norway)
- Norwegian Embassy
- Not on Our Watch (USA)
- Open Society Institute (USA)
- Operation Smile (USA)
- Operation USA
- Otalgeville District Secondary School
- Path Canada
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- People’s Forum on Burma
- Philip Lowry
- Perinatal HIV Prevention Trial (Thailand)
- Peter Moore Foundation
- Pfizer Global Health Programme (USA)
- Planet Care (USA)
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- Thailand Burma Border Consortium (Thailand)
- Thavibu Gallery (Thailand)
- Two Elephant Factory (Thailand)
- UNFPA
- UNICEF
- Union Aid New Zealand
- United Nations Women’s Guild
- Unitarian Universalist Service Committee (USA)
- University of California San Diego (USA)
- University of California San Francisco (USA)
- University of Washington (USA)
- USAID (USA)
- Walden Asset Management / Ann Spelman
- Washington University (USA)
- Wisdom in Action (USA)
- Women’s Commission for Refugee Women and Children (USA)
- Women’s Education for Advancement and Empowerment (WEAVE – Thailand)
- World’s Children’s Prize for the Rights of the Child (Sweden)
- Yam Fow Phaen Din Foundation
- Young Green Foundation (USA)
AWARDS

1999 JONATHAN MANN HEALTH AND HUMAN RIGHTS AWARD (USA)

In 1999 Dr. Cynthia was unable to attend the award ceremony in Washington, D.C., so Jimmy Carter presented the award via video conference to Bangkok. Dr. Cynthia’s acceptance speech was broadcast via satellite to Washington, London, India, and Ghana. Jonathan Mann died an untimely death in September 1998, but he and Dr. Cynthia would have a lot to discuss if they could have met. He brought the world’s attention to the basic notion that improved health cannot be achieved without basic human rights, and that these rights are meaningless without adequate health. Dr. Cynthia works daily towards this ideal.

1999 JOHN HUMPHREY FREEDOM AWARD (CANADA)

Dr. Cynthia Maung and prisoner of conscience, Min Ko Naing, were jointly awarded the 1999 John Humphrey Freedom Award of the International Centre for Human Rights and Democratic Development, for their efforts to empower the people of Burma. “Dr. Cynthia Maung and Min Ko Naing inspire all those who struggle for peace and justice in Burma,” said Warren Allmand, President of the International Centre, upon announcing the decision of the international jury. “We hope that this Award will help provide some measure of protection to Dr. Cynthia Maung and Min Ko Naing and further expose the brutal dictatorship in Burma,” explained David Matas, a Winnipeg lawyer, who chaired the meeting of the international jury held to consider over 50 nominations from around the world.

1999 AMERICAN WOMEN’S MEDICAL ASSOCIATION PRESIDENT’S AWARD (USA)

2001 FOUNDATION FOR HUMAN RIGHTS IN ASIA SPECIAL AWARD (JAPAN)

The purpose of the Foundation for Human Rights in Asia (FHRA) is to contribute to the improvement and development of the human rights situations in Asia. As part of these activities, the Foundation established the Awards to present to individuals and groups who have conducted meritorious services toward improving or solving the human rights situations in Asia. The Women Human Rights Special Award is given to organizations or individuals who have contributed particularly to the human rights of women.
2001 VAN HUEVEN GOEDHART AWARD (NETHERLANDS)

The Van Hueven Goedhart Award is given every second year by Stichting Vluchteling Netherlands Refugee Foundation to a refugee or an internally displaced person or a person who is closely involved in a refugee community.

2002 RAMON MAGSAYSAY AWARD FOR COMMUNITY LEADERSHIP (PHILIPPINES)

The RMAF recognizes and honors individuals and organizations in Asia regardless of race, creed, sex, or nationality, who have achieved distinction in their respective fields and have helped others generously without anticipating public recognition. The Community Leadership award recognizes leadership of a community toward helping the disadvantaged have fuller opportunities and a better life. In electing Cynthia Maung to receive the 2002 Ramon Magsaysay Award for Community Leadership, the board of trustees recognized her humane and fearless response to the urgent medical needs of thousands of refugees and displaced persons along the Thailand-Burma border.

2003 ASIAN HERO AWARD

Dr. Cynthia Maung was included in Time Magazine’s November article on 18 Global Health Heroes. [http://www.time.com/time/magazine/0,9263,7601051107,00.html]

2005 1,000 WOMEN NOBEL PEACE PRIZE NOMINATION (GLOBAL)

Dr. Cynthia Maung was included 1,000 women from more than 150 countries who were jointly nominated for the Nobel Peace Prize. The number 1,000 is symbolic, as the 1,000 women nominated represent innumerable women worldwide who are engaged in the cause of peace and human dignity.
2005 UNSUNG HEROES OF COMPASSION AWARD (USA)

The Dalai Lama and Wisdom in Action. “These individuals have been selected as representatives of the tens of thousands of people worldwide who quietly serve the disenfranchised and work to improve our communities through their personal efforts,” says Dick Grace, board chair of Wisdom in Action, “We don’t see them or hear about them in the daily news, but they exemplify a humanism and heroism to which we must each aspire”. Wisdom in Action (WIA) is a non-profit organization dedicated to increasing awareness of the importance of compassion in action.

2005 THE EIGHTH GLOBAL CONCERN FOR HUMAN LIFE AWARD

Chou-Ta Kuan Foundation, Taiwan

2005 MITWELT-NETZWERK AWARD (GERMANY)

2005 VOICE OF COURAGE AWARD

The Women’s Commission honored Sophia, a refugee from Burma, for her work as program manager of the reproductive health inpatient department at the Mae Tao Clinic on the Thai-Burma border. At the clinic, Sophia trains traditional birth attendants, maternal child health trainees and other reproductive health staff.
2007 SHINING WORLD LEADERSHIP AWARD

Presented by The Supreme Master Ching Hai International Association
January 12, 2007

2007 ASIA DEMOCRACY AND HUMAN RIGHTS AWARD (TAIWAN)

The Taiwan Foundation for Democracy awarded its Asia Democracy and Human Rights Award in 2007 to Dr. Cynthia. Legislative Speaker Wang Jin-pyng who is also chairman of the foundation explained, “Dr. Cynthia is going beyond her mandate as a physician by turning a refugee population into a community based on shared values and respect for human rights, as well as by linking her cause to the international community”. Hsiao Hsin-huang, the foundations’ standing supervisor further explained, “Giving the award to her means we have formed a broader definition of democracy and human rights… from reporters to doctors, everyone can fight for human rights.”

2007 WORLD’S CHILDREN’S PRIZE FOR THE RIGHTS OF THE CHILD (WCPRC) HONORARY AWARD (SWEDEN), CHILDREN’S WORLD ASSOCIATION

WCPRC has grown to become the world’s largest annual education and empowerment process for the rights of the child, democracy and global friendship for children. As part of this process, the children award their prized for outstanding contributions to the rights of the child.

2008 CATALONIA INTERNATIONAL PRIZE (SPAIN)

Jointly awarded with Daw Aung San Suu Kyi for their selfless sacrifice in promoting pro-democracy activities, freedom, and human rights in Burma. “This is the first time the award has gone to Burmese ladies. The prize committee selected them for their sacrifices and devotion to the freedom of Burma, democratic struggle and social work,” said Ms. Teresa Salar, assistant secretary of the prize selection committee.

The award is presented annually to persons who have made remarkable contribution to the development of cultural, scientific or human rights anywhere in the world.
2008 “THAN KHUN PHAN DIN” AWARD (THAILAND)

2009 PEOPLE WHO INSPIRATION AWARD (THAILAND)

International trip to Barcelona, Spain.
ORGANISATION WEB SITES:

Assistance Association for Political Prisoners (Burma)
http://www.aappb.org/

Backpack Health Worker Team (BPHWT)
http://www.backpackteam.org/

The Brackett Foundation
http://www.brackettfoundation.com/

Burma Children Medical Fund (BCMF)
http://www.burmacchildren.com/

Burma Labour Solidarity Organisation
http://www.burmasolidarity.org/

Burma Medical Association (BMA)
http://www.bmahealth.org/

Burmese Lawyers’ Council
http://www.blc-burma.org/

Burmese Migrant Workers Education Committee (BMVEC)
http://www.bmwec.org/

Burmese Women’s Union
http://www.burmesewomenunion.org/

Clear Path International
http://www.cpi.org/index.php

Free Burma Rangers
http://www.freeburmarangers.org/

Global Health and Access Program
http://www.ghap.org/

Human Rights Education Institute of Burma
http://www.hrcib.com/

Kachin Women’s Organisation Thailand
http://www.womenofburma.org/kwat.htm

Karen Aid
http://www.kareaid.org.uk/

Karen Human Rights Group
http://www.khrg.org/

Karen Teacher Working Group
http://www.ktwg.org/

Karen Women’s Organisation
http://www.karenwomen.org/

Karen Youth Organisation
http://karenyouthktl.org/

Lahu Women’s Organisation
http://www.womenofburma.org/lwo.htm

Mae Tao Clinic
http://www.maetaoclinic.org

Migrant Assistance Program
http://www.mapfoundationcm.org/

National Health and Education Committee
http://www.nhecburma.org/

Palaung Women’s Organisation
http://palaungwomen.org/

Partners Relief & Development
http://partnersworld.org/

Shan Women’s Action Network
http://www.shanwomen.org/

Social Action for Women
http://www.sawburma.org/

Thailand Burma Border Consortium
http://www.tbbc.org/

USAID

Women’s Education for Advancement and Empowerment
http://www.weave-women.org/

Women’s League of Burma
http://www.womenofburma.org/

Yaung Chi Oo Workers Association
http://yaungchiao.org/

News & Information:

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http://www.burmalibrary.org/

CIA Factbook Burma

Democratic Voice of Burma
http://english.dvb.no/

Irrawaddy News Magazine
http://www.irrawaddy.org/

Mizzima News
http://www.mizzima.com/
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“For Choo, it’s all work and no play” – Bangkok Post article on December 20, 2009

“Saving Lives on the Burmese Border”, BBC Article from March 2007
http://news.bbc.co.uk/2/hi/asia-pacific/6418645.stm

“In Pictures: Border Healthcare” – BBC photo report from March 2007
http://news.bbc.co.uk/2/hi/in_pictures/6419435.stm


“Burmese Patients Continue to Flock to Mae Tao Clinic” Independent Mon News Agency, November 2009.


http://seattletimes.nwsource.com/special/burma/

“A Clinic Where One Doctor Dispenses Hope” The Ottawa Citizen, 2006.

VIDEO

BBP psychologist Elizabeth Call’s discusses her impression of the Dr. Cynthia Maung and the conversation that led to the creation of Burma Border Projects.
http://www.youtube.com/watch?v=-9ZJfTAIX0

VOA video report, “Refugee Doctor Treats Burmese Victims”
http://www.youtube.com/watch?v=HtupmwRi8d0

The First Lady Laura Bush visited the Burmese refugees camp and the Mae Tao Clinic, where she met thousands of refugees and Dr. Cynthia Maung. 2008
http://www.youtube.com/watch?v=TTACB_tVDJM

http://www.youtube.com/watch?v=-f63-n0RR0s

Today show article about Mae Tao Clinic, 2009
http://today.msnbc.msn.com/id/26184891/#30577978

Time Asia Heroes Profile, 2003
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