MAM Activity Report

January – December 2015

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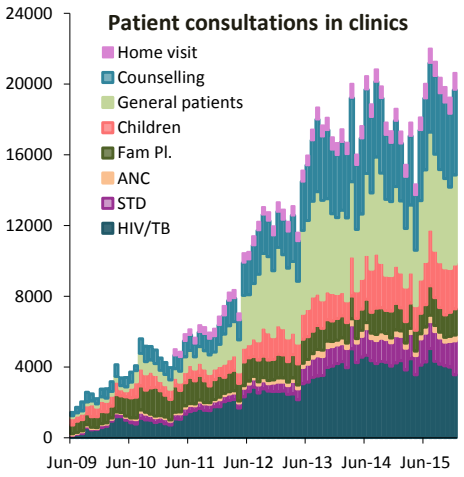
Activity report January to December 2015

1 Summary

The activities of Medical Action Myanmar can be divided in clinic-based medical care performed in 7 clinics and basic health care performed by a network of 930 Village Health Workers (VHW) in the east and far north of the country. Altogether MAM staff performed over 554,000 patient consultations in 2015.



A. Medical care in clinics;

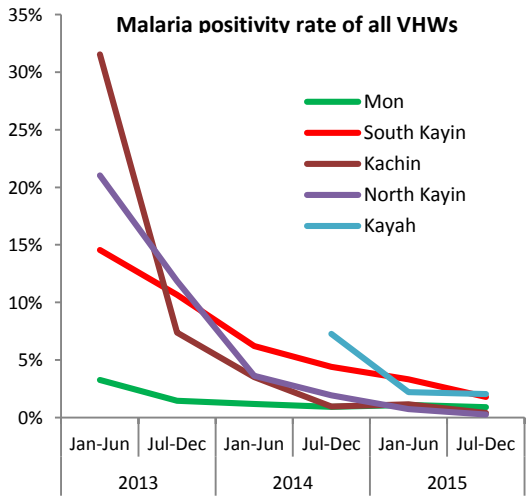
In 2015 MAM supported 7 clinics. Four clinics in poor urban areas of Yangon , 2 clinics in Kachin, in the far north of the country and 1 clinic in the east of the country. The clinics are located in areas where a large proportion of people cannot afford to pay for their basic health needs. The clinics provide a mix of activities including mother and child care, treatment of malnourished children, reproductive health, family planning, treatment of sexually transmitted infections, counselling, and treatment and care for people with HIV/AIDS and Tuberculosis.

226,237 patient consultations were performed in these clinics in 2015. The consultations vary from simple out-patient visits to intensive treatment of severe diseases. The average cost of 1 consultation in the clinic including all expenses (staff, lab, medicines) is 7$.

Health education for patients while waiting for a consultation in the clinic

B. Medical care through Village Health Workers in remote villages;

A village health worker "clinic" in a remote village in Kayin State



MAM is supporting a network of 930 Village Health Workers (VHW) to provide basic health care in the most remote villages in North and East Myanmar (Kachin, Karen, Kayah, Mon states and Thanintharyi division). The villages are small and very remote and a lot of effort has to be made to reach relatively small groups of people. But these villagers need it most. They never got *any* form of health care services so far and this is the first time that they have a trained health care worker with reliable tests and treatment in their villages.

The main goal of the project is to decrease malaria, through the provision of a simple rapid diagnostic test and good quality medicines. But the health care package provided by the VHWs has gradually expanded to other common diseases (like diarrhoea, respiratory tract infections including pneumonia, tuberculosis, skin infections) and family planning. Children and pregnant women are screened for early signs of malnutrition and treated to prevent severe malnutrition.

All VHWs are visited monthly by a medical team who train the VHW in clinical skills and monitor the quality of the activities.

In 2015 the VHWs performed 335,259 consultations in total. These projects are very successful. Malaria has decreased rapidly in villages where VHWs are providing malaria services (see graph left).

2 Clinic activities

In 2015 MAM was supporting seven clinics;

a. 4 clinics in the poorest Townships in Yangon,
b. 2 clinics in Putao, in the far north at the foot of the Himalaya's, where poverty is high and commodities are expensive due to high transport costs.
c. 1 clinic in the South of Mon state. This clinic started off treating children from an orphanage for HIV positive children but is now open for the general public as well.

Consultation in young children

2.1 Treatment of children

27,595 consultations were performed in 2015. Most consultations were for respiratory tract infections, malnutrition, diarrhoea and tuberculosis. Some severely sick children were referred by other NGO's to MAM for the management of complicated diseases. After treatment and stabilization, these children were sent back to the respective NGOs.

2.2 Therapeutic feeding

Screening of malnourished children was done in the communities and malnourished children were referred to the clinics for feeding. 116 children with acute severe malnutrition were enrolled for intensive therapeutic feeding and 108 children with moderate malnutrition and pregnant women were enrolled for therapeutic feeding.

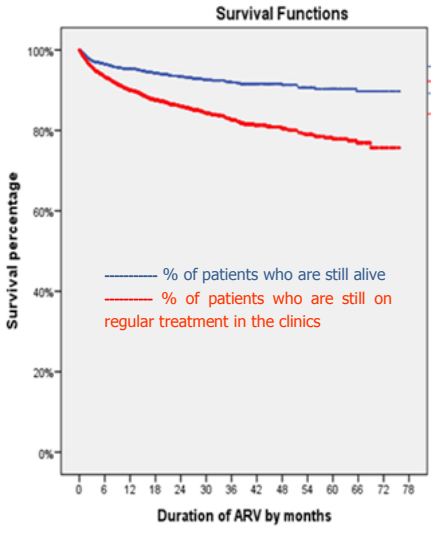
A mother giving plumpy nut to her child

2.3 Sexually transmitted infections (STI)

Screening and treatment reduces the chance to get or spread HIV. STIs are also a danger for unborn babies. Sex workers and pregnant women are therefore the most important targets for this activity. 17,618 patients were examined. 16,856 patients were tested for syphilis of which 1,385 patients (8 %) tested positive. Health education and condoms were provided to the patients and sexual partners.

2.4 AIDS prevention and treatment

The clinics, aim to have a one-stop service where all services including testing, counselling, treatment and support for food and transport fees are provided the same day to improve compliance and make it possible for the patient to live a normal life and return to their job. Of 3,113 patients who started treatment, 2,896 were still on treatment and 110 patients were referred to a treatment centre closer to home (93% still on treatment). 221 patients died over the past 6 years (7%), all of them had a low baseline CD4 count (<100, an indication of severe disease) and 77 patients were lost to follow up during Jan-Dec 2015. 84% of patients who were still on treatment were fit enough to resume daily activities or return to work. These treatment results compare very well to other projects in 3rd world countries. We believe that the low number of deaths and treatment failures is a reflection of the quality care package we give. Next to good clinical management we provide travel expenses and food for 6 months when patients cannot yet return to work. Financial and social issues can have a detrimental effect on treatment compliance (patients selling their medicines to solve urgent financial problems).



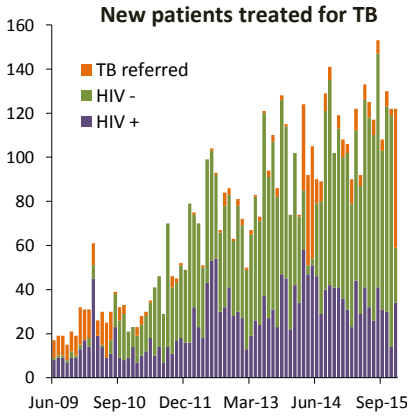
2.5 HIV+ pregnant women and prevention of mother to child transmission of HIV (PMTCT)

Treatment of HIV pregnant women not only save their lives, but also prevents HIV transmission to their unborn or breast feeding baby. The mothers are in the program up to 1 ½ year after the birth of the baby. 62 new HIV+ pregnant mothers started treatment. 55 babies at the age of 18 months were tested during this report period and all of them were HIV negative. A great success***!***

Follow up of a PMTCT postpartum mother

2.6 Tuberculosis Treatment

7,057 patients were tested for TB in 2015. 878 patients tested positive (12%) and 1,285 patients were treated (6-8 months). Note; a large proportion of HIV+ patients who have TB *test* negative for TB and the diagnosis has to be made in another way. 135 patients were referred to hospitals. All patients also received food support to improve their nutritional status.



Examination of suspected TB patient

Chest x-ray in suspected TB patient

2.7 Home visits for patients with chronic diseases

For patients with TB and AIDS and for malnourished children who need to take treatment for a long period adherence is essential. 9,597 home visits were done to strengthen treatment adherence.

A patient with tuberculosis visited at home'

2.8 Family planning;

Many women have more children than they can care for. In poor areas this frequently leads to poverty of the family, poor health of both mothers and children and – if women are desperate – they seek illegal non-sterile abortions, which can result in infection and death of the mother. Family planning can give a family the choice when to take children (when they are ready to take care of the child). 16,326 consultations were provided for family planning. Women can choose the family planning they want; a depot injection, oral contraception tablets, an IUD (intra uterine device) or a contraceptive implant. The implant slowly releases hormones and can prevent pregnancy for up to five years. It can also be removed on request. 328 women received an implant.

Severe malnourished baby in intensive care'

2.9 'Intensive care' and over-night stay

Critically ill patients need intensive treatment (mostly patients with severe dehydration, severe malnutrition, meningitis or sepsis. MAM provides them with "intensive *day* care" in the clinics. These patients are not allowed to stay overnight in the clinic (government rules). For patients who come from far MAM has built a house nearby the clinics, where they can stay overnight.

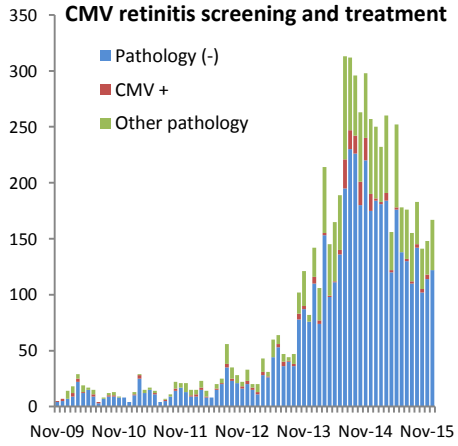
748 patients needed intensive treatment in the clinic for a total of 2,394 days. Several severely sick patients were referred to MAM by other NGOs for further management.

Dr NiNi and Dr Yee Yee performed a lumbar puncture to collect cerebro-spinal fluid. They connected a tube to measure the intracranial pressure. Judging from their eyes on the right picture, the pressure was very high which is highly suspicious for a fungus infection in the brain. This test is important for the diagnosis but is also providing a great relief for the patient who had very severe headache.

2.10 Eye screening for CMV retinitis and other pathology to prevent blindness

People with severe HIV infection have a high risk of developing blindness due to an infection of the retina by *cytomegalovirus (CMV)*. If CMV is diagnosed early, the process - to develop blindness - can be stopped by injecting a medicine (*ganciclovir*) inside the eye ball. Dr Ni Ni Tun is specialized in this procedure. In 2015 2,298 patients were screened. 29 patients (1.3%) were diagnosed with CMV and 566 (25%) patients were diagnosed with other eye pathology (tuberculosis, syphilis and others). All CMV patients were treated immediately and nobody got blind. Some patients with severe CMV retinitis need surgery or laser treatment. MAM works with an eye surgeon who provides his services for free.

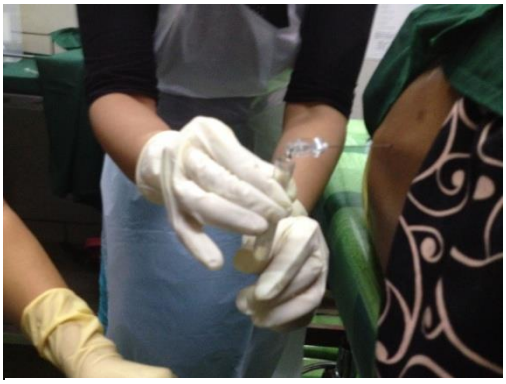
Eye injection to treat CMV retinitis



In January 2015, a training workshop was arranged by MAM in collaboration with eye specialists from SEVA foundation and *Médécins Sans Frontières*. 12 HIV clinicians from MAM and 3 partner organizations were trained to screen, diagnose and treat CMV retinitis patients. After completion, the doctors were qualified to perform eye screening and eye injections. The training makes it possible for CMV retinitis patients in Myanmar to have better access to diagnosis and treatment of CMV retinitis. This should be replicated all over the country.

2.11 Laboratory testing

83,162 laboratory tests (including CD4, CD4%, SGPT, Creatinine, Malaria) were performed in 2015. Tests were performed on blood, stool, urine, spinal fluid, lymph node aspiration (for TB), vaginal smears and skin smears (for penicilliosis, cryptococcosis & TB). 12,959 patients were tested for HIV. 1,047 (8%) of them tested positive.



Fluid from the spinal tap is collected for analysis in our laboratory

2.12 Referrals

Patients who needed surgery (e.g. fractures, cleft lips, cataract and other) were referred to hospitals. MAM paid for the costs.

2.13 Food and travel support

Patients with serious chronic infections are very vulnerable as they cannot work. Some feel forced to sell their medicines, which leads to treatment failure and resistance. MAM provides food for a few months until the patient is able to work again. Food rations (rice, beans, oil, fish and salt) were supplied for 4,140 patients with chronic diseases, handicapped patients, orphans, single-women households, and households lead by grandparents.

3 Village Health Worker activities

Malaria, Basic Health Care, Malnutrition, Tuberculosis and Referral of severely ill patients

3.1 Village Health Workers (VHWs)

RDT test by VHW at VHW clinic

In 2011 MAM started a basic health care project for extremely remote villages, where the population has no access to health care services, unless they travel many hours by foot or motor bike taxi (unaffordable for most) to the nearest town. Initially 61 villagers were trained as *Village Health Workers* (VHWs) and run one-person clinics in Mon State. This project has gradually expanded to Kayin, Kachin, Kayah and Thanintharyi. The number of VHW has now grown to 930 VHWs.

VHW refresher training

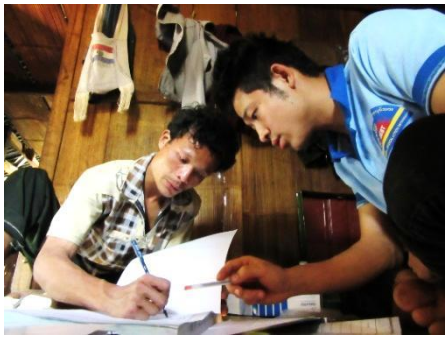
Initially the VHW were trained to manage malaria, which was arguably the most important disease in most villages. After training, VHW received "VHW supplies" which have 2 months stock of medicines and materials. Later the VHW were trained in a broader basic health care package, covering some of the most common pathology (including acute respiratory tract infections, diarrhoea, and skin diseases), malnutrition and family planning. Complicated patients can be referred to hospitals (paid by the project). In 2015 *active case finding* of Tuberculosis (TB) was added to the service package in Kayah, Thanintharyi and Kachin States. Patients suspected for TB are referred for further investigation in township hospitals. Patients will be following up in the hospital on a monthly basis. MAM facilitates the referral and support costs. For people in these very remote villages this is the first access to quality basic health care.

TB training to VHW

Monitoring and training

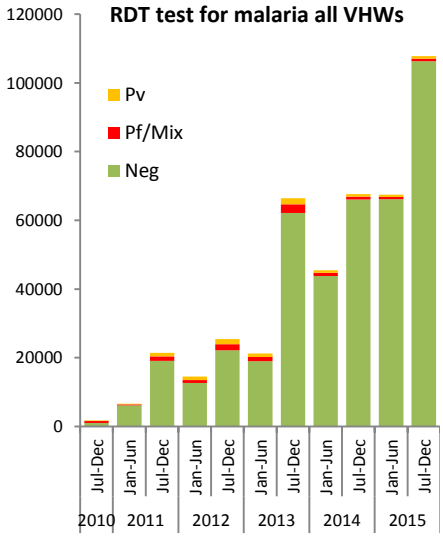
All VHW are monitored on regular basis (monthly) by MAM field teams. The MAM teams have to travel 4-8 hours on the motorcycle to these villages. These teams are led by a team leader (usually a medical doctor) and 2-3 local support staffs who speak the local language. This is essential since many of the patients do only speak Mon language (for Mon project), Kayin language (for Kayin and Kayah project), Kayah (for Kayah project) and Kachin or Lisu language (for Kachin project). The technical performance of the VHW is assessed and on-the-job training is

provided. Patient home visits are conducted to verify quality and perception of services provided. Monitoring reports and data analysis are the bases for action plans to enhance support and output of the VHW sites. In 2015, 7,198 monitoring and supervision visits were performed to 930 VHWs by field teams and project coordination teams. Monitoring and evaluation (M&E) from Yangon Coordination team was done on a monthly basis. There were 57 BHC training sessions and 40 Malaria-BHC-TB Refresher training provided to VHWs. Usually, groups consist of 20-30 VHWs but in very remote sites we arranged small group meeting for 5-10 VHWs from the same neighbourhood to discuss and share experiences and learned from "lessons learned". MAM medical doctor provided partial refresher training.



VHW monitoring and on job training

3.2 Malaria activities

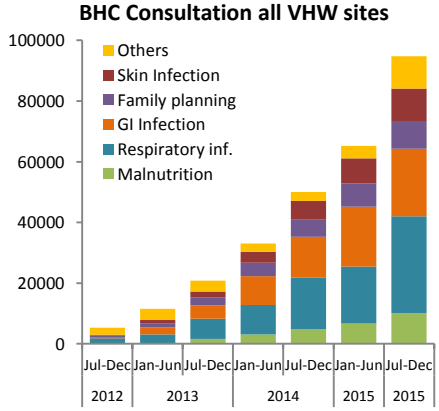


The project aims to contain artemisinin-resistant malaria. This is a major health threat for Myanmar, and for the entire world as artemisinin is the last effective drug to treat malaria. Intensive malaria activities can halt the spread and the aim is to eliminate malaria from South East Asia. The activities concentrate on diagnosis and treatment services and large scale distribution of insecticide-treated bed nets. The treatment is a combination of drugs that can still kill the malaria parasites.

The diagnosis and treatment for malaria is provided by the VHWs who live in the villages. In 2015 VHW tested 175,296 fever patients with a Rapid Diagnostic Tests (RDT) for malaria. 1,302 patients (1%) tested positive for falciparum malaria (the most dangerous form of malaria) and 1,447 patients (1%) tested positive for vivax malaria. 172,547 patients tested negative. Patients with severe malaria are referred to the nearest hospital. Referral is facilitated and paid for. Next to diagnosis and treatment MAM distributed 21,336 people received insecticide treated bed nets in these remote villages. In the other villages bed nets were already distributed by MAM in previous years. The results of the project activities are very encouraging. The malaria positivity rate (proportion of patients with fever who test positive for malaria) is decreasing rapidly since the introduction of the malaria activities by the VHWs.

VHW doing malaria test in the village

Health education before bed nets distribution



3.3 Basic Health Care activities

As a result of the successful implementation of intense malaria control activities malaria prevalence of malaria has been decreasing. Therefore most patients now test negative for malaria. If only malaria treatment were to be provided, most patients would not get treated for their complaints and this would undermine the popularity and uptake of the malaria services. A basic health care package (including referral for severely ill patients) combined with the malaria services increases the popularity and uptake of the VHWs services in general and specifically increases the coverage of testing for malaria even when malaria positivity rates are decreasing. This is the first time that people in these

Wound dressing by VHW

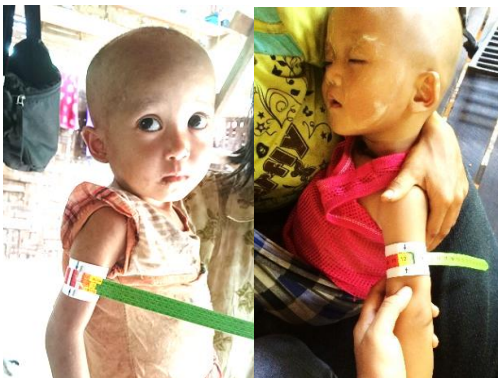
remote village have regular access to a health care package in their village opposed to health care that is only accessible after several hours travel on the back of a motorbike (which is very expensive and not affordable for most!).

Up to December 2015 a total of 894 VHWs were trained to perform BHC activities next to malaria activities. The VHWs performed 159,963 basic health care consultations in 2015. The most common diseases were respiratory tract infections (32%), gastrointestinal infections (26%) and skin infection (12%). For patients who need to be seen by the medical doctor, the VHW arranges that the patient is seen by the MAM medical doctor during the next monitoring visit. If the complication is acute and needs urgent treatment, the patient will be referred to a hospital.

Health education about malnutrition

3.4 Malnutrition screening and therapeutic feeding

The VHWs are also trained to screen all children for malnutrition by measuring the Mid-Upper Arm Circumference (MUAC). If children are malnourished, they receive special ready-to-use therapeutic food (RUTF) for the treatment of acute malnutrition. During Jan-Dec 2015, 2,260 children were screened for malnutrition and 910 mild-moderate malnourished children were provided with therapeutic food. Children with severe medical complications were referred to the hospital. Health education about taking care of malnourished children were provided to mothers/care givers. There are a number of chronic malnourished children (stunted) in the villages that require follow up. In November MAM started more intensive active screening to detect malnutrition among children and pregnant women early (to prevent severe acute malnutrition) in 67 villages. 9 severe malnourished children and 4 severe malnourished pregnant women were enrolled in Nov-Dec 2015. After 3 months evaluation and lessons learned, the project will be expanded to cover 300 VHW villages in Kayin, Kayah and Kachin States.



Malnourished children detected during screening

3.5 Referral of severely ill patients

Realising that the capacity of VHW is limited, MAM set up a referral system for all severely ill and complicated patients. 625 patients were sent to DoH hospitals to receive life-saving treatment. MAM (the donors) paid for the transport and the treatment in the hospital. The aim is to avoid that a VHW will treat beyond his/her capacity and to save lives.

Medical doctor checked a patient consulted by VHW

3.6 Tuberculosis

In May 2014 MAM started to integrate Tuberculosis Active Case Finding (TB-ACF) into the current malaria activities in Kayin State. In 2015 the TB-ACF were expanded to Kayah and Kachin States. 559 VHWs have been trained on signs and symptoms of suspected TB and referral procedure. In 2015, 3,350 TB suspected patients were referred for TB investigation (sputum test, chest X-ray) and 730 patient were identified as having TB and were started on TB treatment (6-8 months). MAM provided transportation, accommodation, investigation costs and accompany some patients to the hospital for initial visit and monthly follow up.

Community meeting in the village

Difficult travelling

Travelling by boat is quite dangerous

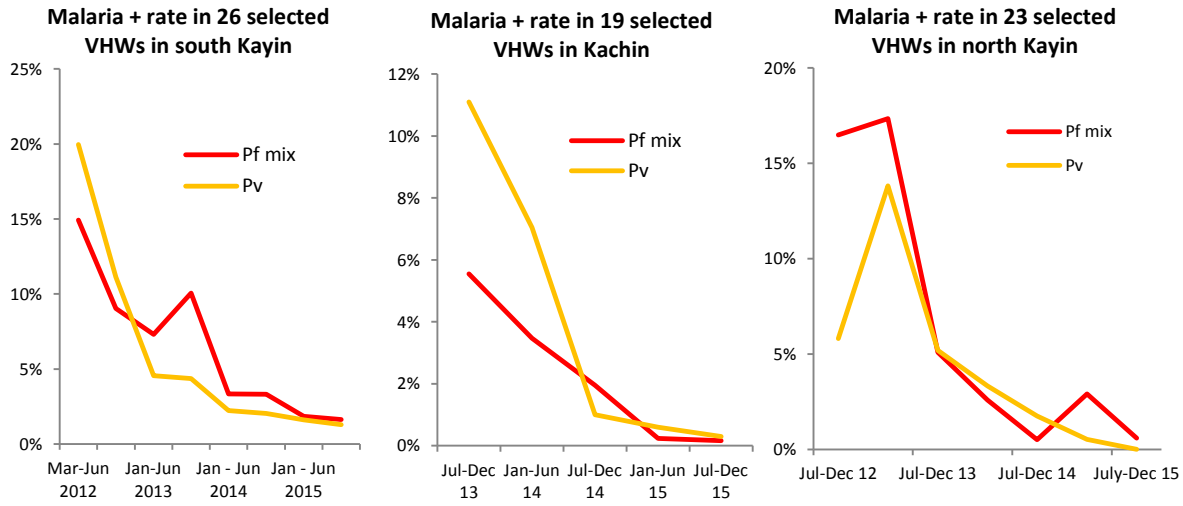
4 Analysis

The malaria positivity rate decreased significantly over the past 2 years. We have seen this trend in all areas where we started malaria activities through a network of VHWs. It seems that the presence of VHWs, with simple 'rapid' diagnostic tests and good quality treatment, is effective in decreasing malaria transmission and therefore decreasing the positivity rate of patients with fever. All patients who tested positive for malaria received treatment and malaria health education.

Data summary	**2011**	**2012**	**2013**	**2014**	**2015**
Number of townships	9	20	22	23	23
Number of VHW (malaria)	99	245	419	576	930
Number of RDTs	25,687	38,712	82,487	108,238	175,296
Pf/mix +	951	2,435	3,987	1,771	1,302
Pv+	758	2,406	3,027	1,334	1,447
Malaria + rate	*7%*	*13%*	*9%*	*3%*	2%

Malaria + rate after introduction of VHWs with RDT & ACT+PQ

A cohort analysis



Note; As the number of VHWs varied substantially, we did cohort analysis of VHWs who a) started approximately at the same time and b) who had relatively high malaria at the beginning of the project. In a village with low initial malaria it is difficult to measure an effect of VHWs

Bank details Medical Action: USD		Bank details Medical Action: EURO	
Bank name	ABN AMRO Bank	Bank name	ABN AMRO Bank
Bank address	Apollolaan 171, 1077 AS Amsterdam, The Netherlands	Bank address	Apollolaan 171, 1077 AS Amsterdam, The Netherlands
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***Note;* Private donations are spent for +/- 68% on medicines, medical equipment and food and for +/- 22% on national staff cost in MAM clinics (unless specifically agreed that the donation will be used for other purposes)!**

5 Annex

An interview with Dr Ni Ni Tun, Medical Director of MAM

AGENT FOR CHANGE
DR. NI NI TUN

BY MIMI WU

Ni Ni Tun with a patient's family, at one of the clinics in Hlaing Thar Yar Township.

Had Ni Ni Tun followed her 16-year-old heart and pursued life as a stewardess, Myanmar would have been robbed of one of the foremost doctors in HIV/AIDS treatment and prevention.

Dr. Ni Ni Tun and I arrange to meet at Medical Action Myanmar's (MAM) office one weekday afternoon. I'm ushered into a conference room and wait until she arrives, petite, long flowing hair, tanned skin and all. She flashes a great big smile as she shakes my hand, and I feel charged by her kind and energetic aura.

Before she became Dr. Ni Ni Tun, she resided in Bago Division until age 15 when her father, an engineer, was posted to a government job in Yangon. By the time she graduated from high school, her top marks meant she could pursue any field for tertiary education. A challenging profession was not her initial desire.

Instead, the stewardess next door had caught her attention. Gorgeous, well dressed, and leaving a trail of perfume, the woman seemed to lead a glamorous lifestyle. Her father wanted Ni Ni Tun to study medicine but rather than push, he compromised: "Start medical school with a backup plan as a stewardess."

In the end, fathers know best. By her second year, Ni Ni Tun's studies fascinated her, and she graduated in 2002 as Dr. Ni Ni Tun. She began her clinical work at Thingangyun Training Hospital but was confronted by the limited medical supply available to doctors and patients.

"If you see a patient with a head injury, you don't have suturing materials, and no gloves. How can you ask the patient [to pay for it] who is very sick? So you buy it yourself. I was asking my mother and sister for money every month for an emergency medical kit. My salary [as a doctor in training] was 1,600 Ks a month," she said emphatically. I was incredulous. She repeated herself, then added, "I had to depend on my parents for bus transportation, everything."

By 2002, Myanmar was the site of Médecins Sans Frontières (MSF) or Doctors Without Borders' largest medical program in the world with attention in Shan State, Kachin State, Rakhine State, and the Yangon Region. The organisation provided free basic healthcare and was the first to provide free antiretroviral (ARV) drugs on a large scale. When

a colleague introduced her to MSF, she leapt at the opportunity to join.

"At that time, there was HIV treatment, but it was not free in my country yet. Hospitals didn't have the medicines to treat AIDS, so many people died. Before [I joined MSF], I thought HIV was an untreatable infection."

Following her mentor, Swedish Dr. Per Bjorkman, Dr. Ni Ni Tun learned not only about antiretroviral therapy but also about hope.

"At Lashio in Shan State, patients were dying and hopeless. [Relatives] told us, 'This is the end of [the patient's] life, so do whatever you want.' But after treatment, the patient was really different and healthy, and could go back to his job. You could see an obvious difference. It made me very excited and gave me job satisfaction."

Dr. Ni Ni Tun was later sent to Muse to care for sex workers infected with HIV and other STDs. Growing up in a conservative household where the family never talked about sex, let alone prostitution, she was not sure what to expect. But the women's kind nature and hard working attitude to provide for their families quickly changed her mind. As their relationships grew, many HIV positive sex workers became peer educators who encouraged HIV testing in their communities and trained on prevention and treatment.

"There are quite a lot of patients who have touched me, especially in Shan State. I was there alone, so the patients were my family. Almost everyone had a sad story. The father left or died, the mother had HIV, so [the children] never had warmth and love. I remember a patient. I said, 'You are sick, but if you take this medicine, you have a good chance to get better.' At the end, I asked if she had any questions. She asked, 'Why are you so nice to me?' I said, 'I'm not nice, I'm doing my job.' Nobody wants to talk to them, so if you are friendly, they can't believe it. They become attached to you. I also love them."

After a year and a half in Shan State, Dr. Ni Ni Tun returned to Yangon

At Lashio in Shan State, patients were dying and hopeless. Relatives told us, 'This is the end of life, so do whatever you want.'

Ni Ni Tun examining a sick patient at the day care centre of one of the clinics.

to care for her ailing father. "It was very painful moment [to leave Shan State], but I still have communication with some of those patients; they come to visit me. Now, they are already healthy. When you see them, you don't recognise them! Many of them are volunteers."

Dr. Ni Ni Tun continued her inspired work with MSF's Yangon team, where she and five other doctors saw hundreds of patients each day at the Insein clinic. Two years later in 2006, she was sent to Antwerp University in Belgium for further training and returned as an HIV trainer for doctors at each MSF program area throughout Myanmar. She retained this role until leaving MSF in 2009. Over the five years she worked with MSF, the organisation treated more than 35,000 patients.

Invited by Dr Frank Smithuis, MSF's Myanmar country director of 15 years, Dr. Ni Ni Tun then joined the newly formed Medical Action Myanmar (MAM) NGO.

MAM's first clinic took over a closing MSF facility in Hlaing Thar Yar. Limited funding initially meant a slow expansion but over time the network of donors grew and MAM now supports seven clinics around the country. MAM further supports approximately 900 village health workers to treat malaria, tuberculosis, and malnutrition and cover basic health care in the most remote villages of Mon state, Kayin State, Kayah State, and Kachin State.

As the clinical HIV coordinator for MSF and later for MAM she has trained a few hundred doctors and other health staff on correctly diagnosing symptoms and their appropriate treatments.

Recalling some of the most emotional moments of her career, Dr. Ni Ni Tun recounted a day of torrential rain when staff heard a baby crying just outside MAM's clinic. "The baby was sitting next to her mother who was lying down on the street in the rain; the mother was severely wasted and died within a few minutes. We kept the child at the clinic, but the clinic closes at night, so what to do? Our staff took her home."

The staff informed Hlaing Thar Yar's Ward Leader, who eventually tracked down the girl's aunt. The background-story was that when the baby's father passed away, her mother traveled from Ayerwaddy Division to search for her sister, who lived nearby the clinic. Unable to track her down and sick, likely infected with HIV, the baby's mother ultimately passed away in front of the clinic. The child was tested and found to be HIV positive. Treated at one and a half years old, the girl is now seven and enrolled at school. She now lives with her aunt and receives MAM support for school and food.

Caring for people and being touched by their lives is why Dr. Ni Ni Tun fell in love with her job at MAM. "My parents wanted me to go [to Australia], but Australia has a lot of doctors. Everyday there is need [in Myanmar]. There are not enough human resources." After a year at MAM, she decided, "It's better to stay here and do something useful."

According to 2014 UNAIDS estimates, Myanmar has a low HIV prevalence rate of 0.7% among adults aged 15 to 49 (200,000 people), and approximately 11,000 children under 14 years old are living with HIV. However, HIV/AIDS is a heavily concentrated epidemic among sex workers, drug users, and populations in certain regions. MAM, other HIV associations like the Phoenix Association and Myanmar Positive Group, and the government recognises that as transportation improves across the country, this fraction could easily rise exponentially.

That is why to prevent its spread, "we need to emphasise treatment among key affected populations. Medical Action Myanmar is working in close cooperation with the government. The government is giving free drugs, and we take care of the human resources, care and support, and home visits. But it's like an iceberg. We only see the tip. We only see patients when they feel symptoms. But we also need to test and treat people who don't show symptoms to prevent the spread of HIV."

"Now we are working on malaria, HIV, and TB. In five years if the government structure is strong enough to handle these diseases, then I might do something else that needs support. I'm looking at patients with non-communicable diseases, like hypertension and stroke, or care for street children or neglected elderly people. "

It seems that at age 39, Dr. Ni Ni Tun's work is just beginning.