International Workshop on Empowerment of Indigenous Peoples Through Community Participation for Sustainable Local Health System: The Case of Tanay, Rizal, Philippines

March 03 - 10, 2015

Workshop Proceedings

Municipal Government of Tanay, Rizal

Integrative Medicine for Alternative Healthcare Systems (INAM) Philippines, Inc.

Asian Health Institute

INAM Philippines, AHI, and the Municipal Government of Tanay would like to acknowledge support for the workshop and this document from the Philippine Institute of Traditional and Alternative Health Care (PITAHC), Philippine Department of Health, Philippine National Commission on Indigenous Peoples (NCIP), Brot für die Welt (Bread for the World – Protestant Development Service), and Shell Philippines.

This report has been documented and prepared by Maria Sonia G. Astudillo and Dan August S. Abril for the Integrative Medicine for Alternative Healthcare Systems (INAM) Philippines, Inc., Asian Health Institute (AHI), and the Municipal Government of Tanay, Rizal, Philippines.

Photos by Leoncio Halili, Municipality of Tanay Public Information Office, Rizal Province Public Information Office, and workshop participants.

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Executive Summary

The International Workshop on the Empowerment of Indigenous Peoples through Community Participation for Sustainable Local Health System: The Case of Tanay, Rizal, Philippines was organized by the Integrative Medicine for Alternative Health Care Systems (INAM) Philippines, Inc., the Asian Health Institute, and the Municipality of Tanay, Rizal, Philippines with support from the Philippine Institute of Traditional and Alternative Health Care (PITAHC), Philippine Department of Health, Philippine National Commission on Indigenous Peoples (NCIP), Brot für die Welt (Bread for the World – Protestant Development Service), and Shell Philippines.

The Workshop was held at the Activity Center of the Tanay Municipal Hall. The participants set-up exhibit booths at the Municipal Hall Lobby to showcase the programs and activities of their respective organizations to Municipal Hall officials and employees and residents of Tanay.

Overall, the Workshop had over 50 participants. 30 of which were community health volunteer (CHV) workers and representatives from non-government organizations in Bangladesh, India, Nepal, the Philippines, and Thailand.

More specifically, there were:

International Participants:

- three representatives from Bangladesh's Development Association for Self-Reliance, Communication and Health (DASCOH), Community Group of Kodom Shohor Community Clinic, and Community Group of Gopalpur Community Clinic;
- three from India's Center for Community Development, Government of Arunachal Pradesh, and Karuna Trust;
- two from Nepal's Milijuli Health Cooperative and Shindhuli Integrated Development Service (SIDS);
- three from Thailand's National Health Commission Office and Trang Hospital;

Filipino Participants:

- 19 representatives from the Aloran Community Health Workers and Rural Health Unit, Barangay Health Workers Organization, Eboangan Indigenous People Tribal Association, General Nakar Health Organizers, Health and Development for All Foundation, Inc., New Corella's Community Health Workers and Municipal Health Office, the Institute for Primary Health Care (IPHC) – Davao Medical School

Foundation, Tanay Community Health Workers, Program Managers, and Rural Health Unit.

Organizing Members:

- 13 from INAM Philippines;
- 12 from the Municipal Government Office of Tanay;
- And three representatives from the Asian Health Institute.

With the Workshop theme **Empowerment of Indigenous Peoples through Community Participation for Sustainable Local Health System: The Case of Tanay, Rizal, Philippines**, objectives were grouped under three aspects of consciousness, methods of work, and relationship.

In general the participants would like to learn and share:

(1) Consciousness

- On traditional medical knowledge and best practices of Indigenous Peoples (IPs) in other countries.
- On conceptual framework, innovative strategies, and approaches and tools that helped in ensuring accessible and sustainable quality health service thru indigenous and/or poor peoples management of their own health program.

(2) Methods of Work

- Involvement of IPs in the management of health programs.
- Policy reforms for the IPs.
- Improved methodologies on documentation of Community Health Workers (CHWs) experiences.
- Innovative programs especially health services that can be replicated in other countries.
- How to promote lifestyle modification for better health status.
- Methods and approaches in training and strategies to develop and enhance capabilities and commitments of Community Health Volunteers (CHV)/CHW.
- Sustainable health strategies that would enhance IPs capacity to participate in local governance.
- How to integrate peace, health, and governance in IP communities.

(3) Relationship

- How the health program of the IPs are mainstreamed while maintaining relationship with the local government.
- Strategies to involve local government to find out critical gaps and health issues and to solve them through participatory approach.

- To build solidarity thru linkages and networking among participant's organizations for future collaboration.

The Workshop focused on the sharing of the Municipality of Tanay, Rizal, Philippines and other countries' experiences on community participation for the development of sustainable local health systems and possible replication of the different practices and strategies in other communities in other countries.
The participants visited and stayed for three days in the IP areas of Tanay to witness first hand the community participation of the IPs in the running of the local health system. Nine families in 4 barangays hosted the participants.

A significant output of the Workshop is the Plan of Action drafted by the countries/organization. Based on what they have learned, each country or organization submitted strategies they can adapt in their work area. Their outputs were discussed and refined during the plenary.

The workshop concluded with the different organizations presenting what they learned from the other countries' presentation and their action plan. With the International Workshop, CHWs, community health volunteers (CHVs), local governments, and organizations from different countries working to improve the health situation of poor communities are bringing home valuable learning points from each other through the sharing of practices and strategies in community participation towards the development of sustainable local health systems in their respective countries.

Workshop Program / Outline

Day 1, March 3, 2015
Moderators: Anicia O. Sollestre and Ric Caminade

Registration of Delegates and Guests

National Anthem

Opening Prayer/Ritual

Welcome Remarks
Honorable Rafael Tanjuatco, Mayor, Municipality of Tanay, Rizal, Philippines

Introduction of Delegates (per country/team/organization)

Inspirational Speech
Honorable Rebecca "Nini" Ynares, Governor, Province of Rizal, Philippines

Keynote Speech
Dr. Isidro Sia, Director General, Philippine Institute of Traditional and Alternative Health Care (PITAHC)

Distribution of Panasonic Solar Lanterns to 9 Barangays of Tanay / Awarding of Certificates of Appreciation to Speakers by:
Honorable Rafael Tanjuatco, Mayor, Municipality of Tanay, Rizal, Philippines
Maria Cristina C. Paruñgao, Executive Director, INAM Philippines
Kagumi Hayashi, Secretary General, Asian Health Institute

Sharing of Expectations / Objectives of the Workshop / Tasking
Anicia O. Sollestre and Ric Caminade

National Health Situation
Dr. Gerry Mejorada, Representative for Rizal Province, Department of Health Region 4A, Philippines

INAM Presentation
Dr. Jennifer Madamba, Department Head, Advocacy Research Training Department, INAM Philippines

Presentation of India Delegates

Raja Dodum, State Nodal Officer, (National Urban Health Mission), Govt of Arunachal Pradesh, India

Anup Kumar Sarmah, Coordinator, North East India, Karuna Trust

Dinner

Welcome Party

Day 2, March 4, 2015
Moderators: Jennifer Madamba and Carmenchu Badilla

Opening Prayer

Recap of Day 1

Key Learning Points

Presentation of India Delegate (continuation)

Addala Jagannadha Raju, Secretary cum Chief Executive, Center for Community Development

Presentation of Bangladesh Delegates

Md. Akramul Haque, Chief Executive Officer, Development Association for Self-Reliance, Communication and Health (DASCOH)

Md. Romzan Ali, Community Group Facilitator/ Community Volunteer, Community Group of Kodom Shohor Community Clinic

Shiree Laxmiram Uraw, Chairman of Community Group, Community Group of Gopalpur Community Clinic

Situation of Indigenous Peoples in Region 4A, Philippines
Jennifer Gerones, Community Development Officer III, National Commission for Indigenous Peoples (NCIP)

Presentation of The Case of Tanay
Rene V. Luce, MD, Municipal Health Officer of Tanay, Rizal, Philippines
Gilda Z. Paterno, Rural Health Midwife, ILDC Alumni 2014

Day 3, March 5, 2015
Moderators: Anicia O. Sollestre and Ric Caminade

Opening Prayer

Recap of Day 2

Key Learning Points

Presentations of Thailand

Nanoot Mathurapote, Acting Head of Global Partnership, Coordinating Unit, National Health Commission Office

Nuanchawee Nedsaengtip, Coordinator Nurse to the Network of Provincial Health Assembly, Trang Hospital

Suvanee Samathi, Coordinator to the Network of Provincial Health Assembly

Presentations of Nepal

Shinduli Integrated Development Service (SIDS)
Deepak Kumar Ghimire, Chairperson cum Executive Director

Milijuli Health Cooperative
Bal Kumari Shrestha, Chairperson

Presentation of Philippines

Municipality of New Corella, Davao
Daisy Rose Gunida Rafael, Barangay Health Worker
Nancy Ulanday Obra-Cacayorin, MD, Municipal Health Officer

Health and Development for All Foundation (HADFAFI), Inc.
Ma. Fatima Cabanes-Tanhueco, Senior Program Officer 2
Jennifer Medina Dumiao, Program Assistant, Health, Nutrition, and Hygiene Unit

Municipality of Aloran, Misamis Occidental
Sagrada Teresa Roa, Public Health Nurse
Lynsie Erigbuagas, Community Health Worker

Barangay Minahan, General Nakar, Quezon
Milagros Flores, Community Organizer, Peoples Organization
Marilyn Buendicho, Community Organizer, Peoples Organization

Briefing for Field Visit/Homestay
Maria Cristina C. Paruñgao, Executive Director, INAM Philippines

Day 4 to 6, March 6 to 8, 2015
Field Visit/Homestay

Assembly at the Municipal Ground

Visit to Tanay Main Rural Health Unit (RHU)

Travel of Mamuyao Group to Barangay. Sto. Niño RHU

Meeting/Orientation with the RHU staff

Travel to Barangay Mamuyao (Mamuyao Group)

Travel of Daraitan and Laiban (Manggahan/Magata) Group to RHU 2 in Barangay Sampaloc

Meeting/Orientation with Dr. Dulce Amor Rivera, Rural Health Physician

Travel of Daraitan Group to Barangay Daraitan

Travel to Barangay Laiban (Sitio Manggahan/Sitio Magata)

Community Immersion

Travel back to Barangay Sampaloc to Visit Regina Rica and Daranak Falls

Travel back to Bakasyunan Resort

Day 7, March 9, 2015
Moderator: Dr. Jennifer Madamba

Municipal Government of Tanay Flag Raising Ceremony

Opening Program

Recap

Key Learning Points

Field Visit/Homestay Reports

Barangay Mamuyao
Anup Kumar Sarmah

Barangay Daraitan
Deepak Kumar Ghimire

Barangay Laiban, Sitio Manggahan
Nuanchawee Nedsaengtip

Barangay Laiban, Sitio Magata
Addala Jagannadha Raju

Synthesis
Sr. Dulce Corazon Velasco, MD, MMS

Guide for Action Plans

Special Activity: Mayor's Night

Day 8, March 10, 2015
Moderator: Anicia O. Sollestre

Opening Ritual

Recap

Presentation of Action Plans

Karuna Trust (India)
Centre for Community Development (India)
Development Association for Self-Reliance, Communication and Health (Bangladesh)
Shinduli Integrated Development Service/Milijuli Health Cooperative (Nepal)
New Corella/Institute of Primary Health Care (IPHC)-Davao Medical School Foundation (Philippines)
Aloran CHWs (Philippines)
Tanay CHWs (Philippines)
Health and Development for All Foundation, Inc. (HADFAFI) (Philippines)
General Nakar CHWs,Quezon (Philippines)
Trang Hospital (Thailand)

Group Reflection

Closing Remark
Kagumi Hayashi, Secretary General, Asian Health Institute

The Workshop – Day 1

PRELIMINARIES

The International Workshop was attended by over 50 participants coming from non-government organizations, government offices, community health groups, and the organizing committees.

More specifically, participants can be broken down into:

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Organizing Members:

- 13 from INAM Philippines;
- 12 from the Municipal Government Office of Tanay;
- And three representatives from the Asian Health Institute.

The Opening Prayer and Ritual was a song and dance presentation of the Dumagat children and Community Health Workers (CHWs), an IP group in Tanay, Rizal, as they express love and care for 'un potok', the ancestral land, the land of indigenous communities in Sierra Madre mountains in the Philippines.

Welcome Remarks

Honorable Rafael Tanjuatco
Mayor, Municipality of Tanay, Rizal, Philippines

The town of Tanay was greatly honored to host the Workshop as expressed by the Mayor, citing that the introduction of community health programs by INAM Philippines and AHI have empowered the CHWs and thus are changing things in their health care delivery.

The IP communities in Tanay belong to the most disadvantaged and vulnerable sector of the society. Their low level of education, lack of productive skills, nomadic way of life, and other factors account for this. Given the situation, the IPs tend to isolate themselves from the rest of the community, preferring to reside deep in the inner lands, faraway from settlements and services such as health care. This has been engraved in their culture since time immemorial.

The IPs are totally dependent on traditional yet unsafe health practices. They have been exposed to an array of health problems particularly influenza, upper respiratory tract infection, pulmonary disorders, tuberculosis, and gastroenteritis. This was the situation for many years but with the introduction of INAM Philippines and AHI of community health programs thru empowerment of IPs, things are changing.

The IP leaders were trained to become community organizers then community health workers, progressive health program managers, and then training facilitators. As a result, the IPs health seeking behavior was altered. That is from total dependence on risky traditional practices, they geared towards systematic and safe methods resulting from the trainings conducted.

As highlighted by the Mayor, the IP situation in Tanay maybe unique but the need to address the health concern of the IPs is universal.

Introduction of Delegates

The International Workshop was well-received and attended by over 50 participants coming from various sectors and organizations. While there were mainly 30 participants from both Philippine and International non-government organizations and partners, there were 20 from the organizing committees who took part in the workshop as observers.

In detail, the participants can be broken down into:

International Participants:

- three representatives from Bangladesh's Development Association for Self-Reliance, Communication and Health (DASCOH), Community Group of Kodom Shohor Community Clinic, and Community Group of Gopalpur Community Clinic;
- three from India's Center for Community Development, Government of Arunachal Pradesh, and Karuna Trust;
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Organizing Members:

- 13 from INAM Philippines;
- 12 from the Municipal Government Office of Tanay;
- And three representatives from the Asian Health Institute.

Inspirational Speech

Honorable Rebecca "Nini" Ynares
Governor, Province of Rizal, Philippines

The Governor of Rizal Province was very thankful to INAM Philippines for their support in promoting the use of traditional medicine which helps not only the people in town but those in far flung areas, most especially the IPs.

In promoting the use of alternative medicine, INAM Philippines is in effect empowering the IPs through an alternative health care system. With this in mind, the importance of traditional medicine should not be overlooked as it is life saving. In fact, research has shown that in many countries, most people, especially those in rural areas prefer to use traditional medicine as their first point of medical support. But in spite of what have been attained, Rizal is still faced with some challenges in bringing traditional medicine into the mainstream of health care - appropriately,

effectively, and above all, safely.

It is known to most that traditional medicine are generally available, affordable, and commonly used in large parts of the Philippines, in Asia, and in Africa. For the millions of people living in rural areas in developing countries, herbal medicines, traditional treatments, and traditional practitioners are the main, and sometimes the only source, of health care. It is true that in most cases, traditional medicine as a form of care, it unquestionably soothes, treats many ailments, reduces suffering, and relieves pains.

Decades of experience tell that a sustainable health care system produces better health outcomes, at lower costs, and with higher user satisfaction. What is needed is a health care system that is fair, efficient, comprehensive, and affordable. The strong call for a sustainable health care system was heard and it created an ideal opportunity to effectively promote traditional medicine, and to take a positive look at its many contributions to health care: it is equitable, accessible, affordable, and people-centered. This is precisely what INAM Philippines is doing for Tanay in Rizal.

The use of traditional medicine and alternative health care is good and it will be better if there are safeguards in the form of systems for regulation, training, and licensing or certification, and strict controls of product safety. One way of doing this is by integrating traditional and alternative medicine into the mainstream health care system in line with the guidelines of the World Health Organization (WHO).

It is undeniable that traditional medicine has so much to offer in terms of prevention, comfort, compassion, and care. It is a great resource that needs to be protected and treasured. The Workshop comes at an opportune time. The time has never been better and the reasons never greater for giving traditional medicine its proper place in addressing the many ills of the modern and traditional societies, including the IPs. It is only when there is recognition of indigenous resources as priority areas for development that the empowerment of the IPS will be attained.

The Governor expressed hope that the experience of Tanay, Rizal set the tone for effective community health programs. Aware that not all have access to health care, the Governor wants to make the program part of the local government's Yes Program to plant trees of medicinal value to make it affordable to people. INAM Philippines's program has been very helpful for both health and poverty concerns. Herbal medicine translates to no side effects, free, clean air, and increased IQ level. All these leading to a community of healthy, intelligent people who have peace of mind.

Keynote Speech

Dr. Isidro Sia
Director General, Philippine Institute of Traditional and Alternative Health Care (PITAHC)

In his Keynote Speech on empowering the local communities toward responsive and sustainable health care delivery systems, Dr. Isidro Sia highlighted four important points:

(1) The Philippines is a multi-cultural nation, with about 185 ethno linguistic groups, among which are 110 IP communities and several Bangsamoro peoples groups. The indigenous communities and urban poor and the people living in (GIDA) may be considered among the the Bangsamoro people together with the rural and geographically isolated and disadvantaged areas marginalized Filipinos.

Delivery of social services including health care services is an urgent concern among the marginalized Filipinos. Lack of access and equity may be said to characterize the delivery of health care services.

(2) A responsive and sustainable health care delivery system should possess the attributes of quality, availability, accessibility, affordability, and acceptability (Q4A).

(3) Determinants for a responsive and sustainable health care delivery include economic, sociocultural, and political considerations, as well as the assertion of a local health agenda that is appropriate, affordable, science-based, and culture-sensitive.

(4) Determinants for successful empowerment of the local communities include assuring livelihood, self-determination, organizational strength, capacity building, and pride of place and culture.

Distribution of Panasonic Solar Lanterns to 9 Barangays of Tanay

Forty five (45) Panasonic Solar Lanterns were given to the 9 Barangays of Tanay namely: Santa Ines, Santo Niño, Tinucan, Laiban, Daraitan, Cuyambay, San Andres, Mamuyao, and Cayabu. Each barangay received five Panasonic Solar Lanterns which will be used by the Community Health Workers for basic health services, referral of patients from the community to the Rural Health Units of Tanay, and for disaster preparedness. The distribution was led by Honorable Rafael Tanjuatco, Mayor, Municipality of Tanay, Rizal, Philippines, Maria Cristina C. Paruñgao, Executive Director, INAM Philippines, and Kagumi Hayashi, Secretary General, Asian Health Institute.

This was followed by the Distribution of Certificate of Appreciation to the Speakers.

Sharing of Expectations / Objectives of the Workhop / Tasking

Ms. Anicia O. Sollestre and Mr. Ric Caminade

With the Workshop theme Empowerment of Peoples through Community Participation for Sustainable Local Health System: The Case of Tanay, Rizal, Philippines, objectives were grouped under three aspects of consciousness, methods of work and relationship.

In general the participants would like to learn and share:

Consciousness

- On traditional medical knowledge and best practices of Indigenous Peoples (IPs) in other countries.
- On conceptual framework, innovative strategies, and approaches and tools that helped in ensuring accessible and sustainable quality health service thru indigenous and/or poor peoples management of their own health program.

Methods of Work

- Involvement of IPs in management of health programs.
- Policy reforms for the IPs.
- Improved methodologies on documentation of Community Health Workers (CHWs) experiences.
- Innovative programs especially health services that can be replicated in other countries.
- How to promote lifestyle modification for better health status.
- Methods and approaches in training and strategies to develop and enhance capabilities and commitments of Community Health Volunteers (CHV)/CHW.
- Sustainable health strategies that would enhance IPs capacity to participate in local governance.
- How to integrate peace, health, and governance in IP communities.

Relationship

- How the health program of the IPs are mainstreamed while maintaining relationship with the local government.
- Strategies to involve local government units to find out critical gaps and health issues and to solve them through participatory approach.
- To build solidarity thru linkages and networking among participant's organizations for future collaboration.

Having presented the objectives of the workshops, all participants were given the task to write down Key Learning Points from each country/organization presentation answering the question, "What can we bring home to our country?" The Key Learning Points are presented and shared to the group the following day.

COUNTRY PRESENTATIONS: PHILIPPINES

National Health Situation

Dr. Gerry Mejorada
Representative for Rizal Province, Department of Health Region 4A, Philippines

The Philippines has a land area of 298,170 sq. km. and is composed of varied topography from mountains, lowlands, and plains. The total population is 103 million and includes IPS. There are several languages and dialects such as Tagalog, Cebuano, Ilocano, Capampangan, Waray, and Ilonggo to mention a few and English is the second language.

The top ten leading causes of mortality are:

1. Diseases of the heart
2. Diseases of the vascular system
3. Malignancy
4. Pneumonia
5. Accidents
6. Tuberculosis
7. Chronic lower respiratory illnesses
8. Diabetes mellitus
9. Nephritis
10. Perinatal death

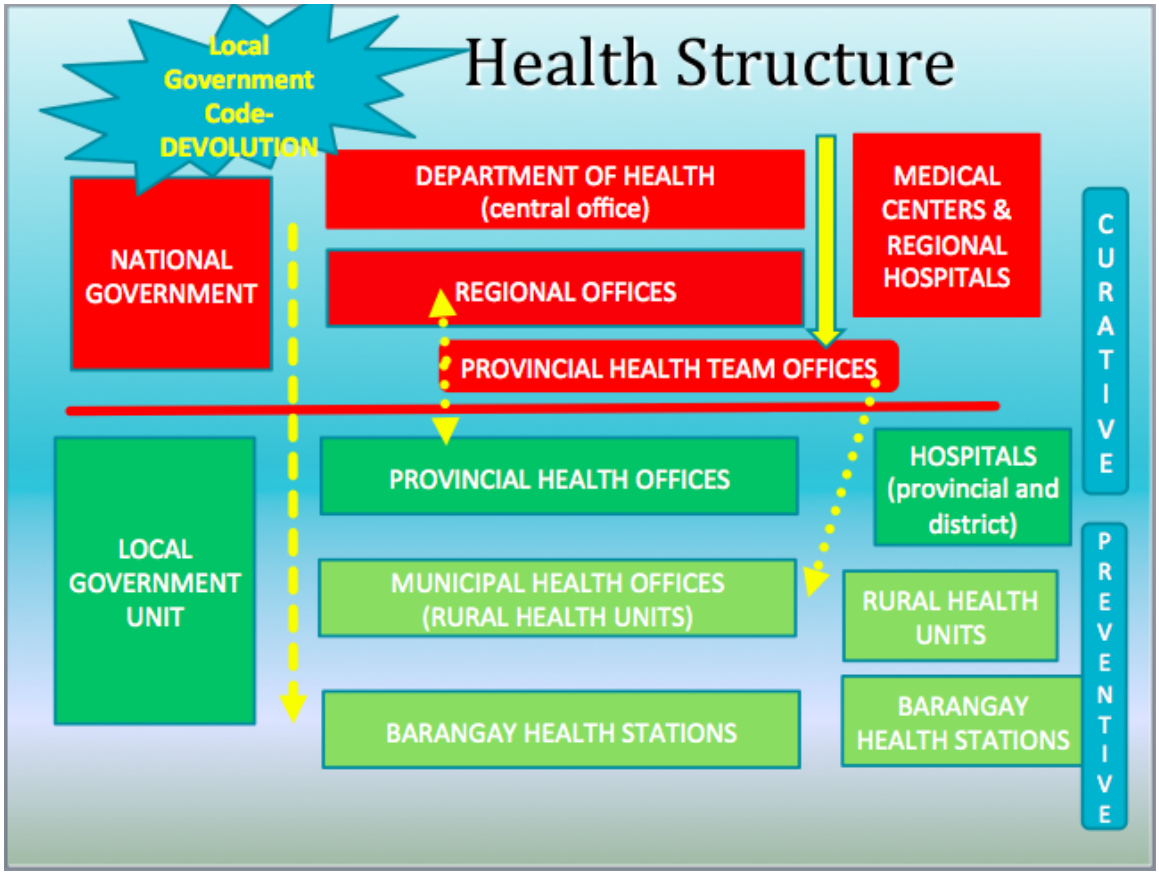
The top ten leading causes of morbidity are:

1. Acute respiratory infections
2. Acute lower respiratory tract infections (pneumonia)
3. Bronchitis/Bronchiolitis
4. Hypertension
5. Acute watery diarrhea
6. Influenza

7. Urinary tract infection
8. Pulmonary tuberculosis
9. Injuries
10. Diseases of the heart

Philippine Health Structure
In earlier years, all health units were under the national government. The regional, provincial, district, municipal, and barangay health units all report to the national office.

In 1991, through the Local Government Code, there was devolution of services including health services. There was a break in service delivery. The central and regional offices remain under the national government while municipal health and barangay health units were placed under the Local Government Unit (LGU). The conduit or the link is the provincial health office. While central and regional offices focus on the curative aspects of health, the municipal and barangay units focus on preventive. The provincial health office works on both curative and prevention health aspects. All work together through the local health board.



Since the devolution of the health sector that dissolved the district health system, the municipalities were divided into clusters or inter-local health zones. In the Province of Rizal, there were 4 clusters or inter-local health zones: AngCaTaBi (Angono, Cainta, Tanay, and

Binangonan), J-P Rizal (Jala-Jala and Pililia), CarTaTeMoBa (Cardona, Tanay, Teresa, Morong, and Baras), RodSaM (Rodriguez and San Mateo) with Tanay falling in the 3rd cluster.

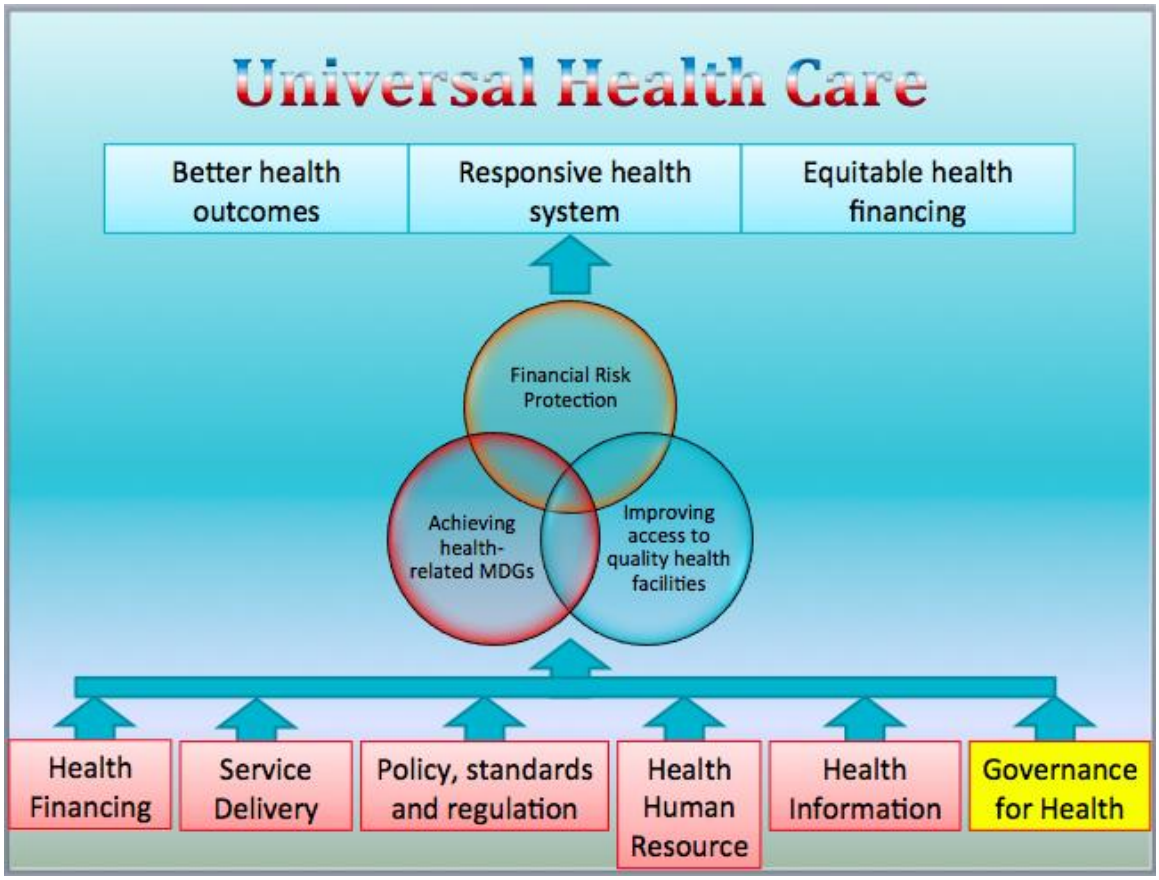
Universal Health Care

Through the years, the health care agenda in the Philippines has evolved to suit the needs of the people. From the Health Sector Reform Agenda: *Kalusugan Para sa Masa* (Health for All) in 1999 to 2004, to Formula One for Health in 2005 to 2010, and the current program of Universal Health Care (UHC) or *Kalusugang Pangkalahatan* (KP) for 2010 to 2016. The program will provide deliberate attention to the needs of millions of poor Filipino families which comprise the majority of the population.

The implementation of Universal Health Care shall be directed towards ensuring the achievement of the health system goals of better health outcomes, fair health financing and responsive health system by ensuring that all Filipinos, especially the disadvantaged group, have equitable access to health care.

The general objective of the program is to promote equity in health through the provision of full financial protection and improvement of access to priority public health programs and quality hospital care, especially for the poor.

Specifically, the Universal Health Care aims to utilize the instruments of Health Financing, Health Service Delivery System, Human Resources for Health, Health Regulation, Governance for Health and Health Information to achieve the thrusts of the program.



However, there are several critical factors in achieving UHC such as:

- Poorly equipped and poorly staffed local health facilities.
- Congested regional and national hospitals.
- Unevenly distributed health facilities in the public and private sectors.
- Inadequate national-local and public-private networking and patient referral systems.

The principle that "Health is a right of every Filipino citizen and the State is duty-bound to ensure that all Filipinos have equitable access to effective health care services" as stated in the 1987 Philippine Constitution serves as the guiding light in the achievement of the program.

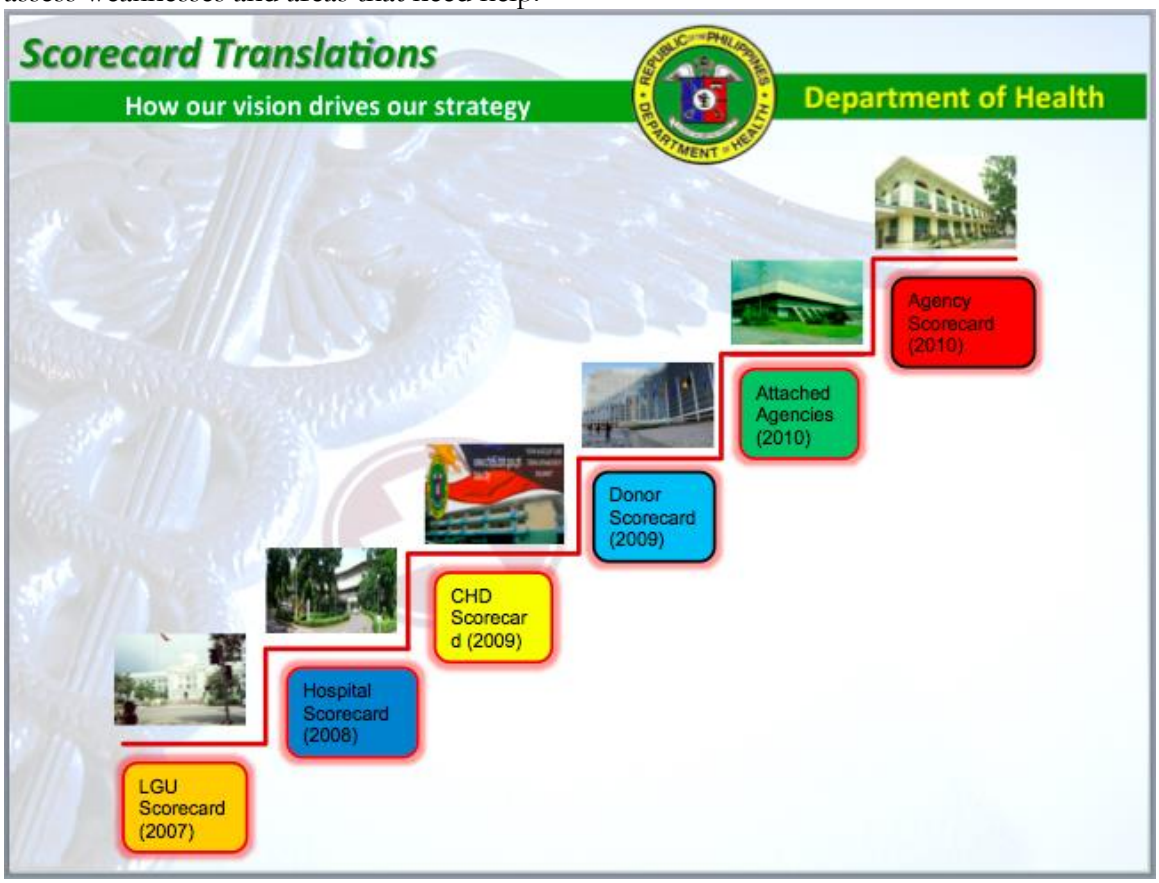
To realize this vision, the Philippine Department of Health has looked into five major initiatives/strategies:

1. Client surveys (responsiveness/satisfaction)
2. Social dialogue (participation/responsiveness)
3. Integrity development review (anti-corruption/efficiency)
4. Performance Governance System (PGS) Balance scorecard (performance/effectiveness)
5. ISO accreditation (quality/efficiency)

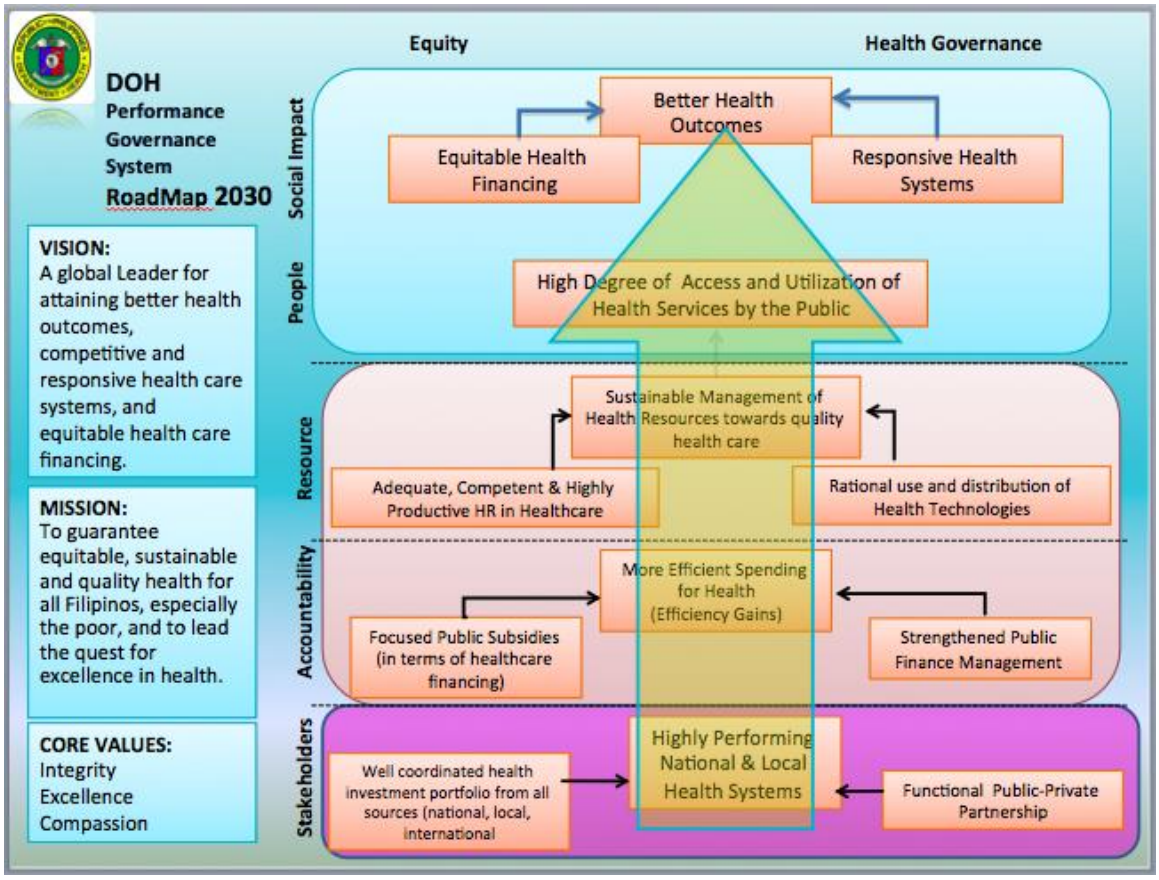
The major elements of the initiatives/strategies address quality, responsiveness, availability and accessibility while focusing on eliminating disparities (equity) and inefficiencies

(governance). The guiding principle is that of providing essential health care packages to all regardless of age, gender, religion, ethnicity, socio-economic status, and ideology.

From 2007 to 2010, the DoH has set scorecards setting the parameters or indicators to assess weaknesses and areas that need help.



The vision of the Performance Governance System (PGS) Road Map 2030 is to be a global leader for attaining better health outcomes, competitive and responsive health care systems, and equitable health care financing. The mission is to guarantee equitable, sustainable, and quality health for all Filipinos, especially the poor, and to lead the quest for excellence in health. In achieving this, the Department sticks to its core values of integrity, excellence, and compassion.



In achieving these goals, the health system is currently providing Essential Health Care Package that includes:

- Maternal and Child Health
- Nutrition
- Oral Health
- Mental Health
- Treatment of Infectious diseases
- Medico-legal services
- Advocacy for healthy lifestyle
- Laboratory package and screening for non-communicable disease
- Essential drug package
- First Aid and Emergency Care
- GIDA (Geographically Isolated and Disadvantaged Areas)
- HLGP (Health Leadership and Governance Program)

The regional offices have also set standards such as good governance through scorecards, service delivery through trainings and grants, regulations through licensing and accreditation, health care financing, networking for placements through retooling, staff development, hiring contractuals, and outsourcing, and ICT through electronic new government accounting system, teleconferencing, and data management to mention a few.

The DoH hospital initiatives include: *Ospital ng Pnoy: Malinis at Mabango*, 100% Smoke-free Facilities, Public Assistance Units, Client Feedback or Satisfaction Surveys, Patient Safety & Continuous Quality Improvement, Fiscal Autonomy & Revenue Generation, and PPPs (public-private partnerships).

With regards to the National Health Insurance Program (NHIP) implementation, several programs are being considered such as new sponsored program (Q1 – 100% subsidy), organize efforts around birth defect registries (BDR), community level membership services, and front load benefit delivery.

Some considerations for the Health Facilities Enhancement Program (HFEP) are the rethinking of priorities for provincial hospital, district hospital, rural health units, and barangay health service, explicitly account for presence of (National Household Targeting System for Poverty Reduction (NHTS-PR) beneficiaries, private sector, retained hospitals, and quality of care, alternative delivery mechanisms (direct transfer vs. performance grants), and public private partnership at the local level to finance high end facilities.

For the community level, considerations are on the need to mobilize community health teams (CHTs) to provide information to families and link families to health care providers, and ensure access to cheaper medicines.

For the health leadership and governance program, there is a need for seminar/workshop that caters to Local Chief Executives, Health Officers & other stakeholders.

Health Indicators for the Province of Rizal

	FBD %	CPR %	MMR	IMR	NMR	ANC %	SBA %	FIC %
ANGONO	88%	24	72 (2)	1.81(5)	2.18 (6)	65%	(945%)	98%
TAYTAY	80%	10.5	0	5(25)	5.71(25)	63%	(91%)	74%
BINANGONAN	61%	34.55	0	7.55(16)	2(5)	51%	(95%)	68%
CAINTA	71%	10.11	0	1.78(6)	0	35%	(91%)	68%
BARAS	20%	46	0	22(11)	8.18(4)	53	21	95
CARDONA	92	50	0	0	1.4(1)	59	8	78
JALAJALA	.47	118	0	4.77(1)	7.16(3)	81	51	116
MORONG	247%	28.77	205 (3)	0	4.1 (6)	88%	1	100
PILILLA	68%	21.66	0	0	14.5(5)	17	89	27
RODRIGUEZ	71%	19.36	55(2)	7.5(27)	7.22(26)	16	37	49
SAN MATEO	92	26.72	110.53(4)	4.42(16)	6.919250	76	93	35
TANAY	69.9	35.36	217(3)	2.9(4)	.73(1)	49	70	90
TERESA	94	43	0	13(14)	3.7(4)	44	95	87

ANTIPOLO	73	86.33	129(9)	21(146)	12.99(90)	21	51	48
RIZAL	84.5	41.23	79.6(26)	8.33(272)	6.15(201)	41	70	64

Legend:

- *facility based deliveries (FBD)*
- *contraceptive prevalence rate (CPR)*
- *maternal mortality ratio (MMR)*
- *infant mortality rate (IMR)*
- *neonatal mortality rate (NMR)*
- *antenatal care (ANC)*
- *skilled birth attendant (SBA)*
- *fully immunized children (FIC)*

Open Forum

A question raised by one of the participant are on the things to do in case a pregnant woman is about to deliver and has natural calamity as a barrier.

To this, the health representative highlighted the need for prenatal care and to enroll in the Philippine Health Insurance System (PhilHealth) for health care coverage.

A representative from Thailand inquired about the Universal Health Care scheme in the Philippines citing that in Thailand there are three schemes - one for civil servant, for employees, and for ordinary people and each receive different packages.

In the Philippines, people are entitled to the same package or coverage. The Philippine health system is different. Health insurance covers employed sector and the sponsored group (indigent). The group that doesn't have coverage includes the informal sectors. The public and private have health insurance coverage but individuals would have to enroll for health insurance if they would like to protect themselves from episodes of illnesses. Individuals have to pay the insurance in full, whereas those employed share payment with the employee.

A representative from India inquired whether the ISO if for private or public sector only. To which the presenter clarified that the ISO is the ISO of the Department of Health. The DoH is trying to improve its services in the office. Licensing determines the quality of the service. Unless a health unit is licensed or certified, they will not be paid by the health insurance. That is the advantage of passing the standard set by the national government.

Another point raised is on the public-private partnership projects in the Philippines and an example cited by the DoH is the National Tuberculosis Program. There is a public-private mix program called TB-DOTS (Directly-Observed Treatment Shortcourse) wherein the government provides laboratory testing and medicines while the private practitioner can help patients access public facility. Tests are availed for free but private practitioner can charge for their fees. In other programs, private laboratories can be in a public hospital and patients will have access to the laboratory for less amount.

A case in question was the relationship of non-government organizations and the local government units to provide health service. The representative from Nepal wanted to know whether such a practice is encouraged in the Philippines saying that in his country, the government doesn't encourage health service provision from NGOs.

A good example presented was on ligation. In the Philippines, this can be provided by an NGO but they should be accredited by the DoH before they can do any procedure. Also, private-public mix is very much encouraged in the Philippines. This comes from the realization that the government cannot provide all the health services to all thus participation by private organization is being encouraged. As a matter of fact, the Workshop is about LGU and NGO partnership. INAM Philippines is providing services in a community. A private-public mix gives better service provision especially to the poor.

In the case of India, NGOs are allowed to spend 10% of the total national budget for health so again public-private partnership is very much welcomed.

A representative from the Health and Development for All Foundation (HADFAFI) Inc. in the Philippines cited that in one their programs, they have an augmentation process. Their organization gets the medicine from the rural health unit (RHU) and they go to upland areas to provide health services using the medicines from the RHU. The DoH added that for vaccines, these are given to the doctors and the doctors provide it to their patients, provided that it is accounted for.

The representative from Japan, wanted to know whether alternative medicine is part or is mainstreamed in terms of public-private partnerships.

INAM Philippines responded saying that health workers are trained in modern medicine and other medicines available in the area. There is a research being conducted on what is the best practice for 10 common conditions in communities. Once the best practice for these 10 common ailments has been established, there is a basis for lobbying and convincing the government that community-based health service are able to give quality service. If this happens, the community based health providers maybe accredited as community based health workers especially in areas where service is not available. This means that they can reimburse from the government.

The Philippine Institute of Traditional and Alternative Health Care (PITAHC) already has a standard for accrediting acupuncture clinics and traditional and alternative clinics based on their criteria. Several acupuncturists trained by INAM Philippines are accredited. The National Health Care Insurance Act of 2013 already includes in their definition of terms the services of alternative and traditional medicine as an accepted health care treatment but there are still no implementing rules and regulations on this. A group such as INAM Philippines, can advocate and collaborate with the Philippine Health Insurance Corporation (PhilHealth) to develop the implementing rules and regulations on traditional and alternative health care.

INAM Presentation

Dr. Jennifer Madamba
Department Head, Advocacy Research Training Department
INAM Philippines

The Integrative Medicine for Health Care Systems (INAM) Philippines, Inc. is a non-stock, non-profit, civil society organization. Its Filipino name, INAM, literally means well-being. Formerly known as Acupuncture Therapeutic and Research Center Inc. (ATRC), the organization was set-up in 1984 as medicines and doctors' services became more expensive. ATRC promoted acupuncture to community based health programs (CBHPs) set-up by NGOs and church programs providing alternative health care service for the poor and vulnerable sectors who had meager resources and no access to quality health care.

The CBHPs were able to establish that health could be in the hands of the people by giving volunteers and through them, community members a better understanding of and enabling them with skills and effective technologies for health care.

The CBHPs also continued to use Philippine traditional and indigenous medicine (herbal, indigenous massage) as these were more available and accessible. Acupuncture needles were expensive. At this point, ATRC saw the need to study the integration of different systems of medicine to arrive at a cost effective

delivery of health services for poor communities and vulnerable sectors.

In October 2001, ATRC changed into INAM Philippines to promote Philippine Integrative Medicine as an evolving awareness or consciousness that views health as a state of total well-being resulting from the interplay of socio-economic, political, ecological, and spiritual aspects of life.

Philippine Integrative Medicine (PIM) adheres to the integration of different systems of medicine based on science and the culture of people that addresses health problems in the community through promotive, preventive, curative, and rehabilitative services.

While government is obliged to provide Q4A health services: Quality/effective, Accessible, Affordable, Available, and Acceptable to the people, basic to PIM as a consciousness is the understanding that health is a fundamental human right.

The current set-up is that public health service provision is done by barangay health service (BHS), and then escalated to the Rural Health Unit (RHU)/City Health Office, then to primary hospitals, to secondary, and to tertiary. Private health services maybe tapped by the government but it must pass government accreditation. PhilHealth, the compulsory health insurance program of government, provides health benefit packages at various levels of health care delivery.

At the municipal or city level, people with disease go to the barangay health workers (BHW) who are extensions of the midwife. BHWs are accountable to the midwife.

In geographically isolated areas, the issue of access to health service is put in question. If there is no access, then how is health care provision possible? If there are problems of access to health service, it will come not as a surprise that there is poor health outcome.

Considering the situation and with the government's limited resources, might it be that something else needs to be done?

Again, basic to PIM is that it is a fundamental human right but is also a responsibility of individual and collectively, of community. The Local Government Code encourages people's organizations to have an active and direct participation in the process of local governance by making them formal members of several local special bodies such as local development councils.

If people are actively participating in local governance, then there is a meeting of minds because people in the community know their situation and they can say what possible solutions might help them given the resources they have.

Philippine Integrative Medicine (PIM) Training

The PIM, as an evolving consciousness, emphasizes the direct, responsible and sustained participation of IPs in the development of their alternative health care systems though an education process that not only verified that people are empowered but also shows the actual processes by which they had taken in their own hands. This education process is what INAM Philippines calls PIM Training.

PIM Level 1 (4 days) on Community Organizing, focuses on the development on a Community Action Plan after identifying three major community problems and their solutions from an analysis of quantitative data from the survey and qualitative data from the health education.

Given the additional knowledge from the training, IPs who initially thought that immunizations bring about fever and disease, no longer run away from the rural health unit staff. They now line up to have their children immunized.

In PIM Level 1 (4 day) Training, the major skills they learn is how to make their own health survey and to conduct health education among families they will survey. Each CHW determines the number of families they will survey. In so doing, the community can become organized. For example, if there are 83 families surveyed by 5 CHWs in one barangay, these families can be organized into five family clusters. If an average family has 5 persons, then a total of 415 individuals are organized under a Community Health Organization (CHO).

In PIM Level 2 (5 day) Training on Community Health Worker Training, the focus is on the development of a Community Health Program with the aim of educating family members and mobilizing the community in addressing their own health and related concerns.

Coming from their experience in PIM Level 1, after analysis of the problem, they define solutions based on available resources in the community, and in the process come-up with related activities for their Community Health Program (CHP). The lack of sufficient income for the daily needs of the families and the lack of adequate health information of parents are two problems that have consistently been identified by poor communities.

For the latter problem, the PIM Level 2 Training provides basic health skills training using different modalities on integrated health care. These include the use of indigenous Filipino herbal medicine, traditional Chinese medicine, tuina massage therapy, anthroposophic medicine compresses, and energy healing (Qi Gong, Tai Chi) for treatment.

Community Health Workers (CHWs) are trained to document their CHP activities through various records done individually by each CHW and collated monthly by the group of CHWs working together in a barangay. These include:

1. Record of Patients Treated, Diseases and Referrals
2. Record of Health Education Conducted
3. Record of Home Visits
4. Record of Herbal and Vegetable Gardening
5. Record of Other Actions (ex. tapping sources of potable water)
6. Monthly Record of CHW Meetings/ Linkages with Partners
7. Monthly Record of CHW Meetings

Thus, in a barangay with a Community Health Organization previously described with five family clusters of 83 families with a CHP, 415 persons have access to daily health care services by CHWs. Health services are based on science (of good quality) and culture (acceptable) using medicinal plants, which are found in their surroundings (accessible) and given by trained community health workers living in the community (available). Cases

beyond their competency are referred to the rural health unit (RHU) and linkages are made between the CHWs and the RHU staff. For other needs (such as environmental sanitation, potable water, transport of), CHWs network with the barangay's local government unit (LGU) and government agencies. Through time, health outcomes can be determined from the CHWs health records.

Components of their alternative health care system gradually emerge. These include:

- programs and services
- referral system
- networking and linkages
- governance (through their Community Health Organization)

Why is it alternative? Because when people understand and move collectively to respond to their situation, their response becomes an alternative to what is existing. Services rendered by CHWs are given directly to the family clusters. Services by the RHU are up to the Barangay Health Station (BHS) level. CHP services thus complement RHU services by enabling health services reach every family, making universal health care possible.

After a year of implementation of their CHP, the CHWs are ready for PIM Level 3 (6 day) Training on Community Health Program (CHP) Management. The focus is on knowledge and skills in planning, implementation, monitoring and evaluation of their CHP as well as knowledge and skills in facilitating a reflection process. The reflection process is a way to allow participants to learn from their experiences, and for them to appreciate and track their own growth as persons.

As the CHWs apply their management skills for their CHP, they are able to enliven their family clusters participation in various CHP activities. Families give feedback regarding programs/services and increasingly have a voice in matters that affect them. Eventually, their CHP turns into a Community Managed Health Program (CMHP) with CHWs becoming not only as CHP managers but also leaders. Some have become representatives of the CHO in the barangay health board and/or barangay development council. An enhanced health care system develops when people are able to participate in policy making.

INAM continues to offer training based on the needs of the CHPs. These PIM enhancement training include training on community health care financing (CHCF) that enables family clusters to pool their resources together for various health-related needs that are not covered by existing LGU or PhilHealth benefit packages. For example, *Saknungan sa Kalusugan,* the CHCF developed by Tanay CHWs include the hospitalization benefit package consisting of transportation and costs of the patient and a companion to the RHU or hospital for patients with urgent care and medicines and laboratory tests that are not available at the RHU or hospital. CHCF completes the various components that make up the community's alternative health care system.

Another PIM enhancement training is the ear acupuncture detox for CHPs that have identified substance abuse (nicotine from cigarettes, alcohol and drugs) as a major problem in the community. Rehabilitative services are thus rendered by these CHPs in addition to

their preventive, promotive and curative health services. In this way, the CHPs/CMHPs of CHOs make them health service providers of their respective communities.

Service provision by Community Based Health Care Organizations (CBHCO), an association of members of the community organized for the purpose of improving the health status of that community through preventive, promotive, and curative health services, are recognized as health service providers by the Philippine National Health Insurance Program (PhilHealth) of the government. Accordingly, the CHPs/CMHPs of CHOs can be qualified as CBHCOs by PhilHealth. However, PhilHealth only accredits health professionals.

As a result, there is a need to do research to show that non-health professionals (such as CHWs) can do preventive, promotive, and curative health services towards PhilHealth accreditation.

Sustainability of the CHPs/CMHPs of CHOs is raised when LGUs recognize their contribution through policy development and budget allocations. Their accreditation by PhilHealth as CBHCOs builds up their sustainability further with their health services being reimbursed by PhilHealth.

INAM Philippines supports the aspirations of the CHOs through training of CHP managers towards expansion of CHP/ CMHP services to more IP families through Training of PIM Facilitators. With the need for greater coordination for CHCF involving families across barangays and the emerging development of engagement with the municipal LGU, a training in organizational management has been identified. These and other possible training can contribute towards the evolution of sustainable health care systems by a Federation of CBHCOs to achieve better health outcomes.

Sustainable development and good governance can thus be achieved with the active and principled participation of government and civil society and business. Principled as the relationship among those who uphold PIM consciousness is characterized by partnership of one among equals and being interdependent and mutually transformative of each other.

Through the years, INAM Philippines's has helped established 45 functioning CHP/CMHPs in 15 municipalities/cities in Luzon, Visayas, and Mindanao, including the National Capital (NCR) serving a total of 3,058 families or 15,290 persons. INAM Philippines has trained CHWs/CHP Managers with capacity to treat 80-90% of common community diseases and refer only 10-20% of those who got sick to health stations/center, and 12 CHP/CMHP with services expanded to include Ear Acupuncture Detoxification for Substance Abuse.

Open Forum

At the end of the presentation, participants were keen to know about INAM Philippines and its local government partnership. A point in question is if INAM Philippines is doing more training in the future, the municipal health office can possibly do these trainings or invite INAM Philippines.

What is missing is the aspect of the participation of the community wherein the community itself manages their own health care. INAM Philippines is now being invited by LGUs to do the trainings and that initiative is coming from them.

Another point raised by India delegation is on livelihood saying that livelihood is necessary when working with indigenous communities and how is INAM Philippines able to meet that.

The solution to the problem is within the resources that a community has. However, currently INAM Philippines would like to focus more on the health aspects and can possibly coordinate with other NGOs for these other needs.

The participants also wanted to know whether the CHWs are volunteers, if this is limited to women, the types of health workers, and how sustainable is the practice.

The CHWs are all volunteers. There are BHWs and CHWs. INAM Philippines realized that as volunteers some will soon leave and this is the rationale for the training of facilitators. It is seen as a solution to increase the number of health workers. There are also men volunteers.

Participants also wanted to know about the insurance system and how it works.

Currently, there is an LGU-sponsored program. The national office is sponsoring people from the marginalized group. The local government of Tanay is doing their best to have their facilities accredited by PhilHealth for some services: primary health care service, maternal care package, TB program where they enroll patients with TB and they get all medicines and check-up service for free, and for animal bite centre. All these services are accredited. If they have patients with PhilHealth, they do not spend anything. The local government is also doing their best to improve the health facility. The laboratory services (level 2) and X-ray (level 1) are also accredited by DoH. Tanay has another RHU and they are trying to duplicate what they are doing in the main RHU to be accredited by Philhealth. The advocacy of the LGU is to enroll more in the Philhealth and to give priority to women in the reproductive age so that all these women could deliver in health facilities and have safe delivery.

With this, INAM Philippines added that part of the effort of government to reach as many families as possible is to put up a sponsored program which addresses the need of the very poor. The sponsored program depends on the level of municipality. For the very poor, 90% is shouldered by the national government and 10% by the local government so that more and more people will be able to avail of health services.

At this point, the one organization from Tarlac has invited INAM Philippines to be their resource speaker to train their IP health volunteers with regards to alternative medicine.

INAM gladly accepted the invitation and said that the conduct of the orientation on PIM will determine what they will expect from each other. They also clarified that INAM Philippines doesn't empower but only assists in helping the community reclaim their power.

Another question raised is whether the government accepts the trainings provided for by INAM Philippines and whether promotion of alternative medicine is in the national policy.

INAM Philippines said that when they do a survey in a community, they coordinate with the government so linkage is formed at the very beginning. Alternative medicine is in the national policy but it is not mainstreamed yet. There is a need to link with the academe as well to strengthen or show proof that non-health professionals can provide health services.

COUNTRY PRESENTATIONS: INDIA

Indian Health System

Dr. Raja Dodum, MBBS, MPH
State Nodal Officer (National Urban Health Mission), Gov't of Arunachal Pradesh, India

India has a parliamentary system of governance. Its total population is 1.27 billion, 66.84% of which are in the rural areas and 31.16% in the urban areas. The GDP growth rate is 8.1%. It has a total of 30 states and 7 union territories, 643 districts, 6,345 blocks, and 638,588 villages.

India got their independence from British colonial rule on August 15, 1947. Their constitution came into place on January 26, 1950, which established the President as the head of the country, and the Prime Minister, who runs office with the support of the council ministers, as the head of the government. The Supreme Court is the apex body of the Indian legal system and the Indian legislature comprises of the lok sabha (house of the people) and the Rajya Sabha (council of states) forming both the houses of the parliament. Lok Sabha has 45 members and the Rajya Sabha has 250 members.

The country is led by the Prime Minister and under him are the members of the Parliaments while each State is led by the Chief Minister and under him are the Members of the Legislative Assemblies. Districts are led by Zilla Parishad Chairmans, Blocks by Block Chairman, Panchayat by Gram Pranchayats, and Village wise by Ward member.

India has over a billion people in over a million places and there is persistence of poverty and under nutrition. There is low public expenditure and high out of pocket on health. There is a large regional disparities and large unregulated private sector. The issue on medicine versus health (water, sanitation) is very much present and there is paramedical divide. There are also challenges on human resources.

Having said this, India's health system is indeed a mixed situation with extremes at both ends of the spectrum. Some of the health issues are limited access to health services in rural areas, communicable diseases like TB,

malaria, and AIDS, malnutrition and anemia. The infant mortality rate is at 40 per 1,000 live birth.

Currently, the government of India has three departments under the Ministry of Health and Family Welfare who are looking after the health system. These are:

Department of Health
The Department of Health deals with health care including awareness campaigns, immunization campaigns, preventive medicine and public health. Bodies under the administrative control of this department are:

- 13 National Health Programs like NVBDCP, AIDS, CANCER, Filaria, Iodine Deficiency, Leprosy, Mental Health, Blindness, Tobacco, Diabetes, TB control, Immunization, Deafness Control Programme
- Medical Council of India
- Dental Council of India
- All India Institute of Speech and Hearing (AIISH), Mysore
- All India Institute of Physical Medicine and Rehabilitation (AIIPMR), Mumbai

Department of Family Welfare
The Department of Family Welfare (FW) is responsible for aspects relating to family welfare, especially in reproductive health, maternal health, pediatrics, information, education and communications; cooperation with NGOs and international aid groups; and rural health services.

The Department of Family Welfare is responsible for:

- 18 Population Research Centres (PRCs) at six universities and six other institutions across 17 states
- National Institute of Health and Family Welfare (NIHFW), South Delhi
- International Institute for Population Sciences (IIPS), Mumbai
- Central Drug Research Institute (CDRI), Lucknow
- Indian Council of Medical Research (ICMR), New Delhi

Department of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy)
The Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) deals with ayurveda (Indian traditional medicine), and other yoga, unani, siddha, and homoeopathy, and other alternative medicine systems.

The National Policy on AYUSH in 2002 envisages overall development, quality control and standardization, and mainstreaming of AYUSH. It sets the validation and evidence base of safety, acceptability, efficacy, and standardization of technologies in Traditional Medicine.

Under this are the:

- Central Council for Research in Ayurveda and Siddha (CCRAS)
- Central Council for Research in Unani Medicine (CCRUM)
- Central Council for Research in Homoeopathy (CCRH)

- Central Council for Research in Yoga and Naturopathy (CCRYN)
- Separate AYUSH Ministry launched recently by Government of India

The government has a lot of national programs on health such as:

- National Rural Health Mission (2005)
- National Urban Health Mission (2013)
- Indian Public Health Standard Guidelines (IPHS)
- Active community Participation- community process
- Public Private Partnership
- National Quality Assurance Program

In the rural area, the Sub Centre provides for health care. This is the most peripheral contact point. Next is the Primary Health Centre (PHC) who is the referral unit for six sub centres. The centres include 4 to 6 beds, 2 medical officers, and 14 subordinate paramedical staff. From the PHC comes the Community Health Centre (CHC) who is the referral unit and has 30 beds. The CHC handles the 4 PHCs with specialized services.

In the urban areas, health care delivery starts at the community level through community outreach services, and then goes up to the Urban Primary Health Care Centre (UPHC) that serves as the primary level health care. From the UPHC, enters the Secondary and Tertiary private providers that serve as the referral unit.

Health programs come from the National Health Mission and brought down to the State Health Mission and passed on to the Mission Director of the National Rural Health Mission and the National Urban Health Mission. From the rural and urban health missions, it is sent to the State Nodal Officer.

The responsibilities of the State Nodal Officer/the presenter include:

- State level Program Officer for PPP project: NGOs coordinator for 10 NGOs, Nodal Officer National Urban Health Mission and Infrastructure of both urban and rural health missions.
- Promoting innovations adopted by Karuna Trust in the state government health centres.

Since the State Nodal Officer has partnered with Karuna Trust, they have handed over 11 rural health centres to Karuna Trust and monitored their progress and performance. They also provide logistic support through National Health Programs, immunization, vaccine supply, and fund sanction and financial support for the project on

traditional medicine work undertaken by the trust on identification of traditional practitioners, and identification and documentation of traditional herbal plants. The presenter also provides inputs to Karuna Trust on the implementation of traditional health care system through AYUSH department.

Having partnered with some NGOs, some of their experiences with the work are:

- Effective implementation of government health programs - synergy from both NGO-Government-community
- Flexibility within their system - not rigid like government
- Dedication/motivation of the staff
- Innovative approach and new innovation on health promotion
- Transparency
- Huge staff attrition rate - irregularities in report submission
- Independence from the district/state health authority
- False report on progress to show their performance
- Termination of non-performing NGOs

Open Forum

At the end of the presentation, participants were very interested in the Department of AYUSH and wanted to know why it is getting more attention and becoming one independent ministry and how the doctors reacted when the department was set-up. To which the presenter responded that even the United Nations is going to observe a yoga day and that India is giving emphasis on traditional medicine. He added that AYUSH doctors can be in charge of primary health centre. With regards to the reaction of doctors, there always have been problems between the two groups. However, since the government has set-up the department, then nobody has an alternative but to follow the system.

Participants also wanted to know what health processes and trainings are provided for to the IPs.

In India, they have community health workers and if they bring in patients, everything will be covered. However, the training on alternative medicine has not been mainstreamed.

Promoting Traditional Health Care in the Public Health Care System: An Innovative Model of Karuna Trust under Public Private Partnership Program

Mr. Anup Kumar Sarmah
Coordinator, North East India, Karuna Trust

Karuna Trust was founded in 1986 in Karnataka state in Southern India. They work in 12 states out of the 29 states in India. They manage 100 government health centres (PHCs) making them models for the state.

Karuna Trust directly provides health services to 1.3 million rural populations with more than 1,600 medical and paramedical staff. Some of the organization's innovations include essential supply chain management, mainstreaming of traditional medicines in government health centres, student health volunteers, community monitoring, community health insurance, mobile medical and dental units, mental health care centre, and a nursing college, among others. They have more than 500 rural health developments activities that include self help groups. They also have an herbal medicine processing industry, central food processing units, and two vocational training centres focusing on 15 trades.

In the North East of India, Karuna Trust works mostly for the indigenous communities in 4 states. The government finds it difficult to provide basic health services in the area due to hilly, difficult, interior, remote, and inaccessible terrains. In this area, where there is no or little road infrastructure, there also is no electricity and no telephones. In the North East, Karuna runs 25 Primary Health Centres covering comprehensive health services to 300,000 tribal communities with 600 health care professional staff and 450 health volunteers.

Among the challenges faced in working in the area are:

- Traditional beliefs are deeply rooted among the tribal people that even educated people expressed their inability to take a rational stand on many occasions against the will and sentiment of the elderly people.
- For any ailment, they first go for spiritual treatment followed by rituals/chanting resulting to further damage or death.
- They have a rich knowledge on traditional medicine.
- Illiteracy and lack of education.
- Excessive opium consumption.
- Early marriage, polygamy, and high fertility rate.

The diseases they have to deal with in the area includes vector borne diseases such as malaria, Japanese encephalitis, dengue, chikungunya, West Nile, and scrub typhus, and non communicable diseases such as cancer and hypertension.

Challenges to access health care include lack of health care consumables, inadequate essential medicines, dirty and unmaintained health facilities, less or inadequate infrastructure, and inaccessible road and connectivity that even government officer cannot go for inspections. Some areas have snows which makes it inaccessible and other areas rain for six months in a year.

When Karuna Trust took over the hospitals from the government, there was a huge difference.

Ayurveda has been practiced in India from 2500 B.C. They have 45,000 plant species and

about 17,500 have medicinal value. The Indian herbal market is US$2.1 billion and India exports herbal raw materials and medicines worth over US$902 million. Out of 700 plant species commonly used in India, only 20% are cultivated on commercial scale and 80% of medicinal plants used by the industries are collected from the wild. Over 70% of the plant collections involve destructive practices which poses a definite threat to the genetic stocks and to the diversity of medicinal plants.

Karuna Trust changed health service delivery by focusing on herbal and traditional medicine. In their model, they identify the herbal plants used by the particular indigenous community, identify the traditional healer (TH), validate information with existing data by PHC MO, and planted herbal plants within hospital campuses to be taken cared of by the doctor and the traditional healer. When a patient is admitted in the health centre, the doctor or traditional healer will gather leaves from the garden and prepare the medication for the patient while also teaching the patient how to do it.

The objectives of the program are:

- Awareness about traditional medicinal plants among all the people of the particular tribe.
- Make demo garden in the health centre where the doctor of the health centre can use the fresh plants for the admitted patient.
- If people know about the use of a particular herbal plant, they will try to save the plant from its extinction/overexploitation.
- Multiplication of these herbal plants for free distribution.
- Publication of small booklets so that new generation will come to know the plant, its usages, and methods of preparation.
- Recognition to the herbal healers in the area.
- TH is encouraged to continue his system of medicine preparation and in some cases Karuna Trust gives him additional inputs.
- TH trains the local people who are interested to learn.
- TH trains health volunteers of Karuna Trust.
- TH makes some products from the garden - dried leaves, powder which he sells locally.
- Make manuals/booklets on the doses of different herbal formulations for free distribution after the training.
- Documentation of entire herbal plants formulations used by a particular tribe.
- Publication of such document through journals for different communities.
- Organizing specific programs for all herbal practitioners by Karuna Trust in collaboration with government.

The government has been very supportive of the projects of Karuna Trust. Support mainly comes from the Department of Health for traditional health care system- Indian System of Medicine (ISM)-Ayurveda and the National Board on Medicinal Plants, which is active in all states.

The government has also offered different schemes for NGOs such as awareness generation, conducting workshop, symposium on herbal plants, identification of TH and their inclusion in health care system, providing equipment to THs, and financial

loan/support to THs to encourage their work. The THs are also registered in the health department and the government has appointed more than 700 health volunteers (ASHA) in the project areas.

There are two types of health volunteers. One is recruited by Karuna Trust and the other by the government. There are now 450 volunteers aged 12 to 18 who are taught about herbal plants available in their surrounding area and are being used by their TH. These volunteers are trained on herbal formulations of locally available plants, which they first teach in their home and then in every village. They are also encouraged to make herbal gardens.

Through the years, Karuna Trust has trained more than 2,000 people and more than 700 student health volunteers, they have 450 student health volunteers (SHV) in Karuna Trust PHCs, demo gardens in 22 health centres, and 29 registered THs. They have also done documentation on 4 tribes and have set-up 240 herbal kitchen gardens, ten community herbal nursery, and a large scale cultivation for commercial purpose which was started by the villagers.

The Karuna Trust model is sustainable, as more people/patient will now come to the TH. Modern medicine is very costly while TH charges nominal fee. The TH can make herbal formulation, which he can sell in the local market and also train almost all village level volunteers who in turn can teach other village people. Women community is encouraged to start herbal garden in their own houses along with vegetables. Dried products are then sold in the market. This way they get some amount while tending plants, which maybe used for home remedies. Economically important medicinal plants are also encouraged for commercial cultivation. Karuna Trust provides technical knowhow to the farmers who undergo commercial cultivation of these plants.

Recently, the Student Health Volunteer Program Trust was cited in the National Summit of Health in India.

Open Forum

The participants were all praises for the works of Karuna Trust. Among the concern raised are the side effects of the herbal medicines being used to which the presenter said that there are herbal medicines that have contra indications but in general, it has less side effects but it must be taken in right dosages.

Another concern is that while hospitals under the organization's management has improved a lot, what are the measures to ensure that this will continue.

The presenter said that the program has empowered the local communities. Now they know what service should be in the PHC. There is now awareness among the people and they can claim it. They are educated enough so even if Karuna Trust is not there, they can claim for these health services and having experienced these services, they can infringe local leaders to retain Karuna Trust so all these things will still be in place. Community participation is a must.

The representative from Bangladesh wanted to know about the funding source for the wonderful works of the organization.

Karuna Trust has convinced the government to give them the budget to manage health centres that are far away and neglected.

Nepal representative wanted to know why the organization appoints health volunteers instead of just training the existing government volunteers and whether the volunteers are being paid.

They have volunteers called ASHA for government health centers for every villages. As in most cases, the volunteers from the government do not work at all. Since government recruits them, it is hard for Karuna Trust to manage them.

Student volunteers are not paid. Those appointed by the government are given incentives. If a volunteer brings someone in the hospital, they get incentives. If volunteers collect blood sample from patient, they also get incentives.

The presenter cited a good example of getting volunteers when the government instructed them to open an adolescent clinic. Normally, an adolescent will not go to a hospital, so they invited them to their program so now they have become volunteers and at the same time they are being taught about adolescent concerns and sex education.

One IP from the Philippines wanted to know how many volunteers were from tribes and how many are involved in herbal medicine preparation and if they have existing medicine for stomach pain.

All are tribe health volunteers and all are involved in herbal medicine preparation. There are medicines for stomach pain in the form of syrup but since this cannot be stored for long, they dry the leaves and often use that instead.

The Workshop – Day 2

The day was started with a prayer led by CHW Christine Mitra of Tanay and an energizer from the Thailand group. Dr. Raja Dodum, State Nodal Officer (National Urban Health Mission), Government of Arunachal Pradesh, India, provided a recap of the previous day's activities.

Recap

Dr. Raja Dodum, MBBS, MPH
State Nodal Officer (National Urban Health Mission), Govt of Arunachal Pradesh, India

The Workshop was opened with the Philippine national anthem, a prayer by Gilda Paterno of Tanay, and a colorful dance presentation by the IPs of Tanay. Mayor Rafael Tanjuatco of Tanay delivered a welcome speech followed by self-introduction of the participants. Rizal Governor Rebecca "Nini" Ynares delivered an inspiration speech and Dr. Isidro Sia of the Philippine Institute of Traditional and Alternative Health Care gave his keynote speech.

Panasonic lanterns were then distributed to nine barangay of Tanay and INAM Philippines, AHI, and the Municipality of Tanay presented the certificate of appreciation to the speakers.

Dr. Gerry Mejorada of the Philippine Department of Health Region 4A presented the Philippine national health situation and then it was followed by an open forum. Dr. Jenny Madamba of INAM Philippines introduced INAM Philippines from ATRC and then how it evolved to what it is now, the programs of INAM Philippines, and why it has evolved. Clarifications were presented for more learning and participants were asked to write down key learning points.

Dr. Raja Dodum presented the India system followed by Anup Sarmah on promoting traditional health care in the public health care system and public-private partnership program.

The day ended with a welcome dinner.

Key Learning Points

Each participant was asked for the key learning points from the previous day's presentation. To sum up,

Thailand

- INAM Philippines's training program to empower people by knowledge management of integrative medicine to improve health service in community and family.

- Purpose of Q4A: accessibility, affordability, acceptability, and availability in health service delivery.
- Systematic capacity building of health workers and IPs by INAM Philippines.
- If IPs know and are aware of their rights, they will reflect their health needs. It is important to open opportunity for them to know their rights and involve them in health programs.

Nepal

- Local government is promoting and supporting NGOs (INAM Philippines) to provide alternative health service.
- In Nepal, people don't usually believe in alternative medicine. The government has established a department on herbal medicine but nobody goes there. No patient ever visits. It is very difficult for Nepal to promote alternative medicine. In the Philippines, however, many people believe in alternative medicine and the participant would further like to learn how this is possible and to further improve the service of alternative medicine so more people will embrace it.

Bangladesh

- The way the local government is involved in alternative health center is excellent.
- Community health workers are contributing to the health of the people.
- Recognition of traditional herbal healers encourages promotion of alternative health care system.
- State government handed over responsibilities of government health center to NGOs for implementing government mandate.
- Performance-based remuneration encouraged volunteers to work hard.
- Herbal gardens within the hospital campus demonstrate and maintain traditional healers.

Tarlac, Philippines

- The increase in awareness of health with the local government as the duty bearers and CBHCOs as claim holders.
- The attendees have a common vision, which is becoming bridging leaders towards filling the gap, filling what is lacking in the community, which is geared towards local governance.
- Active involvement and participation of the community people in the success of a project is very important.
- Rewards method is an effective way for the community to get involved.

Davao, Philippines

- Importance of increasing the consciousness of IPs on their right.
- Q4A struck their attention and they would like to share it in Davao.
- Appreciation of the presence of CHWs. Volunteerism is commendable.
- Use of herbal medicine, which is less expensive.

- Practice of traditional medicine in community and requiring all households to plant herbal medicine and having supporting documents. The tribe has knowledge on how to use herbal medicine for different illnesses in different communities.
- How nurses and other CHWs perform their task, which involves more than health care service delivery.
- Traditional medicine helps Davao and the health workers offer voluntary services, which helps the community. If INAM Philippines did not reach out to Davao, they will not learn about traditional medicine.

Tanay, Philippines

- It's not just IPs in the Philippines who implement herbal medicine. It also happens in other countries.
- CHW experience in the Philippines and other countries, are all the same. In PIM level 1, they identified ten common diseases that are affecting the community, based on this they found the herbal medicines that will be effective for these diseases. These medicines should be of quality, effective, acceptable, easily available, and within the reach of the community. Another significant learning is the importance of proper documentation of experiences. The participant is grateful to know that in India, some of the volunteers are also IPs.

Gen. Nakar, Quezon, Philippines

- CHWs in Tanay are volunteers. Unlike in India, where they get incentive or remuneration for referring patient or for a particular service they are doing for the government. In Tanay, they are not only volunteering services but there are instances when they have to give certain amount of money from their own pocket if need be. It's not only volunteering but giving a part of what they have.

India

- CHWs are really needed in areas where there is less or none at all public health services or facilities.
- If the local health system is cost effective and safe, then the community accepts it.
- Modern allopathic medicine is costly so it is better to go for cost-efficient alternative mode of health care.
- Countries can learn from one another.
- Replicating best practices is possible.
- Convergence with government, community, and NGO shall lead to sustained integrative health care. Working with the government in community health. Working with other NGOs. Key stakeholders working together leads to sustained work.
- Integrating with private hospital (example: laboratories). Public-private partnership can also be mobilized.
- Health insurance or sponsoring.
- Community acceptance of a health care service is prioritized.
- Once CHWs have been trained, they are able to train others.
- Promoting herbal medicine focusing on ten common diseases.

- Using herbs for commercial purposes as income generating projects.
- Monitoring will always help for improvement.
- The indigenous system of medicine is a good option for providing health service for inaccessible areas.
- Allopathic medicine has very high cost. There is a need to come up with system to revive medicine that our forefathers have been using.

Japan

- Role of health volunteer is not just health care promotion but also building sustainability strategies so there are lots of opportunities.
- Knowledge development and participation in decision-making has to go parallel for sustainability of the program.
- Need to maximize new systems and opportunities.
- Karuna Trust's use of young people trained by traditional healers is very unique.
- Responsibility for health. In Japan, health is provided by government and there is little recognition of health responsibility.
- There are herbal medicines to be learned based on INAM Philippines and Karuna Trust's projects.
- Integration of community level efforts such as community health program managed by community people and health services managed by the government.
- There are different possibilities in PPP based on the different situations of the different countries.

Bangladesh to India

- Herbal garden in hospital campus.
- Recognition of traditional healers encourages promotion of traditional medicine especially in remote areas where hospitals are unable to maintain their services.
- Health services are closer to people which increases access of the people.
- Local governments are fully involved in health service delivery.
- Community health workers are working as volunteers and contributing to change the status of the people.

INAM Philippines to India

- The different means of transportation that the health workers have to go through to deliver services.
- Training of youth by traditional healers is good for molding the future generation so that there is a second line of healers.

COUNTRY PRESENTATIONS: INDIA (cont.)

Centre for Community Development (CCD) India

Mr. Addala Jagannadha Raju
Secretary cum Chief Executive, Centre for Community Development

The presentation started with a video on traditional food fair, which aims to promote nutrition, revive traditional crops that have been lost through the years, and mold doctors and the community where CCD is working in.

The objectives of the fair are:

1. To fight against malnutrition at community level.
2. To educate the tribal community of the nutritious values of traditional food items.
3. To promote cultivation and consumption of pulses, green leafy, millets, tuber crops, and other food items.
4. To educate them on the best cooking practices.

During the fair, 160 villages come together showcasing different food, which uses different ingredients available in their locality. There are lots of dancing and sharing of food.

In India, it is a traditional habit that when a woman gets pregnant, the community brings her nutritious food. While CCD promotes this, they also encourage savings for the family of pregnant women by setting aside 3 rupees a day for ten months. This practice helps during delivery time. They also loan three goats to the family of the woman so by the 10th month, the goat are ready to be sold.

The main priority of CCD is livelihood saying that unless livelihood is ensured, they cannot talk about health. They first ensure livelihood before talking about health.

India is the 2nd largest populated country in world with a population of about 1.27 billion - 17% of the world population. There are many castes and many religions.

The country has very high child mortality rate (1.4 million die before reaching the age of 5). There are 940 females per 1,000 males (2011 Census) and there is low literacy rate especially among the women. Sixty percent of the people practices open deficacy. Crude birth rate was 18.3 in 2009 and crude death rate was 7.3. Those living below poverty line make up 21.9% of the population (2011-2012 data). Male domination still exists in most areas. Migration is a threat in rural areas and access to health care is very poor in tribal area.

The major issues affecting health and life of the people are:

1. Poverty
2. Illiteracy
3. Lack of awareness
4. Gender discrimination
5. Blind belief
6. Poor sanitation

7. Lack of responsiveness among health service providers
8. Lack of accessibility and infrastructure
9. People's attitude vs. private hospitals

The major health issues affecting India are limited access to health services in the rural areas, communicable disease like TB, malaria, aids, malnutrition, anemia, infant mortality, under 5 mortality, and maternal mortality.

A major focus of CCD is capacity building for women and persons with disability. Women and children are the worst sufferers and victims in all the major health issues in India. To empower the community, CCD focuses on:

- Capacity building to in-laws, mothers for health and hygiene (water and sanitation)
- Empowering women and PWDs
- Promotion of DPO (SAMARTH), women cooperative and women federations
- Access and control over the resources through institution building
- Enhancement of income sources, skills and entrepreneurship promotion, producers groups, and cooperatives
- Gender equality
- Children and mother care especially on malaria prevention and control
- Good governance
- Good rapport with line departments to mobilize health support services, inclusive education, vocational trainings, and income generation activities

Among the activities are:

1. Capacity building of the community especially focusing on women and PWDs on mainstreaming gender equality, women leadership, and entrepreneurship.
2. Focusing on community health especially women and children to access the health service mechanism.
3. Promotion of village health volunteers and emphasizing herbal healing practices.
4. Promoting women self-help groups who are acting as the change agents for health.
5. Orientation to elected Panchayat representatives who are acting to bring the gap between the community and health support services.
6. Lobby and advocacy coordination. Woman participation in local self-governance, health committee, vec and even forest protection committee.

One area handled by CCD is the Gajapati district, which consists of seven blocks, five of which are completely situated on a hilly terrain. The total area of the district is 385,000 sq. km. The total population is 577,817 with 282,882 (48.96%) male and 294,935 (51.04%) female. Of the total population, 54% are Soura tribal. Lanjia soura is one of the particularly vulnerable target groups living in the district. Religious group includes Hindu, Christian, Muslims, and Buddhist.

Health and other issues of the community are:

1. Poverty - many people migrate to other places
2. Malaria and TB - each is suffering with malaria
3. Malnutrition - half or more of the tribal children are malnourished

4. Infant Mortality Rate: 61
5. Under five mortality: 82
6. Maternal Mortality: 297
7. Non communicable diseases are increasing
8. Water and Sanitation
9. Indebtness and migration
10. Lack of infrastructure/Access to resources
11. Women drudgery and pressure of works

Women in the community had to get water from the stream but now they are using gravitational force. People had to walk 17km (4 hours) to reach the primary health centre and some people die on the way to the hospital.

There is indeed a need for traditional healers when hospitals cannot go to the people. Corruption is also prevalent. If a person pays, then they can get good medicine.

Wanting to respond to the needs of the community, CCD started work in Soura Hill Tribes through identification of the vulnerable community and their health issues, promotion of health volunteers (CCD provides income generation), promotion of community health, formation and strengthening of self help groups of women, PWDs and village development committees, and coordination and collaboration with health and other line departments.

To strengthen the organization, they needed to conduct a needs assessment through family contact, participatory rural appraisal, SWOT analysis, micro planning and resource mobilization, promotion of community based organization and establishing linkages with resource agencies, capacity building and institution building and other sustainable initiatives for strengthening, promotion of best health practices, strengthening of health committees, and promotion of indigenous health and herbal medicinal practices.

For the community-based organizations where collective marketing is possible, they are linked to the market so income will increase and they will take care of health and education.

Contents of the training provided for to the community include:

- Community health
- Mother and child care

- Nutrition
- Health and hygiene/sanitation
- Malaria prevention and control
- Herbal medicine practices

The strategies are

- Promotion of health volunteers
- Convergence with grassroots level health functionaries
- Strengthening of village level health institution
- Malaria-Malnutrition camps: malaria and malnutrition cycle
- Traditional Food Fair - raw and cooked food for nutrition exhibition
- Involvement of PRI members (local self-governance)
- Community monitoring
- Reviving the traditional health practices
- Behavioral changes

To empower the community on health actions, there are

- Capacity building of concerned stakeholders
- Monthly meeting of health volunteers and committees
- Strengthening of Gaon Kalyan Samtie and Village Health and Nutrition Day (ICDS)
- Activating health mechanism
- Convergence with Pri and Health department
- Promoting sustainable livelihood: goats, sheeps, cows, buffalo, non-timber forest produce
- Promoting people's participation
- Regularization of Palli Sabha (village meeting) and Gram Sabha (panchayat level) (Local Self-Governance)

As part of the work of the CCD, health volunteers are given the responsibility of:

- Home visits and identification of health issues - at least half an hour, identify malnutrition, malaria, and other cases
- Health awareness, screening and treatment - training camps
- Close coordination with grassroots level health functionaries and mobilization of medicine - AHSA has medicines provided by the government
- Link between community, traditional practitioners, and health department (ASHA)
- Strengthening of health committees
- Promotion of traditional health best practices - possible income generation

For sustainable health mechanism, the CCD ensures the presence of health services from local health institutions, capacitates frontline health workers, ensures herbal medicine practices and promotion of herbal medicine garden, training of local herbal practitioners, motivating the community as well as frontline health workers to ensure health and hygiene, and ensure regular monitoring mechanism to streamline the AYUSH at PHC level for providing 24x7 health services.

Through their years of work, CCD now has health volunteers in every village, are now working in close coordination with line departments, has reduced malaria prevalence due to active treatment (in 300 villages, malaria prevalence has come down to 60-70%), promoted best health practices, established people participation and village health monitoring, has established PWD organizations and are now working with 3,000 PWDs, established women cooperatives and served as market linkages for a producer's group.

There were and there still are several difficulties along the way such as people access to health services in hilly regions, inaccessible pockets and unreached areas for immediate health services, blind belief and superstitions, home delivery is still continuing which cause IMR and MMR (there are still cases when women go to forest for work and end up giving birth there away from any health support), challenge in providing health service to PWDs, pregnant women and severe health hazard, health personnel leaving the hills and remote areas, regular reporting on health finding is not sustained, and lack of access to infrastructure.

Other challenges encountered through its years of service are convergence of health support services, sustainable livelihood, migration of men and its impact on women, some officials reluctance to accept actual health findings, working in close collaboration with ICDS, health department, and block administration, and providing effective health services to the tribals as there are cases of corruptions and false reporting.

The lessons learned in all these are:

1. Promoting institution building of community
2. Coordination with the health department and Panchayat local self-governance. Unless all stakeholders work together then there will be no results.
3. Participation in decision-making bodies in Palli Sabha and Gram Sabha. You can tell the needs of your area or village but unless you participate, there is no development.
4. Gaon Kalyan Samties are actively monitoring on health and hygiene
5. Regular rapport with line department, village health institutions, and CBOs is resulting to better health system delivery.
6. MIS is helping on effective monitoring and in improving the health care.
7. Convergence. Initiatives with health and livelihood results to better health and hygiene with sustainable income sources.

Other unique and relevant sharing from the CCD:

- Sharing of monthly MIS statistics at village level, which is alarming the community on best health practices and increasing their participation on health, hygiene, and sanitation practices. This helps villages identify the problems and take responsibility of that village.
- Sharing of findings and experiences at district levels contributes to effective health services in unreached areas and also improves the coordination in working together.
- Focusing on women and adolescent improves their health practices and promotes sustainable institutions.

- Strategies and modules adopted are shared and have the opportunity for replication by health policy makers at the state level. Example is malaria control and how to bring behavioral changes.
- Working with vulnerable community is strengthening their institutions.
- Children taking responsibility to be ambassadors in their home

Open Forum
At the open forum, participants wanted to know about the strategies in convergence and what CCD is doing to have good coordination with government offices.

Every health village has an ASHA (government volunteer) who receives incentives. The government provides free medicine to the ASHA and CCD volunteers coordinate with the ASHA, and inform them of health conditions in each household. The health volunteer reports to the ASHA and they also have a referral system wherein if it comes from the health volunteer, then the ASHA accepts it.

The government trains the volunteers and every month they have convergence with the government. Health volunteers also help in vaccination by gathering people.

A Thailand representative was interested in the health committees - membership and whether there are bigger committees that oversee these committees and about the strategies adopted that will be adopted by the state.

To this, the presenter said that the members of the health committee are health functionaries, ASHA, health department, self-help group, women leaders, local self-governance member, local NGO or youth club. Members are given incentives and lots of discussion takes place. The problem happens in some villages where there is no active participation and it is just a pen and paper meeting. Every village has a village committee. Everybody will be there and planning is done in the primary health centre.

Among the strategies adopted by the state are for malaria control and behavioral practices such as use of mosquito net, application of neem oil, and MIS system.

Another question raised is on the type of treatment being supported by the volunteers, the basic qualifications of the volunteers, and who trains the volunteers.

There is a training program for the volunteers to do blood testing to know whether the patient is malaria positive. The training lasts for 15 days and is done in malaria monitoring camp. CCD trains the volunteers but this not accepted/accredited by the government so they also have to undergo training with the government.

The representative from Bangladesh wanted to know about the initiatives for PWDs and if these are income generating.

The district has 14,000 PWDs but to date, CCD can only reach 3,000. These include the vision and hearing impaired PWDs. The income generation helps the parents for their rehabilitation. They are also provided for with bus and train passes and capacity building

through vocational trainings. There is also a pension from the government if a person is more than 60% disabled. There is also a differential rate of interest from bankers and PWDs are provided with 10,000 to 15,000 rupees as loan support to start a small business. They are also given mobility training to be able to go to places on their own.

COUNTRY PRESENTATIONS: BANGLADESH

Development Association for Self-Reliance, Communication and Health (DASCOH)

Mr. Md. Akramul Haque, Chief Executive Officer, Development Association for Self-Reliance, Communication and Health (DASCOH)
Mr. Md. Romzan Ali, Community Group Facilitator/ Community Volunteer, Community Group of Kodom Shohor Community Clinic
Mr. Shiree Laxmiram Uraw, Chairman of Community Group, Community Group of Gopalpur Community Clinic

The Development Association for Self-Reliance, Communication and Health (DASCOH) was founded on June 15, 1994 as a voluntary association in accordance with the Swiss Civil Code in Berne, Switzerland. In Bangladesh, DASCOH was registered with NGO Affairs Bureau on May 17, 1995 as an international NGO. In November 14, 2013, DASCOH Foundation was registered as a national NGO under Societies Registration Act 1860 with the register of the joint Stock Company and Firms. DASCOH Swiss Board handed over the responsibility to the Governing Board of DASCOH Foundation on June 24, 2014. Since inception, DASCOH is complementing and supplementing Bangladesh's national programs as a key non-state development partner in the country.

DASCOH Bangladesh envisions creating and sustaining enabling environment for ensuring equitable access to state and non-state resources in order to alleviate the sufferings of the poor people.

It is committed to empowering the poor and marginalized communities by complementing and supplementing national goals; by facilitating the local government institutions to develop transparent, responsive, and sustainable service delivery systems and processes; and through continued innovation and strengthened partnerships with international, national, and community based organisations.

Its core strategy is working with the government and the core strategic objectives are:

1. To help improve transparency, accountability, and responsiveness of the local governments to deliver services within the framework of the national plans and policies.

2. To strengthen the management capacity of public health care institutions at community, UPs, and Upazila level in order to enable them to render universal and quality health services as per national health standards.
3. To improve access to and utilisation of safe water and promote environmental sanitation and personal hygiene
4. To promote the livelihood of poor and marginalised people.

Among its projects are:

- SDC funded Sustainable Solutions for the Delivery of Safe Drinking Water (SDSD) project which is a water supply sanitation for hard to reach areas.
- SDC funded IWRM project with SRC - for drought areas
- SRC funded Water, Sanitation and Hygiene (WASH) project
- SRC funded Public Health Improvement Initiative in Rajshahi (PHIIR) Project, which is a public health initiative improvement project.
- Support Organization (SO) and Training Organization (TO) of HYSAWA
- Horizontal Learning Program (HLP) Chapai Nawabganj district hub, which is not a funding support but doing horizontal learning program.

Bangladesh Profile

The capital of Bangladesh is Dhaka and the country is divided into seven divisions each headed by Divisional Commissioner. The Urban Local Government has seven municipalities and 307 Paurashava while the Rural Local Government has 64 district Council, 500 Upazila Parishad, and 4550 Union Parishad. The District Council is headed by District Administrator appointed by the government, administered by Deputy Commissioner. Upazila Parishad is headed by elected Upazila Chairman, administered by Upazila Nirbahi Officer. The Union Parishad is headed by elected Chairman with nine ward member, three women member and one secretary. The UP is lowest tier of Local Government. There are 85,000 villages in the country.

In Bangladesh, most areas are rural areas and there are hill areas. The total land area is 147,570 sq. km. The total population is 166,280, 712 as of July 2014 with a population density of 1,033.5/sq. km. The birth rate is 21.61 births/1,000 population (2014) and fertility rate is 2.45 children born/woman (2014). Population growth rate is at 1.6%. Gross Contraceptive prevalence rate is 61.2% and life expectancy rate is 70.65 (68.75 for male and 72.63 for female). National Income per capita is US$840 and health expenditure of GDP is at 3.7%.

The infant mortality rate is 45.67/1,000 live births, crude death rate is 5.64/1,000 and under five mortality rare is 40.91/1,000. There 36.7% of children under the age of 5 years who are underweight. Birth attended by skilled health personnel is 31% and antenatal care coverage (4 visits) is 26%. EPI coverage is 95% and use of improved drinking water is at 83% and sanitation coverage is 65%.

Rajshahi District project

The project area is Rajshahi district in the north-western Bangladesh which consists of Barind tract, Diara, and Char lands. The overall literacy rate is low at 53% (55.8 % male and 50.1 % female). The main occupation in the district is agriculture: 39% male and 24%

female work as daily labourer in the agriculture sector and about 12.44% are involved small businesses. The religious affiliations of the population are: 93% Muslim, 5% Hindus, 1.5% Christian, and 0.5% ethnicity. The ethnic minority groups (Santals mainly) represent 2.3% and are most deprived in respect of health, water and sanitation, and economic activities in comparison to the mainstream population. Barind tract, largest Pleistocene physiographic unit of the Bengal Basin, has long been recognized as a unit of old alluvium, which differs from the surrounding floodplains.

Rajshahi district is a drought area with no rain is prevalently poor area compared to other parts of Bangladesh because many of the IPs live there especially one sub district where 15% of the IPs are living. DASCOH is trying to empower this district.

Among the health issues of the community are:

1. 40% children and 30% mothers suffer from severe malnutrition.
2. 37% of rural pregnant women do not receive antenatal care.
3. 77% of births take place at home.
4. 194 pregnant women die for every 100,000 live births.
5. HIV prevalence is less than 1% among high-risk groups (Eighth Round of the National Serological Surveillance - 2007).
6. The ethnic community still seek health services from traditional healer.
7. Morbidity is dominated by fever, cold, diarrhea, asthma, skin diseases, eye problems, ulcer, gout, jaundice, dysentery, and typhoid.
8. 21% of the patients do not consult any doctor and 24% patients directly purchase medicine from pharmacy.
9. 28% patients are treated by traditional unlicensed doctors.

The top ten main diseases in 2012 are:

1. Diarrhea
2. Peptic ulcer
3. Injury/casualty from assault
4. Enteric fever
5. Poisoning
6. Pneumonia
7. RTA/Head injury
8. Asthma/COPD
9. Anxiety and Depressive disorder
10. Hypertension

This situation however is changing. Nowadays, heart diseases and hypertension are increasing and diarrhea incidents are decreasing.

In 2010, DASCOH started work with 32 Community Clinic of Godagari Upazila under Water and Sanitation project financed by Swiss Red Cross (SRC). They evaluate and share lessons of the Community Clinic with SRC and RCHCIB in 2012. They awarded contract with SRC for Public Health Improvement Initiative in Rajshahi to work with Community Clinic for the period of January 2013 to December 2015. There is a tripartite MoU signed among SRC, DASCOH, and Revitalization on Community Health Care Initiative in

Bangladesh (RCHCIB) for the Community Clinic project of the Ministry of Health and Family Welfare.

Now, health is in the hands of the community people. DASCOH works with more than 30 community clinics and they try to convince the government to involve community people in community clinic. For community clinics, people donate the land and the government runs the clinic. There are now 18,000 community clinics.

The overall goal of the project is for the population of rural area of Rajshahi district to have access to and use improved essential health care services through well-functioning Community Clinics.

Among the major endeavors of DASCOH are:

- Build management capacity of CC Management Committee engaging Local Government Institutions
- Support MOH&FW to develop capacity of health service providers
- Strengthen MOH&FW's efforts to provide supportive supervision

In Bangladesh, there are 18,000 community clinic, 4,860 Union Health and Family Welfare Centre, and 425 Upazila Health Complex offering Primary Level health service. Then there are 59 District Hospitals providing Secondary Level service, and 35 specialized hospitals.

The concept of the Community Clinic is to have 1 Community Clinic established for more or less 6,000 rural population. Community clinic is the first level one-stop service centre for Primary Health Care and is managed by the community. Its service time is from 9 AM to 3 PM. The service providers in CC includes Community Health Care Provider (CHCP) who works 6 days, Health Assistant (HA) who works 3 days, and Family Welfare Assistant (FWA) who works 3 days.

Available services at CC are

- Maternal & neonatal health care services (ANC/PNC)
- Integrated Management of Childhood Illness (IMCI)
- Reproductive Health and FP services
- Immunization (EPI)
- Nutritional education and micro-nutrient supplements
- Health education & counselling
- Screening of Chronic Non Communicable Diseases
- Treatment of minor ailments, common diseases & first aid
- Establishing referral linkage with higher facilities

Among the plans and progress of the project are:

1. Improved quality of basic health services delivered at CC. DASCOH provided training to the Health Service Providers of the Community Clinics on Reproductive and Child Health Care, Patient Management, and rational use of drugs. There are also training to the technical supervisors on hands-on training to the service providers for their capacity building and institutional supervisors on Supportive Supervision.

2. Well-equipped and well-managed CC. This includes forming and reforming Community Group (CG) for the management of Community Clinic, training CG on health situation analysis, participatory planning and local resource mobilization, forming and reforming Community Support Group (CSG) for Community Mobilization, training CSG for awareness raising of the community, and training Union Parishad to act as chief patron of the CC.
3. The population in Community Clinic catchment area has increased health and disease prevention knowledge and is aware about CC. DASCOH has trained health service providers on health promotion at Community Clinic on selected 26 topics and prepare health promotion plan. They have selected and trained Community Group Facilitators as Community Volunteer to Support CG and CSG and health promotion. They have supported CGF to conduct health promotion session at community level and use local cultural form of the community for awareness building on health.

DASCOH also has provided health promotion training (Basic introduction) to 445 CG members (2 person from each CG) and community health promotion training (Basic introduction) to 2,070 CSG members (3 person from each CSG).

Challenges experienced through the implementation of the project are:

- Shift from government-led management system to community-led management of health service centre
- Significant gaps persist in mainstreaming of ethnic communities with government health system
- Political unrest
- Quality of health services: though improving still requires considerable strengthening
- Lack of coordination between Health and Family Planning department
- Traditional mind-set of community to receive medicine.

In the future, DASCOH plans to:

- Organize refresher training/practical training to the health service providers to improve quality of health care
- Establish referral mechanism
- Build awareness of the community on health issue to change health behaviour
- Strengthen capacity of CG, CSG, and UP
- Develop poor patient fund
- Mid Term Review of the Project

Their plan on the working area is to improve the quality of service. DASCOH provides training and are developing training manuals. The government also is working with NGOs like DASCOH. A major concern however is the lack of support for the CC, which currently needs both technical and institutional supervision.

The presenters shared one case where the clinic is well-equipped and well-managed. The CG develops the annual report; they identify the problems and what they can do about it. The CG sits together then makes a plan. Every month, the community group sit together and they monitor the plans - what have been implemented and what are not yet

implemented. They mobilize some local resources and funds are sometimes use for patients who are very poor. At least one person every day comes to the clinic and they do supportive monitoring. This is one of the tasks of the community group. They also develop infrastructure such as new rooms. A function of DASCOH is to link community group with the government health department.

However, when it comes to health care provision to the IPs, not one of them visits the CC preferring traditional healers.

DASCOH also provides training for the CG facilitator. As community group facilitator, he goes to the community's house and tells them about the project. First step is he collects leaders and chooses members. Then they discuss with other community people. If they need further support then they go to the community clinic. They sit together, identify the problem, and solve the problem on their own.

A video was presented showing local transport carrying patient to health centre.

The presenter however is concerned that alternative medicine is not yet mainstreamed. It is not yet included in the government policy.

Open Forum

Soon after the presentation, the participants wanted to know if there are conditional cash transfer programs in Bangladesh. To which the presenter said that they don't. He added however that some NGOs have it but not DASCOH. But the CC can mobilize some funds and use that on their projects. That is not a grant and not a loan. The government also has some conditional cash transfer programs for women and PWDs.

Another wanted to know if there is health insurance in their community and why there are so many malnourished children and what the government is doing about it.

Health insurance is not available in the community. The main cause of malnutrition is illiteracy, then poverty, then poor habits of the people, they don't know how to eat a balanced diet.

More information was needed on the mandate of the CC and why is it difficult to make the shift to community-led management.

There are issues on this. One is local resource mobilization within the community group. Community is now managing community clinic but what is the next step. That is the challenge for the government to involve in the management of the clinic.

To this INAM Philippines added that one of the challenges is to change the mind of the people to believing that it is the responsibility of the government to provide the service. It will however take generations and education to do that.

COUNTRY PRESENTATIONS: PHILIPPINES

Situation of Indigenous Peoples in Region 4A

Ms. Jennifer Gerones, Community Development Officer III
National Commission for Indigenous Peoples (NCIP)

The Philippines has 110 kinds of indigenous cultural kind: 48 in Luzon, 25 in Visayas, and 37 in Mindanao. They have different cultures and traditions and languages.

The Indigenous People's Right Act (IPRA) was signed into law on October 29, 1987. The bill that came to be known as IPRA took ten years to pass congress from 1987 to 1997. It underwent many years to legislative study, particularly in fleshing out the innovative indigenous property concepts enshrined in the 1987 constitution.

Finally, the legislative measure withstood numerous popular consultations, legislative deliberations, plus a decade of consolidated bills related to ancestral domains lands. In the process, the Philippines was commended by the United Nations and International IP advocates for accomplishing the legal breakthrough, the first for any state, during the international decade of the IP (1995-2004).

IPRA was enacted to recognize, protect and promote the rights of Indigenous cultural communities and to create the National Commission on Indigenous Peoples (NCIP) as well as to establish implementing mechanisms and appropriate funds for these purposes.

IPRA is Constitutional and part of the legal system. It is a landmark law on social justice for IPs and defined who are IPs and enumerates their rights. IPRA is supported by the UN and International Law.

Section 22, Article 11 of the 1987 Philippine Constitution and Section 2, Chapter 1 of IPRA declare that the state recognizes and promotes the rights of the indigenous cultural community (ICC) within the frameworks of national unity and development.

The rights of the IPs and ICCs include rights to ancestral domains and land, self-governance and empowerment, social justice and human rights, and cultural identity.

Right to ancestral domains and land
Ancestral domains are all areas generally belonging to ICCs/IPs held under a claim of ownership, occupied and possessed by themselves or through their ancestors, communally or individually since time immemorial, continuously to the present and are necessary to ensure their economic, social and cultural welfare. It includes ancestral lands, forests, pasture, residential, agricultural, hunting grounds, burial grounds, worship areas, and bodies of water.

Ancestral lands on the other hand are land occupied, possessed, and utilized by individuals, families and clans who are members of the ICC/IP since time immemorial by themselves or through their predecessors-in-interest under claims of individual or traditional group ownership continuously up to the present, except when interrupted by war, force majeure or displacement by force, deceit, stealth and as a consequence of government projects and other dealings between government and private corporations.

The concept of ownership among IPs is that ancestral domains and all resources found therein shall serve as the material bases of their cultural integrity. Ancestral domains are the ICCs/IPs private but community property which belongs to all generations and therefore cannot be sold, disposed, or destroyed. It covers sustainable traditional resource rights.

It is the responsibilities of the IPs/ICCs to maintain ecological balance, restore denuded forests, and observe laws.

Right to self-governance and empowerment
IPs/ICCs have a right to self-governance and self-determination, justice system, conflict resolution institutions, and peace building processes, right to participation in decision-making, right to determine and decide priorities for development, and right to tribal barangays.

Right to social justice and human rights
IPs/ICCs have rights to equal protection and non-discrimination, right during armed conflict, right to equal opportunity and treatment, right against discrimination on the terms and conditions of employment and denial of benefits, right to basic services, equal rights for women, and rights for children and youth.

Right to cultural integrity
IPs/ICCs have right to protection of Indigenous culture, traditions and institutions, right to educational system, right to recognition of cultural diversity, Community Intellectual Rights, rights to cultural sites and ceremonies, rights to IKSP, access to biological and genetic resources, rights to sustainable agro-technical development and right to receive from the national government funds for archaeological and historical sites.

The National Commission on Indigenous Peoples (NCIP)
The NCIP was created to carry out policies set forth in IPRA. It is the primary government agency responsible for the formulation and implementation of policies, plans, and programs to promote and protect the rights and well-being of the ICCs/IPs and the recognition of their ancestral domains as well as their rights thereto. NCIP is mandated to protect and

promote the interest and well-being of the ICCs/IPs with due regard to their beliefs, customs, traditions, and institutions.

The NCIP is composed of seven commissioners each representing an ethnographic region, one of whom shall be the chairperson and at least two shall be members of the Philippine bar.

Powers and functions of the NCIP include:

1. Policy-making body to implement rules and regulations, guidelines, rules on pleadings, procedure and practice before the NCIP, and other issuances.
2. Quasi-judicial body handling claims and disputes involving rights of ICCs/IPs, primacy of customary law, regional hearing office, and rules on pleadings, practice, and procedure.
3. Implementing agency for programs, educational assistance, legal assistance, projects, and livelihood projects.
4. Titling of ancestral domains and lands outside and within ancestral domains.

Titling of Ancestral Domains

The IPRA was signed into law for social justice - to ensure equality under the law and so that those who have less in life should have more in law.

Under the Regalian doctrine, all lands of the public domain, waters, minerals, coal, petroleum, and other mineral oils, all forces of potential energy, fisheries, forests or timber, wildlife, flora and fauna, and other natural resources are owned by the State. While the Native Title Doctrine states that the State, subject to the provisions of the Constitution and national development policies and programs, shall protect the rights of indigenous cultural communities to their ancestral lands to ensure their economic, social, and cultural well-being. The Congress may provide for the applicability of customary laws governing property rights or relations in determining the ownership and extent of ancestral domain.

A native title refers to pre-conquest rights to lands and domains which, as far back as memory reaches, have been held under a claim of private ownership by ICCs/IPs, have never been public lands and are thus indisputably presumed to have been held that way since before the Spanish Conquest.

Free and Prior Informed Consent (FPIC)

FPIC is "The consensus of all members of the ICCs/IPs to be determined in accordance with their respective customary laws and practices, free from any external manipulation, interference, coercion, and obtained after fully disclosing the intent and scope of the activity, in a language and process understandable to the community"

FPIC recognizes indigenous peoples' inherent and prior rights to their lands and resources and respects their legitimate authority to require that third parties enter into an equal and respectful relationship with them, based on the principle of informed consent.

Plans, projects, and programs that need to undergo FPIC are anything that will cause relocation, anything that has to do with cultural, intellectual, religious, and spiritual property, any exploration, excavation or diggings on archeological sites, anything that will expose their

biological and genetic resources including indigenous knowledge related to the conservation, utilization and enhancement of these resources, anything involving the exploitation of natural resources, and any maintenance, management and development of Ancestral domains, which are found to be necessary for critical watersheds, mangroves, wildlife sanctuaries, wilderness, protected areas, forest cover, or reforestation.

Further, those that require FPIC are:

1. Extractive, Large-Scale, intrusive (ELSI) plans, programs, projects and activities (pppa). These includes exploration, development, exploitation, utilization of land, energy, mineral, forest, water, marine, air, and other natural resources requiring permits, licenses, lease, contracts, concession, or agreements e.g. production-sharing agreement, from the appropriate national or local government agencies, including feasibility studies related thereto; those that may lead to the displacement and/or relocation of ICCs/IPs; and resettlement programs or projects by the government or any of its instrumentalities that may introduce migrants; declaration and management of protected and environmentally critical areas, and other related undertakings; bio-prospecting and related activities; activities that would affect their spiritual and religious traditions, customs and ceremonies, including ceremonial objects, archeological exploration, diggings and excavations and access to religious and cultural sites; industrial land use including the establishment of economic zones; large scale agricultural and forestry management projects; carbon trading and related activities; large scale tourism projects; establishment of temporary or permanent military facilities; conduct of military exercises, or organizing para-military forces; issuance of land tenure instrument or resource use instrument by any government agency and related activities; and others analogous to the foregoing, except small-scale quarrying.
2. Non-extractive, small-scale activities (NESSA). These includes activities not covered in Section 19 of IPRA; feasibility studies not embraced in the previous item (ELSI pppa); non-extractive exploitation and utilization of land, water and natural resources as defined under existing laws, rules and regulations of governing or regulating agencies; programs/projects/activities not requiring permits from government agencies; other Small scale quarrying; and such other activities analogous to the foregoing.
3. Activities that require validation such as Community-Solicited or Initiated Activities projects, programs and activities undertaken by NCIP by itself or in cooperation with other government agencies and LGU Projects; foreign Funded Project Undertaken in Cooperation with the NCIP; and exercise of Traditional Resource-Use Rights.

Ten barangays in Tanay is already covered by the ancestral domain title. Most of the livelihoods present are government-coordinated projects.

Open Forum

A question raised after the presentation is the ancestral domain in Tarlac which is part of the military reservation. The participant wanted to know how this was done and what they can do to help the IPs.

All reservations can cover ancestral domain titles. In principle of titling, the IPs are the ones to point the boundaries. But if they can prove that it is their area, then the NCIP can help them.

A barangay health worker, adopting traditional method of healing, wanted to know if the NCIP has a program supporting BHW or CHW or if there is a funding or a training that they can provide or support to training that they can give as counterpart to DoH and BHW.

To this the, presenter said that it is possible under the Education and Health Office of the NCIP. A proposal needs to be submitted to the NCIP.

Another point raised is the presence of schools where the IPs may use their own language.

As of now, in schools, IPs cannot use their own dialect. They have to use Filipino. However, there are schools in Mindanao intended for the tribe. There are days when they use their traditional costume.

Protection of self-governance got the interest of the attendees.

Currently, there are many cases raised in the NCIP. When an investor comes to the office of IPs, they have to knock before they can implement any project. To protect IPs, there is a need for them to go through this process to see if the ICC really wants that project. If they don't then the project will be denied. Example is the Canadian-based project, a partner of Ocean Park wherein the fish gathered in Palawan will be brought to Luneta. The project did not push through.

Another point raised is whether ancestral lands may still be bought. According to NCIP, someone else cannot buy titled lands.

Another participant from India wanted to know the process of protecting the IPs and whether NGOs are opposed to that process citing that in India, governments are suppressing the NGOs.

NCIP representative said that most of the time, their partners are NGOs. But before the NGO can go to the IP area, they will have to ask permission first.

The participants are also keen on knowing how the NCIP balances the work in protecting the IPs with the group that wants to use the land.

NCIP said that they are very much affected by this.

In India, constitution has given rights of the tribe. There are some tribal communities, which the government has given some additional development programs. There are also autonomous district councils which means they get more funds from the government

In the Philippines, some areas have a council of elders. Because of the number of IPs, there was a need to create a council of elders who will be in dialogue with the provincial council.

This is practiced in Bukidnon and the Mt. Province. But in areas where there is a lesser number of IPs, they have not organized a council.

Presentation of the Case of Tanay

Dr. Rene V. Luce
Municipal Health Officer of Tanay, Rizal, Philippines

The Province of Rizal has13 municipalities and one city. It is bordered by Metro Manila to the west, province of Bulacan to the North, province of Quezon to the east, and Laguna Province to the South.

The Municipality of Tanay is a 1st class municipality in the Province of Rizal. It is covered mostly with forest. Coastal plains are found along the southern position of the municipality. Comprising about 1% of its total land area is predominantly used for urban purposes. There are ten barangays in the upland areas.

The total population is 111,346 with 67,990 from the poblacion and 43,356 from the upland. The major natural resources are gold, iron ore, manganese, and calcite. Major products are rattan, palay, mango, and coconut.

The mission of the Tanay LGU is to be a regional tourism haven with diversified, highly competitive economy, health and sustainably developed urban, rural, and natural environments a pro-active and responsible governance and God fearing, self reliant, and socially responsive citizenry. Its vision is to ensure the equitable growth and balanced, sustainable development of the municipality thru excellent government governance and the highest standards of public service.

Tanay Municipal Health Office
There are three rural health units in Tanay. The mission of the Tanay Municipal Health Office is to provide quality health care services by making it available, accessible, and sustainable through advocacy, sectoral linkages and community involvement. It envisions to have a healthy and empowered community through delivery of quality health care services in Tanay from 2010 and beyond.

Among the services offered are:

- Safe motherhood and maternal care
- Childcare
- Prevention and control of communicable diseases
- Prevention and control of non-communicable diseases
- Medical consultation
- Dental services
- Laboratory and x-ray services
- Animal bite treatment
- Environmental health services
- Disaster preparedness

- AHYD (adolescent and health youth development) Program
- Social hygiene

Of these services, primary health care benefits, maternal care package, TB dots, and animal bites centre in the main RHU are accredited by the PhilHealth.

IPs in Tanay and the Philippine Integrative Medicine (PIM) training
The IPs often live at the remote sitios of the mountain barangays. It may take 2-3 hours hike from the main barangay to reach these sitios. The IPs prefer to live in these places to sustain their daily needs for food, shelter, and protection. For the IPs, their priority is mainly food before health and most are not aware of the services of the RHU.

The Philippine Integrative Medicine (PIM) was started by the LGU through the Center for Health Development 4A with INAM Philippines. They have decided to have the training for the IPs so that they can establish their own health program. When the program was just starting, the health office were very much challenged because of the culture of the IPs that they had a very hard time reaching them.

Among the strengths of the program are the presence of responsible health providers, complete DoH programs, and good governance.

There still are some points for improvements in facility enhancement, referral system, communication/transportation barriers, human resource, and capacity building.

Challenges are service delivery in GIDA, climate change, territorial dispute and insurgency - there is one barangay which is not considered part of Tanay but are receiving services from the Tanay health office and another area where there is dispute - urbanization and industrialization, unforeseen influx of migrants - there is an area where there are people who relocated from other places - universal health insurance coverage - PhilHealth coverage for all IPs will be very helpful.

At this point, the NCIP representative said that they gave a listing of beneficiaries for a Department of Social Welfare and Development (DSWD) project (4Ps) saying that the last batch of the project is intended for IPs. However, it seems that the IPs were not consulted.

An IP said that they submitted an application form for PhilHealth but up to now, some are still not covered by PhilHealth so they are submitting their applications again. Not all 4Ps

beneficiaries are automatically covered by PhilHealth. It is only recently that DSWD did their survey/interview in the area. The group is hopeful that they will soon be covered.

The presenter pointed out that since NCIP is the office handling the IPs, he hopes that all IPs need not have to go to NCIP for PhilHealth coverage.

Empowerment of the IPs through Community Participation for Sustainable Local Health System

Out of the 33,466 hectares, 28,000 hectares have been identified as the ancestral domain of the Dumagats and Remontados.

They have their own way and practices in maintaining health, delivering babies, family planning, treating diseases such as *buga*, *hilot*, and herbal medicines. They also have their own health practitioners (elderly practicing their culturally-gained knowledge).

The health issues faced by the IPs are morbidities from preventable diseases, mortalities from curable diseases, neonatal and maternal mortality because of very low facility-based delivery, and health care delivery and referral system.

Before the inception of the project, health services are poorly patronized due to financial constraint, geographical limitations, cultural influences (reliance to their own means of healing), beliefs (about the health system), and self-perceptions.

Lately in the municipality, there were lots of cases of teenage pregnancy because of arranged marriages. This is important concerning maternal care issues. However arranged marriages are part of the custom of the IPs. So later, the health office needed to give a lecture that early marriage is dangerous especially for the health of the mother. In Tanay, parental love is not so much practiced as of these days, the ratio nowadays is probably 1:1000.

PIM trainings

Recognizing the gap in health service delivery especially in the remote areas, the health office knew they needed to do something. In 2010, then DoH Regional Director Dr. Juanito Taleon and the presenter visited a barangay and saw a baby being bottle-fed. It turned out that the mother of the baby died while giving birth. Dr. Taleon got interested in the health status of IPs and offered his support to look for all means to address the problem and that is how the presenter met with INAM Philippines.

The first activity was to meet with the tribal chieftain to encourage them and let them choose people among IP community who are able and willing to be trained. The health office tapped INAM Philippines to train CHWs with PIM curriculum.

The PIM training aims

1. To develop community-based health workers and independent community organizers with culturally-applied practices for effective advocacy of health program and services to address health issues among IPs.
2. To empower the IPs by providing capability building on Philippine Integrative Medicine, to become community organizer, community health worker, and community health program managers.

3. To establish Community Health Programs to make health services accessible to the IP's families.
4. To facilitate patients referrals from the Community Health Program to BHS/ RHU.
5. To improve health conditions of the IP's especially in the mountainous areas.
6. To provide venue for IP's community participation and collective decision-making so that the voice and the situation of IP's are heard and communicated to the local government.

PIM Level 1 - Community Organizing
Community Action Plan for Household Survey towards analyzing Major Community Problems & Solutions
At first, the presenter was a bit hesitant thinking the project is not going anywhere because some of the participants were illiterate. But it was an eye-opener for him because they were able to do their own survey forms after the 5-day seminar.

Forty-seven participants gained knowledge and skills on health education and in making a family survey form to get to know their community.

PIM Level 2 - Community Health Worker Training
Community Health Program with aim of educating family members and mobilizing the community in addressing their own health and other related concerns

Thirty-eight participants gained knowledge and skills in analyzing the data gathered from the household survey. They formulated their own survey forms. When they came back for Level 2, they reported the data gathered. They found out the ten causes of morbidity in the locality. They also studied the diseases and the symptoms. They were able to identify four common problems in their barangay: lack of adequate information regarding their health and disease, lack of potable drinking water, lack of knowledge of livelihood, and lack of knowledge on environmental protection.

Basic Health Skills Training enabled participants to draw from their experiences their responsibilities as community health workers. Participants identified solutions and responsibilities as CHWs.

Related activities became the basis of their respective community health program, developed by the people to respond to their own community health needs.

PIM Level 3 - Community Health Program (CHP) Management
Knowledge and skills in planning, implementation, monitoring, and evaluation of the CHP. Knowledge and skills in facilitating a Reflection Process.

The training included:

- Managing community diseases and referral of patients with cases beyond their competency, systematic conduct of health education,
- Addressing their health related issues of access to potable drinking water and sanitary latrines,

- The need to re-survey as a monitoring tool to assess the effectiveness of their CHPs to the community,
- The need for additional CHWs per CHP, and
- Regular conduct of monitoring meetings and evaluation.

Community health workers bring very significant contribution to the health care delivery and referral system among IPs Community. When the program started, IP women didn't want immunization programs, now, they go to the centre for prenatal check-up. They are still resistant to facility-based delivery and would rather be handled by traditional health attendants. They're already into family planning and injectables. There is increased community participation on health program implementation and IPs are now aware of the RHUs, and immediate intervention to emergency cases has been possible.

However, unless the BHS in the IP communities are equipped for birthing capacity and provided with medicines and supplies, there will not be favorable outcomes as far as the FBD indicator is concerned. One of the programs is to construct a birthing facility for IPs. It will be near a health facility as some of them are still resistant to be attended by skilled health worker. The purpose of this is to slowly advocate facility-based delivery to them.

Other impacts of having CHWs are health advocacy to those individuals and families within their cluster, health promotion and disease prevention using an alternative medicine used by the community, initiation of proper referral system, and management of community Health Care Financing.

Through the CHW, there is an increased community access to the basic health services while preserving the IPs traditional health practices. A gradual change in the health seeking behaviour among the IPs were quite evident notably in the increase in IPs immunization and pre-natal check-ups to name a few.

As a result, empowered IP leaders and health providers participate in other health programs for the benefit of the people.

To sustain and to strengthen the program, a Facilitators Training was conducted and produced nine CHWs and three RHU staffs equipped to conduct new batches of trainings. After a year, another batch of additional CHWs trained for PIM 1 and PIM 2 and joined the orientation on Community Health Care Financing Part I and II. Two CHWs attended a Writeshop on Best Practice Guidelines on the Management of the top 8 community conditions together with other CHWS from Sorsogon, Negros Occidental, Misamis Occidental, Noth Cotabato and Sulu held in Quezon City. There is also a representation of the CHWs/CMHPs in the Barangay Local Health Board.

Currently, there are 34 CHWs providing health care to 641 Dumagat-Remontado families or 2,881 persons or 41% of the entire IP population in Tanay. There are eight CMHPs being managed by 24 CHPM. Health care services being provided include treatment of the sick, health education, and referral to barangay health station, rural health units, and INAM Philippines Clinic.

Among the accomplishment of the project is the two-way referral system involving the rural health units/barangay health stations and the CMHPs/CHWs, a monitoring system for health education, patient treatment, referrals, and meetings, and an information system established and copies of reports submitted periodically to the RHU.

Through all these,

- 547 (92%) out of 597 cases of preventable diseases were managed/cured by the CHWs and did not need any referral as of October 2013
- 430 (81%) out of 525 cases of preventable diseases were managed/cured by the CHWs and did not need any referral from Jan to Dec 2014
- Only 145 out of 1,122 (12%) cases needed to be referred to the BHS, RHU etc.
- 103 or 21% of families have access to community health care financing scheme

These preventive health care programs in the communities reduce the high utilization rate for members of a health insurance program through the establishment of CHPs which have health promotion and disease prevention as the main concern.

Community Health Care Financing: *Saknungan sa Kalusugan*

Ms. Gilda Z. Paterno, Rural Health Midwife, ILDC Alumni 2014

The Community Health Care Financing or the *Saknungan sa Kalusugan* is rooted to the IPs cultural practice. Through the consultation and collective decision of CHW's and their family cluster, the CHW's themselves develop the guidelines, benefit package, policies and procedures on how to avail of the benefits of the financing scheme.

The CHW established/developed a Community Healthcare Financing/saving scheme because during emergency situation and the patient needs to brought to a health facility or hospital, they need to rent a jeepney to transport their patient and need to buy medicine and pay for hospitalization. Based on the experience of the CHW families, they would need to spend an average of P5,000 in 4 day hospital stay and to bring the patient to and from the hospital. This drains the family's meager resources. But more than that, it is the experience of embarrassment and losing ones dignity of the IPs especially when they are asking for help to other people like politicians.

Saknungan sa Kalusugan or Solidarity for Health, started in April 2014 after the two part orientation facilitated by INAM Philippines. Twelve CHWs in six different barangays manage the scheme. They have members with a total of 106 families with 402 beneficiaries from April to December 2014, and have a total contribution of P22,900. Included in the benefit package are transportation (P650), food of family members (P550), and budget for medical supplies (P500).

CHWs in the Local Health Board
The local health board addresses other determinants of health and problems previously identified such as: lack of potable water, livelihood, and lack of comfort room and sanitation facilities. Sanitation issues and community diseases associated with lack of toilets and lack of safe drinking water are slowly being addressed with the representation of the CMHPs thru the CHWs in the Barangay Local Health Board

Lessons learned in the project are:

- When they see the value of their efforts, the people themselves are vibrant to take responsibility for their development as a community.
- When people embrace the process, open their mind to new ways of doing things, other possibilities for development emerges.
- People embrace new approaches and innovations when these correspond to their needs, understanding, and readiness.
- Change that comes from the people ensures a sustainable way of health services for the community.

The presentation ended with a photo presentation by the IPs.

Open Forum
The participants were also praises for the program in Tanay particularly the *Saknungan sa Kalusugan* and wanted to know where the fund for this come from.

The funds are contributions from the IPs. This is the result of the lack of funds for their daily needs even more for their health. They know however that when a patient needs to be brought to the hospital, they would need money to do so. The IPs contribute P1 per day per family to the fund. CHWs have a family cluster. Every family who wants to contribute will be a member of the *Saknungan sa Kalusugan*. There is a committee handling the money.

Currently there are 114 members from six barangays, 431 families, and a total of 545 beneficiaries.

It was mentioned that in other parts of the Philippines, there is a similar scheme but instead of using the money for the patient, it is used for the dead.

Thailand delegates wanted to know how the Tanay municipality supports the CHWs. In Thailand, CHWs are getting allowance. They also wanted to know how many families are being handled by the CHWs.

CHWs work for free but now they are trying to move into another state in their job. Through the Sangguniang Bayan, they would like to acknowledge them as partners of health services and they may get monthly allowance. Right now it is difficult even to get them to attend meeting because they have to spend P250 to get to Tanay. The municipal health office wants them to be registered by the Securities and Exchange Commission. As much as possible, they would like to get transportation allowance so that monthly or quarterly meeting will be conducted.

As for the numbers of families, it can go from 44 to 77 families for six CHWs.

The participant also wanted to know whether health services are limited to IPs only or is it extended to non-IPs. To which the presenter said that health services are also offered to non-IPs.

Having mentioned about teenage pregnancy and early marriages, other participants wanted to know the programs of the municipal health office.

As far as the IPs are concerned, nothing can be done if that is part of their cultural practice. But the municipal health office still goes to the IPs and gives lectures discussing the dangers and effects of teenage pregnancy. They already have a counselor and are planning to put up adolescent clinic to tackle early pregnancy, adolescent reproductive bill, and adolescent HIV. The health office will have a meeting soon to mainstream the activities. They will be the lead agency for the program. Among the activities are to go from one school to another and non-school youth, to conduct group discussions. As much as possible, they want the program and the plan of action to come from the target audience instead of dictating to them what needs to be done.

The representative from Tarlac shared that they have a teenage program in their NGO and dealing mainly with high school students. They go to schools and have one pilot school. They conducted FGD with students, teachers, parents, and the Aeta parents. It was good because all ideas were coming from the participants. It is an ongoing project and was positively accepted by the school principal.

The presenter added that he asked the teachers, what is the proper age of introducing sex education to the child. That is very important because up to now, the Department of Education has not come up with a module on what age should sex education be introduced.

Another question is whether government provides for transportation cost for pregnant women.

It was noted that it was indeed the reason for the establishment of the *Saknungan sa Kalusugan*. Each and every barangay should have transport vehicle for emergency cases but there is not always enough money.

In India, subsidies are provided for female children because there are lots of cases of abortion when it is found out that the baby is a girl. So the government provides subsidies (transportation) if it is a girl.

Moving from teenage pregnancy, the participant asked about the prevalence of animal bite incidents since this was mentioned several times in the presentation.

The presenter said that they don't have vaccines and some people are not familiar with animal ownership responsibility.

Almost all participants wanted to know more about arranged marriages in IPs.

Arranged marriages are still prevalent among IPs and certain Muslim communities but by and large it is no longer a practice.

An IP responded that children in their community marry early because their parents do not really expect that the child will go to school. They encourage marriages because it brings happiness to the family, they come together and celebrate. They prefer large number of family members and they have no experience with abortion.

Arranged marriage is also practiced among IPs because usually parents do not have dreams for their children to go to school because they cannot afford it. For them having wedding celebration is an opportunity for them to enjoy, have fun, and gather together as families. For them children are their worth because that is the only thing they can have for free.

For the IPs in Quezon, they do have dreams for their children. But reality is they could not be vigilant for their children having relationship in secrets and to avoid unnecessary pregnancies, they would rather arrange the marriage to make sure unwanted pregnancies will not happen.

In Tarlac, they cited that dowry is still very prevalent. Last year, one student died because she was forced to marry a child she doesn't love so she committed suicide. Just recently they have eight Aetas who had eloped and some of them have some dowry.

The Workshop – Day 3

The day was started with a prayer. Dr. Raja Dodum, Nodal Officer (National Urban Health Mission), Government of Arunachal Pradesh, India, once again provided a recap of the previous day's activities.

Recap

Dr. Raja Dodum
State Nodal Officer (National Urban Health Mission), Government of Arunachal Pradesh, India

The Workshop started with an opening prayer and a recap of the previous day. Key learning points were presented from the previous day's presentation. Addala Jagannadha Raju of the Center for Community Development gave a background of India thru video and presented the health issues in India. He shared cases of how women deliver health services, purpose of CCD, promotion of community health, formation of self-help group, PWD, village development committee, local self-governance, initiatives of strengthening the organization, roles of volunteers, empowering committees, sustainable health mechanism adopted, lessons learned and achievement.

The delegates from Bangladesh presented the beginnings of DASCOH highlighting that it is complementing government health program. They also discussed DASCOH's engagement in health, structure of health service, plans, progress, experience, way forward, and presented a video on capacity building.

Dr. Jenny Madamba provided an energizer and then Jenniffer Gerones presented the number of tribes in the Philippines, the Indigenous Peoples Rights Act, and enumerated the rights of the IPs.

Dr. Rene Luce presented the case of Tanay and how PIM levels 1 to 3 started in the municipality. Gilda Paterno then presented the community health care financing, total benefit package, and lessons learned in the program.

Key Learning Points

Summing up the Key Learning Points from the previous day:

Bangladesh

- (India) Food fair in India promoting traditional crops. Bangladesh has a lot of traditional crops so they would like to do the same program in their country.
- (India) Income-generation activities and support for PWDs. In Bangladesh, they have identified list of PWDs and they are also thinking of replicating this program.

- (Philippines) The savings program of the IPs by CHWs. Bangladesh has not started anything yet on savings in their programs.

Thailand

- Appreciate the tripartite collaboration of the government, NGO, and the people. It makes the work effective and responsive and there is mutual understanding among them.
- (India) In the case of Karuna Trust and PPP, it was an innovative model work by PPP. It was successful to train a lot of volunteers to teach, to train, and to use herbal formulations and how to prepare locally available plants to encourage every village.
- (India) Government support public-private to manage health care in local area that doesn't have access to health service.
- (India) The Indian health system has rural and urban health care system.
- (Bangladesh) The presence of community clinic to give health care to IPs.
- (Philippines) Community health worker helps the community and gives training on community health, nutrition, sanitation, and herbal medicine.
- Promoting women self-help groups to change behavior. Training content: community health, mother and childcare, nutrition, hygiene, sanitation, malaria prevention and control, and herbal medicine practice.

Japan

- Deep commitment can make a change once the person in the position has the determination. Very impressed with Tanay.
- With health in the hands of the people, they can ask both the government and the people to be responsible.
- Advocacy within LGU is important.
- Health cannot work out by health only. Multi-sectoral approach is essential.
- Maximize new opportunities. There is a need to be updated on what is happening and maximize new opportunities for people to participate. Example: support and promote the system of people's participation in local health board and community clinic management.
- Collection of individual commitment creates power to bring change, which is very good for sustainability.
- Various training for volunteers according to their needs: personal skills, management, and sustainability. For example, INAM Philippines' PIM added continuous courses that enhance the capacity of the volunteers.
- Most impressive: health is outcome of good community development. Presentations of various countries prove maximize mobilization of local resource can improve health status of community people.

India

- (Philippines) Community contribution for health care.
- (Philippines) Protection of IPs in various laws in the Philippines.
- (Philippines) Participation of community in local health care.
- (Bangladesh) Community clinic. Hopes to learn more.

- Health financing. Fascinating because this is very new in India but they wish to apply this system in their state or country. Also wishes to know more about the system and the limitations, if there are any.
- Along with other health programs, there should be more income-generation activities. Without economic empowerment there would be no health programs.
- The partnership between Tanay and INAM Philippines to train CHVs is also being done by Karuna Trust.
- IPRA is a very good thing. Other countries should have this. But there is a need to include new points apart from Indian Tribal Protection Act.

Nepal

- Impressed with CHV because they are working with high motivation without any remuneration.
- NGO role is very important and effective to provide health services in Tanay.
- Municipality is providing health services in Philippines. This is not practiced in Nepal.

Davao, Philippines

- Integration of traditional methods of healing with the current modern system.
- Strong commitment of volunteers beyond their capacity to serve which contributes to efficient and effective health care delivery of services.
- Active participation of IPs in LGU health program in their community.

General Nakar, Quezon, Philippines

- *Saknungan sa Kalusugan* - would like to share to their barangay.
- Enhancing capacity of community on health situation analysis to reduce poverty, malnutrition, mortality, and morbidity.

Tarlac, Philippines

- Active participation in developing leaders among stakeholder, government, and other NGO and CSO is an important aspect of empowerment.
- Financial sustainability as an initiative of CHD of Tanay is a very good mechanism to continue their advocacy in health services provision.
- In providing training and health teachings to CHWs, it is very important to address health needs of the community immediately as frontliners in providing primary health care.

Tudela, Philippines

- They need to provide educational opportunities to IPs especially awareness on what happened to the environment so they can actively participate in nurturing the ecology.
- Active participation of IPs in health programs.

Tanay, Philippines

- CHW active work even without remuneration. They continue with their goal to help in the community.
- Ways to increase funds. They have ready money in case of emergency.

INAM Philippines

- (India) Health savings of three rupees daily for pregnant women and food offering from neighbors to the new mother is a concrete expression of self-help and solidarity within the community.
- (Bangladesh) Health services are offered in health centres under the DASCOH. The proximity of health centre improved the families' access to health care. However, there in an interest to know the extent of this accessibility.
- (NCIP) The existence of IPRA to protect and recognize the IP rights is an advantage. However in the context of health care it was not mentioned how NCIP relates with PITAHC on the recognition and protection of IP's cultural healing practices and traditions.

COUNTRY PRESENTATIONS: THAILAND

A Case Study of Health in All Policies in Trang Province

Ms. Nanoot Mathurapote, Acting Head of Global Partnership, Coordinating Unit, National Health Commission Office
Ms. Nuanchawee Nedsaengtip, Coordinator Nurse to the Network of Provincial Health Assembly, Trang Hospital
Ms. Suvanee Samathi, Coordinator to the Network of Provincial Health Assembly

The presentation covered

- Health Systems History in Brief
- Governance by network : What and Why?
- How can we make health in all policies and make people participate in policy making?
- Health Assembly
- A case of Trang province

Health System History in Brief
The Ministry of Public Health (MoPH) was started in 1940. The big change happened in 1970 when they started to bring in the concept of public participation in health activities. In 1980, there were more players in the field including NGOs and the business sector who established private hospitals. In 1990, while the economy was booming, development was not stable. This was when the MoPH started developing universal health coverage. Thailand has many health insurance schemes focusing on the poor but in 1990, they have 100% health insurance.

In 2000, they realized that health issue is more complex and complicated and is not the role of the ministry only. This is when they asked help from other ministries and announced the National Health Act. In 2010, public participation in policy making was started and expansion of health assembly, health statute, and health impact assessment were done.

Governance by network: What and Why?
Governance by network is the totality of interaction in which governments, other public organizations, private companies, and civil society participate in order to solve public challenges and create new opportunities.

The health architecture in Thailand is a bit complicated. They don't have just a health ministry, they have a National Health Commission Office, a National Security Office (handling the funds), a Thailand Health Promotion (in charge of health promotion fund such as fund from sin tax), and emergency services. The ministry was also working with other networks. It was designed this way because they use approach of social determinant of health. The problem is not from the health sector alone.

Due to globalization, free trade agreements, and many issues around that, there was a need to collaborate with other agencies and to analyze the factors that affect health.

There were also other new trends to health such as domestic violence, national crime, climate change, global warming, new communicable diseases, transportation (people travel and bring diseases with them) and free trade (includes import of tobacco and medicines that come with free trade.

How can we make health in all policies and make people participate in policy making?

With all these, how do we make health in all policies and enhance inclusive participation in policy making? There is a need for:

1. Paradigm shift of health
2. Laws and regulations
3. Working structure
4. Working tools

Health is a state of human being, which is perfect in physical, mental, social and spiritual aspects. Before, it was just physical but now, they move to mental, social and spiritual. So other groups can join.

A health system is a holistic system that inter-relates all health-related aspects.

In the National Health Act of 2007, a new definition of health came into play. Health is well being meaning it includes physical, mental, spiritual, and social aspects.

The new governance structure is the National Health Commission Office chaired by the Prime Minister and vice chaired by the Health Minister with equal seat for GO, Academe, and CSO sectors, called the triangle that moves the mountain. Mountain represents different tasks and problems and to move it, you need three powers: government has power, academe has knowledge, and CSO sectors have the people. In addition to Health Minister, the Ministers of Social Development, Education, Natural Resources and Environment, Agriculture and Interior sit on the board. The National Health Commission Office gives advice to the cabinet on policies and strategies on health and facilitates the process of developing healthy public policy with a participatory manner.

The new tools to build health public policies include the Statue on National Health Systems at the national to local level, Health Impact Assessment at the development plan to

community levels, and the Health Assembly that includes National Health Assembly, Area-based Health Assembly, and Issue-based Health Assembly.

Health Assembly
There are three types of Assembly:

1. National Health Assembly (NHA)
2. Area-based Health Assembly (AHA)
3. Issue –based Health Assembly (IHA)

With the principle:

1. Inclusive participation to build Inter-sectoral action
2. Systematic, but flexible management
3. Evidence sharing to build trust and ownership

The NHA is a yearlong process that starts with call for agenda. The government does not set the agenda. Any organization can submit their agenda stating what issues are important - what has been done and what needs to be done. The proposal needs to be seconded by other organizations. Then comes agenda selection based on magnitude of the problem, public interest, feasibility to develop and implement, and urgency of the issue. Then comes drafting of technical background and resolution, then review for public consultation, revision of the documents once they get the feedback, and then circulation for consultation and then submission to the NHA. At this time, everyone is given three minutes to agree or not agree with the project and explain the reason for doing so. It is then submitted to the NHCO. They do not rely on cabinet resolution because they believe that participation from the very beginning will help in the implementation. There is no need to wait for the Cabinet to work. They can start work by the resolution developed at the beginning. From here, comes implementation of the program.

Participatory democracy is crucial. Attendance at national health assembly is not just about health. It can be about environment or natural disaster that makes inequity in access to health. When talking about participatory democracy, they need Provincial Health Assembly across the province.

The need for change agent/synergies is once again highlighted. They have to work with others and view capacity of other sectors.

Trang Hospital
The Province of Trang has a population of 622,659 with 305,678 male and 316,981 female and a population density of 126.62 people/sq.km. The land area is 4,917.519 sq. km.

There are ten districts, 87 sub-districts, and 723 villages. There are 84 Tambon Administrative Organizations and 15 municipalities. The average income is 100,800 THB and most people are fishermen or farmers.

There are ten state hospitals, four private hospitals, 125 primary care units under health ministry called health promotion hospital, five primary care units under municipality, 200 private clinics, and 116 pharmacies.

The top ten causes of mortality in 2008 are:

1. Cancer
2. Cardiovascular ailments
3. Road accident
4. Sepsis
5. Violence
6. Respiratory failure
7. Pneumonia
8. Cerebrovascular
9. Renal failure
10. TB

A video presentation on the Trang Province was shown.

How do Trang people solve their health problems?

1. Organize Trang Provincial Health Assembly (PHA) to address and solve the problems.
2. Develop Health Statute as a framework of community and health development.
3. Conduct Community driven Health Impact Assessment (CHIA) when the development policies or mega projects are planned to locate in the community.
4. Promote self-care for health promotion, prevention, care and rehabilitation.

At the beginning, the cooperation among stakeholders was bad. The attitude toward each other is they are ready to fight each other. When they have health assembly and new tools, people realized that if they continue fighting, they couldn't solve the problem. They can learn the tool and start it.

The problem was not just health. They have environmental problems and social problems but they have to choose the issue that can bring people to cooperation and that can be solved within a shorter period of time. The way the issue is selected is based on evidence and information data and they talk until they can finalize it. It is the same as NHA, that once the issue is selected, they do documentation like resolution. That is why they can create understanding among all stakeholders involved. They present the information and open it for discussion.

PHA Resolutions in 2010 includes

- Behavior change for healthy life - Behavioral change for healthy life is important because they realized that people still use plastic container to store hot food and they wanted to stop this. Under food safety, other than use of plastic, they try to promote organic vegetables and not instant food.
- Quality of lives of the elderly, children, and people living with disabilities - The problem in Trang is about autism. They focused on children with autism because they don't have school for them and so they needed to support children with autism so they can go to normal schools.
- Enhancement of the quality of primary health care - For people living with disability, it is difficult for them to go to hospitals so municipality provide medicine and vaccines to the house, they also have home visits. The best doctor is yourself - this leads to enhancement of quality health care and change in approach to include Buddhist lifestyle, balancing the body: hot and cool temperature, no harming of oneself, merry-making, and relaxing to be peaceful and positive thinking.
- Organic agriculture

PHA Resolutions in 2014

- Health of legal migrant worker
- Environment: forest, paddy field, sea

The benefits gained from the new way of solving problems has led to,

1. Closer collaboration among government, NGO, civil society and private sector: Health and Non-health sector.
2. New role of health volunteer: from health care to health advocate.
3. New role of people: from recipients to prime mover.
4. Responsive and healthy public policy developed by all stakeholders.

Open Forum

The participants welcomed the presentations of the Thailand team and wanted to know more about the work of the assembly on the ground - the major participants, how it is done in the village level, and if there are issues that need to be discussed in the NHA, how is it participated on by people in the village, and how the discussion in the village take place.

There is participation in the village or district and all the members of village, sub district, and district are members of the provincial level. The members of the Trang province are not individual but organizations. If the issue is at the village, it can be solved at the village

and there is no need to go to national level. If it is a common problem, they can send to provincial level and the provincial level can then send to the national level. When they have the draft resolution, it is distributed nationwide and one goes to the provincial health assembly and then discusses it to the village.

Participation of the people in the villages is through Provincial level. It is in the provincial level that a mechanism is designed for participation to happen.

Another issue raised is on how the people react if an issue is not accepted in the national assembly.

The issue is proposed and seconded by another organization. If it is not accepted, then they can present again the next year. NHA is not just one channel for pushing the issue forward; they can go to other channels. If they want to push an issue to become a policy, they can use other channels.

The membership in the Assembly includes NGO and CSO, the participants wanted to know the difference between the two.

NGO is non-profit. CSOs will include cooperatives and can have for profits activities.

For the private sector membership in the Assembly, a concern raised is the issue of balancing the needs and demands of the private sector and the public.

In the beginning, the private sector was not included but lately the idea has changed because if you don't include them, they will lobby in the national level. If they are included they can be informed and know the issues.

Another asked about the presence of corporate social responsibility among business people and the presenter replied that they have councils like commerce.

Citing the very good convergence in Thailand, the participant wanted to know who leads the convergence in the provincial level.

At the provincial level, they have MOU of 18 organizations and they will send representatives to a working group.

India shares that they also have national health system but it is centered. NHRC formulates policy for the whole country with help of the 35 state governments. NGOs are also member of NHRC.

Another point asked is people's involvement in solving local problem.

The presenters cited the case when one CHW realized that when they go to funerals or weddings, they use plastic to put the hot food. They campaigned against it. One CHW can do just ten to 15 households so they brought it to the national level. They put the agenda to the PHA and once it is adopted, they put this issue in the action plan and try to apply it province-wide. CHWs are not just doing health care, they are now health advocates.

COUNTRY PRESENTATIONS: NEPAL

Shinduli Integrated Development Service (SIDS)/Milijuli Savings-Credit Cooperative

Mr. Deepak Kumar Ghimire, Chairperson cum Executive Director
Ms. Bal Kumari Shrestha, Chairperson

The Shinduli Integrated Development Service was established in 1994. It has 41 general member, seven executive board, and 107 staff.

SIDS envisions a dignified society where poverty, illiteracy, unemployment, social discrimination, and social conflicts do not exist. Its mission is to empower the poor people and livelihood improvement through social mobilization.

The goals are:

1. To ensure positive improvements in the lives of ethnic and pro poor groups.
2. Bringing them in the mainstream of development by enabling them to fulfill their basic needs with their own efforts, initiation and participation.

As chairman of SIDS, among the tasks of the presenter are:

- Fund raising, mobilizing the resources
- Mobilizing volunteers and employees for effective program and sustainable beneficial impacts
- Coordination with GOs, line agencies, NGOs and INGOs, community, local leaders, social development workers
- Monitoring and evaluation of program for quality assurance
- Internal management of the organization
- Facilitate the trainings

Nepal has a total population of 26,494,504 (296,192 in Shinduli). The total number of household is 5,423,297 in Nepal and 1,421,123 in Shinduli. Literacy rate is 65.9% in the country and 50.5% in Shinduli. Population growth rate is at 1.35% in the country and 2.23% in Shinduli. Per capita income is US$742. HDI Development Indicator is 157th for Nepal and 47th (out of 75 districts) for Shinduli. The total land area is 147,181 sq. km. (2,491 sq. km. for Shinduli). There are 192 municipalities, two of which are in Shinduli.

In 1990s, Nepal has a democratic and open political and economic system. However there were internal armed conflicts since 1996 to 2006. In December 2007, there was an interim parliament and an election was held for the constitutional assembly in 2008. On May 27, 2012, the country's constituent assembly failed to meet the deadline for writing a new constitution for the country. And now, Nepal is waiting for the new constitution in 2015.

Major health issues include:

1. Malnutrition (Child Health)
2. Reproductive Health and Sexual Disease

3. Mental Health and stressful
4. Waste management problems
5. Insufficient/Unsafe Drinking Water supply
6. Lack of awareness in food habits, health care, personal hygiene etc. (Education)
7. Environmental Pollution
8. Political instability and lack of good governance
9. Poverty and Unemployment
10. Population growth
11. Geographical difficulties

In Shinduli, the problems of the Shinduli people are

1. Poor health system
2. Traditional health system
3. Traditional farming
4. Majority of ethnic group
5. Geographical difficulties
6. Not enough land
7. Most of the young people are going abroad.
8. Poor education.
9. Extreme poverty

The target communities of SIDS are marginalized people, children, women, and IPs.

Some of its major activities are:

1. Health:

Promotional

- Awareness Creating program
- Behavior change Communication
- Celebration of Special day

Preventive

- Immunization
- Family planning

Curative

- Clinical Service
- Reproductive Health
- Child Nutrition
- Health Camps

SIDS has established two remote clinics and these are self-sustaining.

2. Savings, Credit and Cooperative

- 560 Women groups, 3 cooperative formed
- Support for capacity building of groups and cooperative
- Mobilization of fund

- Trainings, study visits
- Support for income generation activities to the members

3. Livelihood/Sustainable Agriculture:
   - Organic vegetable farming
   - Agro forestry
   - Livestock
   - Business
   - Production of organic manure

4. Education
   - School building construction
   - Girls access to education program
   - Non formal education
   - Capacity building to teachers school management committee, Parents-Teachers Association
   - School enrolment to out of school children
   - Formation of child clubs

SIDS supports construction of school building in remote areas. They also support girls' access to education. They have 9-month course especially for the girls.

5. In fracture Development
   - School building construction
   - Irrigation
   - Drinking water and sanitation
   - Micro hydro

SIDS coordinates and links with government agencies and related district level stakeholders, political parties, local NGOs, INGOs, and SWC.

Among its major supporters are
1. Plan International
2. Heifer International
3. World Vision International
4. UNDP/SGP
5. Fund Board
6. Poverty Alleviation fund (PAF)
7. LGCDP(GOV.)
8. ILO
9. CREHPA
10. World Neighbors

Previous donors are
1. UNICEF

2. The Asia Foundation
3. Canadian Cooperation Office
4. Nepal Family Health Program
5. TIFA, Japan
6. ADB
7. SANFEC/USC NEPAL
8. World Education

SIDS has gone a long way from 14 years ago from 1 VDC to 52 VDCs of Shinduli and one VDC of Dolakha, from 7 staff to 107, and from 1 rented room to 20 rooms and two training hall and own land and building. A few years ago, SIDS would go outside to learn, now people and other organizations come to them to learn. They have moved from 1,350 household covered to 38,000 and from lack of skilled man power to many trainers and from no health service to sustainable health programs. The annual budget of US$5,000 from 14 years ago has now reached US$500,000 and from hardly one donor to ten donors.

The strengths of the organization in achieving all these are:

- Clear vision, mission and strategy
- Team work
- Full participation
- Bottom up planning
- Energetic and skilled main powers
- Good image
- Historical track
- Transparency
- Public audit

Among the improvements needed are:

- Area expansion to other districts
- Improve skill to volunteers and employees.
- Updated technology and equipment and ideas
- Transformation of replicable development process
- Innovative approaches for synergetic impact
- Good management of health cooperative for better health service of ethnic/ultra poor people.

The challenges faced are:

- Poverty
- Unstable government
- Short–terms program/projects
- Unclear social development policies
- Most of the young people are going outside the country for job.

Milijuli Savings-Credit Cooperative

The cooperative was established in May 17, 2002 by local farmers, women leaders, beneficiaries of SIDS program with 72 shareholders (three women's groups), 1 paid staff and 9 executive board. At present it has a total of 13 staff and 3,154 shareholders. In 2014, the Health Department has been separated from Milijuli Savings-Credit Cooperative and registered anew as the Milijuli Health Cooperative. The cooperative was formed in order to develop community health care outreach programs that serve specific populations with serious health care needs and limited access to health care. Here, activities of the Savings and Credit Cooperative are introduced.

It envisions to self-help dignified society, where people live without any kind of discrimination. Its mission is to reduce poverty of small-scale farmers through utilizing money properly in the society for their own welfare and self-independence by increasing motivation towards saving.

The goals of the cooperative are:

- To create environment for self-employment to its members
- To develop the habit of savings among the community people and provide higher interest
- To provide fast, simple and reliable service to its members
- To explore the employment opportunity by investing in health, education and service centres
- Act as the pillar for the operation of agricultural activities and micro-enterprises development

The objectives are:

- To make aware and educate members for controlling their surplus expenses and develop savings practice.
- To deposit the surplus of members by giving assurance and providing attractive returns in their savings.
- To provide credits (loans) at reasonable interest rate to its members in the secure areas for better yields.
- To provide training and advices to members for identifying innovative profitable, activities and selecting of new creations.
- To create friendly environment for learning and sharing, interrelationship among members and cooperatives and networking for long-term sustainable development.

Out of 360 cooperatives registered in Sindhuli district, this cooperative has the maximum number of members (especially women) and largest in mobilizing the savings and credit for improving local community people's lives by them for them.

Some of its major activities are

1. Collection of Deposit - Daily Saving, Children Saving, Monthly Saving, Fixed Saving, Safe saving (Pension Type).
2. Loan Mobilization - Income Generation for small business, agriculture, livestock improvement, shop and mills; Treatment; Education of children; Going abroad;

Purchasing land & Construction of house and animal stall; Marriage; and Household consumption

3. Health Services - Clinical Services, Reproductive Health, General Health Service, Family Planning, and School Health Education
4. Education Support for poor families - School fees, uniform, stationary
5. Revolving fund for income generation - For following activities, this cooperative provides loan for "ultra poor families" at very nominal interest rate (usually 6% per year. The interest rate in our cooperative is 13%. The usual interest rates in other cooperatives are 18-24% per year): poultry, buffalo, goat, small business, foreign employment, and agricultural farming.

Major achievements of the cooperative:

- People are organized
- Freed from money lenders' exploitation because they do not have to go to the money lenders for credit
- Living condition in terms of health, agriculture, education has improved
- Women's contributions are valued and their status has improved
- Poor people have access to resources
- Marginalized communities can put their voices and views

Supporting organizations are

- World Neighbors
- SIDS-NEPAL
- Nepal Rastra Bank
- National Co-operative Bank
- RMDC, Nepal (Rural micro-finance development centre)
- NEFSCUN(Nepal Federation of saving and credit cooperative unions)
- Division Co-operative Office

The challenges faced are unstable government, changing rules and regulation, different officers have different views, and not all cooperatives are genuine.

Despite the challenges, the cooperative aims to

- Turn into Cooperative Bank (Specially manage by rural women)
- Provide accessible health service through Health Cooperative
- To develop into learning centre for other cooperatives
- To play as a facilitator role for establishing and functioning effective cooperatives in rural areas

Open Forum

At the end of the presentation, the participants wanted to know more about the health cooperatives and how it is run.

A successful program is the savings cooperative. The health cooperative has just registered and not yet functioning. They registered 6 or 7 months ago. But they have the community clinic managed by the cooperative. SIDS has seven members for the health cooperative run

by the savings cooperative. They regularly provide service to two clinics especially on women. They also have different groups in other areas and the health clinic provides support thru mobile camps. If there are health cases, they provide services such as lecture on family planning and nutrition.

Further, the participants wanted to know the kind of activities and achievements on health. Based on Thailand presentation, health volunteers are now also advocates, participants wanted to know kind of roles expected from health volunteers in relation to the health cooperative which is newly born.

SIDS is not hiring or appointing health volunteer. There is one working for the government. They have support package through training to support delivery techniques. Only women are working there. They also provide education to women. They keep the record and refer them to clinic and hospital. In the government law, they cannot recruit new volunteers, but can only do capacity building. In Dhaka clinic, health volunteers are working good. That time SIDS was providing support but not now and still they are working effectively.

Another question raised is on the relationship of health cooperative to the savings and loans cooperative.

The new act in Nepal doesn't allow health service provision from savings and loan cooperative. But the savings and credit members are there and have established the health service.

Further, questions were raised on how the savings and loan cooperative are being managed, how is the decision-making being managed, and how are policies determined and who is doing the policies. Normally because it is a cooperative, the board does decision-making and other major direction.

The assembly makes the policy. Yearly, they organize a general assembly meeting and they have boards and different committees, and an internal committee.

Another question raised is the role of those supporting the coop.

They support for training and support staff. They facilitate. They support SIDS to establish the group not the cooperative. They are initial donors. They give money to SIDS not to the

cooperatives. From the bank, the cooperative takes loans because they have cheaper interest. SIDS also takes loan from the bank and then loan it again.

Another question is why the students are not going to school. To which the presenter replied that the education condition in remote areas prevents the girls from attending schools and most work in farmlands.

The representative from India wanted to clarify why traditional farming and health practice were mentioned as problems. Beyond witchcraft, traditional healing is best. Traditional farming, which are now being promoted is not a problem.

SIDS is working with the farmers for new technology and organic farming to support new farming methods. In traditional health system, many people are dying because they don't go to hospital. In remote areas, they only go to witchcraft. So SIDS provides training.

Another question is whether there are cases when loans are never repaid.

According to SIDS, there are only about 0.33% of cases with unpaid loans.

The participants were still very interested to know about the workings of the cooperative - whether a non-member can avail of the health services being offered. It was a bit misleading because health coop implies that people need to be a member but if it is only a way of getting around the law that they are calling it a health cooperative, the question was where is the money coming from to spend for the health service whether it is from the cooperative or from other organizations.

Anyone can avail of the health service but not the loan. Since SIDS is new to health cooperative, they decided to give a portion of the profit for health.

At this point, INAM Philippines shared that in the Philippines, they have experience about cooperatives having a health component. What was set up is there is health and savings and part of the benefits is health insurance or health provision so that a certain amount of the profit they get is put into medical fund for the members so they can use part of that. That is also part of the profit. They assign a certain percentage of the profit that they can use for health benefits.

SIDS shared that in their upcoming assembly, they are planning to decide how many percentage will go to health cooperatives. They are not providing free services. They will be charging but very cheap.

Further, participants wanted to know how the money of the members is being spent and how it is being used. As members of the cooperative, they have the right to the benefits of the money they should be getting out of the loans and profits. Who determines how many percent is given for dividends and the rate of dividends depends on the amount of profit and what could be released as dividends for the members. If the members want to assign a certain amount of profit, how much will be kept and how much will be part of the coop? If health is being provided as part of the benefits therefore it can create a gap for members and non-members.

SIDS shared that health cooperative is open membership.

To which INAM Philippines cited that it is always the limitation of the concept of cooperative. It always separates the members and non members. That way, service is being provided to people who can afford but what happens to the majority of people who can't afford especially now that the organization is making health cooperative and opening it for membership. That means they have to create ways and means for the health cooperative to create profits.

Currently SIDS is inviting all of saving credit members to take membership in the health cooperative, around 300 women members. Family of members can also take service from the health cooperative.

COUNTRY PRESENTATIONS: PHILIPPINES

After the lunch break, Dr Jennifer Madamba of INAM Philippines introduced the next part of the workshop. Following the program and strategy presentations of the foreign delegates, Philippine representatives presented the programs in their areas. Their reports included strategies put in place, challenges faced, and how these challenges were or are being met.

Municipality of New Corella: Experience in Community Empowerment

Ms. Daisy Rose Gunida Rafael
Barangay Health Worker and Patrocenio Tribal Organization Chairwoman
Dr. Nancy Ulanday Obra-Cacayorin
Municipal Health Officer

Daisy Rose Gunida Rafael, President of the BHW organization in New Corella and Chairperson of the Patrocenio Tribal Organization discussed the experiences of the area. Her presentation discussed the following:

- The demographics and geography of New Corella as well as its economy and its administrative breakdown.
- The organizational structure of the area's health care system.
  - The Municipal Health Office (MHO) is the main health institution and oversees the activities of the Barangay Health Workers (BHWs). Each barangay has a committee on sanitary inspection and a nutritional scholar.
- Indigenous Peoples Organizations are under the administration of the Barangay. Generally, IPs are aware of their health rights.
- BHWs are at the frontline of providing health services. Each barangay health worker takes care of about 20 – 60 families and are at the forefront of providing health services. BHW tasks include analysing health services provided to the community, assisting health personnel in dispensing services, and preparing reports for the MHO.
- Current systems in place include:
  - A Barangay Health Board. Previously, New Corella did not have a Barangay Health Board. The boards assist in addressing the needs of the community and it is composed of representatives from the Department of Education (DepEd), Barangay health teams, and Barangay captains.
  - Nutrition posts in hard to reach areas.
  - 9 to 12 percent budget allocation for the area's health needs.
  - Health services for all indigents.
  - Regular meetings and consultations for the people to voice their concerns *(Taho sa Barangay)*.

- The area also recently adopted a "No Home Delivery" ordinance to reduce delivery risks.
- The results of the programmes have shown progress and development in terms of seeing a more enhanced awareness towards health/healthy living.
- However, New Corella still has to tackle challenges such as changes of leadership (municipal and barangay level), pervading superstitious beliefs (ex: burning the house down after a death) and IPs are mostly nomadic.

Open Forum
After the presentation, Dr. Luce was quite interested in the "No Home Delivery" policy. He inquired about its implementation and about significant changes occurred after its implementation.

Dr. Nancy Ulanday Obra-Cacayorin, a municipal health officer, helped in answering queries and imparted that the policy was implemented in 2014. The policy however does not cover the entire area of New Corella. Each of the 20 barangays has its own policies and currently, only three barangays has a "no home delivery" policy. As for the significant changes, she stated that she doesn't have the data from the other areas but in their barangay there is an improvement. Based on municipal data, the figures rose from 73 percent facility-deliveries to 85 percent. Additionally, in 2013, there were two maternal deaths and with the adoption of the policy, there were no deaths the following year.

Dr. Luce further inquired if there any hospitals in the area and what are the systems in place to ensure safe deliveries. Dr. Cacayorin replied that there are no hospitals in the area and it is highly like that there are no doctors either. In delivering babies, the midwives attend to the deliveries at the municipality's birthing and PhilHealth facility. Two facilities function as a birthing centre, one is a private line-in clinic and the other is at the district with two beds. The referral hospital is 20 kilometres away from the main health centre.

Dr. Luce then asked about PhilHealth's coverage in the area. Dr. Cacayorin cited that PhilHealth covers 95 percent of indigents in the area. Dr. Luce then commented that he would not hesitate to adapt a similar resolution in his municipality, especially in the upland barangays; but he feels that the situation is not ideal/suitable in his area with the lack of personnel, transportation, and facilities to handle deliveries.

A participant from India inquired how the policy was brought about. Dr. Cacayorin explained that it was through a series of consultations with the barangays and through educating the community that deliveries should not be done at home and those were in the upland barangays.

Asked about the percentage of women IPs following the policy, Dr. Cacayorin replied that it is their weak point, as there is no separate data on IPs. Since there are no barangays with a dominant IP population, records do not indicate if the mother is IP or non-IP. In any given purok, there are only about five or ten IP families. She recommended in their last meeting that there should be a separate data on IPs

Dr. Luce observed that Tanay has similar problems as New Corella's in terms of the health-seeking behaviors of the IPs. Tanay IPs prefer traditional practitioners when it comes to infant deliveries and they are educating (through the help of the CHWs) the communities to move away from home deliveries to facility deliveries.

The presenter then cited an experience where a couple asked for her help in delivering a baby. As she is not a doctor and the facility is kilometres away, she asked a midwife for assistance. However, the woman did deliver the baby. They then transported the mother and child to the facility receive post-partum care.

A participant inquired about New Corella's process of recruiting CHWs. According to Dr. Cacayorin, New Corella has a policy that lists down the incentives, the requirements, and the process of recruitment. CHWs are given incentives during their period of involvement.

In regards to IP traditions, particularly the burning down of houses after a death, a participant asked if it is still practiced. Dr. Cacayorin shared that it is a tradition but only a few practice it nowadays as some tribes have totally done away with it but they still encounter it from time to time.

A participant observed that New Corella seems to be well organized. As such, she asked how does the area's/group's/organization's policy handle changes in leadership at the municipal and barangay level. Like with any groups, explained Dr. Cacayorin, it's a challenge every three years but through activities sponsored by the Department of Health (DOH). The Municipal Leadership Governance Program ensures that each new set of mayors will be trained on health governance. It is stressed that health is the responsibility of the mayor and the municipality. The same policy applies to every elected official of the barangay. They must be trained on health issues, to ensure that budget and support for volunteers are upheld and there is focus on sanitation, food, and health.

Another participant asked to further explain the public and private partnerships in the area. Dr. Cacayorin simply stated that the corporations, the business sector, and other NGOs help in providing New Corella with resources.

A participant cited from the presentation that CHWs get some form of incentive. In terms of sustainability, he asked, if New Corella has an income generating project to motivate CHWs, apart from getting intensive support from the government and private sector.

The presenter pointed out that CHWs have their own contribution and health insurance. It is a self-help organization. CHWs contribute when someone is sick or in events such as

deaths. Some barangays have herbal processing units, there is a *botika ng baragany* (barangay pharmacy) where 60 percent of the income goes to the CHWs or barangay.

Health and Development for All Foundation, Inc. (HADFAFI) - Tarlac

Ms. Ma. Fatima Cabanes Tanhueco
Senior Programme Officer

Ma. Fatima Cabanes Tanhueco, Senior Programme Officer of HADFAFI presented their organization's community health service programmes. The highlights of her presentation are:

- HADFAFI's focus is on sustainable development with a holistic approach to health. Aside from the physical and mental needs, spiritual health is also highlighted.

Issues

- Poverty is a main issue in their area as it is one of the regions badly hit by Mt. Pinatubo's explosion.
- IPs have no formal education and are malnourished. Immunization is also a problem as IPs think that immunization causes death.
- The area has no sanitation and no proper human wastes disposal.
- Other pervading issues include access to health facilities, poor health seeking behaviors, unplanned parenthood and teen pregnancies, lack of natal care, and dependency on traditional birth deliveries/home deliveries.

Programmes

- The creation of Damayan Leaders. This is a council of leaders taken representing each barangays. Council leaders are Aeta Health Volunteers who have taken a course for Damayan leadership.
- The program promotes healthy lifestyles such as organic farming and a monthly food basket.
- Sustainability programmes are supported by TESDA.
    - Seedlings are given to IPs and other members of the community.
    - Self-supporting/livelihood programmes are put in place such as goat ranches.
    - Together with leadership trainings for both women and men, natural family planning trainings are also provided for Aetas and the men.
    - Education sponsorship of children.

Challenges

- The acceptance and participation of the community
- Barangay support for their interventions
- Natural events/calamities
- The area's terrain, some areas are inaccessible during the rainy season.

Lessons learned

- HADFAFI learned the importance of developing leaders. Community Health Volunteers (CHVs) are also important and health is a share responsibly of the community.

Open Forum

A participant inquired about the involvement of IPs in. The presenter explained that some CHVs are also Aetas and that they volunteer to be part of the programme and some are already leaders.

Inquiring about the community's sanitation, a participant asked about access to toiletries and latrines. The presented cited that prior to their organization's interventions, the community had no system of disposing wastes, the organization provided latrines: two for larger communities and one for smaller areas.

Another asked how many volunteers does the organization have. According to the presenter, there are 33 CHVs and more Aeta CHVs are being trained.

With such a good health service delivery good programme, a participant inquired about their strategies regarding non-immunized children. Through the records of the RHU, the presenter explained that HADFAFI can trace children who have not been immunized. They use the records to track the families down and deliver the service.

The participant then followed it up by asking if there *is* a database of immunized and non-immunized children. Yes, according to the presenter. There is a database of health, immunized children, and of mothers who have given birth. These data are in health centres, the organization reviews the list, recommends it to the health board for intervention. If the government cannot, the organization has been given authority by the government to deliver the services in areas where it is needed/lacking.

Another participant posed an intriguing question, what's the role of the RHU then with HADFAFI delivering all the work? The presenter clarified that the organization is ***in*** partnership with them, the municipal health officer goes with the group. The municipal midwives are also present. Not all the time though, the organization furnishes the health officer with their monthly schedule and if the doctors and midwives are free, they go with the organization to help in attending to the needs of the community. She further stressed that there is no gap between CHWs and RHU people. The teams are composed of CHVs and professionals and they work well.

A participant asked how large the IP population is in their area. HADFAFI stated that the Aeta population is about 20 percent in their area. The organization wanted to sponsor an Aeta interested in taking midwifery but the parents did not want to and during the run of the programme, the organization sponsored four Aetas who have enrolled and graduated from their midwifery courses. Unfortunately, one of them died in an automobile accident.

Municipality of Aloran, Misamis Occidental

Ms. Sagrada Teresa Roa, Public Health Nurse
Ms. Lynsie Erigbuagas, Barangay Health Worker

Sagrada Teresa Roa from the Municipality of Aloran in Misamis Occidental reported on the health programmes and services available to IPs and the larger community. Below are the key points of her prssentation:

The Geography, Government, and Population

- There are 38 barangays, five barangay health centres, and one municipal health center.
- Aloran is prone to landslides and families living coastal areas are always usually displaced after violent typhoons.
- There are IPs in the area and she herself is an IP.
- Previously, majority of Aloran's population were illiterate, as parents did not want their children to get any education. Now there are policemen, teachers, etc in their area.
- Aloran's IPs (Subanon) were previously wary of foreigners, now they bring their children to nearby barangays to study and a road network has been built.

Health Issues

- The area has 12 percent infant mortality. The most common diseases as compiled by the CHV who surveyed the area are cold, asthma, hypertension, mumps, PTB, and skin diseases.
- Substance abuse (alcohol and nicotine addiction, mostly) has also been identified as a major health issue.

Health Programmes and Services

- Maternal, dental, laboratory services, and medical consultations are provided by the RHU.
- INAM Philippines conducted PIM training with 29 participants from 6 barangays.
- Herbal medicines are made available in the communities, if symptoms are persistent, patients are then referred to the RHUs.
- The community conducts ear acupuncture to treat and detoxify substance abuse patients.

Open Forum
Acupuncture as a treatment for substance raised several questions, a participant from India inquired about the procedures

Ric Caminade of INAMs-Philippines explained that acupuncture is a Chinese traditional modality and practiced in most Asian countries. It works on the idea that the body is a network of invisible pathways similar to chakra in the Ayurveda. Acupuncture works by balancing the flow and circulation of energy in the body with the use of needles in specific areas of the body. That is acupuncture in general

Now there is a microsystem of that, meaning there is a system for the ears. Based on the Chinese perspective, there are points in the ears that can stimulate parts of the body/organs. So if you target specific points in the ear, it will create harmony in the body.

For detoxification, there is a set of points targeted to treat substance abuse. One set of points that we are using here is a set of five points, which is also being used in the US. INAM Philippines taught those set of points to CHWs in Aloran because they identified substance abuse as a problem in the area. Aside from reducing the hunger for nicotine, it also induces relaxation; the patient is able to sleep better.

What are the results of the treatment, the participant asked. The presenter answered that results are not final at the time of the workshop as the course was only recently finished and the CHWs do not have the needles to practice ear acupuncture.

A Thai participant then commented that acupuncture can only be practiced by medical professionals in Thailand. In contrast, it seems the Philippines can practice it. Sr. Velasco explained that non-medical practitioners can practice ear acupuncture; anyone who is interested does not even need to know acupuncture. Even without background on acupuncture, they can go ahead with the five specific points. They only need to meet competency standards in order for non-medical people to practice acupuncture and that competency training does not cover ear acupuncture.

The Philippines has a law passed in 1997 that called for use of alternative medicines and the standardizing of protocols for practitioners. INAM Philippines petitioned the government even prior to 1997, as they were already practicing non-traditional methods.

An AHI representative commented that acupuncture requires supplies/needles, and as such cases who covers the cost? How will the CHWs keep on serving the treatment? Carmenchu Badilla of INAM Philippines explained that before they commence with the trainings, it is ensured that the local partner (LGUs) can support and continue the practice.

Tudela Ear Acupuncture

- Tudela is a locality near the municipality of Aloran. Similar to Aloran, INAM Philippines conducted ear acupuncture trainings for Tudela's CHWs.

- This brief presentation defined the importance and benefits of ear acupuncture. Through photographs, she identified and demonstrated the five ear points then proceeded to show how the patients are treated. She explained that before CHWs were allowed to practice ear acupuncture, they had to go through INAM Philippines's training and demo.

- Aside from developing skills on acupuncture, skill on counseling is also developed. CHWs provide counseling for the patient, the family, and the community.

- Based on some of the patients' response to the therapy, developments can already be seen during the first week of treatment.

- Ear acupuncture therapies start with alcohol and nicotine cessation. If other signs of substance abuse become visible, then the remedy requires further counseling and treatment sessions. As substance abuse is a sensitive issue, doctors and the CHWs cannot directly ask or confront the patients about their addiction.
- Ending the report, the Tudela CHW showed a video testimony of one of their patients.

VIDEO CLIP

- The video is a testimony of a 42 year-old male. He is addicted to nicotine. He has been wanting to stop because smoking for a long time as cigarettes are expensive and it causes arguments with his wife.
- His addiction is severe. His children cannot go to school as he spends his already eager income on cigarettes. (30 Php/Day)
- He then availed of the RHU's detoxification program and the program helped.

Barangay Minahan, General Nakar, Quezon

Ms. Marilyn Buendicho, Community Health Worker

The presenter is a new graduate of INAM Philippines' PIM Level 1; she also apologized for not their lack of preparation. In any case, she proceeded to share the experiences of the IP communities in General Nakar. The highlights of her sharing were:

- IP communities are not easily accessible. The local government health units would have to take boats or take the long route to get to their community. Their area is especially difficult during the rainy season. Previously, sick IPs have died because of health services cannot be readily delivered.
- Health workers can only visit during the summer.
- IP children remain uneducated, more and more of the IP communities are deciding to come down from the mountains to avail of the services given by the government. Primarily, education for their children.
- IPs go to the municipal hall to be able to access treatments and services. These are usually illnesses that they cannot treat with their traditional medicines.
- Through INAM Philippines, the community was able to develop their health/treatment skills.

Open Forum

A participant asked about other activities the community has. The presenter stated there are undertakings on sanitation, the environment, and even women's issues. The women of the community are involved with KALIPI, it is a women's organization, put up by the mayor's wife. There is also an herbal garden tended to by the barangay.

Another participant asked how often does the BHW provide services in the area and what are the services provided and what are the IPs view on family planning. According to the presenter, barangay health workers visit once a month and they provide maternal health services. IPs are still wary of vaccines but are receptive to family planning. The IPs believe that they no longer need more children because they can't provide enough education for children.

Synthesis

Sr. Dulce Corazon Velasco, MD, MMS

Sr. Dulce Corazon Velasco MD, from the Medical Mission Sisters and Vice President of INAM Philippines delivered the synthesis of the presentations from the past three days. She began by stating her synthesis is an attempt or a starting point for the group. The synthesis can serve as a framework for the different delegates and from there, they can add or remove any of the points she raised.

Sr. Velasco's synthesis underscored the following:

A. Each of the four countries have a couple of things in common:
   - Poverty – The World Health Organisation (WHO) declared that poverty is the main cause of illnesses in developing countries.
   - New threats to life – These are the effects of **climate change, political instability**, and **worsening natural calamities** (as a consequence of climate change).

B. Each organization has addressed these challenges in their own ways. In these strategies, there are phases of community participation or expressions of community participation. These can be seen through:
   - **Service provision** in forms of voluntarism and voluntarism with remuneration. Service provision however must meet the Q4As. It must be affordable, available, accessible, acceptable, and of quality – meaning the service must be safe.
   - **Participation in the decision-making process.** Some communities were directly involved in decision making for the programmes. If not, they are involved in deciding whether they would reject or accept the services. This is relation with the community's right to decide on matters that affect their lives.
   - **Financing.** Community initiatives were financed.
   - **Networking.** Many of the countries are networking with different groups. They are finding the right people or organization to work with on projects that need to be implemented. These projects may be community clinics, for the development of health volunteers, or programmes focused on children.

C. *These are already the components of a local healthcare system.* Whether it is private or public, the components are the same and community participation can be seen in the building up of the components of a local healthcare system.

D. *The community's relationship with local government units (LGUs).* The relationship with LGUs in terms of getting support, some are implementers of projects and programmes of the LGU. Some are recipients of services and benefits.

E. *The community's network and linkages.* This has to come from an understanding of what health is - if health is determined by social determinants. The building of Linkages by the government with NGOs, networking with sponsors, networking with communities (organizations, federations), the projects are transitioning from top to down, the networks and links that need to happen however should be horizontal because participation needs to broaden in order to mobilize those mostly affected by policies (ex, the poor).

F. The above is the current system of all the participating countries. However, there must be a change in the mind-set in order to face arising challenges and threats. There must be a change in the mind-set in the minds of the leadership.

G. The rising of new threats has not been tackled yet and it is becoming increasingly necessary to include it in the programmes. To face natural calamities for example, do communities need to build evacuation centres? How is the community going to face this challenge?

H. To meet challenges and threats, there must be a paradigm shift. The change in perspective can be made through the following:

- Projects can focus on vulnerable sectors such as IPs, women, PWAs, and PWDs.
- Acknowledging that local health care systems can be built up through participation. With communities involved, new threats can be faced and can be informed on efforts are needed for a sustainable programme.
- Health needs to be redefined. It is no longer enough to state that health is the total well-being. **Health should be defined as the total well-being of a person or communities, as a result of the interplay of political, economic, spiritual, and socio-cultural aspects.**
- How we see the poor should also be modified. There is a need to move away from seeing the poor as uneducated and therefore need help. If the new definition of health comes into play, it becomes evident then that **health improvement is community development**.

I. Without a shift in consciousness, organizations are bound to repeat mistakes again and again.

J. The mind-set on how resources are viewed should also be considered. What is the basis for choosing partners/sponsors? Is it to attain a sustainable local health care system, or more than that? There are more important things to make programmes sustainable. Sustainability can be had with community participation.

Open Forum

After the synthesis, a participant from Tarlac commented that in the context of community development or poverty as a whole, they do not only deal with health. Although Aetas are primarily healthy – they lack in other areas – she states they are illiterate and lack spiritual development. Sr. Velasco quickly corrected her statement and said that her observation is coming from a mind-set that those who cannot read nor write are not developed. In her experience, those who cannot read nor write make the best CHWs, they are the ones with the most to share. The poor has a lot of wisdom even though they do not have formal education.

A participant from India then inquired about sustainability. He cited that one of the major challenges they face is that the new generation has no understanding of the old traditions. To address that, they are aiming to include it formal education so that the new can appreciate the old traditions. Sr. Velasco expressed apprehension and remarked that they might use it the same way other information is used: discarded when not needed. She added that they have already done that and new ways of responding must be developed and probably, it may become possible.

A participant then wondered what would be the role of traditional knowledge with this new challenge and paradigm shift. It used that knowledge is strict and there are no choices or no chances of integrating other points. Sr. Velasco explained that it is a matter of broadening the field of options for people, the appropriate action is to allow or to provide venues for people to make choices, and so if they choose to do it in the way they know it will work for them. Rather than telling them do things in a certain way but if they are given the chance to do what they want to do, we might learn something new. What we need to do is to provide venue for participation and believe that people know what they want and know how to get what they want.

Another partner asked what role does globalization has to play in this shift in consciousness. Simply put, according to Sr. Velasco, it is taking the challenge of globalizing the issue.

A participant then expressed that there is too much emphasis on NGOs. Although he believes in community participation and rights-based approaches; in one hand we there is community participation – but in doing so – the responsibility of the government is compromised, the challenge is how to conscious of the government side. Sr Velasco clarified that it is the part of the paradigm shift. Services need to be provided by the government but the reality is governments are unable to deliver. Something has to be done. So tapping on the potential, the potential to create the service; it needs to be in dialogue with the government and the government should also be ready to accept the innovation offered by the communities. The programmes are for the communities' children and for the next generations to come. If the government accepts it, then there is a dialogue, as equals. In the

end, the government no longer tells the people what to do, but at the same time the people need to respect the authority of the government, none of us has the answer to anything and everything.

A participant from Bangladesh commented that the synthesis is excellent but it did not explore the influence of party politics on programme decisions and so he asked how will it address the concern that sometimes NGOs are influencing the community. It does happen, it is acknowledged. According to Sr. Velasco, that is a common experience especially among professionals. NGOs – or not only NGOs – but people moslty educate people to accept the way they think most of the time. The challenge is how they can give without influencing others; that is getting the people from the community to share their own wisdom and their own knowledge. If they're only given the chance that they will not be afraid that they will be insulted, or laughed at. Sr. Velasco stressed that they have to build a climate that what the communities say will be accepted.

Commenting on the environment aspect, a participant from India explained his situation in is work area. Stating that 50 percent of biodiversity in his area is already lost, maintaining or preserving the remaining percentage is a challenge. The environment aspect needs to be included in the programmes, stated Sr. Velasco, if this new threat is to be addressed.

Given that there were no further questions, comments, or additions, the synthesis was then presented to the assembly and accepted by the group.

Field Visit/Homestay Orientation

Before formally ending the session for Day 4, Ms. Maria Cristina C. Paruñgao, Executive Director of INAM Philippines, oriented the group on the program for the field visit/community exposures the following days. Nine families in three barangays are willing to host the IWS delegates. The nine groups were assigned in Barangay Mamuyao, Barangay Daraitan, and Barangay Laiban in Sitio Magata and Sitio Manggahan.

As it is a valuable learning experience, Ms. Paruñgao instructed the participants to be aware of the key learning points – lessons and insights from integrating with the host family, the community, talks with the local government, and the experience of the community health worker in managing their community health program in their respective barangays. Feedback/reporting per group commenced on March 9 (Day 7).

Field Visit/Homestay – Day 4 to 6

For three days, the participants stayed with the IP communities in four barangays in Tanay. Before leaving for their field visits/homestay, Dr. Luce advised the participants on what to expect in their respective areas. Some of the photos taken from the three day community visit are below:

The Workshop – Day 7

After the flag ceremony, Day Seven started with an introduction of the day's activities. Dr. Jennifer Madamba of INAM Philippines acted as a facilitator for the day and Ms. Arneth Versonda of the IPHC-Davao Medical School Foundation did a recap of Day Three's presentations as well as the Field Visit/Homestay during the weekend.

Recap

Ms. Arneth Versonda
Project Manager, Institute of Primary Health Care (IPHC) – Davao Medical School Foundation

The recap noted that based on the presentations of the different groups last March 5, these strategies/points resonated well with the participants:

A. The excellent health care system in Thailand
B. The system of cooperatives, savings, and loans in Nepal
C. The representation of IPs in the Philippines
D. And ear acupuncture as treatment for substance abuse.

The presenter further noted Sr. Velasco's synthesis of the presentations at the end of Day Three, she reminded the plenary that there are new challenges such as terrorism, political instability, and effects of climate change ahead.

To face these difficulties, she stressed that a paradigm shift needs to happen. Communities need to think out of the box or otherwise, they risk creating the same mistakes repeatedly. Afterwards, she briefly discussed the field visit/homestay from Day Four to Six.

Recounting that the participants were divided into four teams and were assigned to different barangays, Day Four started with a visit to the Regional Health Unit (RGU) for a quick orientation and a chance for the participants to discuss experiences and strategies with the RHU personnel. Afterwards, the teams were then taken to their respective areas.

Key Learning Points

Before proceeding with the day's activities, the participants shared their key learnings from March 5. Below is a summary of their insights:

India:

- The successful cooperative system in Thailand and the process of the health care system in Thailand.

- Two learnings: the women cooperative groups for the financial and health benefit of women and Thailand's National Health Commission Office (NHCO) can be a model for India. It can be replicated in our working areas by involving all stakeholders.
- Good synthesis by Sr. Velasco, reminding us of the threats and pinpointing priorities for planning. The active participation of the community in Thailand.

Bangladesh

- Thailand's networking strategies in addressing public issues and challenges.
- "No Home Delivery" resolution in a Barangay in the Philippines and the integrative medicine trainings that pursue community participation, giving IPs the voice.
- The sustainable savings and credit cooperatives in Nepal. It has a good network with banks.

Philippines:

- Thailand's tripartite partnership involving the government, private, and civic sectors to solve public challenges and to create new opportunities for the country as a whole.
- Thailand's "bottoms-up" approach and ear acupuncture as a treatment for substance abuse.
- Sr. Velasco's synthesis that community participation requires a lot of components and that there must be a paradigm shift to affect/effect community development.
- Situations are somewhat similar, citing a situation in which a woman giving birth was also carried to the health care centre via hammock because area is inaccessible.
- Tanay's community funding for community health needs.
- Community participation is key to sustainable development.
- There are other IPs in other countries (she thought IPs are only in the Phils) Different IPs have similar problems.
- LGU has a strong working relationship with the NGO in Tarlac regarding the delivery of health services.
- The Davao community has an excellent "No Home Delivery" ordinance.
- Appreciated that herbal medicines used in their area are also used in other communities.

Nepal:

- Thailand's government is providing good health services to the people.
- The participatory approach in Thailand's Government Health Assembly.
- Our common concern for providing affordable, acceptable, available, and accessible health services is important.
- PPPs is the way develop quality of life, good health services and the help of the private sector to motivate, advocate, and to service people in Nepal

Japan:

- It is important to cite NGO and community efforts can enhance GO schemes and make it function.

- Need to build new relationships with people and LGUs we work with. We need to have a new or wider concept for this we need a new mindset and a new way of doing. We need to question critically and to constantly if our actions a contributing to change or not.
- The creative approach to treating addiction.

Field Visit/Homestay Reports

After the morning coffee break, the teams presented their field experiences. Their presentations should cover their learning experiences with the host family, the community health workers, the local government units, and the community.

Barangay Mamuyao Group

Presented by Mr. Anup Kumar of Karuna Trust

Group Members:

Workshop Participants:
- Anup Kumar (India)
- Raja Dodum (India)
- Ma. Arneth Versonda (Philippines)
- Daisy Rose Gunida (Philippines)
- Sagrada Teresa Roa (Philippines)
- Jennifer Medina (Philippines)
- Mila (Philippines)
- Marilyn (Philippines)

Asian Health Institute:
- Yayoi Takada

INAM Philippines:
- Carmenchu Badilla

RHU:
- Jenny Ansay
- Biboy Gabut
- Karen Repato

CHW:
- Ofelia Pineda
- Gemma Porciuncula
- Sherlita Delazada

Learning Points from the CHWs
The presenter remarked that the community field visit was a very enriching experience and cited that his team found CHWs strong commitment, spirit of voluntarism, selflessness, and efforts in bridging gaps to be most commendable.

Learning Points from host family
His team found it stirring that despite their meagre living conditions, the host families were very hospitable. Also noteworthy is that there is gender equality. Whether male or female, household responsibility/chores is shared between husband, wife, and the children. The team also noticed the family's love for nature as the houses and surroundings were filled with different types of flowers and plants. Finally, the team noted the family's good relationship with the neighbours and their trust and support for the health workers.

Learning Points from the Community
Like the host families, the team found the whole community to be friendly. They also noticed that old methods or customs (such as rice husking with a heavy mortar) are still being practiced. Also to their surprise, the community is well kept with good sanitation and excellent drainage system. They also observed that there is a healthy relationship between the IPs and the non-IPs.

Learning from the LGU
Based on the team's reflections, the LGU in Barangay Mamuyao provides good health care services to the community. The LGU does this through the formation of different committees, income generating activities, and setting up health infrastructures within the area.

Barangay Daraitan Group

Presented by Mr. Deepak Kumar Ghimire of Shindhuli Integrated Development Service

Workshop Participants
- Deepak Kumar Ghimire (Nepal)
- Bal Kumari Shrestha (Nepal)
- Dr. Nancy Cacayorin (Philippines)
- Roberta Lagata (Philippines)
- Lynsie Erigbuagas (Philippines)

INAM Philippines
- Ric Caminade

Asian Health Institute:
- Kagumi Hayashi

RHU
- Mildred

CHW
- Analyn Pranada
- Amor Pentason

Learning Points from the CHWs

The team noticed that as the CHWs are quite dedicated to their responsibilities, and has a good working relationship with families, the barangay, and the LGU, they are quite popular in the area.

Learning Points from the host family

Similar to the first group, the second group found the host families to be quite friendly and hospitable, despite the scarce food resources.

Learning Points from the community:

The team took note of the community's terrain. They remarked that it can be quite difficult to access even more so with typhoons and other natural events. However, the area is beautiful and can be a tourist destination.

The team asked the residents about their needs and priorities and found that health is the least of the community's priorities. From their talks with the people, they discerned that food is the community's first priority. They also added that the community's natural resources should be maximized as currently; the area's income is low and is largely dependent on processing wood for charcoal.

As such, poor health seeking behaviours abound. Pregnant women have no access to health care and there is little support coming from the main government. Education is also not a priority. The team remarked that even if the school is only ten minutes away from the barangay, out of the 68 households, only one household has a child that goes to school. Apart from the health seeking behaviours, the team observed that vices such as cockfighting, tobacco chewing, *jueteng*, and bingo games are prevalent. The team also thought it significant that some residents have expressed a dislike and level of frustration with NGOs, stating that NGOs have done nothing for them.

Learning Points from the LGU

The team expressed slight disappointment for the LGU. They remarked that the LGU is not that familiar with the community's demographics. They also discovered that there are no programmes specific to the needs of the IPs.

Finally, the presenter offered a couple of recommendations, one is to develop cooperation between GOs and NGOs and second, create programmes to address the community's poverty.

Sitio Manggahan, Barangay Laiban Group

Presented by Ms. Nuanchawee Nedsaengtip of Trang Hospital
Ms. Suvanee Samathi

Workshop Participants:

- Nuanchawee Nedsaengtip (Thailand)
- Suvanee Samathi (Thailand)
- Marilou Almacion (Philippines)

INAM Philippines

- Tina Urag

RHUs:

- Ma Teresa Domeyeg
- Dang Paterno

CHW:

- Myrna Velasco

The Sitio Manggahan group departed from the reporting format and instead of delivering their insights categorized into four sources of learning, the group presented their community experience as a whole. The report can be broken down as follows:

Learning Points from the host families and the community

- There is gender equality in the household, both men and women cook, children learn responsibilities at home. Often, children are left alone at home when parents leave to work in the farms.
- Houses have vegetable gardens; this is in addition to the community vegetable garden alongside the riverbank.
- The area has large families and most of the children have skin problems as they opt not to wear clothing.

Learning Points from the community

- The team quickly noticed that the area is prone to natural calamities.
- Transportation is provided by a single jeep, commuters/travellers who missed it, must take the *habal-habal* instead which costs 400.00 Php per ride.

- The barangay has no recreational facility but it manages with makeshift sports and play areas.
- Because of the large families, the team noted that the community is congested and current housing is not conducive for living.
- The barangay has a school and it has five teachers attending to the education of about 200 children.
- The team observed that the riverbank and domestic animals play a significant role in the community's economy. There, the community cultivates taro plants.
- Together with the CHWs, there are also traditional birth attendants in the area.

Learning Points from the LGU

- The community conducts monthly health education/discussions, the topic during their visit was TB prevention and there are also proposals for a women's summit to address women's issues and concerns.
- The Community Health Clinic is open five days a week but midwifery services are only delivered once a month.
- The team commended the barangays sanitation efforts. They specifically cited the area's toilet ordinance – in which each family has to have one – and the ordinance prohibiting animals to be leashed along the roads or in/near farming areas.
- Government mobile services are provided by the LGUs. However, IP families are not registered in the country's census, as families are not formally married.
- The team congratulated the community for putting up a health care financing system for emergency health needs.

Recommendations

- The team offered the following recommendations for the area, one is to provide family health planning education to its residents, and second, for the LGU to setup a housing fund and device an evacuation warning system for its residents.

Note:
Before wrapping up their presentation the team's members from Thailand commented that the area is rich with a type of weed – that is used in traditional Thai medicine for treating or easing nicotine cravings. Capsules made from the weeds are sold at 10 baht per blister pack in Thailand but the residents can avail of it for free as it is abundant in the area.

Open Forum
A representative from Bangladesh asked the presenter about how ordinances in Sitio Manggahan are passed. He wanted to know if CHWs play any active role in the passing of the ordinances.

The CHW from the team explained that the CHW does have a role. First, the CHW compiles a report primarily on the health situation of the community and present it to the LGU. The LGU then reports it to the RHU and the RHU finally determines the policies and ordinances needed by the barangay.

Sitio Magata, Barangay Laiban Group

Presented by Mr. Addala Jaggannadha Raju of Centre for Community Development

Workshop Participants:

- Md. Akramul Haque (Bangladesh)
- Md. Romzan Ali (Bangladesh)
- Shiree Laxmiram Uraw (Bangladesh)
- Ma. Fatima Cabañes Tanhueco (Philippines)

INAM Philippines

- Gilbert Hernandez

AHI

- Shiori Ui

RHU

- Laurence Asinas

CHW

- Josefina Amit
- Alicia Teves

Learning Points from CHWs
First, the team recognized that the CHWs are aware of their role as community leaders. They actively promote and protect the rights of IPs and as such, the community puts so much trust in them. The team also appreciated the CHWs knowledge about traditional herbal medicines and amazed that even with the

absence of modern technology and devices, CHWs are able to readily communicate with one another.

Learning Points from the host family

The team found the families to be generous and hospitable. There is no gender inequality and as in the other communities, all household members share responsibilities and house chores. The team also noticed that the family – and the larger community has little regard for family planning and education. In any case, families are able to maximize their resources and often state that they don't need much to be happy.

Learning Points from the Community

It is clear that the community values its traditions as it keeps the local culture alive. A downside to this is that blind beliefs/superstitions still thrive. The area lacks places of learning but it has quite a number of churches and religious places.

While there are no livelihood programmes and living conditions are inadequate, the people are content with what they have. Generally, the community is peaceful and there is very little discord among neighbours. The team also commented for the virtually non-existent vices in the area. They found that residents consume alcoholic drinks on special occasions. Also, reflecting the attitude of the families, the community has no gender disparity as males and females are treated equally.

Learning Points from the LGU

Discerning the role of the LGU in the community, the team found that the councilor is close to the community. They underlined that an active council makes quite a difference in the area and it manages even with a low budget allotment. There is strong support for IP rights and it has a system for providing assistance in emergencies (hospitalization or death). The team however also found certain areas lacking, such as there are no current ordinances on sanitation, the absence of doctors, and medical referrals are not properly in place.

International Workshop Synthesis

Sr. Dulce Corazon Velasco, MD, MMS

Before presenting her synthesis to the group, Sr. Velasco acknowledged that the participants had a very enriching experience with the communities. Nevertheless, she needs to ensure that everyone is on the same page, understand her synthesis, and connect it with the experiences and realities of the communities.

Defining the term synthesis, Sr. Velasco stated that a ***synthesis is a summary of an experience of a certain point in time***. Relating it to the presentations the previous days, she stated that her synthesis is based on the commonalities of among the different participants. Looking at the context of each country, she recognized poverty as a common aspect and because of poverty; communities are vulnerable to ill health and diseases.

As non-profits or social justice groups, the organizations need to address the needs of the poor and make a choice on which sectors to address. In the context of the workshop, it is the Indigenous Peoples but engagement can also happen with other vulnerable sectors, such as women, children, Persons with AIDS (PWAs) and Persons with Disabilities (PSDs).

Now, poverty and health issues are already being addressed by the participating organizations in their own unique ways, India through Karuna Trust, Nepal through cooperatives and health savings, Bangladesh through community clinics, Thailand through political networking, and the Philippines through community-motivated health programmes.

It is in line with the workshop's theme, which is the empowerment of IP communities through sustainable health programmes. Though the strategies may slightly differ, the workshop revealed that there are similarities. These are:

1. **Community Participation.** These community members as:
    - Implementers
    - Recipients of services
    - Service providers, whether as full volunteers or as volunteers with remuneration[1], again, it must be noted that services provided to the community must exhibit the Q4As.
    - Members of financing strategies
    - Initiators of programmes and projects.
    - Part of a referral system
    - Decision-makers

    These expressions are already components of a health care system. Through the integration of community participation, surfaced components of a health care system.

[1] Sr. Velasco noted that receiving remuneration for his or her services is not a volunteer.

2. **Countries and/or organizations have a working relationship with the LGUs.**

A recurring hypothesis is that health care programmes must be coordinated with the LGUs for sustainability. While a strong relationship with the LGU matters, it is also important to define and perhaps redefine the roles of the LGU and the community. LGUs must be ready to accept poor communities as partners or equals and the community must stop seeing itself as mere beneficiaries or recipients of services.

3. **Presence of networking and linkages with other sectors.**

Another recurring theme is the building of linkages with GOs, other NGOs, and private companies.

4. **Emergence of new challenges.**

Participants are also facing new challenges such as more violent natural calamities brought about by climate change, terrorism, and political instability. To tackle these difficulties, the challenge of creating a new mind-set or shifting to a different paradigm is must be met.

Experiences from the Community Visits

Sr. Velasco commented that the guide questions and the format of the reporting helped in bringing the different team's experiences together. From the reports, Sr. Velasco summarized the experiences as such:

Experience with the CHW

- The strong commitment of the CHWs.
- Services are given to the community given via alternative methods of treatment and education.
- Health services are given/taken to where communities.
- CHWs are responsible and know how to multi-task. This comes naturally, as CHWs are trained on different levels, from organizing to education down to health care provision.

Experience with Host Family

- Families are generous and hospitable despite the glaring poverty.
- Families are happy and content despite the poverty.
- IP Families are one with nature.

  Here, as part of the challenge in changing mind-sets, Sr. Velasco commented to not define or categorize IPs as nature lovers. It is the nature of IPs to be connected with the land and therefore are not nature lovers but they see themselves as part of nature.
- Families have very limited aspirations. Because of poverty, the families cannot think about the future. The challenge is letting them realize that they still have a future.

- Empowerment and the lack of gender disparity. There is sharing of responsibility among households.
- The maintenance of old traditions while nurturing quality relationships with others in the community, including non-IPs.

Experience with Community

- The cleanliness of the environment/barangays.
- Due to decentralization, local councils can have regular meetings and decide on how to raise their area's revenues and decide where to allocate the finances.
- Communities are able to provide basic health services.

Sr. Velasco then concluded the synthesis that the communities they went to have been implementing sustainable health programmes for the past five years. After such a brief time, the communities have undergone change and this amount of development can be credited to the education process. IPs have reclaimed and are comfortable with their traditions.

Open Forum

A participant inquired if the communities visited are the communities who have undergone a five-year programme with INAM Philippines.

Sr. Velasco confirmed that the areas are communities under INAM Philippines and further commented that she is quite happy that their communities have achieved a lot in five years. She also remarked on the previous observation that some of communities were wary if not hostile towards NGOs. Sr. Velasco acknowledged that some communities have been victimized by NGOs. Often, such groups would come, survey, leave and never come back. Communities can become frustrated and develop a dislike for NGOs and this sentiment is quite common in some communities. Sr. Velasco then also cited that the lack of vices in some barangays is a product of a long education process and struggle with the residents.

A participant from India commented on his experiences in Barangay Mamuyao and asked if it might be more advantageous to put the RHU under the care of NGO instead of the government.

Sr. Velasco stated that that is not an option and not viable. She explained that even if government health services stop at the RHU, CHWs have a good working relationship with the RHU. CHWs are at the forefront of delivering services down to the family level and in turn, CHWs often look to NGOs such as INAM Philippines to provide trainings. With the help of such NGOs, health services are realized even in furthest areas.

Another Indian participant raised that CHWs are trained by NGOs and wondered if a CHW alone can provide quality health services. To answer this, Sr. Velasco cited statistics, stating that 85 to 92 percent of diseases and cases in the communities are handled by the CHW and only 8 to 12 percent are referred to the RHU. In addition, INAM Philippines is putting together a best practices manual addressing the ten most common diseases in communities. Once finished, the manual will be used by CHWs in different areas so as to standardize the quality of service and treatment delivered by the CHW.

A participant from Japan then remarked that the community visited by the participants have trust in each other. She also appreciated NGO efforts (like INAM Philippines') of educating and raising awareness, however, she also saw this as an opportunity for identifying leaders in the community. She suggested that perhaps the people can identify potential leaders and that perhaps the role of the NGO is to help identify these leaders and develop their potential. She then expressed concern about the referral system in other areas. Realizing that some systems are lacking, she asked what kind of capability is needed for the community to overcome this problem.

Sr. Velasco clarified that health programmes are already structured in that manner and is integral part of the government structure. In the case of Tanay, Dr Luce initiated trainings and the communities identified leaders that will attend the trainings. The graduates of the trainings become the CHWs and they are the ones who put together reports for the RHU. In turn, the RHU implements policies or interventions based on the reports.

Another participant then shared that there is a big difference between the CHWs in Tanay and the CHWs in Tarlac. She observed that in Tanay, particularly among the IPs, CHWs are not hesitant to accept responsibilities whereas in Tarlac, there is some form of trepidation among the CHWs.

Sr. Velasco then commented that one of the key learnings from working with communities is that the identification and delegation of tasks or responsibilities should come directly from the IPs/communities. Based on experience, people tend to forget tasks assigned to them in contrast roles voluntary chosen by the individual.

Introducing the Guide for Action Plans

Shiori Ui of the Asian Health Institute then provided the participants with a set of questions for the participants' action plans. The guide contains only two questions and is focused on the experiences and lessons from the past week.

The guide questions are:

1. What are your key learning points/insights from this workshop?
2. How can you apply your key learning points in your work area?
    - Actions: What are your plans of actions based on what you have learned from the workshop?
    - Strategies: What your specific strategies in implementing the plans of action?

The participants were asked to be concise and to write down their action plans on a large sheet of paper or present it in PowerPoint. The teams were given an hour to work on the presentation and the time set for action plan presentation was set at 9.30 AM, the following day.

The Workshop – Day 8

Opening Ceremony

As the day's facilitator, Anicia Sollestre of INAM Philippines led the opening ceremony of the workshop's final day. In this energizing exercise, she directed the group to close their eyes and to feel the energy of the air, the earth, and light. With a calm and relaxing voice, she explained that the communing with nature's energy is effective in recharging one's energy. After, she and Ric Caminalde, also of INAM Philippines taught the group a simple exercise to get the energy flowing through the body.

Recap

Dr. Raja Dodum, MBBS, MPH
State Nodal Officer (National Urban Health Mission), Govt of Arunachal Pradesh, India

Before commencing with the day's activities, Dr. Raja Dodum did a recap of the previous day. He recounted that the week started with a flag ceremony headed by Tanay's Mayor, the honorable Rafael Tanjuatco. After, the field visit/homestay teams reported on their experiences and learning points from the community, the CHWS, the host families, and the LGUs. Sr. Dulce Velasco then synthesized the reports and related it with her synthesis from March 5.

Shiori Ui then presented a guide for the group's action plans. The groups were given two questions and were told to prepare a ten-minute presentation.

Action Plans

Please see Annex A for presentations
The action plans of each group were presented after the morning coffee break. The groups are to discuss, first, their key learnings the past week and second, how they will utilize this knowledge in their communities or work areas. The nine groups were given ten minutes to talk about their action plans and five minutes was allotted for questions, clarifications and comments.

Karuna Trust (India)

Presented by Dr. Raja Dodum

Dr. Dodum enumerated the key learnings which his group found to be applicable in their working area, these are the financing for health services, the involvement of stakeholders,

the "No Home Deliveries" ordinance, and the active involvement of women in the programmes.

As such, Karuna Trust, drafted the following strategies to be implemented by the second quarter or by the second half of 2015. These are:

1. **A "No Home Delivery" campaign.** The group is aiming for a 100 percent NHD delivery in the area. Their strategy includes IEC production, CHW involvement, midwife visits, and offering attractive packages for pregnant women. If successful, they are planning to replicate the project in other areas.

2. **Community Health Financing.** Karuna Trust together with three PHCs and the government shall implement a policy of health savings/finances for the community. The group will engage the health department and based on INAM Philippines guidelines, they will draft a policy that is suited for their community.

3. **Health Assembly at PHC level.** Learning from the experiences of Thailand, Karuna Trust wants to hold a health assembly to discuss the issues and problems faced by the community. It is envisaged that the health assembly will result to immediate and concrete actions by the government and concerned agencies.

4. **Formation of a cooperative.** With Nepal's experience serving as a guide, Karuna Trust shall form a coop in communities.

Open Forum
For clarification purposes, a participant inquired on the purpose of the financing scheme. Karuna Trust explained that the purpose of the program is to provide financial support in aspects of health care. The presenter pointed out that there are different insurance programmes available but those do not cover peripheral expenses such as referral transfer costs. These, especially the needs of the poor and those in rural areas can be covered by the scheme. If successful, it can be replicated in other communities.

AHI then expressed concern about the group's target date. She reminded the group that an attempt at schemes and programmes at this scale require organizing and financial resources or that a system should already be in place to handle the project. She then advised the group to allot more time for the strategies.

Karuna Trust explained that they have been working with communities on a lot of issues for the past ten years. They have established committees in those areas and that as for them, the more important aspect is trust and they have that. The second is getting the reference guidelines from INAM Philippines. With that, Karuna Trust is optimistic that by August or even earlier, they can start on the programme.

Ms. Paruñgao of INAM Philippines then advised that before they could come up with a committee on financing there should be a process to be taught to the community. She stressed that the community should be prepared to handle the demands of a community

financing. A project such as a financing scheme, the community must be consulted first, if such a strategy is acceptable to them.

Mr. Caminade added that a community health financing scheme works on a formula. First, the community must be organized and should have its own programme to meet the health care needs of the community. The community must be able to address conditions that can be treated at home. Otherwise, the insurance or the financing scheme will fail without an underlying programme to support the basic needs of the community.

Karuna Trust clarified that they have thought about that when coming up with their strategy. Looking at their organization's structure, the group rationalized that since Karuna Trust works like an intergovernmental agency, and they have CHWs and health professionals, and that they can socially prepare their communities before venturing into the scheme. Their plan of action is to discuss it with the communities and hope that that they will agree.

Centre for Community Development (India)

Presented by Mr. Addala Jagannadha Raju

Raju immediately jumped to his organization plans. Guided by the lessons he has seen and heard the past week, his action plan and strategies are as follows:

- Promote public and private partnership
- Promotion of Community Health Volunteers
    - Select candidates and conduct trainings to build their capacities
- Health assembly/public hearing
    - Organize health hearings with orgs and PHIs.
- Community Health financing
- Promotion of herbal medicines at the household level
- Include climate change in programmes as it has an effect on sustainability of communities. Here, he stressed the importance of network with other both local ad international NGOs.

Open Forum

AHI commented on the Mr Raju's plan of promoting public and private partnerships. Given Karuna Trust's experience in promoting and developing PPPs, AHI inquired how his approach will be different or similar with that of Karuna Trust's.

The presenter explained that there are already PPPs in his area but not in regards to health. His plan is to bring public and private sector to cooperate and make health programmes successful.

Sr. Velasco then commented that the presenter carefully chose key words in his presentation and she's wondering what's the overall purpose of his action plan?

The presenter expounded that the action plan is an attempt at incorporating new strategies or focus. There is a promotion of PPPs as well as the development of CHWs and the appreciation of herbal medicines. He also thought that the pressing issue of climate change

should be addressed as he earlier stated, changing weather patterns compromise the sustainability of communities and its programmes. It is also a chance for networking with other NGOs on issues or matters that affect the community.

Development Association for Self-Reliance, Communication, and Health (Bangladesh)

Presented by Mr. Md. Akramul Haque

Haque likewise jumped directly to DASCOH's action plans. His group put emphasis on promoting herbal medicine use and participatory approaches in addressing other health issues. DASCOH's strategy are the following:

- To organize a workshop with community and let it be a venue for sharing experiences.
- A union level assembly where communities and support groups can discuss health issues and adopt resolutions to address the issues.
- Work with the government on implementing resolutions such as "no home deliveries", setting up of latrines.
- Promote institutional delivery by putting together a database and establishing contact with pregnant women.
- Promote health education among IPs, currently there are health education efforts but the focus is not IPs. DASCOH hopes to modify this by involving IP leaders in the health education projects.
- Promote herbal medicine use.
- And Enhance community participation in health and planning implementation.

Open Forum

AHI asked if herbal medicine use is already in the mainstream and if not, what are DASCOH's persuading points to get the government and other sectors to promote herbal medicine use.

According to the presenter, there is already one pharmaceutical company promoting the use of herbal medicines. Aside from that, like in the Philippines, herbal medicines are quite popular in Bangladesh, especially among the folks in rural areas.

AHI then followed it with another inquiry, noticing that the action includes the involvement of several sectors and setting up meetings with CHWs, clinic committees and the union, the plan requires a lot of advocacy work. AHI wanted to know of the strategies that DASCOH picked up from the workshop.

In Bangladesh, the presenter explained, there is a written clause that the union can pass bylaws. They are hoping to use that clause in order to organize the community and to address health issues.

Shinduli Integrated Development Services/Milijuli Savings-Credit Cooperative (Nepal)

Presented by Ms. Bal kumari Shrestha
(Translated by Deepak Kumar Ghimire)

Nepal mentioned that the workshop has given the group several ideas that can be adapted to their area. These are the focusing on an NGO and LGU partnership in delivering health services, the provision of alternative medicines and treatments especially in rural areas, the mobilization of female CHWs, the use of herbal medicines, and delivering health services to the people in the rural area.

As such, Nepal's plan is to increase community health standards by focusing on IPs, mobilizing and training more female community health volunteers, distributing herbal plants, the setting up of a health camps and a referral system, and providing services to where the people are. They added that folks in the rural areas have limited access to health services and the group is aiming to change that.

Open Forum
A participant commented that the plans are good but is it enough to merely distribute herbal plants.

The presenter acknowledged that it is not enough but it could be a start. Their purpose is to introduce herbal plants to the people. Their idea is to hire resource people to train communities on cultivating herbal plants. If possible, they also want to provide technical support for farmers in maintaining the herbal medicine gardens.

AHI commented that strategy of mobilizing existing CHVs instead of training a new batch of CHVs very interesting and she wondered about the expected difficulties of mobilizing the CHVs.

In Nepal, they explained, only the government can train CHVs but they are able to mobilize them. They added that mobilizing the CHVs may be very difficult as the CHVs are completely volunteers and thus, organizing them can be a challenge but it is a task they are willing to face.

New Corella/Institute for Primary Health Care (IPHC)-Davao Medical School Foundation (Philippines)

Presented by Dr. Nancy Ulanday Obra-Cacayorin

Davao's key learning from the workshop is that modern medicine can be integrated with traditional modes. Another is the importance of having a community-participatory approach. Its underlying principle of decision-sharing and listening to the communities needs are the key in sustaining health care programmes.

Based on the two key learnings, Davao's action plans are:

- Attend consultative meetings to present their action plans to Barangay Health Council. This is to impart learnings down to the purok level, hoping that in presenting their action plans, it will help the community in develop nursing remedies and maximize their use of local resources. This includes the identification and documentation of available herbal plants, maintaining a garden, etc.
- Continue with IEC campaigns develop community health financing that include IPs.
- Integrate traditional treatments in the healthy lifestyle ordinance.
- Planning will be participatory and will involve all stakeholders.
- Tap INAM Philippines to provide an orientation-seminar on Integrative Medicine, acupuncture, and others.
- Include other sectors in their health programmes such as schools, corporations, coops, and other people's organizations.
- Promote a health care financing system.
- Raise awareness on climate change by integrating it with all their activities and programmes.

Open Forum

A participant inquired if the promotion of traditional medicines is not enough in the area. The presenter pointed out that they are already promoting traditional modalities but not all barangays and particularly new CHWs are endorsing it. What they want to work is for the all areas to include in their approach and together with the modes they are already promoting, they want to include other remedies such as ear acupuncture for treating substance abuse.

The participant from Tarlac then commented that New Corella plans and its existing programme is really fantastic. However, she hopes there could be some form of student exchange as actually experiencing it is quite different from merely reading it from a handout or a PowerPoint presentation.

The New Corella representative stated that New Corella is an exposure ground for other NGOs. If anyone is interested to know about the area's programmes, they can contact their mother NGO, go to Davao and visit New Corella.

A participant asked for further explanation about their strategy on documenting herbal plants. Would it be a simple documentation or would it involve complex analyses. The presenter expounded that it would be a simple documentation process at this stage. They would ask the help of traditional or IP healers in identifying plants. From their knowledge, they will create a baseline of plants in the area and the list of illness that can be treated by the plant. Later perhaps, the Indian delegates can help in providing solid science behind the plants.

In regards to the financing scheme, a participant inquired about strategies the organization will employ. The presenter clarified that their task is to simply inform the area about what they learned from the workshop and to propose a similar scheme. Ultimately, it is up to the community to adopt it and to formulate the policies suitable to their needs.

Aloran, Misamis Occidental (Philippines)

Presented by Ms. Roberta Lagata

Aloran's presentation was quite straightforward. Looking and hearing about the experiences of the areas, she learned that there should be collaboration between stakeholders: the community, the barangay health workers, NGOs, and the government. She also found that a strong relationship between IPs and non-IPs as a good base for community sustainability.

As these are already in place in her community, her action plan is to continue with their existing programmes and further promote a harmonious relationship between IPs and non-IPs. A sturdy support from other stakeholders should also be maintained.

Open Forum

A participant asked, as an IP herself, what specific points with Tanay did she find most impressive. The presenter responded that what struck her the most is the community's health financing. She explained that in Aloran, there is a finance assistance scheme in cases of death but none for the living. What she hopes to establish is to have a system in place that will lend financial assistance to the living.

Another inquired if IPs are represented in the barangay council meetings. The presenter highlighted that aside from being a CHW, she is also a member of the council. When she attends meetings, she wears two hats. She puts on either a CHW cap or an IP cap depending on what issues are being discussed.

Her role in the barangay council raised interest and AHI asked about her position. As an IP, she explained, she is representing a tribe and she is in the council because the community elected her.

A participant remarked on the harmonious relationship of the area's IPs and non-IPs and wonders how does one go about it, exactly. Again, as often stated, trust is important and it is a matter of relating to each other as equals. In their case, establishing organizations that are open to both IPs and non-IPs help foster a healthy and equal working relationship between IPs and non-IPs.

A follow-up question asked if whether IPs are separated from the non-IPs in their area. Describing how the community is organized, she demonstrated that no distinctions are made. IPs and non-IPs work together and it is evident in matters such as nominating people to undergo health care trainings.

Tanay, Rizal (Philippines)

Presented by Ms. Christine Mitra

Out of the weeklong workshop, the Tanay group grew to appreciate the importance of PIM trainings. They themselves were a part of the trainings but never fully appreciated it until the results became evident in the workshop. They also learned that other countries, like the Philippines are burdened with other health problems. Despite the health issues however, community cooperation, involving the youth sector and the availability of herbal medicines can help ease the burden.

Their action plan is strengthen already existing programmes and to improve their recording and referral system, develop the community's financing scheme, put up a birthing facility for IPs, and further their relationship with GOs and NGOs.

Open Forum

A participant observed the community's pleasant attitude towards each other. She then wondered if the community ever experiences conflicts and if it does, how does the community respond. The presenter admitted that conflicts happen and it cannot be avoided. When it does occur, it is quickly resolved through meetings and discussions. So far, the community has not experienced a conflict big enough that it cannot be solved.

A participant inquired about if there were any instances when the RHU failed to respond to the needs of the area. The presenter cited instances where the assistance was delayed but requests are always responded to especially for ill patients needing medical care from the RHU.

In envisioning a birthing facility, a participant asked about specific strategies in going about this request. The process, Ms. Teves explained involves sending a request to the MHO, signed by the CHWs. The request is duly noted by the Barangay Captains and doctors to show support for the IPs' need for a birthing facility.

At this point, Dr. Luce chimed in and broke the news that the birthing facility for IPs is already included in the budget. The next step is identifying a strategic location and the IPs could help in pinpointing a location that will be suitable to them.

Health and Development for All Foundation (HADFAFI), Inc. (Philippines)

Presented by Ms. Jennifer Medina Dumlao

The Tarlac team cited community participation, delivery of quality health services, the role of women in development, and a change in thinking as their primary learnings from the workshop. From there, they have devised a set of action plans that seek to strengthen the role of IPs in their area.

They plan to do this via ocular inspection of other potential sites, allowing the IP to take leadership in the organizations, strengthening NGO-GO-Community partnerships, and adopting INAM Philippines strategies in their work area.

Open Forum

AHI asked the group to further clarify the purpose of the ocular inspections. Ms. Fatima Tanhueco explained that their current programme does not reach into other communities. Through site visits, they hope to introduce their health services in even further areas.

AHI also wished to know about which particular INAM Philippines strategies the group is hoping to replicate or apply. HADFAFI said that if the proposal gets an approval, they want to bring INAM Philippines to Tarlac and to conduct their PIM trainings there.

General Nakar, Quezon Province (Philippines)

Presented by Ms. Marilyn Buendicho

The Quezon Province team cited several important key learnings but what struck them most was the efforts in some areas to preserve IP culture and knowledge. As IPs, this resonated well with them. Second is the importance given to herbal medicines. Such an approach is a big boost to the sustainability of community health programmes. Third, they appreciate *Saknungan sa Kalusugan*. It is a positive force in the community as it is aims to providing assistance to people in need.

Inspired by the key learning points, the group has planned to :

- Promote own traditions and cultures so that it will be preserved and appreciated by future generations.
- Form their own *Saknungan sa Kalusugan*, they are planning to invite families to a discussion and lay down the benefits of having such a scheme in the community.
- Encourage IPs to harness herbal medicines available in the area, particularly in barangays with no or limited access to health centres.

Open Forum

Regarding the IPs language, a participant asked if IPs in the area are still speaking their mother tongue. She also inquired if schools in the area teach the language.

The presenter explained that at the moment and the way things are progressing, the younger generation is losing touch with their language. Currently, only the elders know how to speak the dialect. Also, in their town, only one barangay teaches the language. Sr. Velasco added that there are IP groups that have purposely set up their own schools in order to preserve and teach their language and culture.

Further, the current school curriculum puts the emphasis on Tagalog and not on the dialects of the IPs. The K12 curriculum is currently exploring or processing guidelines to teach local dialects alongside Tagalog but it is taking some time as not all barangays have IPs or a set of barangays in a given town may have differing cultures.

A participant clarified that the National Commission for Indigenous Peoples (NCIP) and the Lyceum University of the Philippines has a programme covering Bulacan, Cavite, and Rizal. As part of the program, students from the K1 to K12 levels are encouraged to go back to their dialects and customs. In the context of Mindanao, the Department of Education (DepEd) is still not adapting it but NGOs have set up programmes to revive the culture of the IPs.

In the case of the mutual health benefit for the living, AHI was interested to know if the group would be able to mobilize the people to participate in a *Saknungan sa Kalusugan* type scheme. The team said they will talk directly with individuals and groups. In the end, it is still up to the people to if they would join or not, she finished her report by stating that they will not insist or force the people to participate.

Trang Hospital (Thailand)

Present by Ms. Suvanee Samathi and Ms. Nuanchawee Nedsaengtip

Thailand began their report by stressing the importance of empowered volunteers. With a strong team and a sturdy support from GOs and NGOs, organizations can meet and handle any threats that may spring up. According to the team, empowerment occurs when there is information and knowledge exchange.

As for their key learnings, they concluded that poverty is the main issue. The goal now is to acknowledge that the situation can be remedied by taking responsibility and appropriate management. The strategies they enumerated include strengthening public and private partnerships, developing a holistic approach to health care, and developing a system suited to the needs of the IPs. Encouraging private sources to come together and provide budgetary assistance for running the programmes can support the strategies.

Open Forum

In the questions part, AHI asked the group to further explain with what they meant when they said private networks as well as sources of budgetary support. The team cleared that the private networks mentioned mean private hospitals, private professional organizations but it can include any sectors on health and development. As for the budgetary support,

they want to involve the government and local government units to support any programme growth for IPs.

Group Reflection

This week's final activity is different from previous key learning reports. This time, with a more personal approach, the participants are asked to share their personal journey and development the past week. For a more intimate group reflection, Ms. Sollestre asked the participants to form a circle. She further instructed that people who can assist with translations can sit beside participants in need of assistance.

Their individual reflection are as follows:

- After this workshop, Participant One promised that whatever help she extends, she multiply it three to four times more. She expressed gratitude that she was able to attend the workshop as it raised her awareness and made her more understanding. She also significance of herbal plants and thanking participants from Thailand, she realized learned a common weed can help ease her cigarette/nicotine addiction.

- Participant Two felt blessed and happy as the workshop gave her the opportunity to gain new friends and experiences. It also had an impact on her way of thinking. She realized that the government is there with its existing policies but she can train herself and her coworkers to improve the situation of the communities. She expressed that people – government or medical people - often forget who they are serving. It is time to rekindle that spirit, that public servants are there for the people in the community. Finally, she said that there should be respect for each other's rights and opinions, as the rights and opinions of others are often neglected. She then thanked everyone for the experience especially the exposure in IP communities as it helped her the clients – particularly – the very poor.

- Participant Three promised to help teach alternative medicines so that the people will be able to help and heal themselves.

- Participant Four shared that she enjoyed the solidary and the sharing of stories. She reminded herself to be open to a paradigm shift. As Sr. Dulce said, it is something the groups need to embrace and health workers like her should be open and flexible. She also expressed thanks that the workshop challenged her commitment to her work, especially her work with IPs.

- Participant Five offered her thanks and she's happy that even she was not able to understand most of the sessions. She's grateful were eager to learn their experiences, even the stories of people as far-flung as Mindanao.

- Participant Six shared that she's happy as she finally met her goals in the community, thanks to the help of INAM Philippines and the midwives. For the past five years, they were able to face great challenges and yet were able to broaden the experience of IPs. She is at her happiest when she is able to help instead of receiving assistance.

- Participant Seven stated that she is happy after nine days of learning; she will finally be able to go home. She gained a lot of knowledge as a CHW and feels that her time at the workshop gave her enough skills to further serve those in need.

- Participant Eight is happy to have met other delegates and appreciated that even with the differences in language, they were able to understand and relate with each other. She further congratulated the participants for embracing the community visits despite knowing that the communities are very poor and have very little to offer.

- Participant Nine shared that she learned a lot despite that the majority of the sessions were done in English. She thanked the translators for helping her understand some of the points and discussions.

- Participant Ten is pleased to know that herbal medicines are also in use in other countries. She is also thankful and sees the workshop as a means of offering different solutions to problems.

- Participant 11 expressed her overwhelming joy and realized that her sacrifices for the community have not been in vain. As a mother, she is hoping to balance the demands of her role as CHW and demands of her family. Still, she is filled with joy to realize that the foreign participants recognize the efforts of her community.

- Participant 12 shared that is very touched and so very humbled to know the situation of other nations especially in regards to their IPs. She stated that she is open to change as long as it is for the good of the community.

- Participant 13 stated that she feels blessed after learning so many things from the workshop.

- Participant 14 shared that the organizations in the workshop has the power for change. She then thanked the translators for their untiring assistance.

- Speaking in Nepali and translated into English by her colleague, Participant 15 shared that in her flight from Kathmandu to the Philippines, she had questions in mind. Those questions were answered as she learned that the people are very friendly and helpful. She cannot speak English but she does understand the language, yet despite this setback, she's happy that there is no discrimination. The challenge now is in maintaining coops and she is encouraged to do more after this workshop.

- Participant 16 acknowledged that organizing an international workshop is not an easy task. Thus, he congratulated INAM Philippines for a wonderful workshop. He also congratulated the IPs and the CHWs for working on difficult issues.

- Speaking in Bangla and translated into English by his colleague, Participant 17 remarked that, first, he is impressed that Sr. Velasco's fluency in Bangla. Second, it is his first time to visit another country and he is quite happy to have met other people. Third, he learned a lot from the field visit/homestay and it encouraged him, as a health volunteer, to do something for his people

- Participant 18, also speaking in Bangla, and translated again by his colleague, said that the food was great even if it was so different from Bangladeshi food. As for the workshop, he learned a lot of things that he can utilize in his community. He also praised the facilitators for handling the sessions quite well. The energizers and the interesting stories made the time pass. He also appreciates that he was able to absorb all the info despite that his limited English skills.

- Participant 19 jokingly remarked that he found it difficult to concentrate on the sessions as he was busy translating from English to Bangla. However, he can summarize the weeklong workshop into three words: appreciate, connect, and

replicate. He explained that he appreciated that nobody hesitated to participate despite the communication difficulties. In the meantime, with the sharing of experiences, he feels connected with the other organizations and lastly, what he or they learned, they can replicate in their respective areas.

- Participant 20 stated that it is rather unfortunate that he was not able to bring along one their community volunteers. As that volunteer does not have formal education and cannot read nor write, they encountered problems in the processing of his travel documents. He felt that the workshop would have been a fantastic learning ground for the volunteer. At any rate, he learned that communities may be deprived of material wealth but they are definitely happy. He also learned the value of networking with other NGOs and he would be happy to work and be a partner in some programmes.

- Participant 21 observed that in his years of participating in workshops, he learned that participants never contact each other afterwards. He hopes that even after the workshop, they maintain that connection so that they can help each other. Also, he renewed his energy and enthusiasm of working for the people and that he should work with IPs.

- Participant 22 stated that he felt supplemented with minerals and vitamins. The info and learning experiences enriched his perspective. He admitted that the world is getting too small but for the group, there is no barrier that divides them, may it be race, religion. He sees the group as a family, a team, a network that could lend support when needed. As the head of a medical department in India, he shared that his experience the past week has humbled him and he has found new respect for the IPs in his country.

- Participant 23 shared that the workshop helped broaden her views and inspired her to continue with her work with marginalized sectors.

- Participant 24 imparted that she is now ready to change her mind-set and in her work with IPs, she could consider and integrate their culture in the services provided.

- Participant 25 stated that she is happy and encouraged. She is particularly inspired by the spirit of the traditional peoples.

- Participant 26 expressed that a paradigm shift is her key learning. Taking this into account, she realized that she can gain knowledge from them and that only the IPs themselves know what is good for them. It is a challenge to be conscious of this and to be responsible in her work with the IPs.

- Participant 27 shared that given her role with AHI, she felt responsible with what went on in the workshop. She felt that it was too ambitious but realized that the international workshop is an empowering process for all concerned. All the different regions and the strategies help put the group where it is now. They have done so much and there is more that needs to be done. She also learned that the way to move forward is to have patience and to have flexibility. With such, the learning process can be appreciated. She also expressed gratitude to the municipality of Tanay for hosting the workshop and lastly thanks everyone for participating, as she fully understands the time away from families can be tough.

End of Reflection

Closing Remarks

Ms. Kagumi Hayashi, Asian Health Institute

Kagumi Hayashi of the Asian Health Institute (AHI) delivered the workshop's closing address. In her heartfelt closing speech, she extended her appreciation and compliments to not only INAM Philippines but to everyone who has participated in the workshop.

She observed that everyone is happy and during the run of the workshop, some feelings may been hurt but it is a part of the learning process and she hopes that it the hurt may be a reason to improve and give one the courage to move forward.

She then underscored that the workshop was an opportunity for everyone to reflect on their activities and what they have achieved. She cited the CHWs of Barangay Daraitan for their cheerfulness and willingness to serve others. The *Saknungan sa Kalusugan* is another worthwhile venture as it ensures the future of the next generation – and that should be the focus of their work – the future generation.

She then also expressed understanding for her colleague's previous apprehension about sustainable health care systems but she realized that with confidence and faith, such systems – deemed to be too ambitious – can become a reality.

She expressed gratitude for Dr. Luce and his energetic team of RHU people and CHWs. Their knowledge and skills are truly valuable. Finally, she cited INAM Philippines and their commitment - she acknowledged this commitment to be quite unique and deeply rooted among the people. As such, she feels very special for having INAM Philippines as a partner.

Closing Ritual

In leading the closing ritual, Ms. Anicia O. Solestre directed the participants to raise their right hands and to hold their left hands up in a receiving position. Then while singing a short hymn of peace and friendship, she instructed the participants to face the cardinal points to receive the healing and energizing gifts of the North, South, East, and West.

Annex A: INAM-Philippines and Tanay Presentations

3/21/2015

EMPOWERMENT of INDIGENOUS PEOPLES through COMMUNITY PARTICIPATION for SUSTAINABLE LOCAL HEALTH SYSTEM

The Integrative Medicine for Alternative Health Care Systems **(INAM)** Philippines, Inc.

- is a non-stock, non-profit, health non-government organization (NGO)

INAM Philippines (formerly ATRC - Acupuncture Therapeutic and Research Center Inc.)

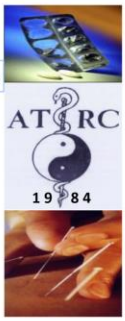
In 1980s, as medicines and doctors' fees became more expensive

Promotion of acupuncture by ATRC to

CBHPs (Community Based Health Programs) set up by NGOs and Church programs provided

alternative health care services

for the poor and vulnerable who had little or no access to quality health care.



Health in the hands of the people.

CBHPs were able to establish

- that health could be in the hands of the people

- by giving volunteer Community Health Workers (CHWs) and, through them, community members
- a better understanding of and enabling them with skills and effective technologies for health care

CBHPs also continued to use Philippine traditional and indigenous medicine (herbal, massage) as these were more available and accessible.

ATRC saw the need to study

the **integration** of different systems of medicine

to arrive at a cost effective delivery of health services

for poor communities and vulnerable sectors

1

In October 2001, ATRC changed into INAM Philippines, Inc.

to promote Philippine Integrative Medicine (PIM) as

- an evolving awareness or consciousness
- that views health as a state of total well-being
- resulting from interplay of socio-economic, political, ecological and spiritual aspects of life

Philippine Integrative Medicine (PIM)

adheres to the integration of different systems of medicine:

- based on science and the culture of people
- that addresses health problems in the community
- through promotive, preventive, curative and rehabilitative services

Health Services **(Q-4A)**:

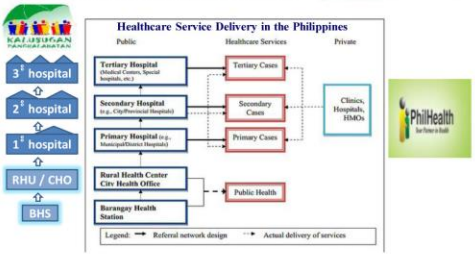
- ***Q*** uality/ effective
- ***A*** ccessible
- ***A*** ffordable
- ***A*** vailable
- ***A*** cceptable

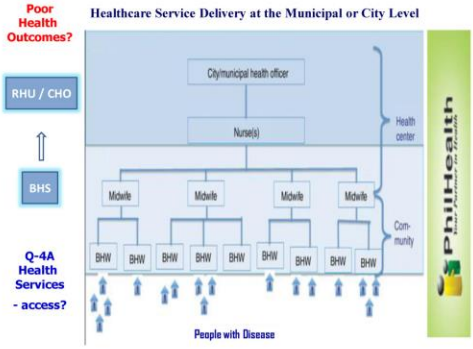
to the people

Basic to PIM as a consciousness is the understanding that health

- is a fundamental human right (*an obligation of government*)

HUMAN RIGHTS



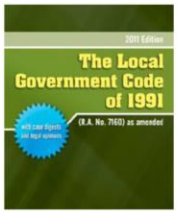


Basic to PIM as a consciousness is the understanding that health

- is a fundamental human right
- is a responsibility of individual and, collectively, of community.

HUMAN RIGHTS

HUMAN RIGHTS



Section 34:
Role of People's and Non-governmental Organizations

- encouraged active and direct participation of POs, NGOs and the private sector
- in the process of local governance
- by making them formal members of several local special bodies such as local development councils

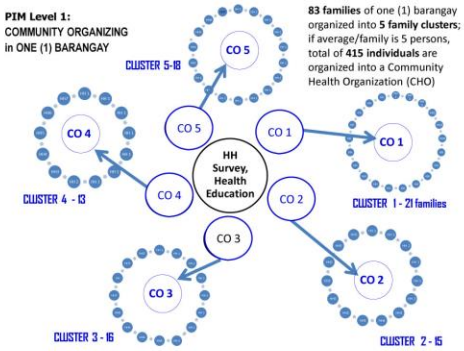
PIM, as an evolving consciousness,

- emphasizes the direct, responsible and sustained participation of indigenous peoples
- in the development of their alternative health care systems
- through an education process
  - that not only verified that people are empowered
  - but also shows the actual processes by which they had taken health in their own hands.

Philippine Integrative Medicine

(PIM) Training

PIM Level 1: (4 days)
COMMUNITY ORGANIZING
> Community Action Plan for Household Survey and Health Education towards analyzing their 3 Major Community Problems and Solutions



Philippine Integrative Medicine

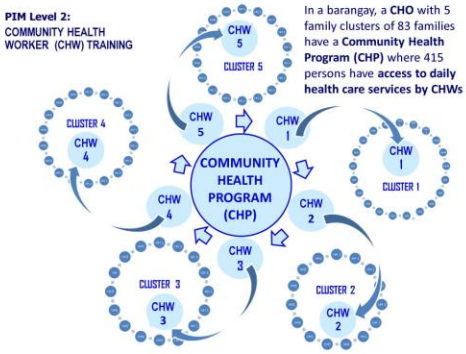
(PIM) Training

PIM Level 1: (4 days)
COMMUNITY ORGANIZING
> Community Action Plan for Household Survey and Health Education towards analyzing their 3 Major Community Problems & Solutions

After 2-6 months

PIM Level 2: (5 days)
COMMUNITY HEALTH WORKER TRAINING
> Community Health Program with aim of educating family members and mobilizing the community in addressing their own health and related concerns
> Further training on EAD if with problem of substance abuse/ addiction

Different Modalities on Integrated Health Care:
Indigenous Filipino herbal medicine, Traditional Chinese Medicine tuina, Anthroposophic Medicine compresses and Energy Healing

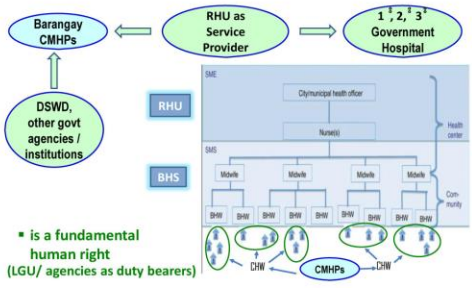


CHW RECORDS for PIM 2 TRAINING

1. **Record of Patients Treated, Diseases and Referrals**
   1.1 Monthly Summary of Patients, Diseases, Referrals by CHW
   1.2 Monthly Summary of CHP
2. **Record of Health Education Conducted**
   2.1 Monthly Summary of Health Education conducted by CHW
   2.2 Monthly Summary of CHP
3. **Record of Home Visits**
   3.1 Monthly Summary of Home Visits by CHW
   3.2 Monthly Summary of CHP
4. **Record of Herbal and Vegetable Gardening**
   4.1 Monthly Summary of Families with Herbal/ Vegetable Gardens
   4.2 Monthly Summary of CHP
5. **Record of Other Actions** (ex. tapping sources of potable water)
   5.1 Monthly Summary per CHW
   5.2 Monthly Summary of CHP
6. **Monthly Record of CHW Meetings**
7. **Monthly Record of CHW Meetings/ Linkages with Partners**
   (ex: meeting with RHU, DENR, Municipal / City Social Welfare Dept)

PIM: towards an **alternative** health care system
by Barangay CMHPs to achieve better health outcomes

Basic to PIM as a consciousness is the understanding that health



- **is a fundamental human right**

(LGU/ agencies as duty bearers)

Philippine Integrative Medicine (PIM) Training

PIM Level 1: (4 days)
COMMUNITY ORGANIZING
> Community Action Plan for Household Survey and Health Education towards analyzing their 3 Major Community Problems & Solutions

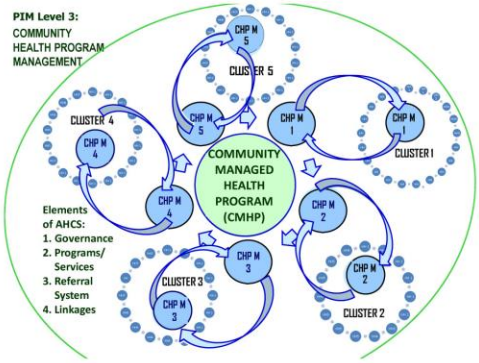
After 2-6 months

PIM Level 2: (5 days)
COMMUNITY HEALTH WORKER TRAINING
> Community Health Program with aim of educating family members and mobilizing the community in addressing their own health and related concerns
> Further training on EAD if with problem of substance abuse/ addiction

After 1 year

PIM Level 3: (6 days)
COMMUNITY HEALTH PROGRAM (CHP) MANAGEMENT
> Knowledge and skills in planning, implementation, monitoring and evaluation of their CHP
> Knowledge and Skills in facilitating a Reflection Process

Different Modalities on Integrated Health Care:
Indigenous Filipino herbal medicine, Traditional Chinese Medicine tuina, Anthroposophic Medicine compresses and Energy Healing



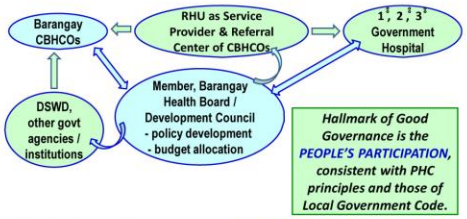
PIM and ENHANCEMENT COURSES	
PIM ORIENTATION	Alternative Health Care System Element
PIM LEVEL 1: COMMUNITY ORGANIZING	Governance - Community Health Organization at the barangay level

PIM and ENHANCEMENT COURSES	
PIM ORIENTATION	Alternative Health Care System Element
PIM LEVEL 1: COMMUNITY ORGANIZING	Governance - Community Health Organization at the barangay level
PIM LEVEL 2: COMMUNITY HEALTH WORKER (CHW) TRAINING	CHP - Promotive, Preventive, Curative Services, Referral System, Linkages with LGU, agencies

PIM and ENHANCEMENT COURSES	
PIM ORIENTATION	Alternative Health Care System Element
PIM LEVEL 1: COMMUNITY ORGANIZING	Governance - Community Health Organization at the barangay level
PIM LEVEL 2: COMMUNITY HEALTH WORKER (CHW) TRAINING	CHP - Promotive, Preventive, Curative Services, Referral System, Linkages with LGU, agencies
PIM LEVEL 3: COMMUNITY HEALTH PROGRAM MANAGEMENT	Health Governance – Potential of Representation and Participation at Barangay Health Board/ Dev Council

PIM: towards a **enhanced** health care system
by Barangay CBHCOs to achieve better health outcomes

Basic to PIM as a consciousness is the understanding that health



- **is a fundamental human right**
(LGU/ agencies as duty bearers)

- **is a responsibility of an individual and collectively, of the community**
(CBHCOs as claim holders of Right to Health)

PIM and ENHANCEMENT COURSES	
PIM ORIENTATION	Alternative Health Care System Element
PIM LEVEL 1: COMMUNITY ORGANIZING	Governance - Community Health Organization at the barangay level
PIM LEVEL 2: COMMUNITY HEALTH WORKER (CHW) TRAINING	CHP - **Promotive, Preventive, Curative Services**, Referral System, Linkages with LGU, agencies
PIM LEVEL 3: COMMUNITY HEALTH PROGRAM MANAGEMENT	Health Governance – Representation and Participation at Barangay Health Board/ Dev Council
PIM ENHANCEMENT: 1. Ear Acupuncture Detox for Substance Abuse	Rehabilitative Services

PIM and ENHANCEMENT COURSES	
PIM ORIENTATION	Alternative Health Care System Element
PIM LEVEL 1: COMMUNITY ORGANIZING	Governance - Community Health Organization at the barangay level
PIM LEVEL 2: COMMUNITY HEALTH WORKER (CHW) TRAINING	CHP - **Promotive, Preventive, Curative Services**, Referral System, Linkages with LGU, agencies
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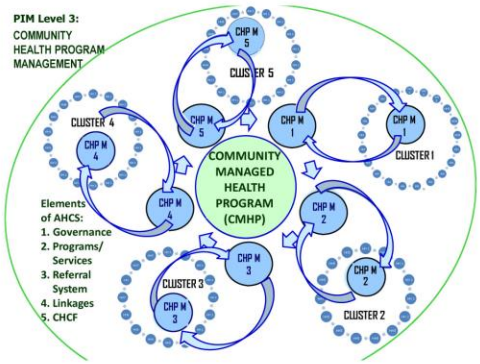
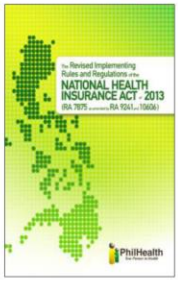
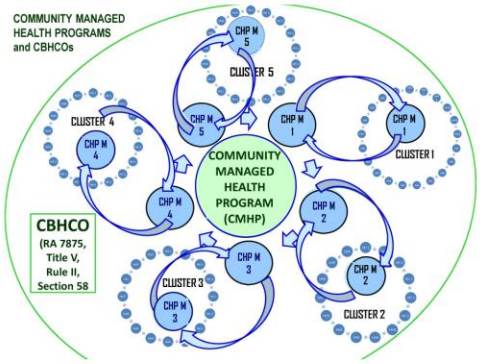




National Health Insurance Program - compulsory health insurance program of government, which provides universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all Filipinos

A **Community Based Health Care Organization (CBHCO) -** an association of members of the community organized for the purpose of improving the health status of that community through **preventive, promotive, and curative health services**.

Note: Section 58 – PhilHealth shall prescribe requirements for accreditation of group health care institutions …. and CBHCOs.



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3. Training of PIM Facilitators	Governance - CHP Expansion

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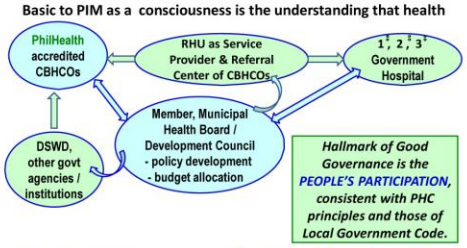
3. Training of PIM Facilitators	Governance – CHP Expansion
4. Organizational Management	Governance - Community Health Organization at the municipal level

PIM: towards the **evolution** of sustainable health care systems by Federation of CBHCOs to achieve better health outcomes

Basic to PIM as a consciousness is the understanding that health



- **is a fundamental human right** (LGU/ agencies as duty bearers)
- **is a responsibility of an individual and collectively, of the community** (CBHCOs as claim holders of Right to Health)

Relationship among those who uphold PIM consciousness is characterized by partnership of
- one among equals
- being interdependent and mutually transformative of each other

Key Actors in Sustainable Development

Thank you for the Opportunity to Share and for your Sharing

INAM Philippines
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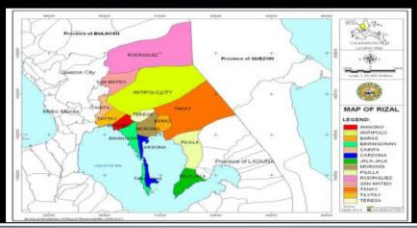
Magandang TANAY HANE !!!!

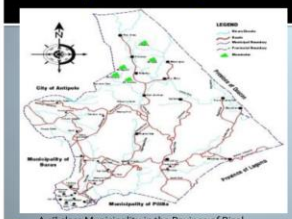
TANAY, RIZAL, PHILIPPINES

Province of Rizal



Have 13 municipalities and 1 city. Bordered by metro manila to the west, province of Bulacan to the North, province of Quezon to the east and Laguna Province to the South.

Map of Tanay



GEOGRAPHICAL LOCATION

– 54 KM. EAST OF MANILA

- LAND AREA – 33,466 HECTARES

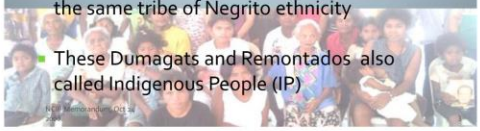
95 % RUGGED AND HILLY

5% FLAT AGRICULTURAL

- A 1st class Municipality in the Povince of Rizal
- This areas are covered mostly with forest.
- The coastal plains found along the southern position of the municipality
- Comprising about 1% of its total land area are predominantly used for urban purposes

Community Profile

- Out of the 33,466 hectares 28,000 hectares have been identified as the ancestral domain of the dumagats and remontados.
- The Dumagats and Remontados are one and the same tribe of Negrito ethnicity
- These Dumagats and Remontados also called Indigenous People (IP)



Total of 19 Barangay

POBLACION- 67,990
UPLAND- 43,356
TOTAL POPULATION - 111, 346

POBLACION

1. Brgy. Kay Buto
2. Brgy. Pinagkamaligan
3. Brgy. Kat- Bayani
4. Brgy. Mag- Ampon
5. Brgy.Tabing Log
6. Brgy. Plaza Aldea
7. Brgy. San Isidro
8. Brgy. Tandang Kutyo
9. Brgy. Wawa

UPLAND

1. Brgy. Sampaloc
2. Brgy. Daraitan
3. Brgy. Cuyamaby
4. Brgy. Laiban
5. Brgy. San Andres
6. Brgy.Sto Nino
7. Brgy. Mamuyao
8. Brgy. Cayabu
9. Brgy. Tinucan
10. Brgy. Sta Ines

Indigenous People Population

Barangay	IPs Inside AD		IPs Outside AD		Non-IPs Inside AD	
	HH No.	IND No.	HH No.	IND No.	HH No.	IND No.
Sto Nino	58	270	0	0	65	319
Laiban	178	807	36	91		83
Mamuyao	63	234	0	0	93	411
Tinucan	44	178	0	0	120	533
Daraetan	360	1,682	77	299	353	1,640
Cayabu	31	99	0	0	103	441
San Andres	111	399	23	102	77	228
Sta. Ines	215	839	0	0	228	985
Sampaloc	93	427	17	78	1,030	9,893
Cuyambay	301	1,359	3	16	54	203
TOTAL	1,454	6,294	156	586	2,123	14,736

NCIP Memorandum, Oct 24 2014

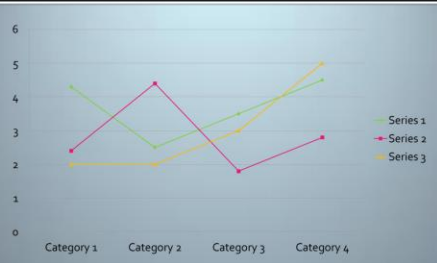
Igorot Tribe: 55 Families or 229 Individuals

MAJOR NATURALRESOURCES:

- >Gold
- >Iron ore
- >Manganese
- >Calcite

MAJOR PRODUCTS:

- >Ratan
- >Palay
- >Mangga
- >Coconut



TANAY- LOCAL GOVERNMENT

TANAY- LOCAL GOVERNMENT

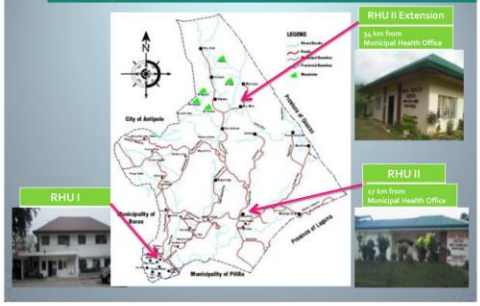
MISSION

- A regional tourism haven with diversified, highly competitive economy, health and sustainabbly developed urban ,rural and natural environments a pro-active and responsible governance and God fearing, self reliant and socially responsive citizenry.

VISION

- To ensure the equitable growth and balanced, sustainable development of the municipality thru excellent government governance and the highest standards of public service

Tanay Rural Health Unit



Tanay Municipal Health Office

MISSION:
- To provide quality healthcare services by making it available, accessible and sustainable through advocacy, sectoral linkages and community involvement.

VISION:
- To have a healthy and empowered community through delivery of quality healthcare services in Tanay from 2010 and beyond.

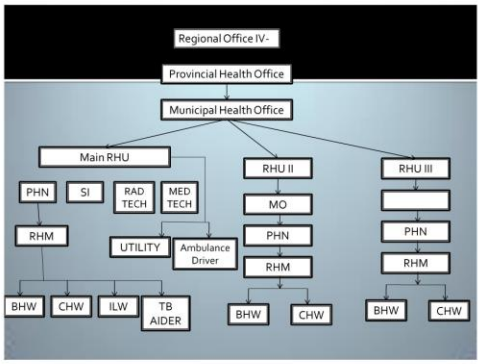
Services Offered

SAFE MOTHERHOOD/ MATERNAL CARE
CHILD CARE
PREVENTION AND CONTROL OF COMMUNICABLE DISEASES
PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES
MEDICAL CONSULTATION
DENTAL SERVICES
LABORATORY AND X-RAY SERVICES
ANIMAL BITE TREATMENT
ENVIRONMENTAL HEALTH SERVICES
DISASTER PREPAREDNESS
AHYD PROGRAM
SOCIAL HYGIENE

- PRIMARY HEALTH CARE BENEFITS
- MATERNAL CARE PACKAGE
- TB DOTS
- ANIMAL BITE TREATMENT CENTER

PhilHealth
Your Partner in Health

ACCREDITED



RHU STAFF

Position	Permanent	Job Order
Doctor	2	-
Nurse	2	3
Medtech	3	-
X-ray Technician	1	
Midwives	13	2
Sanitary Inspector	1	1
Ambulance driver	1	2
Aide	-	3
TOTAL	23	11

DOH- NDP: Nurses- 9 Midwives- 2

BHW-206
CHW- 34

… Indigenous People Community

Indigenous People

- This tribal group often lives at the remote sitios of the mountain barangays
- It may take 2-3 hrs hike from the main barangay to reach these sitios
- They prefer to live in these places to sustain their daily needs for food, shelter, and protection.

Indigenous People

- Their main priority is how to obtain food not giving much attention to their health.
- Most of them are not aware of the various health services available in the Barangay Health Station or in the Rural HealthUnit.

…..reaching IP's community

……IT is a CHALLENGE to one's PHYSICAL STRENGTH….

You need to cross several rivers to reach your DESTINATION›››

….Philipine Integrative Medicine started…

- Tanay Local Government Unit- MHO thru the then CHD4A, collaborated with INAM to provide training for the Indigenous People so that they can established they own health program.

Tanay Municipal Health Office

STRENGTHS

- Responsible Health Providers
- Complete DOH Programs
- Good Governance

POINTS FOR IMPROVEMENT

- Facility Enhancement
- Referral System
- Communication/transportation Barriers
- Human Resource
- Capability building

Challenges

- Service Delivery in GIDA and remote area
- Effects of Climate Change
- Territorial disputes and insurgency
- Urbanization and Industrialization
- Unforeseen influx of migrant
- Universal health insurance coverage

...there's so much job to be done to help improve the health status of the Ips community. We still need additional efforts and perseverance to pursue the dream of everyone... **A better community....**

Empowerment of Indigenous Peoples through Community Participation for Sustainable Local Health System

Indigenous People

- Out of the 33,466 hectares, 28,000 hectares have been identified as the ancestral domain of the dumagats and remontados.
- These Indigenous People (IP) are called Dumagat Remontados

Cultures

- They have their own way and practices in maintaining health, delivering babies, family planning, treating diseases such as *buga*, *hilot*, and herbal medicines.
- They also have their own health practitioners belongs to the elderly practicing their culturally-gained knowledge.

Health Issues

- Health Services are poorly patronized due to:
  - Financial constraint
  - Geographical limitations
  - Cultural influences (reliance to their own means of healing)
  - Beliefs (about the health system)
  - Self-perceptions

Health Issues

These includes:

- Morbidities from preventable diseases.
- Mortalities from curable diseases (e.g. *bronchopneumonia*)
- Neonatal and Maternal Mortality
- Health Care Delivery and Referral System

...the strategic approach

Community Health Workers

The beginning…

- Year 2010, Dr. Taleon, a Regional Director of the DOH and Dr. Rene Luce, Municipal Health Officer of Tanay had a visit at Brgy. Sto. Nino for gift giving.
- Meanwhile, they saw a newborn IP's feeding on a bottle.
- They ask the woman cuddling the baby, then they found out that she is not the mother of the baby because the baby's mother died while delivering the baby at their house.

The beginning…

- Dr. Taleon got interested about the health status of the IPs community despite of the efforts and health program implementations of the Rural Health Unit.
- With all the ideas of Dr. Luce to improve IPs health condition, Dr. Taleon offered his support to look for all means on how to address the problem.
- Then they met INAM with the same vision to realize.

The beginning…

- Initially, they had a meeting with the tribal chieftains of upland Tanay to encourage them and to let them choose people among IPs community who are able and willing to be trained.

Dumagat-Remontados expressed the lack of access to basic health services for their geographically remote communities

As a solution

- developed a strategy to address this significant issue and this is how the Community Health Worker was born.

INAM Philippines

- was tapped to train community health workers (*CHWs*) from these communities through its PIM Curriculum

Philippine Integrative Medicine

- PIM training aims to develop community-based health workers and independent community organizers with culturally-applied practices for effective advocacy of health program and services to address health issues among IPs.

Philippine Integrative Medicine

- To empower the Indigenous people by providing capability building on Philippine Integrative Medicine, to become community organizer, community health worker and community health program managers
- To establish Community Health Programs to make health services accessible to the IP's families

Philippine Integrative Medicine

- To facilitate patients referrals from the Community Health Program to BHS/ RHU
- To improve health conditions of the IP's especially in the mountainous areas
- Provide venue for IP's community participation and collective decision- making so that the voice and the situation of IP's are heard and communicated to the local government

Philippine Integrative Medicine Level 1

COMMUNITY ORGANIZING

Community Action Plan for Household Survey towards analyzing Major Community Problems & Solutions

- 47 participants gained knowledge and skills on health education and in making a family survey form to get to know their community.

Community Health Workers

PIM Level I

Philippine Integrative Medicine Level II

COMMUNITY HEALTH WORKER TRAINING
> Community Health Program with aim of educating family members and mobilizing the community in addressing their own health and related concerns

- 38 participants gained knowledge and skills in analyzing the data gathered from the household survey
- Identified four major common problems among barangays:
  1) *kakulangan ng kaalaman sa pangangalaga sa kalusugan*
  2) *Kakulangan ng pagkukunan ng malinis na tubig*
  3) *Kakulangan ng kaalaman sa kasanayang pangkabuhayan*
  4) *Kakulangan ng kaalaman sa pangangalaga sa kalikasan*
- Basic Health Skills Training enabled participants to draw from their experiences their responsibilities as community health workers (*CHWs*).

Philippine Integrative Medicine Level II

- Participants identified solutions and their responsibilities as *CHWs*.

Related activities became the basis of their respective community health program (*CHP*), developed by the people to respond to their own community health needs.

Pag-aaral ng sakit
Paggamot ng maysakit
Pagdala sa health center ng mga maysakit na di kayang gamutin sa bahay
Pagtulong sa pagpapanatili ng kalinisan sa kapaligiran
Pakikipagtulungan sa RHU/MHO/Midwife/Health Center para sa programang pangkalusugan
Pakikipagtulungan sa iba't-ibang ahensya para sa programang pangkabuhayan

Philippine Integrative Medicine Level III

COMMUNITY HEALTH PROGRAM (CHP)MANAGEMENT
> Knowledge and skills in planning, implementation, monitoring and evaluation of the CHP
> Knowledge & Skills in facilitating a Reflection Process

- The training included:
  - managing community diseases and referral of patients with cases beyond their competency,
  - systematic conduct of health education,
  - addressing their health related issues of access to potable drinking water and sanitary latrines,
  - the need to re-survey as a monitoring tool to assess the effectiveness of their CHPs to the community,
  - the need for additional *CHWs* per *CHP, and*
  - regular conduct of monitoring meetings and evaluation.

Philippine Integrative Medicine

PIM Level III

Community Health Workers

Impact

- Community health workers bring very significant contribution to the health care delivery and referral system among IPs Community

Community Health Workers

Impact

- These includes:
  - Health advocacy to those individuals and families within their cluster
  - Health promotion and disease prevention using an alternative medicine used by the community
  - Initiation of proper referral system.
  - Manage community Health Care Financing

Community Health Workers

Impact

- As a result:
  - IPs aware in the RHUs and BHS services, thus increasing EPI, prenatal visits;
  - Immediate intervention to emergency cases
  - Increased community participation on health program implementation.

Community Health Workers

- Unless the BHS in the IPs communities are equipped,for birthing capacity and provided with meds and supplies,we can have favorable outcomes as far as the FBD indicator is concerned-this is a challenge because most of theses Ips women still prefer to be handled by the TBAs during their delivery.

Community Health Workers

Impact

- As a result:
  - Increased community access to the basic health services while preserving their traditional health practices
  - A gradual change in the health seeking behaviour among the IPs were quite evident notably in the increase in IPs ,immunization,pre-natal check-ups to name a few.

Community Health Workers

Impact

- As a result:
  - Empowered IPs leaders and health providers to participate in other health programs for the benefit of their people.

Sustainability and Empowerment

- To sustain and to strengthen the program, Facilitators Training was conducted and produced 9 CHWs and 3 RHU staffs equipped to conduct new batches of trainings.

Sustainability and Empowerment

- After a year, another batch of additional CHWs trained for PIM I and PIM II
- Orientation on Community Health Care Financing Part I and II
- Two CHW attended Writeshop on Best Practice Guidelines on the Management of the top 8 community conditions together with other CHWS from Sorsogon,Negros Occidental,Misamis Occidental,Noth Cotabato and Sulu held in Quezon city.
- Representation Of The CHWs/CMHPs In The Barangay Local Health Board

Resources

- All of these trainings were and will be funded using the shared resources of LGU-Municipal Health Office of Tanay, CHD-IVA, INAM, and AHI.

.

IPs Community

IP'S PICTURES

TANAY COMMUNITY-MANAGED HEALTH PROGRAMS

	Barangay CMHP	No. of CHWs		No. of Families under CHW Care		Total No. of Individuals
		Batch 1	Expansion	Batch 1	Expansion	
1	Laiban	2	0	120	0	600
2	Cuyambay	1	2	44	19	304
3	San Andres	2	0	54	0	214
4	Daraitan	5	2	52	36	409
5	Sto. Nino	4	1	83	24	330
6	Mamuyao	6	0	77	0	341
7	Sta Ines	2	1	38	13	256
8	Tinucan	2	0	20	0	82
9	Sampaloc	0	1	0	13	70
10	Tandang Kutyo	0	3	0	48	275
	Total	24	10	488	153	
			34		641	2,881

TANAY COMMUNITY-MANAGED HEALTH PROGRAMS

34-Community Health Workers provides health care to 641-Dumagat-Remontado Families or 2,881 persons or 41% of the entire IP population in Tanay

Eight Community-Managed Health Programs being managed by 24 Community Health Program Managers

Health care services being provided include treatment of the sick, health education, referral to barangay health station, rural health units, INAM Clinic, etc.

ACCOMPLISHMENTS

A two-way referral system involving the rural health units/barangay health stations and the CMHPs/CHWs

A monitoring system for health education, patient treatment, referrals, and meetings

An information system established and copies of reports submitted periodically to the RHU

IMPACT

547 (92%) out of 597 cases of preventable diseases were managed/ cured by the CHWs and did not need any referral as of October 2013

430 (81%) out of 525 cases of preventable diseases were managed/ cured by the CHWs and did not need any referral from Jan to Dec 2014

Only 145 out of 1,122 or(12%) cases needed to be referred to the BHS, RHU etc.

103 or 21% of families have access to community health care financing scheme

ACCOMPLISHMENTS

These preventive health care program in the communities reduce the high utilization rate for members of a health insurance program through the establishment of community health programs (CHPs) which have health promotion and disease prevention as the main concern.

Community Health Care Financing

- This health care financing scheme called " Saknungan sa Kalusugan" (Solidarity for Health) rooted to their cultural practice similar to Bayanihan.

- Through the consultation and collective decision of CHW's and their family cluster the CHW's themselves develop the guidelines, benefit package, policies and procedures on how to avail the benefits of the financing scheme.

Community Health Care Financing

- CHW established/developed a Community Healthcare Financing/saving scheme
- because during emergency situation and the patient need to bring in the health facility/ hospital they need to rent a jeepney to transport their patient and need to buy medicine and pay for hospitalization.

Community Health Care Financing

- Based on the experience of the CHW families with sick family members referred to the hospitals spent an average of P5,000 in 4 day hospital stay, to bring to and from the hospital. This further drained the families meager resources.
- But more than this, it is the experience of embarrassment and losing ones dignity of the Indigenous People especially when they asking for help to other people like politician etc.

Community Health Care Financing

- Saknungan sa Kalusugan or Solidarity for Health, start Last April 2014 after they finished the two part of orientation facilitated by Integrative Medicine for Alternative Health Care System (INAM) Philippines Inc.

Community Health Care Financing

- 12 CHW's in 6 different Barangay's Managed this Community Health Care Financing scheme "Saknungan Sa Kalusugan" They have members with a total of 106 families with 402 beneficiaries from April to December 2014, and have a total contribution of P22,900.

Beneficiaries availed	7 patients	P 11, 900
CHW's others expenses and transportation	-	P 3,200
Total		P 15, 100
As of December 2014: Cash on Bank		P 7,800

Community Health Care Financing

- **The benefit package shall include the following:**
- **Transportation.....P650.00**
- **Food of the family member .....P550.00 who is with the patient(4 days)**
- **Budget for medical supplies.....P500.00**
- **Total P1,700.00**

Annex B: Country/Group Action Plans

Karuna Trust Action Plan (India)

18/03/2015

Key learning & Plan of Action

Dr Raja Dodum, NUHM, Dept. of Health & FW, Govt. of Arunachal Pradesh, India
Anup Sarmah, Coordinator, Karuna Trust, India

Key Learning

- Community Health care financing
- Health Assembly at PHC level by involving other stakeholders
- No home delivery in health centres
- Cooperative society involving women SHGs

No Home Delivery

Who?	When?	How?
National Urban Health Mission, Govt. of Arunachal Pradesh	May 2015 Where? Karsingsa & Pasighat UPHCs	• Online Maternal & child tracking system (MCTS) • House to house visit by Midwives • Enough IEC, awareness programs • Involving Urban ASHAs (CHW), Mahila Arogya Samity (MAS), Karuna Trust, religious leaders • KT to put additional manpower • Attractive gift pack (birthing kits) to mothers which may attract them to choose for hospital delivery

Community Health Care financing

Who?	When?	How?
Karuna Trust managed 3 PHCs with state Govt	Aug' 2015 Where? PHC Anpum, Sangram, Bameng	• Guidelines from INAM for reference • Formulating new guidelines based on local conditions & needs • Advocacy with state govt.- MoU for implementing this new program • Involving Health Dept for support

Health Assembly at PHC level

Who?	Where?	How?
Arunachal Pradesh state Govt. & Karuna Trust	Karuna Trust & Govt. managed PHCs	• Learning of NHA Thailand (NHA at province level) • Identify the problems of the area in addition to the health problems • Homework with the community people/PRI for the assembly • Inviting different stake-holders to the PHC on a particular day: (Dist. Administration, Dist health authority, Panchayat & municipal (LGUI, PHED, PWD, Power Dept, RWD, Social welfare, Horticulture, Agriculture, Education, UD&H, NGOs, SHGs) • Officials will listen the problems from the community • Immediate action to be taken by the stakeholders • Karuna Trust/NHM to take follow up with the different stakeholders

Formation of cooperative society

Who?	Where?	How?
Karuna Trust	Assam Province When Oct 2015	• Visit to CCD (India) & Sinduli society (Nepal) to study about their system • Registration in India • Implement as per the guidelines

1

18/03/2015

Key Learning & its implementation plan in my organization

A.J Raju
CCD, India

Promote Public Private Partnership (PPP)

- program for sustainable health care
- To take atleast one PHC under PPP mode
- Promote people & PRI participation
- Involving SHGs and VDC members
- Coordination with the Health Department
- Capacity building of health volunteers
- Netwoking with other NGOs in the area

Promotion of Community Health volunteers (CHVs)

- Selection of CHVs
- Capacity building of CHVs
- Involving SHGs,
- Establishing linkages with health Dept
- Organize training for the CHVs with the involvement of health Dept. for recognition

Public hearing/Health Assembly

- Organize community meetings involving health dept & PRI (LGU)
- Identify the health issue (area wise)
- Close coordination with the ASHA & AWW
- Networking with NGOs

Community Health care financing

- Promote peoples contribution for health care
- Identify key stake holders like microinsurrance for health care
- Establishing linkages with the existing cooperatives for health care
- Mobilize the existing govt provisions.

Promotion of herbal medicines

- Promote herbal garden in the household level
- Involving students community
- Raising herbal nurseries
- Linkages with the state medicinal plant board
- Organizing the traditional healers & sharing
- Training on herbal medicine

18/03/2015

Plan of Action
DASCOH, Bangladesh

Akram, Romzan and Laxmiram

- Organise workshop learning sharing meeting with Community Group, Community Support Groups and Union Parishad
  - Share experience of the workshop and plan of action
  - Share the concept of Community Managed Health Program
- Union level assembly with Community Groups and Community Support Groups
  - Community Support Groups meeting to identify major health issues
  - Community Group meeting for summarizing identified health issues.
  - Organise union level health assembly and prepare resolution.
  - Put health issues as agenda of the union council meeting.
  - Resolution by Union Council on each health issues.

- Resolution by Local Government
  - Institutional delivery
  - Hygienic latrine
    - Identify households without hygienic latrine
    - Share resolution passed by union council
    - Provide rings and slabs to the hardcore poor family
- Promote Institutional delivery
  - Prepare list of pregnant women
  - Individual contact with them
  - Ensure antenatal care at Community Clinic
  - Meeting with Traditional Birth Attendance

- Promote health education to the Indigenous People
  - Communicate with the leaders of the Indigenous People on health issues
  - Involve leaders of the Indigenous People to organize health education sessions
  - Motivate leaders to follow-up health behavior of the Indigenous People
- Herbal plantation in the Community Clinic campus
  - Collect information related to herbal medicine and plants, orient Community Groups
  - Collect herbal plants and plantation in the Community Clinic campus
  - Orient and encourage community to use herbal medicine

- Enhance community participation in health planning and implementation
  - Information collection from households
  - Participatory analysis and prepare action plan
  - Implement health plan and monitor regularly
- Open budget and planning session
  - Draft annual plan and budget for the Union Parishad
  - Share draft budget in public
  - Revise budget based on comments and suggestion of the communities

- Construct connecting road of the Gopalpur Community Clinic
  - Discussion with communities
  - Initiate repair/construction of the road involving local people
  - Communicate with MP/UPs for financial assistance for the road
- Ensure water supply and electricity to the Gopalpur Community Clinic
  - Discussion with Community Group
  - Discussion with UPs and Local authority
  - Collect community contributions

Shinduli Integrated Development Services/Milijuli Health Cooperative
Action Plan (Nepal)

18/03/2015

"Empowerment of Indigenous Peoples through community participation for sustainable local health system"

Key learning and Plan of action
March 3,2015-March 10,2015

Major Key learnings

- All NGOs/GOs (Participants of this workshop) are focusing on health for IPs/Ultra poor communities.
- Mobilizing the CHWs as a volunteers for effective health services.
- People are believing on Alternative/herbal medicine and available/affordable within the community.
- Local government is providing free health services to the people in Philippines.

Plan of Action for Improvement

Activities	Date	Responsible
Sharing experience about workshop	Within March,2015	Deepak and Bal kumari
Make a plan to improvement of Health cooperative	March 15th to April 15th 2015	Bal kumari, HC team, S/C cop. Team and SIDS
Increase the shareholders of HC	Regular	Bal kumari, HC team.
Allocation the budget to distribution of herbal plants to the farmers by sustainable agriculture program.	July 1015	SIDS
Increase the number of health camps and focus on IPs/Ultra poor communities.	Regular	Health cop.

Strategic:

Mobilize of Gov. Female community health volunteers (Like CHWs) around the health cooperative for referral system and to provide health service in community level.

Thank You

Bal Kumari Shrestha
Deepak Kumar Ghimire

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18/03/2015

KEY LEARNINGS / INSIGHTS FROM THE WORKSHOP

- Not to rely on the modern medication for minor illnesses.
- There is a need to integrate traditional & modern modalities.
- Children's education is important for development.
- Community Based Self help for health is interesting

- Listen to others opinion
- Shared decision making
- No discrimination on provision of health services.
- Provision of health services with Q-4A's
- There is a need to continue the regular Information Education Campaign
- Strong collaboration among BHW, Purok leaders , barangay leaders & different stakeholder /sectors.

- Despite many tasks & limitations as Barangay Health Workers I can do something for COMMUNITY DEVELOPMENT and we should not stop **DREAMING**.

PLAN OF ACTION

Program	Major Activities
Promotion of Barangay Based Integrative Medicine	
	• Attendance to consultative meeting ➢Barangay Council session ➢ BHW meeting ➢Tribal Meeting ➢Purok meetings • Conduct training on Nursing Home Remedies • Continue collection, identification, documentation of traditional herbal plants available in the area. • Establishment of backyard herbal garden at home

Program	Activities
	▪ Continue IEC on the usage of common herbal plants available in the area.
Promotion of Community Based Health Care Financing	• Conduct series of meeting with the BHW. • Formulation of policy for Health Care Financing . • Presentation of Health Care policy to the Barangay Development Council for approval. • Information drive on Community Based Health Care Financing.
Enhanced Healthy Lifestyle Promotion Program through integration of traditional medicine	•Conduct consultative meetings ➢ Municipal Local Government ➢Healthy lifestyle advocate ➢ANAK-NC ➢Association of Barangay Captains •Conduct Participatory Planning with the different stakeholders

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18/03/2015

Learning Insights of the Workshop

Aloran,Misamis Occidental Mindanao

Members
Lynsie B.Erigbuagas
Roberta S.Lagata
Sagrada Teresa N. Roa

- Strong collaboration of the community people,barangay officials,BHW and other stakeholders
- Good relationship between IPs and non IPs community
- Strong collaboration with other agencies (Philippine Army)
- Strong collaboration between NGO and LGU on Health Basic Services (Tarlac)

- Community acceptance for the Health Financing (Saknungan)
- Strong commitment of the CHW inspite of minimal amount of honorarium
- Very supportive family members
- Traditional alternative medicine are still being used

- How can we apply our learning insights in our work /area ?

THANK YOU

- To attend regular monthly session to the Barangay Council
- Presentation of the Health Financing (Saknungan)
- Meeting with Household Head whom we taking care of
- Continued good relationship between IPs and non IPs community

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Magandang Umaga sa inyong lahat!

- Tanay Community Health Workers

Alicia Teves
Christine Mitra
Gemma Porciuncula
Sherlita Dela Sada
Francisca Pranada
Ofelia Pineda
Josepina Amit
Myrna Velasco

Key Learnings

- As a Community Health Program Manager, we have seen and appreciate the importance of PIM LEVEL 1,2 and 3 training of INAM.
- Because of this international workshop, we observe the success of our Community Managed Health Program as we have witnessed the improvement that happen in our community. All the hard works are paid-off with this beautiful outcome in our community.

Key Learnings

"Health problems like malnutrition, death due to delayed hospitalization and others occur because of several factors and exists not only in the Philippines but also in other country"

"Adolescents in other country became partners in health by providing them knowledge on how to make and use herbal medicine. And that this herbal medicines can also be sold to the market. We also feel grateful that the herbal medicines we are using were also used in other country"

Key Learnings

A change in mindset, maximizing capability of the community, and utilizing the knowledge and resources that we have is what we need in order to build an appropriate health plan for our community.

Key Learnings

Each of us play a great part for improvement of the Health of Community, that with proper coordination and good partnership of LGU's, NGO's and PO's we will be able to formulate and implement an enhanced health program or plans thus achieving a better and desired health outcome.

ACTIONS AND STRATEGIES

- Intensify service provision of CHW to the Community by conducting training for other Indigenous people to become a new community health worker.
- Strengthen health programs through health education, treatment of disease using herbal medicine and our Community Health Care Financing Scheme
- Strengthen community managed health program so that in the future this program will be acknowledge and accredited by the Philhealth (Philippine Health Insurance)

18/03/2015

HEALTH AND DEV'T FOR ALL FOUNDATION, INC.
Sta.Juliana, Capas, Tarlac
MARCH 10, 2015

Ma.Fatima C. Tanhueco, RN
Jennifer M. Dumlao, RN

Key Learnings/ Insights

- The health care delivery services can be achieved by Q4A (Quality, Accessibility, Availability, Affordability, and Acceptance)
- Public-private partnership will be strengthened.
- That community participation is an important component in health care delivery system
- Strengthening the leadership ability of the women in terms of health management programs
- the opportunity to discover and learn by Facilitate the community participation giving them themselves.

Key Learnings/ Insights

- Assistance and support of the Local Government (Municipal and barangay) as an important stakeholders of acquiring collaboration and community participation.
- Learned more on the Bridging Leadership concept (ownership to co-ownership towards one common and shared vision/goal.
- Strong sense of leadership by the CHWs and accepts responsibility without hesitation.
- Change of mind set (paradigm shift)

Plan of Action

- Strengthen the Collaboration and lobby with the Local Government Unit (Municipal and Barangay) together with other stakeholders Aeta community, CHWs, BHWs, community leaders and health workers
- Conduct ocular visit and community consultation for new areas.
- Community Organizing will be facilitated in the Aeta community.
- Focus Group Discussions will be facilitated for Aeta Health Volunteers for them to identify by themselves their roles and responsibilities as leaders

Plan of Action

- Finally, we would like to have an application of the INAM strategies on the community organizing, monitoring, reporting and eventually management of the health programs.

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Magandang Umaga!

Presentasyon mula sa
Quezon Province

Marilyn Buendicho
Milagros Flores

KEY LEARNINGS

1. Kailangan na mapanatili ang sariling kultura at patuloy na isabuhay.
   - -pangkabuhayan, pagtatanim ng halaman
   - -sariling kaalaman sa wika
   - -kasuotan na kinasanayan

There is a need to preserve and promote our own culture and way of life:
- ·Livelihood; planting /farming
- ·Knowledge of own dialect
- ·Traditional clothes

2. Ang pagtatanim ng halamang gamot ay mahalaga dahil agad na nabibigyan ng unang lunas ang mga may sakit.

Planting of herbal medicine is important because it could bring relief to the sick

KEY LEARNINGS

3. Saknungan
   - nakita ko ang mas malaking kaluwagan nito para makatulong sa bawat pamilyang nangangailangan at hindi biglaan ang pangangailangan ng paghahanap ng panggastos.

The Saknungan would be big help to each family in need. With the saknungan health expense will not be a on time payment but can be given on a contribution basis.

ACTIONS/ STRATEGIES

1. Ipaliwanag sa komunidad ang kahalagahan kung bakit hindi kailangan alisin at kalimutan ang sariling kultura, lalong lalo na sa komunidad na maraming nakakaimpluwensya.

To explain to the community why it is important not to forget our own culture especially in a communities open to be influenced by others

ACTIONS AND STRATEGIES

- Alamin kung paano makabuo ng saknungan
- Hikayatin ang mga magulang at ipaliwanag ang kahalagahan ng bubuuin na saknungan, magpatawag ng simpleng pagpupulong para malaman ng lahat na gustong sumapi, magbuo ng patakaran sa paggamit at pagpapatuloy nito.

18/03/2015

Friendship is the driving force to change the world to peace.

Thailand

Empower volunteers ,we are ability to manage their own communities. Health problems in all age groups Along with social knowledge (A society that is going to change quickly). The important parameters such as the use of mobile technology in the communication between them is easier and faster. Access to media such as the Internet would lead to a cultural exchange to imitate each other. and society is unlimited access to technology is simple, just flip the palm. Coping with social change. State power will be challenged and proven in a variety of formats. Analysis of strengths, weaknesses, opportunities and threats that will affect the lives of people in society. Is to be pondering and intensity, because the changes will spin faster

Remark

1. The goal is to be developed jointly.
2. Dependence among the group And the proposed requirements to those responsible at all levels.
3. Language to communicate with the outside.

What are your key learning / insights from this workshop?

- Poverty is an important issue but not the end of quality of life. What is important is to have knowledge and awareness to change the situation by taking responsibility and appropriate self-management. This responsibility is shared among human beings and society through participation.

How can you apply your learning /insights in your work /area?

Strategies

- The collaboration between the public and private health services (PPPs).
- Development cooperation in providing holistic health care, including medical treatment. Health Promotion Prophylaxis And rehabilitation
- The State shall encourage the development of Indigenous health. Into an organization that is well-managed.

Action

A way to encourage the private network to come together, share and learn the system. And budgetary support or opportunity to plan the work. Facto property and manpower resources together.

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Annex C: Participants

INTERNATIONAL WORKSHOP MARCH 2-10, 2015						
	Country	**Organization**	**Name**	**Organization Type/Year of ILDC Participation**	**Roles**	**Organization's Address**
International Participants						
1	Bangladesh	DASCOH (Development Association for Self-reliance, Communication and Health)	Md. Akramul Haque	NGO/ILDC2008	Chief Executive Officer	Lutheran Mission Complex, Dingadoba, Rajshahi, Bangladesh
2		Community Group of Kodom Shohor Community Clinic	Md. Romzan Ali.	N/A	Community Group Facilitator/ Health Volunteer	c/o DASCOH Lutheran Mission Complex, Dingadoba, Rajshahi, Bangladesh
3		Community Group of Gopalpur Community Clinic	Shiree Laxmiram Uraw	LGU-Union Parishad	Chairman of Community Group	Adarpara, Pirijpur, Godagari, Rajshahi, Bangladesh
4	India	Karuna Trust	Anup Kumar Sarmah	NGO/ILDC2009	Coordinator North East India	Ward No.4, Vivek Vihar, H-Sector near Power House, Itanagar, 791111, Arunachal Pradesh, India
5		Health Department	Raja Dodum	LGU-State	State Nodel Officer	c/o Karuna Trust Ward No.4, Vivek Vihar, H-Sector near Power House, Itanagar, 791111, Arunachal Pradesh, India

6	India	CCD (Center for Community Development)	Addala Jagannadha Raju	NGO/ILDC1986	Secretary cum Chief Executive	Sridhar Nagar, Parlakhemundi, Gajapati-District, Odisha, India - 761200
7	Nepal	SIDS, Nepal (Shindhuli Integrated Development Service)	Deepak Kumar Ghimire	NGO/ILDC2013	Chairperson cum Executive Director	Kamalamai Municipality - 6, Sindhuli Madhi, Nepal
8		Milijuli Health Cooperative	Bal kumari Shrestha	PO	Chariperson	c/o SIDS Kamalamai Municipality - 6, Sindhuli Madhi, Nepal
9	Thailand	NHCO (National Health Commision Office)	Nanoot Mathurapote	GO	Acting Head of Global Partnership Coordinating Unit	National Health Building 3rd floor, 88/39, Tiwanon 14 Rd., Mueang District, Nonthaburi 11000, Thailand
10		Trang Hospital	Nuanchawee Nedsaengtip	LGU Provincial Hospital	Coordinator nurse to the network of Provincial Health Assembly	212/4 Trangkapoom road, Kantang District, Trang Province 92110, Thailand
11		Self-employment	Suvanee Samathi	Self-employment	Coorinator to the network of Provincial Health Assembly	19/2 Bannpao Rd. Tub Tiang Sub-district, Muang District, Trang Province 92000, Thailand
Philippine Participants						
12		Municipality of New Corella	Nancy Ulanday Obra- Cacayorin	LGU/ILDC1996	Municipal Health Officer	Municipal Health Office- Poblacion, New Corella, Davao Del Norte, Philippines
13		Barangay Health Worker Organization	Daisy Rose Gunida Rafael	PO	BHW President / Patrocenio Tribal Organization Chairwoman	Patrocenio, New Corella, Davao Del Norte, Philippines

14		EBIPTRA (Eboangan Indigenous People Tribal Association)	Marilou Almencion	PO	BHW / EGIPTRA Secretary	P1 New Bohol, New Corella, Davao Del Norte, Philippines
15		Health and Development for All Foundation, Inc	Ma. Fatima Cabanes Tanhueco	NGO/ILDC2012	Senior Program Officer 2	Puruk 2, Barangay Sta. Juliana, Capas, Tarlac, Philippines
16			Ms. Jennifer Medina Dumlao	NGO	Community Health Nurse	
17		IPHC (Institute of Primary Health Care - Davao Medical School Foudation)	Ma. Arneth Castronuevo Versonda	NGO/ILDC2012	Project Manager	Institute of Primary Health Care - Davao Medical School Foundation, Bajada, Davao City, Philippines
18		Tanay CHW	Christine Mitra			
19		Tanay CHW	Ofelia Pineda			
20		Tanay CHW	Gemma Porciuncula			
21		Tanay CHW	Francisca Pranada			
22		Tanay CHW	Myrna Velasco			
23		Tanay CHW	Sherlita Delazada			
24		Tanay CHW	Alicia Teves			
25		Tanay CHW	Josefina Amit			
26		Tanay CHW				
27		Aloran CHW	Sagrada Teresa Roa			

28		Aloran CHW	Roberta Lagata			
29		Aloran CHW	Lynsie Erigbuagas			
30		General Nakar CHW	Marilyn Buendicho			
31		General Nakar CHW	Milagros Flores			
Organizing Committee						
Asian Health Institute (AHI)						
32	Japan	Kagumi Hayashi		General Secretary		
33	Japan	Shiori Ui		International Program Coordinator		
34	Japan	Yayoi Takada		Training Staff		
35	Japan	Kohei Takahashi		University Student/ AHI Supporter		
36	Japan	Itaru Nagasaka		Anthropologist/ AHI Supporter		
Integrative Medicine for Alternative Healthcare Systems (INAM) – Philippines, Inc.						
37	Philippines	Sr. Dulce Velasco		Vice President - BOT		
38	Philippines	Ms. Maria Cristina C. Paruñgao		ILDC2006 Executive Director		
39	Philippines	Teudelinda Paduada				
40	Philippines	Leoncio Halili				
41	Philippines	Menandro Verana				
42	Philippines	Vilma de Blas				

43	Philippines	Emelyn Marfil		
44	Philippines	Lenie Sedano		
45	Philippines	Cristina Magno		
46	Philippines	Anicia O. Sollestre		
47	Philippines	Ma. Luisa Tinga		
48	Philippines	Jennifer Madamba		
49	Philippines	Florentina Urag		
50	Philippines	Carmenchu Badilla		
51	Philippines	Jorelyn Casayuran		
52	Philippines	Gilbert Hernandez		
53	Philippines	Ric Caminade		
Municipal Government of Tanay, Rizal				
54		Hon. Mayor Rafael Tanjuatco	Mayor, Municipality of Tanay, Rizal	
55		Rene Luce, MD	Municipal Health Officer - Municipality of Tanay, Rizal	
56		Gilda Z. Paterno	Rural Health Midwife - Municipality of Tanay, Rizal	
57		Engr. Roberto Peñaranda	General Services Office - Municipality of Tanay, Rizal	
58		Jeffrey Pino	Tourism Office - Municipality of Tanaym Rizal	
59		Jenny Ansay	Regional Health Unit - Municipality of Tanay, Rizal	

60		Biboy Gabut	Regional Health Unit - Municipality of Tanay, Rizal	
61		Karen Repato	Regional Health Unit - Municipality of Tanay, Rizal	
62		Mildred	Regional Health Unit - Municipality of Tanay, Rizal	
63		Ma. Teresa Domeyeg	Regional Health Unit - Municipality of Tanay, Rizal	
64		Dang Paterno	Regional Health Unit - Municipality of Tanay, Rizal	
65		Laurence Asinas	Regional Health Unit - Municipality of Tanay, Rizal	

Annex D: Mayor's Night/Awarding of Certificates

Annex E: Workshop Photos


THAILAND


BANGLADESH


INTERNATIO
owerment of Indigenou
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ACTIVITY
MUNICIPAL G
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SIN


CONTENT:
POVERTY
NEW THREATS TO LIFE
- CLIMATE CHANGE — NATURAL CALAMITIES
- POLITICAL INSTABILITY
- TERRORISM
COMMUNITY PARTICIPATION


INTERNATIONAL D


ASIAN HEALTH INSTITUTE AND INAM PHILIPPINES
WELCOMES
INTERNATIONAL DELEGATES, GUESTS & PARTICIPANTS
TO THE


ANG TAWID SA
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WELCOMES
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