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Lessons From The Thai Universal Health Coverage

From your Editor Ms. Joy A. Bastian:

All UN Member States have agreed to try to achieve the Universal Health Coverage (UHC) by 2030, as part of the Sustainable Development Goals. UHC provides access to quality essential health services with protection from financial risk. UHC is yet a never resting issue in most countries in the world. Government, non-government organizations, civil service organizations, and the common people are always in search for effective and efficient ways to achieve it.

Young volunteers joining health promotion in Thailand.

In Japan's case, a scientific research conducted by Tokyo University revealed that it successfully established the universal health insurance system in 1961, which was attributed to three converging conditions such as low health care costs, high economic growth, and people's shared sense of solidarity (Kobayashi 2009).

Fortunately, in December 2016, Dr. Viroj Tangcharoensathien from Thailand, a former AHI participant to the International Training Course in 1985, came to Japan for his series of lectures. His presentations on Thailand's Universal Health Care, summarized by Ms. Kagumi Hayashi, is a good benchmark for others to follow suit or learn from it. Dr. Viroj emphasized that UHC is not merely a financial protection but it encompasses comprehensive coverage of quality health services regardless of social, economic, and academic status. A participant from Myanmar also wrote her reflection about Dr. Viroj's lecture.

Up to this writing, the UHC is still a hot topic that developing and underdeveloped countries are facing difficulties. The mainstream reason is the lack of financial capacity of governments. However, Dr. Viroj rather emphasizes political will and dedication of health workers.

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Experiences of Thailand Towards Universal Health Coverage to Strengthen the Health Systems
Lecture by Dr. Viroj Tangcharoensathien, summarized and edited by Ms. HAYASHI Kagumi, AHI

Dr. Viroj

Dr. Viroj Tangcharoensathien, is now the secretary general of the International Health Policy Program Foundation, after his 35 years of service for the Ministry of Health in Thailand. He is one of the former AHI participants who joined in its International Training Course in 1985, who has been working for the Universal Health Coverage (UHC) in Thailand. He came to Nagoya in December 2016, being invited by the School of Nursing, Nagoya City University, and gave the lectures to share Thai's experiences and his thoughts for UHC. The succeeding part is the summary of his lectures.

1. What have been done

In Thailand, Health is to be secured with everyone under the National Health Security Act 2002. Its Chapter 1 states that the Thai population shall be entitled to a health service with such standards and efficiency as prescribed in this Act.

Source: International Health Policy Program

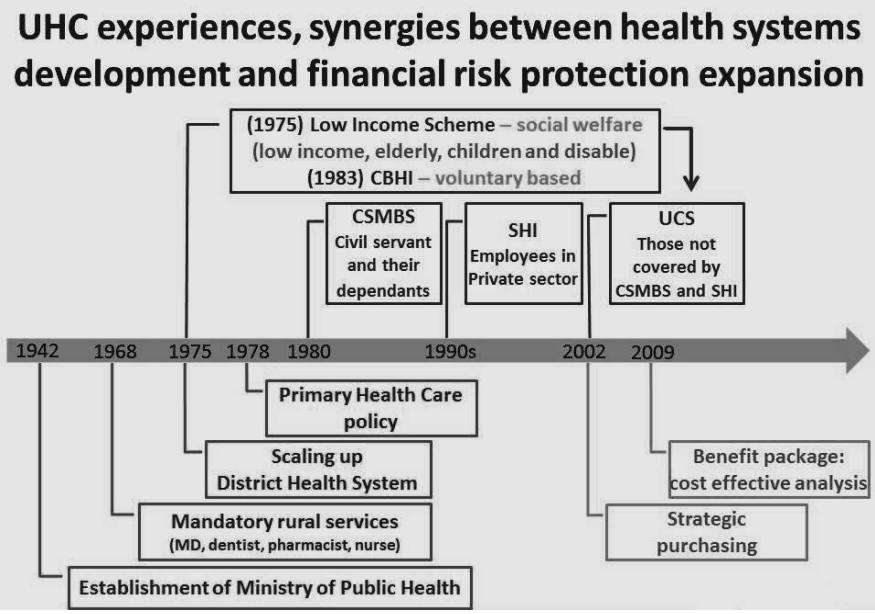
District Hospital

Health Center

There are two essential components to achieve UHC. One, is to build the solid platform for UHC, which means the development of health delivery and health workforce. Human development of health personnel is primarily important. In Thailand, the population per doctor has been decreased to less than 2,500 by focusing on human resource development of medical doctors and nurses. The local health care facilities have been developed as well. Each of the district hospitals with 30 to 120 beds covers 30,000 to 80,000 population. Under them, one health center serves 2,000 to 5,000 population being managed by three to six health personnel.

The other, is financial risk protection. In Thailand, there are three different schemes such as 1) the Civil Servant Medical Benefit Scheme (CSMBS) which covers the public servants since 1980, 2) the Social Health Insurance (SHI), which covers the employees of corporations that started in 1990, and 3) the Universal Coverage Scheme (UCS), which was established in 2002 to cover the informal sectors, that comprised 75% of the total population. It includes farmers, day wage workers and others who do not work at corporations, including self-employed who are engaged in micro-business. When the UCS was realized, Thailand has achieved 100% universal health coverage for its population.

When UHC is discussed, only the aspect of financial risk protection is oftentimes emphasized. Yet the Thai experience shows the synergies between health system development and financial risk protection expansion.



Source: International Health Policy Program

2. What have been achieved

The Increase in Access to Primary Health Care			
Year	**Regional/ General Hospital %**	**District Hospital %**	**Rural Health Centers %**
1977	**46**	**24**	**29**
1987	**27**	**35**	**38**
2000	**18.2**	**35.7**	**46.1**
2010	**12.6**	**33.4**	**54**

Source: International Health Policy Program

The top change is the increase in accessing medical care, especially primary care delivered in the rural health centers. In 2010, 54% of the patients received health services in the rural health center, while 33.4 % in district hospitals, and 12.6% in regional/general hospitals. The research shows health care delivered in rural health centers has become far accessible than before.

Public health expense of the national budget has increased from 5% in the 1980s to 14% in 2013. The total health expenditure has increased by 3.3% of the GDP in 2001 (before UHC) to 4.6% in 2014.

The most important change is the reduction of health impoverishment. UHC is very powerful in reducing poverty due to heavy financial burden.

After UHC was realized, other financial resources has been mobilized for health. “Sin Tax” on tobacco and alcohol has mobilized approximately US$116 million in 2014 so as to strengthen health promotion activities.

It is also important to save cost for health services. The National Health Security Office (NHSO), which manages the UHC, is a big purchaser of medicine and medical supplies, and negotiates the prices. The strategic purchasing, including effective management and strategic payment mechanism is very essential. Thus, “More money for health, and More health for money.”

3. Remaining challenges

Three different health schemes have different benefit packages, delivery systems, payment mechanisms and budget, resulting in different financial contributions and burdens. There is still coverage gap between low and high socio-economic groups as well as rural and urban.

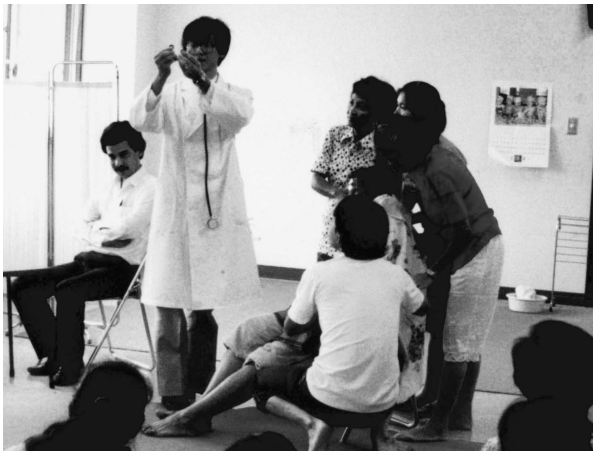
Another challenge is financial sustainability. At present, the national health expenditure is still less than 6% of the GDP. However, financial sustainability is very challenging. Due to technology development, increasing demand and expectation for better and advanced health services, as well as aging population increase drove the health expenditure up to 14% of the total government budget. With limited fiscal space, efficiency needs to be improved through the Health Intervention and Technology Assessment (HITA), pooled procurement and cost control measures. Co-payment (self-payment at health service delivery) might arise in the future.

Dr. Viroj summarized UHC into three points:

- UHC does not mean only ‘financial protection’ but more on universal access to comprehensive essential quality health services’.
- Achievements and sustainability of UHC depend more on the committed spirits of health workers, the ownership by the people, and the good governance systems than money.
- It is context specific. You can learn from others and adapt, not copy, based on your own situation.

Dr. Viroj's Sharing: A Single Hero Never Wins

I participated in the AHI-ILDC in 1985, when I was the director of the district hospital in Ubonrajthani, Thailand. In the rural province, I needed to fight in order to save people's lives. In the villages, it was very difficult to bring patients to the referral hospital, because of the physical distance. I even donated my blood to the patients, when they were in such an urgent and serious condition. Family members are sometimes reluctant to bring the patients due to their anxiety as well as required financial burden. And it is not sure if the patient can fully recover to come back home after spending so much money for the treatment.



Dr. Viroj (2nd, left) in the ILDC 1985 roleplay.

The Thai culture does not traditionally allow to take a dead body cruising villages. So, I needed to promise to the patients' families that I would take the dead body back to their home during night time. I do remember well the case of the farmer, who was taken to a larger hospital, uncertain if the patient can fully recover to come back home after spending so much for the treatment, but unfortunately passed away. I took him back to his village. When I carried the dead body into his house, I saw almost nothing (like furniture), except a kerosene lamp and an old pillow. The life of the village people was so difficult. Once they get sick, they needed to spend so much that sometimes they get heavily in debt. These experiences are still deeply engraved in my mind.

In 1987, I got a scholarship and studied in the U.K. I finished my PhD in health planning, financing and economics in 1990. My experiences in rural hospital made me work for the health system and financial mechanism, that assured every poor person access to appropriate health services when he/she is in need.

When I came back to Thailand after my study, I started to think it would be very important to build a good organization and a strong linkage among different people in health and other sectors, so as to change health policies and systems.

"The study in the U.K. has changed my life. Before that, I was working like a soldier fighting alone everyday in a battlefield. I may win today, but I might loose tomorrow. A single hero could never change the situation. A strong troop would be essential."

I worked hard being a role model, and tried to get people with commitment in their works. In 1998, the International Health Policy Program (IHPP), Thailand was established within the Ministry of Public Health. I am one of the three people when it started. Currently, it has more than 70 staff. IHPP conducts researches on various health related issues. With those results as evidence, we do advocacy. Research results need to be reflected in the national health systems and policy.

Advocacy and negotiation are not easy. We often need to confront with some related industries. resist against the policy that affects or controls their marketing. We need to mobilize more people and train them on health policy research. For example, when we launched taxation over sugar, which could negatively affect one's health. Industries such as softdrinks resources in order to establish a firm structure and more effective strategies to negotiate with the opposers. We have generated good policies, and will do more collectively involving more committed people organizations like IHPP.

International Migration of Health Personnel: One's Right or What?

Dr. Viroj chaired the negotiations of the World Health Organization's (WHO) Global Code of Practice on the International Recruitment of Health Personnel. This was adopted at the World Health Assembly in May 2010.

The Code is voluntary, unlike convention. member States and other stakeholders are yet strongly encouraged to use the Code. The Code is to promote the ethical international recruitment. Below is the summary of his lecture.

Dr. Viroj, front, second from left, with AHI staff and participants during his lecture in Nagoya.

The Article 3 of the Code describes the guiding principles as follows.

The specific needs and special circumstances of countries especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of this Code, should be considered. Developed countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development." "Member States should take into account the right to the highest attainable standard of health of the populations of source countries, individual rights of health personnel to leave any country in accordance with applicable laws, in order to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries.

Health volunteers selling traditional sweets in the promotion event in Bangkok.

In Thailand, although facing shortage and maldistribution of health workforce especially doctors, dentists and nurses, along with the medical hub policy in the ASEAN region, the international recruitment concern is not among the major issues. The Ministry of Public Health of Thailand is yet very active in implementing the Code as well as raising social awareness. The National Health Commission, being chaired by the Deputy Prime Minister is responsible for the implementation.

Healthy snack during the health volunteers' meeting.

The Code was translated into Thai Language in 2010. Since then, its contents have been disseminated in terms of recruitment and migration of health work force not only with health sector, but across multi-sectors nationally and locally.

WHO Global Code of Practice on the International Recruitment of Health Personnel: www.who.int/hrh/migration.

Meetings with private are organized so as to establish good practice guideline for international recruitment of health personnel. The Thai Nurses Association and Nursing Council annually recognizes the forum for nursing students to create awareness of the Code, rights of migrant nurses and fair practices, balancing their rights to migrate and social responsibilities in their motherland.

High-spirited health workers

In accordance to Article 4, the Thailand Labor Act assures that the international health personnel enjoy the same legal rights and responsibilities on employment as those domestically trained. On the other hand, all health practitioners have to pass national licensing examination in Thai languages, as being required by health professional councils.

The Ministry of Public Health has its policy focus in strengthening health system, specially for health work force planning, health professional education and retention strategy. Its strategic plan for 2016 to 2025 has its goals, including producing quality workforce distributing them equally with right numbers, right skills and on right time, and improving work environment which promotes retention performance of health workforce. To strengthen rural retention, different measures need to be taken such as increasing the provision of financial and non-financial incentives, implementing rural recruitment, local training and hometown placement.

Dr. Viroj concluded that the national capacity to manage is a pre-requisite in discussing international recruitment of health personnel, and international cooperation is needed so as to promote sharing good practices of managing HWF mobility.

Reflection of the Seminar Participant from Myanmar

Ms. May Thet Khine, Doctoral Student on Public Health in Japan

Ms. Thet

Poverty is not an obstacle for health, and health is not a cause of poverty. What is more, health can bring peace to Myanmar. This is my learning from Dr. Viroj Tangcharoensathien of Thailand. With his attempts to improve the health of the poor, he has not only been awarded as the "Best Rural Doctor" but also as one of the leaders to achieve UHC in his country, Thailand.

Group discussion on 4A1Q during the workshop.

Last December, he was invited to give lectures and workshops in Japan. Indeed, I was fortunate to learn about important points in achieving UHC in Thailand and the "4A1Q" dimensions in healthcare services.

I learned that there were three important points towards UHC such as 1) strong political commitment, 2) commitment of health workers, and 3) good governance in the health system.

First, before the UHC scheme was introduced in Thailand, there were a number of health coverage schemes. Yet, 29% of the population excluding civil servants and employees from the private sectors were not insured. UHC resolved several sporadic schemes by merging smaller ones together into a single one. This resulted in the coverage of the entire informal sector population, with a strong political commitment to the publicly funded scheme.

Currently, three different schemes cover different population groups. However, one of the challenges remaining today in Thailand is the inequity across these three main schemes. Nonetheless, without strong political commitment for fundamental changes in 2002, UHC might be far from reality.

Second, the commitment of health workers is important for the sustainability of UHC. For example, without mandatory rural services and rural retention of health workers, there would be a huge discrepancy in the availability of services between rural and urban areas in Thailand. Thus, UHC will be sustained with the commitment of health workers.

Third, good governance plays a vital role to sustain UHC. As explained by Dr. Viroj, in building rural health facilities, there was no investment in urban areas for five years. As a result, primary care becomes more accessible.
I also learned about the 4A1Q Framework in accessing and providing healthcare such as 1) availability, 2) accessibility, 3) affordability, and 4) acceptability and appropriate quality.

Briefly, the 4A1Q means that the people access healthcare when services are available in a place either in rural or urban areas with an affordable payment, appropriate quality, and willingness to accept the services.

For instance, in my country, Myanmar, has a wide geographic and socio-economic variations; 135 ethnicities, multi-languages and multi-cultures. Of the population, 70 % resides in rural areas, wherein insufficient public transportations and less availability of services cause difficulty in accessing healthcare.

In addition, high out-of-pocket payments representing about 51% of total health expenditure discourages people to access healthcare. So, we have been facing less accessibility of healthcare due to the absence of affordable fees in Myanmar. What makes it worse is the long decades of internal conflicts following the independence in 1948. It produced vulnerable people who are desperate to access appropriate quality healthcare in conflicted areas.

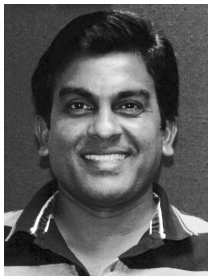
Therefore, for Myanmar to reach the goal of UHC, and ensure inclusive access to healthcare needs without financial burden, it needs a strong political commitment to give space for healthcare, benchmarking from the Thai experience.

As a public health student, I dreamed to become a researcher and play my role to obtain more evidence-based researches for my country.

FLASH ARTICLES

Empowering People Against Militarization in Jaffna, Sri Lanka

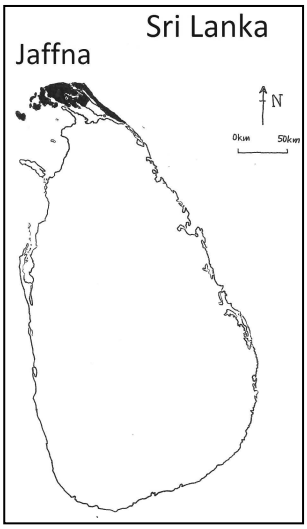
Mr. Pradeep Wanigasuriay, ILDC 2015, National Fisheries Solidarity Movement (NAFSO), Sri Lanka



Mr. Wanigasuriay

1. The people's outcry

"We want our land back!" This is the voice of the people who struggle, campaign in front of the main gate of the Air Force Camp in Pudikudirippu, Mullathive. They demand their own land back from the Air Force because it has grabbed the lands which belonged to the civilians during the final war period in 2009. The landowners have legal deeds to ensure the ownership of their lands. The people had been living for generations in the land until the occurrence of the battle between the Liberation Tigers of Tamil Eelam (LTTE) and the Forces of the Government of Sri Lanka (GOSL). As a result of the war, numbers of lands which belonged to the people were captured by the forces (Army, Navy and Air Force) in the north and east in the name of national security. The forces used those lands to build security zones and they occupied the houses previously owned by the people.



Jaffna, blackened area.

2. Land grabbing in action

The forces captured the private lands in two ways. One, is that the forces directly intervened to banish the people from their houses and villages in the name of national security. One concrete example is that the army ordered the people to vacate their houses for inspection in Mullikulam, Mannar in 1997. People had no chance to take any belongings

The destruction of land grabbing.

and were ordered to go to the school nearby the village. After that, the people were never allowed to enter their houses even in the post war situation. The Government declared that place as a high security zone and the GOSL built a Naval Base there.

Two, is that the GOSL occupied 6,400 acres of land in Valigamam, North in Jaffna to engage in tourism industry. The forces are directly involved in business ventures with the investors by building hotels in the field. The Thalsevana Holiday Resort has been built by the Army in Jaffna Peninsula where the Valigamam Tamil community people had lived. Those who lived in Valigamam were totally displaced and living in temporary shelters in Jaffna. Some of them have been living as refugees in India and in European countries. Those who were displaced have been living in welfare camps without basic facilities even after the war. Most of the people came from the fishing and farming communities. Now, communities totally lost their livelihood.

Some services that the forces have been involved are construction, keeping some cities clean, vegetable farming and animal husbandry for sale, providing food and accommodation in the hotel, arranging boat trips and sightseeing; which are against the rules and regulations and influence the civil activities. The forces are giving permission to the migrant fisherman, who came from the southern areas, to access the sea in Jaffna. Providing permission to the fisherman is actually the responsibility of the Department of Fisheries. Relevant department was established and officers were recruited for civilian or public works like monitoring and giving permissions. Yet the forces went beyond their legal mandate by involving themselves on civil matters.

They have engaged in vegetable and rice farming on a daily production basis by developing large scale farms in Jaffna. The forces supply vegetables, food and daily items in low prices compared to other private suppliers and shops because they do not spend much on the cost production. For instance, they themselves work in the farm while at the same time receiving their salary from the government as members of the forces. They use the forces' vehicles to, and also their storage in the camps. Therefore, without spending on the costs of labor, transportation and storage, the forces could naturally sell their products in low price.

Because their basic salary form the Ministry of Defense is stable, they don't have to worry about personnel cost and other incurring costs. As a result of this uneven competition, the forces disrupted the source of income or job opportunities of the civilians. Not only that, the GOSL uses the troops for the construction and maintenance in the north. This directly influenced the income of the people especially the laborers who are willing to do the job.

People protesting against land grabbing.

3. NAFSO's involvement

Based on the situation in the northern province, NAFSO ensured the rights of the people in implementing different programs such as initiating to organize people, and providing technical and legal aids for the people in the community. In the former regime, NAFSO used to face huge difficulties working as an NGO in Jaffna. Also the governor in the Northern Province was a major general of the army. Our field activists as well as the secretariat staff have been directly questioned in the premises of the Criminal Investigation Department (CID) headquarters in Colombo. Now, the new government is somehow allowing us to freely work in the field. But the forces are maintaining a systematic intelligence service network specially in the north and east. There are separate units of the forces brigades. Intelligence officers observe, monitor and gather information about the intervention of civil organizations like us.

Once, there was a huge pressure to the government against land grabbing not only in the national but also in the international political arena during the war. But gradually the people's bond of the campaign has been destroyed purposely through the new intervention of the military. The military has changed their strategy through direct intervention to destroy the unity of the local Tamil community, by observing and collecting information from the community people. For example, the military directly influenced the Tamil community leaders through home visits, informing them not to take part of some particular programs, which were organized by the NAFSO in Jaffna. Military forces gave benefits like housing and job opportunities for selected community leaders, and developed community structures in Jaffna to disintegrate the campaign.

NAFSO's main strategy is to empower the people, victims, marginalized group, vulnerable people, women headed families and internally displaced people, who have no voice to uphold their rights. Empowering the people affected is the most important to achieve this goal. NAFSO facilitates series of dialogues between the policymakers and the victims in Jaffna. It organizes consultation at the regional and the national levels. NAFSO is always concerned in collective actions and building network with other stakeholders to ensure the rights of the people. They believe on the "Power of People" to mitigate the influence of unjust decisions of the GOSL. They should show their power and voice their concerns and issues to the policymakers.

4. Citizen Forum

Under the new government scheme, NAFSO has implemented Active Citizenship for Development Network (ACDN) to increase people participation in local governance. Citizen Forum is one of the activities of ACDN were people can build constructive relationship with the local government institutes. Members regularly gather and discuss over the situation people face. It is composed of the civil representatives of the various groups such as women fisheries, farmers, and youths.

A common message spread among wider community through the links of the citizen forum. As well, the citizen forum organizes the dialogues with policy markers in a different level. The members are encouraged to participate in the people's gallery of the local government institutes to observe the council meetings. The observers share the relevant information in the citizen forum to plan their actions. Civil representatives then directly participate in the decision-making process in both the standing committee and advisory committee in the local government. This is a perfect stage for the civil representatives to raise their voice during the dialogue at the policymakers' level.

Citizen forum meets the government agent in Mannar.

Citizen forum holds the People Council, where people the platforms people where can question or challenge the policymakers in the same footing. The policymakers are required to give any response to the relevant questions on the development issues such as infrastructure facilities, environment, some services like drinking water, primary health, primary education and people propose the alternative solutions for the particular issues.

The land grabbing and other issues related to the militarization is always a concern and being discussed in the citizen forum in Thelippalei, Jaffna, where it is a burning issue of the people. Here is a case that citizen forum took joint action with the other stakeholders against land grabbing issue.

In November 2016, the Navy has threatened to the fishermen in Senthankulam, Jaffna ordering not to access to the sea in that area. The Navy has destroyed some fishing equipments of the fishers. This particular area has been opened to the civilians for the fishing purposes after the war but the Navy does not allow the fishers to engage with the fishing industry in that area. This issue has been raised by the members who represent the Senthankulam in the Citizen Forum. This issue is deeply discussed in the Citizen Forum and they decided to publish it through the media.

The Citizen Forum organized the media conference for disseminating in the wider communities in the country. As well as the citizen forum has consulted the secretary of local government involved to find a solution in discussing with the Navy.
NAFSO conducted some researches to get proper view of engaging the troops for tourism industry by using the grabbed lands. We published the findings in the name of "Dark Cloud Over the Sunshine Par-

adise" as a book. NAFSO has gathered information about the land grabbing as well as people who live in the camps in Jaffna. NAFSO initiated to seek international attention for the situation in the North due to the involvement of the forces and the GOSL.

5. Other Structures

NAFSO facilitated to form different structures according to various sectors of the community in Jaffna. Northern Province Fisher People Unity is one of the strong platforms which directly involves the fisheries issues in the North. It has been keeping dialogues with the local government, provincial council and parliamentarians to find solutions in fisheries issues in the North. NAFSO also facilitated to form the District Women Federation (DWF) which represents the women issues and women's rights in Jaffna. The DWF has taken the initiative to raise the women issues in the mainstream discourses even with the Minister of Women Affairs.

Community leadership is being built by NAFSO to direct/lead the community people to ensure their rights. We provide leadership training to improve the capacities of the community people. Technical support and legal aid are given to them. We are able to see that there are good community leaders, especially women leaders, who are armed with knowledge. NAFSO has facilitated to create a strong foundation in the community which can be used to improve and ensure people's rights.

NAFSO advocates for the wider communities, policymakers and other political elites highlighting the issues in mainstream media and in social media. The result of the campaign against land grabbing by the forces and other elites gained well. In 2016, a total of 2,035 acres of land was released to the people of Jaffna of which 1,518 families have resettled. Also, a 474 acres was released in Killinochchi, in the North, wherein 79 families have resettled.

6. Conclusion

Every right of the people has been won through the struggle, campaign and movement according to the political history in the country. Historically, almost all governments neglect the rights of the people. "Power of the citizen" in the campaign, struggle and movements are very essential in asserting people's rights. There is no alternatives or shortcuts to this end. Empower the people by building their capacities in order to strengthen the people's movement.

Visit http://assets.gfbv.ch/downloads/berichtjaffnafinal_low.pdf, to download ***Under the Military's Shadow*** book published by NAFSO.

HERE AND THERE

AHI Study Tour 2017 In South India

Ms. Tomoyo Hidekuma, former AHI staff

Ms. Hidekuma

From March 20 to 30, 2017, the AHI study tour participants visited Tamil Nadu State in South India. There are 19 participants including 4 high school students, 5 university students, 8 adults, 2 interns staff and myself. Before leaving Japan, I felt really nervous, because it was my first time to be the in-charge of the Study Tour.

In Tamil Nadu, the participants visited each NGO offices, slum area, Primary Health Center, Dalit community, and Special Economic Zone (SEZ). The AHI alumni efficiently arranged each visit and took good care of our participants who seemed to have a really good experience through the tour.

One of the most impressive programs for the Japanese participants was the visit to the slum area. For most of them, it was only known on television and was their first time to be there. They were shocked to see a lot of garbage thrown away in the river nearby the slum, because the waste collection system was not functioning well. However, the participants were rather impressed that the local people live actively even in such an environment. They run small shops for daily necessities in the slum. We had opportunities to speak directly with the self help group members, and we learned that people are helping each other to live.

Homestay program was also very memorable for the participants. They stayed for four nights in the house of Indian host families. Through the program, participants experienced to live together with local people in India and they could know the Indian customs and culture. AHI also expected that the participants would reflect their own lives and the Japanese society from the experience.

Reflections from the young participants:

- "I was impressed by the strength of the community, wherein Persons with Disabilities and Persons

with Non-disabilities are happily living together." (Male, 21).

- "To have a good relationship with the host family, I have felt that I should actively participate in their conversations. To learn the local language makes it easier to establish friendship." (Male, 20).
- "Lack of English communication skills was not a big constraint. My host family willingly tell me the subject again and again until I understood. Therefore I did not feel uneasy." (Female, 18).

A participant with her host family during the homestay program.

Tirupani Trust Association (TTA) is one of the host organizations of this tour. Mr. Murugan Kalirathnam (ILDC 1994) gave us the following comments about the study tour.

"Study tour is a good opportunity to introduce Dalit's history, culture and our activities. In the home stay program, host families can learn how to treat guests from abroad. And also, by accepting guests from other countries, they would be respected by others in their community and become confident. In this year's study tour, one of the Japanese participants was an occupational therapist. She advised that our occupational therapy for children with disabilities in a tribal community would become more patient-centered. I am very happy to receive such advice. I hope that in the study tour, the Indian local people and the Japanese participants can learn from each other through sharing of experiences."

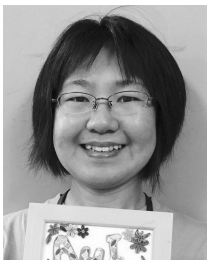
As I mentioned, I was very nervous before leaving Japan. However, in this tour I saw young participants changed from passive attitude to positive attitude to communicate with the host organization's staff and host families. Furthermore, when some participants had heatstroke and diarrhea, the ILDC alumni always took care of them very well and offered them some places to take a rest. By those facts, I felt that the responsibility was shared with everyone. I am sure that this study tour was meaningful for the participants. I would like to conclude this report to express gratitude to the ILDC participants and staff of host organizations for the excellent coordination of the Asian Network for Innovative Training, Research and Action Trust (ANITRA-TRUST), TTA, and Revival Church Fellowship (RCF) in hosting us.

I left AHI on April 28, 2017. My big learning from AHI is participatory way. In typical Japanese organization, limited people do the decision-making, however in AHI every people have the right to express own ideas. Everyone shoulder the responsibility of the decision by participatory way. After leaving AHI, I would like to continue this participatory way. I was impressed by the AHI alumni's sincerity toward local community people and their activities.

Thank you very much for your support and friendship. I would like to participate AHI as supporter and volunteer from now. I appreciate your continuous connection.

What Does Health Mean To Me? Reflection through Internship in AHI

Ms. Megumi Motose, AHI Intern



Ms. Motose

I was AHI's intern for a year, where my views about health changed. For the past 17 years, I worked as a Public Health Nurse in a Health Center in Japan. I supported persons with mental health disorders like schizophrenia, and incurable nervous system diseases; Amyotrophic Lateral Sclerosis and Parkinson's. My work involves visiting homes and providing assistance for their support group. In this work, people with these conditions, oftentimes experienced discrimination that results to lower self confidence or self-esteem. I can't just ignore it. I hope I could change the situation. When I worked in the health center, health means to me as "even with disabilities or diseases one's, decision is possible."

My various involvements in AHI made me realized that health is a right of everyone - for everyone and not just about presenting health condition. Though I worked in the government agency, I was unaware that health is a right. AHI helped me understand

more about peace, fairness and equal right for everyone - in our daily lives. That will be lost if I am not conscious about it, and I may be the one that will take away that right from someone else.

Women fetching water in the slum area in India.

Dr. Kawahara, the founder of AHI, believes that "Health is Sharing." Once, I was asked, "what does health mean to you?" I said: health is giving mutual support; inspired by what I observed during the ILDC Training, where participants from different countries shared their situation and showed how they solved their problems.

When I was a child, I dreamed of being a volunteer in a foreign country. In April 2017, I went to the Philippines and joined the collaborative project on Skills Training for Community-Based Rehabilitation Workers and Communities Through Community Activities for the Empowerment of Children and Adults With Disabilities, by the NPO Community Life, with Ms. Tez Cangao (ILDC 2009).

Ms. Megumi Motose and Ms. Tez Cangao (front, L-R) in the Philippines.

I will be conducting research on the needs of Persons With Disabilities (PWD). I observed that there are many differences between Japanese and Filipino lifestyles and practices. I want to carefully learn from the PWDs and their families. Then, I would like to work and be part of the development of a society where everyone - each one of us can make and achieve our dreams - working together with mutual sharing and respect.

The Voices from Southern Muslim Islands Speaking Tour 2016 of the ILDC Alumni Filipino Team

Mr. Takahiro Nakashima, AHI

1. Resource Persons for the AHI Speaking Tour

Every year, AHI organizes speaking tour with former participants of ILDC resource persons.

It aims to let the Japanese become aware of the culture and reality of the participants' working field in Asia, the efforts of people to solve their problems, and start to think how to contribute to health and development in Asia that includes supporting AHI.

Ms. Emelyn Bahin Jalani (Emy), and Ms. Gaida Hunnoh Jainal (Gai) were the resource persons for the speaking tour on October 11 to 18, 2016 right after their participation to the ILDC 2016.

Ms. Emy is the Chief of District Hospital in a remote island of Mindanao. Ms. Gai is the representative of People's Organization working in the same island.

2. Life event giving direction to Emy's life road

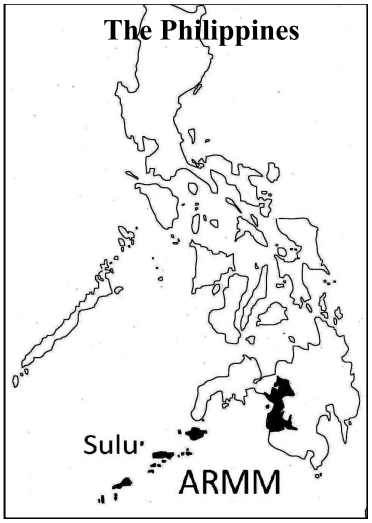
Emy was born and raised in Jolo, the capital of Sulu Province, Autonomous Region Muslim Mindanao (ARMM), the Philippines. She went to high school in Manila fleeing from civil war. She got an aptitude exam and she was upset with the result because it showed the best suited course for her was social welfare and social development, rather than medicine which she wanted to pursue since she was small. This could be one of the reasons to develop her career as a doctor by serving the community with wider perspective rather than to be confined only in the hospital. After 13 years of schooling far away from home, she was finally returning to Sulu as a medical officer at the Sulu Provincial Hospital.

In 2001, she was assigned as Chief of the District Hospital of Pangutaran island that can be reached only by boat traveling three to four hours, three times a week from Jolo, the capital town of Sulu.

Just three days after her arrival at the hospital, a war broke off in the island, and the hospital was heavily damaged. For 13 years (2001 to 2013), she was the lone doctor serving a 25-bed capacity government facility.

3. Participation in the PCHAP course

From 1999 to 2007, AHI was commissioned by the Japan International Cooperation Agency (JICA) to conduct the Participatory Comprehensive Health Administration Promotion (PCHAP) Course for ARMM. This course was aimed at capacitating public health workers from ARMM to be equipped with knowledge, attitude and skills in facilitating community participation and linkage with local governments and their agencies as well as NGOs.



ARMM, blackened area.

In 2002, Emy participated to PCHAP in high hope of being able to uplift the quality of healthcare in her municipality. After seven weeks course in Nagoya, Emy applied her Plans of Action in Pangutaran. She recruited volunteers from communities, trained and organized them. The volunteers managed health nutrition post or community pharmacy. She also started to make wider linkage with the mayor, and Department of Education, Department of Social Welfare and Development, business sector, and the Philippine National Police for quality and accessible health care by the people.

R-L, Mr. Takahiro Nakashima, Ms. Gaida Hunnoh Gaidal, and Ms. Emelyn Bahin Jalani at AHI.

4. Insights on the exchange program in Thailand

In 2012, she participated in the National Health Assembly organized by the National Health Commission Office in Thailand through AHI support. During the exposure visit, she found out that the village managed clinic is accessible to all villagers who paid only a small amount of premium.

Based on this model, she conceptualized an innovative health care financing scheme, for which she coined the term “Piso Mula sa Puso” or PMP (A Peso from the Heart). It is a matching-up financial scheme that gathers one peso per month from each household and the total amount collected is matched-up by an equal amount by first level matchers. The total amount of the first match-up is then matched-up with an equal amount by the second-level matcher. In the same way, this scheme encouraged higher level matchers to match up the amount, so that the villager’s fund could be enough to finance the projects identified by themselves.

Emy introduced PMP to the village of Pangutaran in order to apply in their respective communities. Gai responded to her call and implemented PMP in her small island.

In 2013, the PMP community health care financing organization was organized and more than 150 households in the village were members. PMP provided assistance to members when they get sick or admitted in the district hospital. It also funded the project which solved the common issues identified by members, for instance, the solar powered street lights to protect villagers from accidents like falling down into the sea at night.

5. Participation in ILDC 2016 with Gai

Emy was determined to participate in ILDC 2016 with Gai as a partner so that the course could help Gai to develop her leadership. The expectation of Emy for this course was to know how to make people’s organizations sustainable. During the course, Emy and Gai shared their rich experiences as well as learned from other participants who were from seven different countries. Most of the participants were social development workers and a few were from health sectors. She was popular as “a mother of the ILDC 2016” among younger participants because her characteristics was so simple and approachable, that she always did “selfie” with other

participants or Japanese friends whenever she found time. That earned her the jestingly nickname "Doctor Selfie". We hardly imagined that a medical officer loved selfie so much.

One significant component of her Plan of Action (POA) was the Rights Based Approach (RBA). She made the POA that health volunteers or community people would realize that every person has the right to access to health services equitably, and they would acquire power to assert their rights. Another component of her POA is to influence officers of the Department of Health as well as other departments, to recognize people's health rights and improve their knowledge and attitude in order to perform their duties.

6. Prevailing peace through health

In Pangutaran island, the peace and order situation is not yet stable, for example, kidnapping incidents often happen. Due to this, even NGOs and other government line agencies hardly penetrate these islands. Therefore, Emy pursues peace activities in the grassroots level with Gai through their POA. In this way, Emy together with Gai would bring about not only health but also peace to the people in Pangutaran and Sulu.

Through the three AHI programs that Emy participated, we can assume that she is developing her career as a doctor to tackle health with wider perspective so that she can work on social determinants of health in the remote islands of Sulu, the Philippines.

7. Speaking tour, a mutual learning opportunity

During eight days of the tour, they were so energetic that more than 670 people in 14 different groups were encountered and inspired by Emy and Gai. The audiences were university students, church members, Muslims in Nagoya area, and concerned citizens. The following is the excerpts from their presentation.

Referring to the objectives of the said speaking tour, we are sure that Emy and Gai were successful to give impacts on the Japanese audience. Through their presentation and interaction, the audience understood that in spite of unfavorable external conditions surrounding them, they carried through consistently their purpose to serve the marginalized people in Sulu. Mr. Kato, the administrator of Ryujo Women's College in Nagoya, mentioned that many of the women students were impressed by Emy's powerfulness.

(Standing, R) Ms. Ms. Gaida Hunnoh Gaidal during the lecture at Chukyo University.

One of the participants in the meeting of Budou no Kai asked a question, saying: "As a director of the home for the aged, I am now struggling for organization improvement. Am I required to change myself as well?" Emy answered, "I believed it is important to analyze the changing social and political environment, and we should develop ourselves to be a change agent. This is my learning from the AHI training course."

All in all, we can conclude that the AHI speaking tour is a good opportunity for both Japanese audience and Asian participants for mutual learning.

Maryknoll High School Workshop
Exposing Students to the Real World of Health, Economic Gap and Development

Ms. Joy A. Bastian, AHI

1. What is it?

A yearly event, the Maryknoll High School for girls in Mie, Prefecture, Japan holds a day long workshop on February 16, 2017, for their first year high school students (aged 16 to 17). The main objective of this year's workshop is to expose the young students to the realities of the world particularly on health, economic gap and rural development focused on the Philippines and Asia. Unique for this year is the active participation of three AHI women volunteers. One of them facilitated a group dynamic on how to make a better world.

The students did research about the Philippines prior to the workshop. They were divided into small groups of which each has an assigned focus information to gather, prepare and present in the workshop. This gave the students confidence in knowing the realities of other countries, understanding them

and raising their awareness. In Japan, everything is available from social services, health and education facilities, economic opportunities, and more. Most young students are confined in their own comforts without knowing that other people and countries have several issues. This gap is what AHI is trying to fill. Through this yearly workshop conducted by AHI for Maryknoll, the young students were able to realize that health care is still a major problem, and the importance of caring for others especially the underprivileged.

2. During the workshop

The flow of the workshop was the introduction of AHI by former staff Ms. Tomoyo Hidekuma, a symbolic group dynamics on economic gap in Asia using chocolates by an AHI volunteer, and storytelling about the Children Health Scouts (CHS) in the Philippines by Ms. Joy A. Bastian.

During the small group workshop.

For the group dynamics, the AHI volunteer, in her part of the event, divided the chocolates in random quantity and gave to each group. To compare two extremes, one group had only one chocolate (as shown in the photo) for 8 members, while the other group had a few extra. Students clearly expressed their sentiments in the distribution of chocolates to each group. Those who had too many were happy. Those who got less than enough were ok. But those who got only one chocolate were sad, discontented and they asked why. The activity successfully transcended to the minds of the young students that inequality is never fair. This scenario triggered rich reflection on economic gap. Furthermore, the students realized that inequality is not only in terms of money but also access to health, education and many others. That in our global society, many people don't have, have less, or have too much is a matter of problematic reality.

A symbolic lone chocolate.

A Maryknoll teacher who serves as interpreter helps distribute chocolates for the workshop.

In the storytelling, the students understood that poverty deprives the rural people from availing health services. It also compelled the parents to leave their very young children unattended by adults while they were working hard in the farm for a living. This led to the boy's accidental drinking of kerosene that alarmed the community people. Hence, the creation of the CHS as a support mechanism for the parents to work peacefully while leaving their children all by themselves at home. The CHS were trained on very basic health care and hygiene. They served as little community health volunteers with a smaller scope (just among their age group) and lighter tasks like hygiene promotion. At the same time, the children themselves support each other in the community not only about health and hygiene but sometimes in their homework.

The students were impressed on the role of the CHS, like boys scouts and girls scouts, in upholding the situation of their community as health promoters. This is beyond imagination for the Japanese high school students.

3. What now?

Starting from the young ones to inculcate social awareness seems a reasonable move. The Maryknoll High School students through this workshop were given the opportunity to know first hand experiences about the realities in the world. Hopefully, their consciousness is awakened, then on, create ripples and eventually makes a difference.

AROUND JAPAN

Foreign Migrant Women and Poverty: An Interview with Ms. Motoko Yamagishi Solidarity Network with Migrants Japan

Translated by Gabriele Koch
Compiled by Ms. Michiko Umeyama, The Asia-Japan Women's Resource Center (AJWRC)
An article taken with permission from the "Voice from Japan" No.31, March 2017.

1. Introduction

The administration of Prime Minister Shinzo Abe has promoted the "use of foreign personnel" as part of its effort to increase the labor force participation of Japanese women. This has included the introduction of national strategic special zones in which foreign domestic workers will be employed and the creation of the category of "nursing care" within the Technical Intern Training Program [TITP] targeting foreign nationals. It is a program implemented in 1993 to extend Japanese skills to developing countries by accepting workers as technical interns in the Japanese industry. It is expected that a future revision of the Immigration Law will establish the new visa category of "caregiver." What issues will these changes bring and how will these affect foreign migrant women who are already in Japan and those who are yet to come to Japan?

2. How the expansion of the Technical Intern Training program(TITP) will affect migrant women

A January 2015 report on reviewing TITP by expert panel of the Ministry of Justice and Ministry of Health, Labour, and Welfare suggested that "nursing care" be added as a target occupation under this program. An expansion of this field under the auspices of this program as the effective usage of foreign labor power, however, is the main concern.

It is estimated that 2,530,000 care workers will be necessary nationwide by 2025 and there will be a shortage of about 380,000 such workers. The non-regular employment rate of care workers stands at 44.6 percent, while there is as high as 79.4 percent non-regular employment rate among home care workers. Their average monthly wages are ¥215,077, which is ¥110,000 lower than that of workers in other businesses.

The solution of the government in the face of personnel shortage is not to improve the wages and working conditions of care workers, but to look toward the even lower-wage working force the TITP provides. The United Nations and U.S. Department of State, however, have sharply criticized the harsh working conditions of this program more than once as human trafficking.

3. An environment in which it is difficult to flee or seek help

While the TITP is being expanded to include "nursing care," the government is trying to strengthen the domestic regulations concerning this program. It remains to be seen whether these changes will be effective or not. Agencies and brokers in sending countries are involved in this system too, thus, the program has formed a hotbed of exploitation. Often, interns pay large sums of money to brokers in their home countries as a security deposit. If they do not complete the full three years of the program, they cannot get the security deposit back. In some cases, even a penalty charge is imposed. Under such circumstances of multiple exploitation, the existence of Japanese regulatory bodies alone will make a little difference because there are many loopholes in the policy.

Another policy change proposed by the government is the introduction of a new category of "nursing care" in the revised Immigration Law. The target workers are foreign students, as with the TITP, this is not a policy change of accepting foreign workers. The notes from the Policy Affairs Research Council of Liberal Democratic Party in May 2016 indicated as follows: The period of stay under the status of residence should be a maximum of five years and during the period, would permit returning home or re-entry to Japan. It should be all right to make it possible to renew the status of residence, however, problems with prolonged residence such as family

members coming along, and settlement need further consideration. The Japanese government must abolish the TITP which is a hotbed of sweatshop labor and human rights violations. They should make a transition to a system that accepts all foreign workers coming to Japan who are justly recognized for their labor rights.

4. Poverty and distress of migrant women linked to international marriages

Let's take a look at the changing situation of migrant women living in Japan including difficulties in daily life and poverty. In the 1980s, the number of Filipino women entering Japan on entertainment visas increased dramatically. Since 2005, the number of women entering on that visa has decreased as measures against human trafficking was taken, and the investigation of their status of residence became stricter. However, the large number of marriages between Japanese men and Filipino women from the 1990s through the mid 2000s increased. Meanwhile, among those who lived together or got married to Japanese men, there has been an increase in the number of victims of domestic violence or other offensive acts who got divorced. The divorce rate for Filipino women in the 1990s was only one percent, but it jumped to more than eight percent by 2010.

In recent years, the regulation of the Immigration Law has further tracked down migrant women who were victims of domestic violence and separated from their husband or the man they were living with. Its revision in 2012 added a stipulation that a foreign spouse who "has failed to continue to engage in the activities of a person with the status of spouse for over six months while residing in Japan," would lose status of residence. Although there are supposed to be exceptions for reasons like domestic violence, that is not announced well. Therefore, many women feel that they can't get away from their husbands for fear of losing their status of residence. The law, thus, ends up. fostering domestic violence. There have actually been cases in which women have lost their status of residence despite being victims. This stipulation is extremely unfavorable for migrant women unable to explain enough their situation of being victims of domestic violence in Japanese and afford a lawyer.

Serious issues facing Filipino single mothers are difficulties at work and resultant poverty. The rate of employment for migrant single mothers has increased in recent years. According to the 2010 national census, the foreign labor force ratio of Korean, Chinese, Filipino, Thai, and Brazilian people, regardless of their nationality, is as high as 70 to 80 percent. Most migrant single mothers are working. Their working conditions and the state of their everyday life, however, are often quite harsh.

The instability of their employment is apparent from the high unemployment rate. Looking at the data available on the unemployment rate of single mother households by nationality, in contrast to 7.8 percent of Japanese single mothers, very high are Koreans (14 percent), Chinese (18.3 percent), Filipino (13.3 percent), and Thai at 14.8 percent. Most migrant single mothers are involved in blue-collar work such as production of ready-made dishes and lunches, dry cleaning, parts assembly, cleaning hotels or offices, or other jobs in the service sector or in the field of nursing care. The same is true for migrant women who even have the permanent residency status and have been in Japan for a long time. They still have unstable work with low wages. In other words, jobs that have low wages and poor working conditions are what migrant women take on.

Another big issue facing migrant women is a cycle of poverty which extends to their children. Migrant women often cannot read or write well in Japanese, thus, they cannot understand flyers or other written forms of communication that are sent home from children's schools. Additionally, they usually work long hours so they cannot spend enough time with their children. Such factors may pile up and cause problems such as a decline in children's academic ability and school bullying.

Being raised by a migrant mother, the children tend to be susceptible to alienation from society. Consequently, they have low self-esteem and cannot feel safe to grow up in society. It is important that migrant mothers and their children at home and school receive support not only individually but inclusively from their immediate community and society. Related supporting organizations should consider the individualized needs of the family and adequately respond to them, such as providing study assistance, offering daily life support, subsidizing tuition or educational expenses, and so on.

In recent years, there has been an increase in cases of exploitation of Japanese Filipino Children (JFC) who are born to Japanese and Filipino parents. With the Japanese Nationality Act revised in 2009, it became possible for JFC to get Japanese citizenship regardless of whether their parents are married, so long as they do the necessary procedures by the age of 20. Furthermore, as the primary caretaker of the children, the mother can also legally reside and work in Japan. Since the passage of this revision, however, the existence of heinous brokers, who

coax them into employment in Japan for several years in sites such as nursing facilities, factories, or bars (all places with poor working conditions) and put them in significant debts, has come to light.

5. The necessity of special employment support measures for migrant women

One issue that has been raised with regard to addressing the poverty of migrant women is the lack of employment support based on language acquisition. To start with, there is not much of a support system in place in local communities for migrant women who marry or live with a Japanese man. Although there are women building mutual assistance networks in areas where there are other international marriage couples or women from the same regions of origin, there is hardly such an effort given to women who live either in rural areas with low population or in large cities but in isolation. At present, there is inadequate specialized employment assistance for migrant women, while the number of migrant women receiving welfare is high.

To help migrant women escape poverty, educational support aimed at expanding work opportunities is essential. While there are some municipalities that offer Japanese classes to teach them the language for everyday use, they are not nearly enough to get a job. Creating new support systems such as establishing programs that will allow them to learn intermediate and advanced levels of Japanese and Japanese culture on a long-term basis, or opening up opportunities for enrollment in junior high, high school and university, can make it possible to improve the living conditions of migrant women.

NEWS FROM FRIENDS

SRI LANKA

"Silver Jubilee Celebration"

Mr. Perumal Pitchai Sivapragasam, ILDC 1997, Human Development Organization (HDO)

Mr. Sivapragasam

Human Development Organization (HDO) is a non-profit making, non-racial development and human rights organization that work with underprivileged and excluded communities in the plantation and rural areas of Sri Lanka. HDO is registered under the Social Service Act, Sri Lanka and was accredited by the UN for the WCAR & SDGs. The mission of HDO is "Establishment of a socially just, equitable and peaceful civil society through poverty eradication and sustainable development". Since last 25 years the organization has developed appropriate strategies, methodologies and approaches to challenge the development issues among the people in concern, and in the region and the country.

Tea Plantation workers in Nuwara Eliya, Sri Lanka.

Since 25 years, development projects like community development, women & children empowerment, education & health education, human rights & reconciliation are being implemented in Kandy, Nuwara Eliya, Kegalle, Ampara and Mullaitivu districts. Over the past 25 years, thousands of children, women and men have benefited directly and indirectly through these programs. With this background, the HDO is celebrating its Silver Jubilee arranged on with its past 25 years of history, struggles, challenges and achievements.

PHILIPPINES

Mr. Danny Dionaldo, ILDC 1995, Davao Medical School Foundation-Institute of Primary Health Care (DMSF-IPHC)

It has been a long time since I connect with AHI. I have been very busy with my task as the Personnel Officer of the Davao Medical School Foundation system. Formerly, I concentrated on field work that gave me a fruitful knowledge and experiences in community organizing; making peoples' lives better particularly in their health, economic and leadership development. I was one of the lucky participants of the AHI-ILDC held in Japan. It gave me a wider perspective of how other community organizers like me overcome the challenges they face in the field.

I salute AHI, its staff, volunteers and supporting members for unselfishly serving the people of Asia through its training course, study tours, and provision of financial support on a case by case basis.

My new task now is mostly administrative, but I surely apply my learnings in management, organizing and staff development as the situation demands.

Thank you AHI for your unending love and support for the people of Asia. The image of Dr. Hiromi KAWAHARA is still alive. It is his imprint that you, I, we are one, committed to pursue and spread till the tides of time. I hope that one day, we can see the fruits of our labor: a fairer society, just, loving, caring and harmoniously co-existing.

2017 ILDC Participants

2017 International Course on Leadership for Community Health and Development on People's Participation in Local Governance in Health

August 27 to October 9, 2017

13 Participants from 11 countries: NGOs = 9, People's Organization =1, Local Government = 3

We will publish a course report in the coming issue!

	**Mr. Rajon Been** Program Coordinator Protibondhi Community Center, Bangladesh		**Mr. Binaya Prakash Acharya** Senior Officer: Planning, Monitoring and Evaluation Friends Service Council Nepal, Nepal
	**Mr. Chheangkim Heng** Program Manager /Fundraiser ARV Users Association, Cambodia		**Ms. Dayang Carlsum Sangkula Jumaide** Assistant Secretary for Administration and Finance Department of Health, Autonomous Region in Muslim Mindanao (ARMM), Philippines
	**Mr. Moeurn Mirn** Chief of Maternal Child Health Department Svay Antor Operational District, Cambodia		**Ms. Subashini Kamalanathan** Coordinator Sri Vimukthi Fisher Women Organization, Sri Lanka
	**Mr. Tashi Thukmat** Deputy Director Ladakh Environment and Health Organization, India		**Mr. Songpon Tulata** Director of PHPP Development Center in North Eastern Part Area The National Health Commission Office, Thailand
	**Mr. Feri Qotro Verhat Amaith** Project Manager Community Based Rehabilitation Development and Training Center Solo, Indonesia		**Mr. Theera Watcharapranee** Manager Stopdrink Network, Thailand
	**Ms. Mandkhaitsetsen Urantulkhuur** Executive Director Center For Human Rights and Development, Mongolia		**Ms. Le Nguyen Hanh Nguyen** Project Manager Foundation for International Development/Relief, Vietnam
	**Ms. Naw Eve Nan** Secretary of Human Resource Development Department National Council of YMCAs of Myanmar, Myanmar	Photos of the daily scenes of the training course will be occasionally posted on Facebook. Please check; https://www.facebook.com/AHI.JP	

SUPPORT AHI!
BE A MEMBER NOW!

AHI has some of its alumni as supporting members. AHI is supported by over 4,000 individual regular members and occasional donors. Recently, however, the number is decreasing due to aging population and sluggish economy in Japan. Even so, it is getting more important for AHI to commit working with the disadvantaged people living in endless uncertainty in Asian communities. That's why we need to get more supporters to achieve our goals. For those who live in foreign countries and have credit cards, AHI started its secure online money transfer system thru PAYPAL (www.paypal.com), by which the membership fee or donation is easily and safely transferred to AHI's account.

Type of Supporter	Annual Membership Fee
1. Supporting Member	**Amount**
Organization (S)	$300 per year
Individual (A)	$100 per year
Individual (B)	$ 50 per year
Individual (C)	$ 30 per year
2. Donation	Any amount, anytime

*Please check our website and go to the page of "support AHI". **http://ahi-japan.sakura.ne.jp/english/html/.** If you have any questions, please e-mail to: **info@ahi-japan.jp.***

Did you know that… ?

- At least 400 million people globally lack access to one or more essential health services.
- Every year 100 million people are pushed into poverty and 150 million people suffer financial catastrophe because of out-of-pocket expenditure on health services.
- Globally, two thirds (38 million) of 56 million deaths each year are still not registered.

Source: World Health Organization (2016)

CALLING ALL AHI ALUMNI!!!
WRITE YOUR ARTICLES

- Participatory Techniques for Self-Sufficiency
- Alternative Awareness-Building Strategies
- Health and Peace-building in Conflict Areas
- Disaster Prevention, Response & Management
- Community-based Inclusive Development
- Civil Society Organizations' Role in Development
- Rights-Based Approach Development
- Collective Bargaining

NOTE: Please write your articles using simple format. Don't indent, underline, italicize nor highlight your text. Special effects will only delay the editing process. Send us high your high resolution face photo and photos taken in your villages or work places with caption to support your article. Thank you.

How to Write?
The Rule of Thumb: WH Questions
What, Who, When, Where, Why, How

1. What is it?
2. Who are/were involved?
3. When did it happen?
4. Where did it happen or occur?
5. Why did it happen or occur?
6. How did it happen?
7. Results and Conclusion

The most common mistake of contributors who are not trained writers is to omit the critical and essential information. For example: ***The water project improved the people's situation. The people are now very happy.*** Clearly, the writer failed to specify that ***improvement***. Readers are more interested on what improvement exactly.

Try this:

The water project improved the people's health and hygiene situation. The neighborhood is now clean and the current health data indicated that water-borne diseases dropped by 70%. (or BHWs noted less cases of water-borne diseases.)