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987-30 Minamiyama, Komenoki, Nisshin, Aichi 470-0111 JAPAN
Tel +81-561-73-1950 Fax +81-561-73-1990 Email: info@ahi-japan.jp
Homepage:http://ahi-japan.sakura.ne.jp/english/html/ Facebook:https://www.facebook.com/AHI.JP


# FOCUS: Revisiting Primary Health Care


***Dr. David Sanders of PHM South Africa speaking at the opening of PHA-4. (Photo by PHM)***

In this issue, Ms. Hayashi Kagumi revisits the Declaration after 40 years, and hopefully provides insights on how to move forward better. Whereas, the articles on Peoples Health Assembly 4, written by Ms. Anneleen De Keukelaerere, Ms. Shiori Ui, and Mr. Songpon Tulata, reinforced Ms. Hayashi's narrative.

Experts and common people alike are wondering why there seems no end game for this battle; giving impetus to more questions. Is "Health for All" unrealistic? Let's ask ourselves, all of us! Are we doing enough?

***From your Editor Ms. Joy A. Bastian …***

Results are emerging after four decades of struggle, commitment and dedication to uphold the mantra "Health for All", the 1978 Alma Ata Declaration's most coveted slogan. Primary Health Care (PHC) is a pivotal approach in achieving "Health for All" that leads nations globally to trigger governments, civil society organizations, academes, religious groups, activists, and ordinary people to participate and make it happen. Yet it is not good enough. Thus, Astana Declaration (2018) evolved, trumpeting Universal Health Care for the same end goal.

Ironically, the disparity between the rich and the poor is sustainably building up, inter-country and within the country.

There are promising experiences like in Thailand. However, majority of the countries globally are still struggling to catch up. Globalization seems to contribute to the distant reality: "Health for All".

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# FOCUS ARTICLES

**Looking Back: The 1978 Alma Ata Declaration On Its 40 Years**
*Ms. Kagumi Hayashi, AHI*

## 1. A Brief Look

The late Dr. Hiromi KAWAHARA, the founder of the Asian Health Institute (AHI) thought during his medical mission in Nepal in 1978 that community health workers, not necessarily doctors or nurses, could bring health closer to the people. Then he started to think of providing training opportunities to community health workers, which led to the birth of AHI in 1980. The Alma-Ata Declaration of 1978 was a stimulus to the emergence of AHI, a sort of affirmation that it was the right time. Since 1978, many efforts have been made.


***As an effective health educator, ask yourself: How much do I do to help the poor gain control over their health and their lives? ("Helping Health Workers Learn", 1982).***

In 2008, that is, 30 years after the Alma-Ata Declaration, the World Health Organization (WHO) stated in its World Health Report 2008 entitled "Primary Health Care Now More Than Ever", that:

The Alma-Ata Conference mobilized a "Primary Health Care Movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "Politically, socially and economically unacceptable" health inequalities in all countries. The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, participation and solidarity. There was a sense that progress towards

***Ms. Sobita Sapkota, ILDC 2014, Mental Health training for self-help group members.***

these values required fundamental changes in the way health-care systems operated and harnessed the potential of other sectors.

With this understanding, WHO urged therein i) health sector reforms along with other sectors' actions towards universal access to health services, ii) service delivery reform to ensure "putting people first", iii) public policy reform for public health, and iv) leadership and effective government.

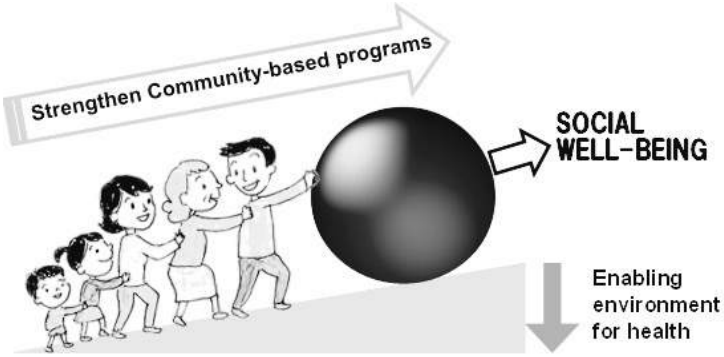
It is already another 10 years since then. Although the world as a whole has been accelerating progress such as in reducing the under - 5 mortality rate, disparities exist in across regions and countries, as well as within countries geographically or by social-economic status.

## 2. Mounting Health Issues is Like a Sustained Challenge 40 Years and Beyond

At the 40th anniversary of the declaration, the Global Conference on Primary Health Care at Astana, the capital city of Kazakhstan was organized on October 25-26, 2018. The Astana Declaration states, "Reaffirming the commitments expressed in the ambitious and visionary Declaration of 1978 and the 2030 Agenda for Sustainable Development in pursuit of Health for All".

For the full text of the Astana Declaration, please visit the website below:
***https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf***

When we look at the last 40 years, we see huge global social changes, which have been all affecting people's health in different aspects. We must admit huge global transactions of information and monetary or non-monetary resources. Globalization along with the very rapid development of information technology, has been accelerating gaps, which was already "unacceptable" 10 years ago. Urbanization is also global trend which has made children and their grandparents left in rural villages. The working generation dwell in urban or in foreign countries as unskilled labor, often resulting in family breakups. Unfortunately we need to admit even larger health discrepancy today. Not only between the countries, but also within respective countries. Aging along with lifestyle change, luring in the global market threatens us. For the last 10 years or more, non-communicable diseases like diabetes have become larger threats in developing countries. Today, they must have been tackling these with double burdens,
After PHC, the concept of Health Promotion followed in late 1980's. That is defined as "the process of enabling people to increase control over, and to improve their health". Health promotion goes far beyond health education to individuals for their lifestyle changes. It emphasizes social and political interventions, as health is to be determined by different social factors. Besides personal eating habits and lack of physical exercises, socio-economic status would affect diabetes patients, with limited resources and access for information in pursuing health. Public policies in different areas must be integrated towards public health, making social settings health-oriented.



**HEALTH PROMOTION CONCEPT**

In fact, threats are getting too strong to tackle, and challenges to us getting much bigger. We yet can find some opportunities. One of them is decentralization which has provided societal mechanism in some countries with people to participate in local decision making. Many civil society organizations, including many of former AHI participants, have been facilitating people's/community-based organizations as well as local government towards people's participation in management of local health facilities by strengthening village health committee or by organizing community health forum in order to make people's voices responded by health services and integrated in concerned programs and policies.


***People's participation in managing the community clinic in Rajshahi, Bangladesh.***

Some government institutions try to lead multi-sectoral collaboration so as to realize "Health in all policies". The National Health Commission Office (NHCO) of Thailand, where one of the writers herein Mr. Songpon Tulata belongs to, is one of them. It has been promoting tri-party - collaboration that is among government, civil society organizations, and academe. NHCO also has been providing the common platform for different stakeholders of multi sectors nationally as well as locally.

About the same time when WHO refocused PHC, it commissions on Social Determinants of Health (SDH) published its report. SDH is a condition where people are born, grow, live, work and age. They are shaped by the distribution of money, power and resources at global, national and local levels. SDH implies that poor health is not responsibility on individuals, but on societies. In order to respond to the health gap within and between countries, we have to question how resources are currently distributed and to work for desirable social system of equity, as health is not personal but "political".

**The 4th People's Health Assembly**
**(Key Issues and Demands)**
***Ms. Anneleen De Keukelaere, People's Health Movement (PHM)***

*PHA returned to Savar after 18 years, where the first Assembly was held in December 2000. PHM was founded in the Assembly, which adopted the People's Charter for Health, the founding document of the Movement. The first PHA and the People's Health Charter it adopted emerged as a response to the failure of the countries of the world to achieve the goal of "Health for All by the Year 2000", that they had set for themselves as part of the Alma-Ata Declaration of 1978, and the weak implementation of its key strategies. The second Assembly was held in Cuenca, Ecuador in July 2005, and the third was in Cape Town, South Africa in July 2012.*

*Note: A reprint of the PHA-4 report published by the People's Health Movement.*

### *1. Introduction*

The People's Health Assembly (PHA), is organized every 5 to 7 years by the People's Health Movement (PHM), a global network of grassroots health activists, civil society organizations and academic institutions. The 4th PHA was hosted by PHM-Bangladesh from November 15 to 19, 2018 at the campus of Bangladesh Rural Advancement Committees-Centre for Development Management (BRAC-CDM), Savar, Dhaka, Bangladesh.

PHA-4 is a gathering of around 1400 delegates, representing 74 countries of the world. An approximate breakdown per region is Bangladesh 52%, India 18%, Nepal and Sri Lanka 9%, Africa 7%, Europe 4%, Southeast Asia 4%, Middle East 2%, Australia 1%, and North America 1%. Participants in the Assembly, among whom were a large number of young activists, included representatives of various organizations and institutions working in the field of public health, including popular science movements, trade unions, women's organizations, other civil society organizations, governments, inter-governmental bodies, and academic institutions.

PHA at Dhaka has to be remembered for its indomitable spirit. The organizers were told by the Bangladesh government officials, at the very last minute, that the event might be cancelled because of pre-election. Thereby, many delegates had spent hours in immigration before being allowed into the country and a few were even deported. After delicate negotiations, the event got a green light but the event was shortened from 5 to 4 days, in a new venue. Despite the shortened timeframe, the national and international organizing groups managed to arrange a new venue (thanks to BRAC), revised and printed the program.

The first day of the Assembly was used as an opportunity for regional meetings and mobilization. As the PHA opened on November 16th, the mood in the plenary hall was very upbeat. The difficulties that some faced in entering Bangladesh seemed to feed into the strong sense of solidarity at the Assembly. Key processes and policies affecting health and healthcare all over the world were discussed. A wide range of health workers and activists attending the assembly shared experiences and pledged to take actions to secure universal and equitable access to health and health care.

***Bangladesh delegation calling "Health for All!"***

### *2. Key Themes Discussed in the Assembly*

The Assembly had nine plenary sessions and 18 sub-plenary sessions and a series of thematic strategy discussions, workshops and cultural activities spread over four days. The discussions at the Assembly revolved around four "thematic axes" – (1) the political and economic landscape of development and health, (2) social and physical environments that destroy or promote health, (3) strengthening health systems to make them just, accountable, comprehensive, integrated and networked, and (4) organizing and mobilizing for Health for All. The opening ceremony was a curtain raiser to the different thematic axes, interspersed with cultural expressions by participating countries. Plenary sessions focused on the major themes of the Assembly. An additional special plenary session on the last day was on the 40 Years Alma Ata Declaration. Sub-plenaries elaborated each of the four themes. Parallel discussions which took place on different key issues that together make up PHM's Health for All campaign developed strategies to align and co-ordinate activities and struggles across continents. There

was space for civil society organizations/networks and other participating groups to organize workshops on topics related to their own priorities within the framework of the Assembly themes. There were more than 10 concurrent self-organized workshops every day, with a total of 43 workshops being held.

**3. Highlights of the Sessions**

Mr. Eduardo Espinoza, the Deputy Health Minister of El Salvador, delivered the opening plenary session of the Assembly. He hailed the importance of PHM as the broadest global health movement and as a voice of resistance in current era where neoliberal policies dominate and governments fail in providing health for all. He explained how neoliberal policies and the dominance of Multi-National Companies (MNCs) are resulting in the uncontrolled exploitation of natural and human resources in the Latin American countries. He highlighted the crises of displacement, armed conflicts, and frustration manifested by lack of development in large parts of the developing world, which are contributing to the current situation of violence and counter violence. Climate change, manifested in the form of global warming, rising sea levels, emission of poisonous gases, rapid loss of bio-diversity, extinction of exotic species are, according to Mr. Espinoza, not a result of a natural development process but a reflection of mindless greed.


***(center) Mr. Karuppusamy, ILDC 2018, with delegation from India.***

Prof. Fran Baum, past chair of the Global Steering Council of the PHM, while delivering her address, expressed solidarity with indigenous people worldwide and expressed her anguish about the atrocities by national governments. Dr. David Sanders, one of the founding members of PHA and one of the PHM global steering council co-chairs, showed how developing countries are prone to higher burden of deaths in children, whereas unprecedented accumulation of wealth is taking place in a small percentage of the population, mainly in developed countries, as a result of neoliberal globalization.

***3.1. The plenary on Political and Economic Landscape of Development and Health***

Issues raised ranged from the examination of the dominant economic model of development, power relations between and within countries, trade agreements, and the role of powerful actors such as the Bretton Wood Institutions, multinational corporations, private foundations, global partnerships, and religious fundamentalist forces. It also addressed the underlying factors, global and regional, which are driving forced migration and precipitating a humanitarian crisis in many regions of the world.

Prof. Jane Kelsey raised concerns about the rise of populist authoritarianism globally and the fact that genuinely progressive governments are finding it difficult to survive the onslaught. She also emphasized the enormous power of lobbying Trans-National Companies (TNCs) have over global policy making processes like the Trans-Pacific Partnership. She drew attention to the fact that foreign investors are suing governments over supposed infringements of their right to reap uncontrolled future profit.

Mr. Amit Sengupta, one of the global coordinators, the leading voice in PHM and a key force behind the success of PHA 4, pointed out in his speech that the world had to bear the ill effects of austerity measures in developed countries in their efforts to bail out the corporates, which has affected the working population disproportionately. He also highlighted that though there are improvements in medical technology and medicines, the benefits are reaching only the rich, and mainly in the developed nations. A few days after the Assembly, Mr. Amit died in a tragic accident, leaving us in utter shock and grief.

***3.2 The Plenary on Social and Physical Environments that Destroy or Promote Health***

It focussed on how the existing layering of society through differences in power dynamics related to class, gender, ethnicity, caste, etc. are contributing to a global trend of rising xenophobia, war-mongering and intolerance. These, perhaps more than ever before, contribute to inequity in access to healthcare services and to a worsening of many social determinants such as food security and sovereignty, secure employment and decent housing.

Speaking in the plenary Ms. Shireen Huq, a women's rights activist in Bangladesh, talked about the plight of displaced people and how women are par-

ticularly vulnerable in such situations as that of Rohingya Refugees from Myanmar. Bangladesh hosts one of the largest refugee camps in the world for Rohingya refugees belonging to both Muslim and Hindu communities. The Rohingyas had faced years of hardship with discrimination, hatred, no health and family planning services, and no access to education; apart from religious schooling. They arrived in Bangladesh at a time when it was making considerable social progress in education and health and it was feared that the inclusion of Rohingyas would pull the country down. Despite this, the civil society in Bangladesh along with the government and international agencies, attempted to provide aid. However, due to intensified crises in many other countries, international aid has started to dry up. Myanmar was also supported by big countries in the region including China, Russia, and India that made Bangladesh isolated internationally.

### *3.3 The Plenary on Strengthening Health Systems to Make them Just, Accountable, Comprehensive, Integrated and Networked*

Various alternative models of healthcare delivery that are better suited to promote equity in access, that are fair, and that promote accountable systems built around popular participation, particularly women and others who are socio-economically and politically marginalized were discussed.

Mr. Rapeepong narrated the Thai experience on Universal Health Coverage (UHC). To make it functional, the country invested heavily in building public health infrastructure; increased producing doctors and nurses; and introduced measures like compulsory rural posting; decades before formally introducing UHC. Schemes catering to various sections of the society include: government employees and civil servants; armed personnel, and the majority of the common people. One key feature of UHC is the involvement of local bodies and decentralization of decisions and planning processes.

Mr. Mauricio Torres highlighted continuing violation of the right to health in Columbia and the limited contribution of the health system in addressing the health needs of ordinary people. In the absence of formal public and private systems and as opposed to the hegemonic international order, communities are working to develop their own health system.

Mr. Kedar Baral narrated how reforms were continued amidst political turmoil and immense conflict in Nepal. The health system was strengthened and the expansion of health services continued. Women were central to these developments; mothers' groups and cooperatives were handed over forestry and health services. He opined that the recent elections in local bodies which took place after 19 years would strengthen the decentralization process further, and are expected to have far reaching implications on health system.

### *3.4 The Plenary on Organizing and Mobilizing for Health for All*

Various struggles for health and actions by groups, peoples movements, NGOs, and community based organizations as sources of inspiration, mutual learning and strategizing for future actions emerged.

Mr. Alexis Benos highlighted the role of the Solidarity Movement in Greece against the gold extraction industry there, which is leading to irreversible climatic disruptions as huge number of trees are being cut. He pointed out that the refugee crisis and closure of border in European countries is being resisted by people. The people are protesting for the rights of the refugees. As a collective response to fascists, grassroots movements are being strengthened and people to people bonds are established.

Ms. Sulakshana shared the role of Mitanins (community health volunteers) in protecting forests against mining projects and preventing deforestation in Chhattisgarh State, India. The Mitanins struggled to stall the mining project for four years supported by PHM. PHM also raised a crucial issue on the right to family planning services especially the vulnerable Tribal Communities in Chhattisgarh State.

### *3.5 Plenary on 40 Years of Alma Ata Declaration*

It started with the tribute of Dr. Halfden Mahler, the three-time WHO Director General, who was instrumental in organizing the Alma Ata Declaration. He has been a great source of support for the PHM. He is the true upholder of the spirit of PHC as envisioned in Alma Ata Declaration. Ms. Maria Zuniga highlighted how the history of PHM is associated with people's struggles — Nicaragua in the early 1990s, independence in apartheid South Africa, and the fight of Palestinian people against Zionist onslaughts. The International Peoples' Health Council was a predecessor of PHM; formed in 2000 at Savar, Bangladesh

UNICEF's Mr. Paul Rutter differentiated the Alma Ata Declaration and the Astana Conference. The former argued for Health as a human right and health for all, while the latter is on equity through UHC. PHC is a key approach to improve health.
Dr. David Sanders pointed out that the Alma Ata Declaration has called for a New International Economic Order based on equity, sovereign

equality, interdependence, common interest and cooperation among all States, irrespective of their economic and social systems. The concept of PHC had strong sociopolitical implications. These aspects have been lost in the Astana process.

The PHA4 ended with incredible energy, enthusiasm, and passion. Delegates from each region of the world took turns to sing a rousing call to arms. The inspiration that comes from such passion is vital to a progressive health civil society movements.

**4. Key Issues, Calls and Demands Emerging from the PHA**

PHA drew in civil society organizations and networks, social movements, academia and other stakeholders worldwide. It provided a unique space for sharing experiences, mutual learning and joint strategizing for future actions. The Assembly called attention to the "global health crisis that is characterized by inequities related to a range of social determinants of health and in access to health services within countries and between countries".

The key theme that emerged out of four days deliberation was that the current global and political regime, with its protection of the rights of TNCs and its creation of mind numbing economic inequalities, is the greatest threat to the health of people and planet. Several speakers articulated that everyday living conditions (such as housing, employment, opportunity to access health services, educational opportunities) drive people's health status and these are, in turn, driven by underlying political and economic factors and the corporate determinants. The assembly also heard positive stories, like innovative models of healthcare, challenges to corporate power, and so on. These models represent the few voices who protest the fact that many governments are failing to invest in the public infrastructure needed to promote health or to question growing corporate control over our lives and health.

Action plans on the issues derived from the main themes of the conference — health systems; food and nutrition; trade, health, and access to medicines; gender; environment and development; and occupation, militarization, and war—were shared.

The final declaration of PH-4, .org."The Struggle for Health is the Struggle for a More Equitable , Just and Caring World" is now available at **www.phmovement**

**Global Gathering of Health Organizations and Activists in Asia**
***Ms. UI Shiori, Rikkyo University, Tokyo***
***Former AHI staff***

**1. Background**

I joined the 4th People's Health Assembly held in Dhaka, Bangladesh. in 2018. In the AHI's international course and others, I have been always introducing the People's Health Movement (PHM) and the People's Health Assembly (PHA) to the participants as good examples of counter actions from the grassroots to tackle the issues of health and its social determinants at global level. So knowing the assembly be held in Asia again after 18 years, I did not dare to miss a chance to join for the first time.

I am currently working full time in an academic institution in Tokyo, but at the same time involved in some Japanese NGOs including AHI. Being informed that in previous assemblies, there were groups of Japanese participants, I was surprised to find myself the only one from Japan this time. Soon, I met quite a number of AHI alumni and members of related organizations in the assembly. I was very happy to know how actively AHI alumni have been engaged in the grassroots/field level and in parallel putting importance on updating global trends and building global linkages.


***(left) Ms. Moon, ILDC 2014, with Ms. Ui meeting health volunteers from Africa.***

Twenty years ago, the assembly's major issues were focused on people's health, the factors and structures affecting them in the developing countries. Now, the health gap is prevalent regardless of country or society, and the gap is not shrinking but rather widening. Primary Health Care is not only the issue

of countries with less resources and weak health systems, but a common concern of all cross borders.

**2**. **Health and Trade: Global Trade Threatens People's Health**

During the assembly, each region held a series of discussion on selecting priority issue for joint action for the next few years. As Japan was part of the South-East Asia and Asia Pacific Region, I joined in the discussion. Various common issues were raised such as: migrants' workers health rights, climate change and health, antimicrobial resistance, and reproductive health rights.

The group selected the Regional Comprehensive Economic Partnership (RCEP) and its impact on access to medicine, as an urgent issue. RCEP is one of the mega free trade agreements that started its negotiation in 2013. Its member countries are 10 ASEAN countries, Japan, China, Korea, Australia, New Zealand, and India. These 16 countries in total covers about a half of the world's population, and there is a mix of very big different stages of economic development among its members.

As other free trade agreements, negotiations are not transparent. One negotiation item is the extension of Intellectual Property Rights of medicine, so called patent protection for 20 years agreed by the World Trade Organization. In RCEP, this is proposed by economically advanced member countries, Korea and Japan. This extension would lead to the high price level of medicine, and the delay of producing generic medicine at lower price.

Aside from access to medicine, such unequal trade agreement would widen gap between the rich and the poor, rather than achieving equity, by allowing more power to control resources to big companies of rich countries. Actually, the issue of high price of medicine does heavily affect the people in developing countries. Furthermore, it also threatens the financial sustainability of national health insurance system in other countries. Japan is not an exception.

**3**. **Joint Action, Linkage and Collaboration**

As the negotiation speed seems accelerated from 2018, civil society organizations are concerned to take joint actions urgent. This RCEP, unlike another mega free trade agreement like Trans-Pacific Partnership (TPP) involving Japan, is not much highlighted by media in Japan, and people are not aware of the concerns in developing countries. After the assembly, the PHM regional group drove a signature campaign to raise the concern in time for the negotiation meeting in Indonesia in February, 2019. The negotiation is continuing, and we need to monitor further. For those of you would like to know more about RCEP for a good summary, visit **https://www.bilaterals.org/rcep.**

As trade issue is very complicated, it seems rather hard for field level health organizations and workers to catch up the updates and get involved. When we look around, there are other organizations/groups (maybe not big but rather small scale) working on this issue. We are not able to do all the works, as we have focused activities and limited capacity. We can link with their network and join, get information, and share with common people in understandable way to raise awareness and question to wrong trends affecting our health and lives. Such linkage, you can find through PHM network. PHM is an open network to anyone interested or agreeable to principles of Primary Health Care, of which focusing on achieving Health Equity. We can start our small contribution by joining PHM network.

## 4. JOIN NOW! For Health for ALL!

*To start with, why not you register in its mailing list, which is free and open. It is a great source of information to update global health trends and issues, exchange experiences among practitioners, and involve in joint advocacy. Just visit* ***https://phmovement.org/phm-exchange-network-peoples-health-movement-exchange/****. If interested, you can find your country (or regional) coordinators list and contact them to include you in the country mailing list for concrete national policy advocacy and joint actions.*

**Revisit the Core Principles of Primary Health Care**

The Alma Ata Declaration on Primary Health Care (PHC) was adapted in 1978. After 40 years, Astana (new name of Alma Ata, the capital city of Kazakhstan) Declaration was endorsed during the WHO sponsored official meeting in 2018. PHM examined critically its contents and proposed alternative civil society Astana Statement on PHC. This alternative statement emphasizes again the principles of comprehensive PHC, and expresses social and structural factors affecting health gap in more explicit manner with specific issues. It reminds the responsibility of government and public funding, rather than leaving it to the profit oriented health business. One of the most important issues is shifting resource utilization from military to health and social services. Please check the alternative statement, and if you agree, please endorse from its site: **http://surveymonkey.com/r/5Y6GWCL**.

**NHCO Participates in PHA**
***Mr. Songpon Tulata, ILDC 2017, National Health Commission Office, Thailand***

***1. NHCO's Participation***


***Mr. S. Tulata at the PHA-4.***

The People's Health Movement marks the anniversary of the landmark Primary Health Care Declaration of Alma Ata with the 4th People's Health Assembly in Savar, Bangladesh on November 15-19, 2018, which I participated.

I belong to the National Health Commission Office (NHCO) as in charge of the Department of Area-Based Policies Movement.

NHCO is a government organization that works with multi-sectoral organizations including the government, the academe, and the civil society in order to develop and drive participatory health public policy at every level. NHCO facilitates and supports policy reform tools under the National Health Act 2007: Health Assembly, Health Charter, and Health Impact Assessment.

Experience would tell that People's Health Movement (PHM) is a good platform to study and connect to global NGOs and POs networks. Through it, NHCO can keep in touch with the NGOs and POs movements from many countries.

I shared the NHCO experience during the PHA4; being a team member of the self-organized workshop on "Rethinking an Approach to Mobilize Health for All: An Experience from Thailand". It is a case study about multi-sectoral collaboration at the community level in Noen Maprang District.

**2. Noen Maprang District: Gold Mining as Health Hazard**

Noen Maprang District is an area under the gold mining concession project. Before the mining company starts the project, there is a collective effort among the community people, NHCO, GOs, and POs to hold Health Impact Assessment (HIA). The HIA is one of the tools under National Health Act 2007, to determine the effects of nearby mining sites, social resources, and people's capacities. The result of which, shows that a better alternative for gold mining is eco-tourism and agriculture.

Before the onset of gold mining in Noen Maprang District, the community already learned from the case study conducted in the neighboring areas like Akkara Mining, Phichit Province, and Thung Kham mining, Wangsapung, Loei Province. They became aware that Noen Maprang will suffer cyanide, lead, mercury, and arsenic poisoning should the gold mining starts. Toxins contaminate water and soil that affect community health and environment. Apparently, the ecosystem will be destroyed.

The people of Noen Maprang, with the assistance from NHCO, organized a working group composed of local communities, local university, local authorities (local government, department of community development (district level), district public health office, and CSOs in Phitsanulok Province. All of them are key stakeholders in the Community Health Impact Assessment (CHIA) process.

***3. Processes, Problems, Prospects***

NHCO introduced the CHIA tool to the working group through capacity building. Equipped with new knowledge, skills and factual information, they applied the "Rethink" concept. By rethinking, they aimed at changing the community people's mindset; from protest to "fight against the mining company" to "fight with data".When the mindset is settled, they did "Reframe" their study framework using focus issues. The issues range from local tourism, bio-diversity, to design research tools, and to collect data together. These efforts are assurances that the

social capital are capable of proposing policy options.

Through CHIA, it was discovered in Noen Maprang that there are plants, mushrooms, and Siamese crocodiles in the forest near the proposed gold mining area. How? The researcher from Naresuan University and the community people explored around Chomphu river basin. They also found some rare flowers that denotes a very fertile forest.

The area is nestled in a geography for eco-tourism and organic farming. The best product here is export grade organic mangoes. The CHIA working team hit the true capacities of Noen Maprang more than the Environmental Impact Assessment data.

After the working group collected the community data, they fed it back to the communities. They presented the study results to stakeholders and specialists. They advocated their policy to the Provincial Health Assembly, HIA Commission, and related organizations at all levels. They made their data public on social media and other media, by which they caught attention from other areas, too.

At last at this point, the local people "redesign" the strategy according to the comparative advantage of the community which is on eco-tourism and organic farming. Now, Noen Maprang is one of the top tourist destinations in Northern Thailand.

**4. The Workshop Reminds Me to Refocus**

***The NHCO team presenting the Thai case in a self-organized workshop.***

Sharing the success story of Noen Maprang in the workshop through a video clip provided a concrete image of the situation. Showing the beauty of Noen Maprang and the destruction of gold mining in its nearby areas was a compelling comparison. The video viewing triggered dynamic discussion with a guide question: "What would you do if you were the people in this community?"

Most of the workshop participants proposed some aggressive ways to fight with the government and the mining companies. It was then that the actual workable and proactive strategy of Noen Maprang in managing the situation was presented in details. They used positive approach to conflict rather than confrontational approach.

As manifested in the discussion (self-organized workshop, and other PHA sessions), I realized that the Thai health system is more advanced than other countries, because it covers not only primary health care but also other social determinants of health.

However, the health system alone does not work without community involvement.

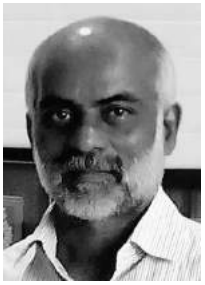
Participating in PHA4 is a big reminder for me to always look back to basic; Health is a basic human need. We should start from the basics of health needs before introducing complicated health care system. Otherwise, participation is less.

My PHA4 experience will surely improve my performance. I especially incorporated in my Plan Of Action (POA) to develop Area Health Charter in our areas of operation, which is a tool that promotes better multi-sectoral participation and collaboration, especially POs and NGOs.

# FLASH ARTICLES

**CARPED Won Polestar Special Award**
***Mr. Bharath Bhushan Mamidi***
***ILDC 2018, India***

**1. CARPED Awarded for Its Advocacy**



***Mr. B. Mamidi***

The PoleStar Special Award for Best Social Impact Organization in Health was given to the Centre for Action Research and People's Development (CARPED). The award came with a trophy, citation and cash prize of Rs 100,000. The PoleStar Jury Special Award 2018 for CARPED was conferred for its Yeomen service, in saving the lives of thousands of women from the hands of unscrupulous medical practitioners, by preventing more number of unwanted hysterectomy cases according to the citation. Hysterectomy is a surgical operation to remove all or part of the uterus.


***CARPED garnered the Polestar Award.***

The Rashtriya Swasthya Bima Yojana (RSBY) the health insurance scheme of Government of India and similar state health insurance like Arogyasri in Andhra Pradesh are schemes aimed to enroll the population below the poverty line in India for availing surgeries in hospitals. However, these insurance programs are incentivizing unethical practice leading to the large number of irrational and unnecessary surgeries.

"In Andhra Pradesh, for instance, hysterectomy can cost up to Rs 60,000, an amount that was reimbursed under the state's Aarogyasri health insurance scheme based on public private partnership comprising the insurance company, private hospitals and the state agencies[1]. As there was scope for quick money to be made in surgeries, private hospitals used registered medical practitioners (RMPs) to refer poor women with gynecological problems as hysterectomy cases. In Andhra Pradesh 'Aarogya Mitras' (health assistants) are appointed by private hospitals to scout around for patients who can be enticed to get operated upon in private hospitals.

CARPED was alarmed at the rate of young women operated wrongly for hysterectomy, without their knowledge due to ignorance compounded by illiteracy. It played an activist role in exposing this illegal and dangerous practice and continues to save large number of tribal and poor rural women from the clutches of the perpetrators", the citation mentioned. Abuse of community health insurance schemes was rampant not only robbing the public money but also harming the gullible people by forced surgeries not only in Medak District. CARPED investigated the cases in Medak District and initiated campaigns and community mobilization, but also in other districts of the state and other states as well. Abuse of community health insurance and serious threat of forced surgeries of varying incidence levels has become rampant in several states.

**2. Information-Based Approach of CARPED**

CARPED has been instrumental in national debate on the need for medical ethics and transparency, and strengthening government responsibility in ensuring the health rights and medicare are not threatened by malpractices in private healthcare. It has conducted field studies on the rampant incidence of forced hysterectomies and its ill effects on the affected women, organized public hearings with authorities, elected representatives and subject exerts among others, where the affected women presented their testimonies of the tragedy of forced hysterectomies.

Thrift and Credit Women Self Help Groups (SHGs) of the district joined in programs organized by CARPED for awareness generation among women folk to be cautious about hysterectomies and to consult government doctors or seek second opinion before agreeing for hysterectomies. SHG members informed other women of the consequences and post hysterectomy suffering.

Field studies also helped in campaigns to sensitize the authorities and the civil society for arresting unnecessary hysterectomies which have become a curse for the affected women who are forced to suffer surgical menopause due to hysterectomies in young age. Authorities conducted raids on erring private hospitals owing to pressure of the civil society.

Today, about 10 million women in the age group of 19 to 45 years, according to the National Health and Family Survey (NFHS) Round 4 Report (2018), and most of them had unnecessary surgeries. Dr. Sharda Jain, Secretary General of Delhi Gynecologists Forum and former Chairperson of the Women Wing of Indian Medical Association says, "India is home for unnecessary hysterectomies", of which 80% of it could be avoided.

However, Mr. Dhuru Shah says around 90% of hysterectomies could be avoided. Evidence based advocacy by CARPED and like-minded groups of women SHGs and NGOs as well as media supporting the fight against medical malpractices

[1] See for details "**Hysterectomies and Violation of Human Rights: Case Study from India**" by Bharath Bhushan Mamidi and Venkat Pulla, International Journal of Social Work and Human Services Practice, Vol.1. No.1 September, 2013, pp. 64-75. **http://www.hrpub.org/download/201309/ijrh.2013.010110.pdf**.

has been effective in convincing state government to repel hysterectomies from Arogyasri community health insurance scheme in 2011, which earlier used to pay handsome money to private hospitals for removal of uterus.

A few other state governments have also repelled or introduced checks on hysterectomies in community health insurance schemes. However, there are innocent women forced into these surgeries in private hospitals which can be arrested only by more vigilant and effective monitoring by authorities. Studies, campaigns and community mobilization efforts in this regard since 2005 have been pioneering, and assisting other agencies in exposing the violations of human rights through abused community health insurance schemes, sharing empirical data and field studies, and providing material for media advocacy and research in public health as well.

## From Grassroots Worker to NGO Leader

***Ms. UI Shiori, Rikkyo University, Tokyo***
***Former AHI staff***

*Note: English translation of an article published in AHI Japanese Newsletter 2018 August Issue.*

***Mr. Soeung Saroeun at CCC Office.***

### 1.Revisiting a long-time friend in Cambodia

I visited my 20-year long friend in Cambodia in February 2018 as I knew that he was planning to come to Tokyo, Japan in the following week. He is Mr. Soeung Saroeun (38 years old), the executive director of the Co-operation Committee for Cambodia (CCC), the largest NGO network organization in Cambodia with 170 members.

When I arrived in his office, he was just opening a computer on his desk and said: "UI, what do you think is my computer password?" I replied: "It is… India is my first trip". He mused: "Really? You mean…THAT trip to India?" At that moment, I looked around worrying that we talked about password in such a loud voice. "That training was really an unforgettable memory in my life."

### 2. Born Right after Pol Pot Regime, From Volunteer to NGO Worker

Saroeun was born four months after the fall of Pol Pot Regime* as the 4th child of 8 brothers and sisters in Samrong District in Takeo Province, about 30 kilometers south of Phnom Penh. In spite of the extremely hard living situation with scarcity of food even as farmers, his parents made every effort to send their children to school. Bicycle ride of 14 kilometers one way was so hard for him, especially during the floody rainy season, but he continued to go to school. During his statistic major study in a university in the capital city, he got involved in NGO work as a volunteer. After his graduation, he became a full time staff of that local NGO.

### 3. Training in India Built Basic Capacity as Community Worker

Soon after he joined the NGO, his director suggested him to apply for a training in India. That was the South Asia Regional Training Course organized by an Indian NGO Deenabandu, in collaboration with ACHAN, an Asia-wide health network, and a Japanese NGO Asian Health Institute (AHI). As a Cambodia Program Coordinator of AHI, I met Mr. Saroeun for the first time during the selection interview. He was a sincere, slender, young man with big bright eyes.

For Saroeun, everything was the first experience; from participating in training, to traveling abroad, and to eating spicy curry every day. He tried to adjust to everything and face any challenges. He lost his weight by five kilograms in his first two weeks in India. He was the youngest participant in the course. Other participants loved calling him "Tambi" which means younger brother in local language. "I was just starting my NGO work. I did not know anything about India. I knew little about Cambodia even.", he recalled with a smile.

In order to realize the motto "People's Health in People's Hands" learned in the training, he applied it in his area. The "Course was so empowering to me. I engaged people in the grassroots through collective actions among themselves." Practical knowledge and skills on community work such as: how to do participatory action research, how to train illiterate people, how to mobilize local traditional knowledge and existing resources, such as herbal medicines, and how to get local government support, gave him motivation. The participatory training methodology he experienced during the course was impressive, and applied in his grassroots work.

Several years after his work, the system of community participation in health center management was introduced by the Ministry of Health. The time has come for Saroeun to put his learnings into practice

in health sector. At that time, I was doing a small research about the functionality of community participation in health sector and roles of local NGOs. He said: "UI, you are welcome to my place." Saroeun invited me to visit his working area, the rural villages in Pursat Province. I was so excited to see his pioneer work to make the community participation system function, using multiple approaches to grassroots people and local government facilities. He grew up as a confident and yet humble community worker in such a short period. I see his big efforts with full dedication and commitment.

**3. Taking a New Role of Supporting NGOs and Community-Based Organizations**

In 2004, Saroeun moved to the capital city to work with an NGO network organization, CCC, with a mission to enhance transparency, accountability and management capacity of small-scale local NGOs. He took a lead in setting up a local NGO accreditation system. "The starting point is that training in India, and is well linked to my current networking and advocacy work."

***Health education for villagers.***

Now, Saroeun represents the civil society in Cambodia, generates and disseminates information on issues faced by Cambodian grassroots people inside and outside the country. Furthermore, he promotes advocacy works on wider global issues in collaboration with NGO networks in other countries as well. In these years, the social environment surrounding NGOs is getting restricted, and working as an NGO network leader may fraught with danger. "We, NGOs, can compromise operation/working approaches according to the situation, but not on principles and values." He listed "ACTIVE": Accountability, Cooperation, Transparency, Integrity (honest, free from corruption, free from nepotism), Value each other, and Effectiveness in implementation and resource use. "Even if we criticize conflicting actors, we should not stop dialogues and try to find cooperative manners for better understanding." His mission continues. "I wish to strengthen the capacity of 10,000 community based organizations in the country and spread these principles."

**4. Relationship with Japanese People Started on AHI Training**

During the 4-day visit to Japan, Saroeun met various actors: NGOs, and government officials, and made dialogue and suggestions regarding Japan's future cooperation with Cambodia. On the last day, he delivered his message in a seminar. At the start of his speech, he mentioned that his relationship with Japanese people started 20 years ago by participating in AHI training. He made one hour clear presentation with full confidence in fluent English without looking at his notes or scripts. I was proud of him as an alumnus of AHI and was happy to be there as a longtime friend.

Right after the seminar, he left for Narita Airport in a hurry in order to catch his flight back home. He had to deliver a speech representing the civil society in Cambodia, in a national conference on Democracy and Good Governance in the following morning. Right after an overnight flights, he dared to go straight to the conference site. What a hectic schedule! With full of meeting schedule from morning to night, he might have not had any time for sightseeing nor buying souvenirs for his family and colleagues. I sent him off with a package of Japanese traditional snacks in his hands.

By the way, the password is changed every 6 months at CCC office, so by the time you read this article, it is changed already. So, do not worry

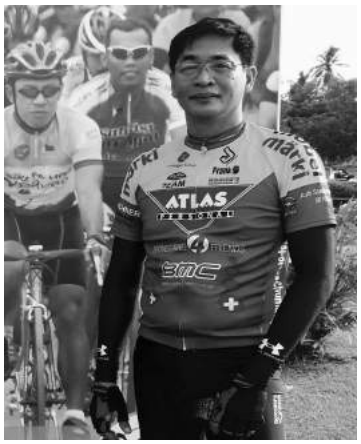
*Note: Pol Pot Regime (April 1975 to January 1979), tried to change Cambodia into extreme communist society in a short time. During the period, about the country's population 1 out of 5 died due to hunger and sickness in addition to direct execution.*

**My Personal HLPP Journey**
***Mr. Joel Quinanahan, ILDC 2000, ANAK-New Corella, Davao del Norte, Philippines***

**1. A Life Journey to Good Health**

Achieving good health is a journey through life. Everyone aims for a well-nourished body, a happy wellbeing. Longevity in age is what we ultimately aim to enjoy longer company with family and friends, to become productive, and able to contribute to community growth.

In the Philippines, managing healthiness for a lesser-informed individual is such an uphill climb owing the variety of tempting foods in the market. Too many enticing products are promoted on TV, social media, radio and malls. Far-reaching the most remote upland villages through retail stores, and yet information of their nutritional value or consequences on health are not readily known. One ill-effects of globalization,



*Mr. J. Quinanahan*

***Children in New Corella participating in the Healthy Lifestyle Fiesta.***

they say.
When the Healthy Lifestyles Promotion Program (HLPP) was introduced by New Corella Partners (LGUs, ANAK Inc., AHI, POs) in 2011, the trained advocates rallied for more natural food sources and physical activities. We pledged to combat smoking, alcoholism, and other vices. It is imperative for an advocate to learn HLPP ideals, re-echo Knowledge, Attitude and Skills, and be a role model.

Transforming oneself into a healthy masterpiece seemed an impossible dare to every HLPP advocate, and yet many has accepted the challenge. Personally, it was a jumpy, bumpy ride of change now; cheat later. The body can do so much discipline, old ways recur over time, but overall there was considerable gain in doing HLPP practice.

**2. Diet Modification, Discipline, Dare**

I have realized that diet modification was hard when being dependent to buying vegetables and herbs. Most crops are bombarded with harmful chemicals and a fresh produce spell a huge difference, and so I have decided to produce my own food by establishing a backyard-scale garden. I planted in pots local varieties like ampalaya (bitter gourd), beans, leafy vegetables, tomatoes, eggplant, lady finger, cucumber, and more for the past four years

***Bitter gourd and other vegetables planted by Mr. Quinanahan as part of the Healthy Lifestyle practice.***

for family consumption.
It is a satisfying experience when harvesting fresh vegetables daily. The sweet taste and crisp of a newly picked fruit and green leafy is delightful. Knowing what we eat is safe and nutritious, sharing the excess produce to friends and relatives is a rewarding gesture.

Recently, I have produced new varieties like lettuce, kale, spinach, chaism, beet roots, and strawberry among others. I came to realize that introducing this kind of vegetables generate interest and a new lifestyle to others like eating more salad, steamed vegetables, and making juice combinations as part of their diet. Consuming fresh or steamed foods can help us do away from fried and fatty foods.

***Spaghetti and white bread.***

***Mr. Quinanahan is tending his vegetable farm.***

**3. Generating Little Income Out of Hobby**

I have also begun packing and selling excess produce at affordable prices. This is to ensure the revolving of capital expense and at the same time earn while enjoying a hobby. In my small farm, I also propagate blue ternate, grapes, ornamentals and many others. Organic wastes were also supplied to vermin worms and some were fed to my turkeys, chicken and ducks. The idea is first ensuring a chemical-free food source, at the same time cutting food expense cost.

***Turkeys and chickens raised by Mr. Quinanahan in his backyard that supplies non-GMO and chemical-free meat protein.***

I believe doing these practices can help sustain and strengthen one's advocacy works. What we practice as our lifestyle is a strong foundation in convincing people to adopt a healthy lifestyle. Preaching by doing as they say.

***4. Emerging in the Barangays***

Partner barangays have gradually institutionalized community and backyard gardens, doing regular zumba and walking exercises, and Healthy Lifestyle (HL) Fiesta. Now, the HLPP has been one of the most talked about topic among groups and communities, aside from politics and investment scams. The advocacy has helped instill a consciousness of keeping a healthy mind and body. Aside from regular broadcasts in our local radio stations of Healthy Lifestyle ads, our advocates and health workers continuously hold information and education campaigns. I think we are at the right track towards aiming a healthy people through disease prevention and control.

***5. Current Issues of HLPP***

Sustainability is still a pressing concern of HLPP. ANAK is continuously finding means to address it. Another challenge is the attractive TV and radio commercials promoting junk foods. Children are easily lured to buy from the sari-sari store (like a small/simple convenience store). To counter this, we are constantly conducting mass information drive for healthy lifestyle, and making model backyard gardens to promote nutritious food. We also regularly celebrate the Healthy Lifestyle Festival to remind the people that the road to health is physical fitness, nutritious food, and production os small scale farms or backyard gardens.

# HERE AND THERE

**The Reunion Seminar of the Mekong Sub-Regional Countries**

The reunion seminar of the Mekong Sub-Regional Countries was held in Bangkok, Thailand from December 11 to 14, 2018. It was organized by AHI in collaboration with the National Health Commission Office (NHCO). There are 11 participants of AHI alumni from 4 neighboring countries namely Cambodia, Vietnam, and Thailand.

***Participants to the Reunion Seminar.***

Apart from sharing each experience after ILDC, participants attended the 11th National Health Assembly of Thailand (NHA11), which is the platform to dialogue, develop and drive public policies with emphasis on multi-sectoral participation from the government sector, academia and people. Furthermore, the participants of NHA come from various backgrounds both health and non-health fields. This is to make Health included in All Policies in Thailand.

The participants also visited a sub-district hospital and the organic farming group in Chachoengsao Province, which are working with the community people to develop and implement the health charter, while promoting public participation in the health policy process. During the reunion seminar, participants learned the schemes and good practices of multi-sectoral collaboration both at national and local levels in Thailand.

Here is the reflection of Ms. Thippawan Mokpha, a Thai participant, about the reunion seminar.

Thailand has promoted engagement of civil society in developing health systems since Alma Ata Declaration in 1978. The National Health Act passed in 2007 has proposed three schemes which are 1) Health Charter, 2) Health Assembly and 3) Health Impact Assessment. NHCO has been facilitating to implement these schemes.

**Ms. Thippawan Mokpa, ILDC 2016**
***AIDS Network Development Foundation Northeast Office, Thailand***

**1. The Nature of AIDSNet**

***Ms. T. Mokpa***

The AIDS Network Development Foundation Northeast Office (AIDSNet) has been working for the capacity building of the health agencies delivering HIV/AIDS services. Moreso, it promotes empowerment of People living with HIV/AIDS (PLWHA) in communities. The northeast area has been extremely hit byHIV/AIDS epidemic. People in the community infected with HIV/AIDS from their parents or husband who lived in Bangkok for day labor jobs out of farming season and were likely to have unsafe sexual relationship with others.

The Thai national and local governments have a policy focusing on Social Development Goals (SDGs) at all levels. Inspired by this, I have tried to apply to my activities the SDGs' slogan: "No one is left behind." I facilitated workshops in our community that deals with conscientization of local government and village leaders.

The workshop is focused on the participants' deep understanding on the situation and linkage for PLWHA. I applied the method called "spider net" that I visualized from ILDC in 2016 to let every participant understand the situation of PLWHA and the roles of other stakeholders in the community, such as the nurse, local government, leaders, youth, and so on. Through the roleplay, all participants recognized each stakeholder's role to support PLWHA. In particular, the local government staff and leaders of the community who participated in

this workshop are gradually willing to support PLWHA as a team.

We also strengthened the capacity of PLWHA through physical, mental and social activities. In the monthly meeting of the self-help groups of PLWHA, they conduct yoga and meditation, by which they feel more peaceful both mentally and physically and become more confident. Apart from the group members, the supporter's team which is composed of the government staff and leader of PLWHA and community leader and nurse also take part to be the facilitator in the meeting. These supporters got closer with the PLWHA and developed more positive mindset and reduced discrimination and stigma against PLWHA. The supporter's team started to involve the group members in all activities in the community and let the PLWHA meet a chance to get small budget from local government.

**2. Mekong Reunion**

In 2017 I became a member in establishing the local health charter of Khonkean Province, where our organization is based. My role was to share the idea and health problems of the vulnerable group such as PLWHA, homeless youth, drug dependency, and unwanted pregnancy in youth. These people are likely to be left behind. The challenge is the continuing discrimination and stigma in society. I also belong to a committee for vulnerable group of the Health Charter in Khonkean. I attended the Mekong Reunion because I wanted to acquire deeper understanding on my role in people participation in health policy, leaving no one left behind. In the reunion I met many social workers in and out of Thailand. We shared and learned about each others experience.

***Health volunteers are testing pesticide contamination in imported vegetables according to the local health charter.***

In one of the side meetings conducted by NHA network members, I worked as a translator for AHI

***Participants are visiting the group that is implementing and promoting organic farming based on the health charter.***

alumni participants from other countries. The local member of Stopdrink Network, shared his experience about how to make the policy of stop drinking alcohol into the local heath charter in the community. They first organized the core team of various stakeholders of the community. The core team collected data on problems related to drinking alcohol such as traffic accidents, violence, and alcohol spending. Then, the core team feedback the data gathered to the community. Through sharing this assessment, the community people can develop evidence-based recommendation to decision-makers and set rules onto the Health Charter together.

This experience not only gave me insights for the steps for people participation in the community, but inspired me a lot to work for group learning to support PLWHA in my area. I tried to find words to make all of participants of non-Thai language speakers understood the activity. I was happy to contribute for the alumni participants.

I am going to introduce SDGs in my project. Presently, I got one project working with local govern-

ment and local NGOs in four provinces of north-eastern Thailand. I will design SDGs for training workshops and let them learn and share their experiences.

In the future, I hope that the empowered members of the group will share their own activities and learn with other organizations in Asia.


***(From left) Mr. Heng Sarik, ILDC 2010, Cambodia, Mr. Binaya Prakash Acharya, ILDC 2017, Nepal, Ms. T. Mokpa.***

# NEWS FROM FRIENDS

**BANGLADESH**
**Ms. Musharat Sayed Moon, ILDC 2014**
***Unnayan Shahojogy Team (UST)***

The economic empowerment of rural farmers through Solar Conduction Dryer (SCD) for dehydration of agro products is on going in Bangladesh. SCD uses solar energy which is used to dry the food through radiation, conduction and convection.

***Ms. M. Moon***

UST has been piloting a Nutritional Project using solar energy to preserve seasonal agricultural produce for domestic consumption. During lean period they still can meet their nutritional requirements. There will be no food shortage all year round, among rural poor women and women farmers.

UST with the support of Science for Society (S4S) in India and Bangladesh Agricultural University,


***A female farmer is using the Solar Conduction Dryer.***

provided solar conduction dryers to 110 rural women farmers in Nilphamari of Jaldhaka and Nilphamari Sadar Upazila, in five villages which dehydrate vegetables and fruits for preservation. Women farmers preserve seasonal foods such as potato, cabbage, cauliflower, ginger, carrot, onion, papaya, red pepper, spinach and gourd family as they are commonly consumed. The SCD with measurable and potential impact on economic improvement helps in the reduction of post harvest losses and ensures food security.

**INDONESIA**
**Sr. Maria Francisca, ILDC 1996**
***PERDHAKI***

PERDHAKI is committed to provide social service activities, particularly free dental clinic, in order to increase the knowledge of parents and children regarding dental and oral health. On January 27, 2019, PERDHAKI and Saint Mary Blitar Catholic Playgroup And Kindergarten held a Healthy Dental Competition for kindergarten children in Bendogerit, Blitar. In addition to the competition, there were also free dental examinations, done by general practitioners, as well as dental counseling for parents. This activity was attended by 230 kindergarten children. Dental examination was carried out by 15 dentists, while general health check was done by three practicing doctors.

Activities from 9:00 am were coveted by children and parents. Parents were very helpful in assisting the free dental check up. Dental services given to the attendees were gum treatment, tooth filling, pulling, and cleaning. Healthy teeth competition also encourages children to continue to maintain the health of their teeth and mouth. Prizes and trophies

were given by the committee as encouragement for children who take part in the competition. For those who did not win the competition, the committee also provided souvenirs for all contestants and those who conducted the dental services.

***Sr. Francisca (left) with the awarded children.***

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**NEPAL**
**Mr. Bishnu Prasad Prajapati, ILDC 2015**
***Center for Mental Health and Counselling - Nepal (CMC-Nepal)***

***Mr. B. Prajapati***

I have been busy with a new project phase agreement with the local Palika (municipality) government, as well as gathering baseline data through survey. Nowadays most of the existing working areas with active SHGs, the Palika allocates budget for psychotropic medicines. The budget also covers the cost of SHG activities. This is all achieved through the persistent request of SHG members to VDC and Palika.

Some Palikas already initiated to conduct the mental health training and psycho-social support program to government health workers with technical assistance from the Center for Mental Health and Counseling-Nepal (CMC-Nepal).

Today the mental health activities are spread in 14 districts in Nepal. We are giving mental health orientation for the health post staff at the Palika level in some districts. The Palika shoulders all the training and consultancy costs. It also supplies the psychotropic medicines for health centers to treat the mentally ill patients. It is good to note that the Palikas are ready to allocate mental health budget for their health institutions. Most of the local Palikas

SAYONARA SHIROSAKI-SAN !
***Mr. Takahiro Nakashima, AHI***

agreed to give around 15% - 20% of the total activity cost hosted by CMC Nepal.
Mr. Sachiko Shirosaki, our great mother of all the participants since 1997.

Shirosaki-san passed away on December 29, 2018, at the age of 92. Her funeral ceremony was held on January 2, 2019 at Minamiyama Church where several AHI staff attended. We were so surprised to see many guests (more than 80) along with her family and relatives. Two distinct groups that came to the wake: Tomonokai and the Minamiyama church members. She went to Minamiyama Church every Sunday as a member since she became a Christian, soon after her marriage. She had lived in the residence of Makiba or Home for the Aged.

Her connection with Tomonokai started when she studied at Jiyuu Gakuen in Tokyo at the age of 16. Jiyuu Gakuen is known as a school funded by Ms. Motoko Hani, the same founder of Tomonokai. In a sense, the school developed her Tomonokai spirit since she was teenager.

Many of you know her as an energetic, strong, approachable woman and an awesome cook for us most of all. She cooked for the participants of ILDC, for high school students and other guests at AHI. Even she was in her eighties, she could manage to cook for more than twenty people. All of the participants were amazed and appreciated her work as a volunteer. Aside from that, she kept writing messages to each participant on his or her birthday card sent by AHI. Therefore all the ILDC alumni must know her name through birthday cards.

***(3rd L-R) Shirosaki-san happily socializing with the ILDC participants in the dining room.***

Her involvement at AHI is just one part of her life. She might have more exciting stories that gave impact on so many people whom she encountered.

Furthermore, I was so much affected when I saw her last time before her passing away in the middle of December 2018. She was in bed in the special ward, Makiba. In early December, she lost appetite and refused life support medical care, and chose death with dignity.

Since then she did not take any food but only water for two weeks, When we met her in the end, she expressed her appreciation to each staff including me. I was also a bit perplexed because we, AHI staff, should express thanks to her and not otherwise. Even so, she expressed it. I guess she thanked us because she thought she got more than she gave us by being a volunteer for AHI.

Her dedication to AHI, the ILDC participants, and other members, is and will remain as a precious memory. We will forever keep you in our hearts.

We all love you, Shirosaki-san…

## ANNOUNCEMENT

The Centre for Disability in Development (CDD) has developed the video documentary of AHI Reunion Seminar held on 15-18 March, 2018 in Dhaka, Bangladesh. It has English subtitle and Bangla sign language subtitle, Please check it out the link **(https://youtu.be/ueTGQ2mI20E**)

## CALL FOR ARTICLES

*Calling All AHI Alumni!!!*

- Privatization of Public Services
- Water Conservation and Protection
- Efforts on Sustainable Development Goals
- Participatory Conflict Management
- Inclusive Development Activities
- Social Media and Social Networking
- Youth Participation in Community Building
- Case Stories of PWDs
- Governance, Policy Making, Lobbying
- Alternative Resources Mobilization

**NOTE:** ***Font style and size: New Times Roman, 12, no indention, single space, attach your face photo and 3 action photos to support your article.***

## SUPPORT AHI!
## BE A MEMBER NOW!

| 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 |

Membership contributions of supporting members in Japan is the bloodline of AHI. The economic slack affects the number of supporting members which is declining continuously. This reality encourages AHI to reach out people from overseas like the AHI Alumni, partner organizations, and all generous persons to become supporting members. Kindly refer to the above table to determine how much you are willing to contribute.

AHI's call got response and some **AHI Alumni** became supporting members.

Your contributions will help sustain AHI programs that are crucial in developing the capacities of community organizers, civil society organizations, leaders from both government and non-government organizations and other sectors to become more effective and efficient change agents.

Together we can make a difference. Let's do it now! *Please check our website and go to "support AHI".* ***http://ahi-japan.sakura.ne.jp/english/html/. If you have any questions, please e-mail to: info@ahi-japan.jp.***

***"We make a living by what we get, but we make a life by what we give.***

***" Winston Churchill***