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The Path to Universal Health Coverage

From your Editor Ms. Joy A. Bastian

Health education session by the Community Support Group (CSG), DASCOH, Bangladesh.

"Transforming our world: the 2030 Agenda for Sustainable Development", agreed at the United Nation in September 2015, states the commitment of international community for sustainable development. It has 17 goals as Sustainable Development Goals (SDGs) and 169 targets including Universal Health Coverage (UHC).

For countless years, millions of people all over the world suffer from no or lack of access to quality health care particularly in the remote villages. Even those who live in urban areas are not spared by this suffering. Though for the underprivileged urban dwellers, they suffer from unaffordable cost of health care like professional fee, use of facilities, and medicine. The 1978 Alma Ata Declaration, "Health for All by 2000", is yet far from real. All are concerned on this lingering issue for many decades now. Numerous global and local institutions are working hard towards the solution of expensive and non-inclusive health care system. Yet the impact remains to be seen.

Now, we are in the era of Universal Health Care (UHC), which is for me the "Health For All by 2000" redressed, still carrying the same end goal. Simply put, UHC's goal is to ensure that all people obtain the health services they need without suffering from financial hardships when paying for them. The biggest challenge to attain this goal is money. Creative measures must be implemented to complement the government's scarce resources for UHC. Herein, articles from Bangladesh and the Philippines show some facilitating measures and supportive interventions in making pro-people public policies and schemes.

UHC is now gaining momentum propelled by the joint efforts of all sectors of the society.

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Mr. Md. Akramul Haque, ILDC 2008

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Mr. Haque

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1. Background

Bangladesh is one of the poorest and most densely populated countries of the world which is located in Southeast Asia. Since independence in 1971, Bangladesh has achieved substantial improvements in several economic and social indicators like increased Gross Domestic Product (GDP), decrease in infant and maternal mortality, decrease in women fertility and increase in life expectancy. However, despite significant Millennium Development Goals (MDGs) improvements, the health status of millions of people remains poor, with gaps between urban and rural (urban women twice likely to receive antenatal care or ANC), educated and non-educated, age groups, gender and level of wealth. In rural areas the health situation remains a priority due to the inadequate quality of care at basic health facilities in general and due to limited access.

Due to widespread poverty, children (40%) and mothers (30%) suffer from moderate to severe malnutrition. Life expectancy is 68.9 years according to the United Nations Development Program Health Development Index 2011. In Bangladesh, 43 infants out of every 1,000 and 53 out of children under five years old die. Thirty seven percent (37%) of rural pregnant women receive no ANC from a trained health service provider and 77% of births take place at home. Forty percent (40%) of children under five are stunted, while 17% are wasted (World Bank Development Indicators Database 2011). For pregnancy-related complications, 194 women die for every 100,000 live births. HIV prevalence is less than 1% among high risk groups (Eight Round of the National Serological Surveillance 2007). The annual population growth rate is 1.37% according to the 5th Population and Housing Census 2011.

Referral System in Bangladesh	
National Level	Secondary services
Zila (District) Level	Secondary care
Upazila (Sub-district) Level	Referral care
Union and Community Level	Primary care

Considering the situation, from 1996 to 2001, the Government of Bangladesh initiated to establish community clinics (CC) at the village level to extend Primary Health Care (PHC) at the doorstep of the rural people all over the country. The target was to establish 18,000 CCs of which 13,500 were built to date. Each CC serves about 6,000 rural population. So far, 12,550 CCs start functioning. But unfortunately they stopped operating due to changed of government in 2001 and they remained closed until 2009.

The present government has taken initiatives for the revitalization of CCs as the topmost priority project in health sector. The project is called "Revitalization of Community Health Care Initiatives in Bangladesh (RCHCIB) was approved by the Executive Committee for National Economic Council (ECNEC) on September 17, 2009. The CC is a tiny clinic at the grassroot level including the remotest and hard to reach areas.

2. What is a Community Clinic?

The main objective of the CC is to provide quality primary health care at the doorstep of rural community particularly the poor, disadvantaged and vulnerable group of people.

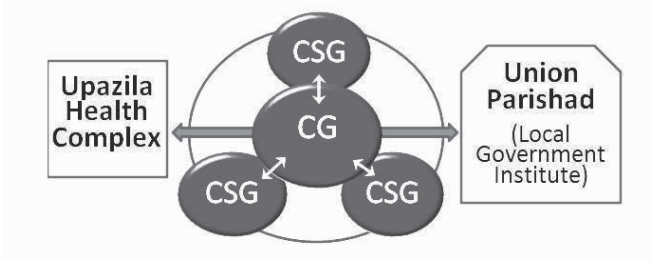
Its services include primary health care services, maternal and neonatal health care services, immunization, acute respiratory infection, diarrheal disease control, health, family planning and nutrition education, treatment of minor ailments and first aid of minor injuries, effective referral linkage with higher authority for complicated cases, and normal delivery.

Community Clinic in Rajshani visited by the participants of the Reunion Seminar 2015.

2.1 Human resources

One Community Health Care Provider (CHCP) is working full time six days a week. S/he also acts as the member secretary of the Community Group (CG) managing apex body of the CCs. The health assistant (HA) from the Health Department and the family welfare assistant (FWA) from the Family Planning Department are taking turns providing services three days a week. One medical officer from the Upazila (Sub-district) Health complex is providing technical support to the CHCP once a month. The health inspector is providing supervision in record update and logistics.

2.2 Management of the Community Clinics



Community Support Group (CSG) in each Community Clinic (CC) to ensure effective community participation.

The management of the CC is led by the people. Every CC has a main management body called Community Group (CG) comprising 13 to 17 members such as Union Parishad (UP; Local Government), women, youth, religious group, the poor and landless people. The catchment of the CCs is subdivided intro three parts for better management. Every part has a committee called Community Support Group (CSG) consisting 13 to 17 members such as women group and farmers, who support the CG in managing the CCs.The UP is functioning as chief patron and oversees the quality of services and coordinates with the health and planning department. The Upazila Health Complex has provided technical and supervisory support to the CCs to ensure quality services.

The CC is a unique example of Public Private Partnership (PPP) as all the CCs are constructed by the government on community donated lands. The government provides medicines, services and other logistic support. The management of CCs is by the government and the community. On the other hand, the NGO is strengthening the capacity of the CC. NGO helps improve the quality of services by giving appropriate training to the service providers and the management committee members.

3. SRC-DASCOH Public Health Improvement Initiative Rajshahi (PHIIR) 2013 to 2016

With the support of Swiss Red Cross (SRC), DASCOH gained considerable experiences on promotion of public health care facilities to the people through activating rural health centers in Rajshahi district in collaboration with the health and family planning departments. DASCOH has undergone far-reaching transformation and preserved its core competency in rural self-help. In 2011, SRC and DASCOH have established a formal linkage and coordination with the Ministry of Health and Family Welfare-for the RCHCIB (MoH and FW) to activate and build the capacity of CCs and mobilization of CSGs. A memorandum of understanding between MoH and FW and DASCOH was signed and witnessed by SRC named as Public Health Improvement Initiative in Rajshahi (PHIIR).

Community Group meeting.

The PHIIR project provides some funding support in strengthening the capacities of CGs and CSG

while government health and family planning departments extends support for deploying health personnel, logistics support and medicine. The CCs follow the government procurement system to use project grant if any. However, the general procurement for the project conforms with the DASCOH financial and administrative manuals.

3.1 Goal, beneficiaries and outcomes of the PHIIR Project

There are 1,740,578 rural people beneficiaries in the catchment areas of 233 CCs in 9 Upazilas in Rajshahi district. Women, pregnant mothers, under five children, poor and indigenous people are the top priority of PHIIR project. Its goal is to provide the population of the rural area of Rajshahi district access to improved essential health care services through a well-functioning CCs.

Basic health service at the community clinic.

The outcomes of PHIIR project are improved quality of basic health services delivered at the CCs, well-equipped and well-managed CCs, and increased people's knowledge on health and disease prevention and awareness on CC services.

3.2 Priorities, approaches and strategies

The project intends to support the RCHCIB of the Government of Bangladesh to strengthen the health service delivery in the planned CCs through community involvement, and the MoH & FW as service provider ensures sustainability.

3.3 Strengthening basic health services

Focus has been given to improve competencies of the service providers in managing PHC services based on national protocol. Monitoring and supervision directly by institutional and technical managers is strengthened to ensure quality of care provided to the beneficiaries. Several training has been conducted.

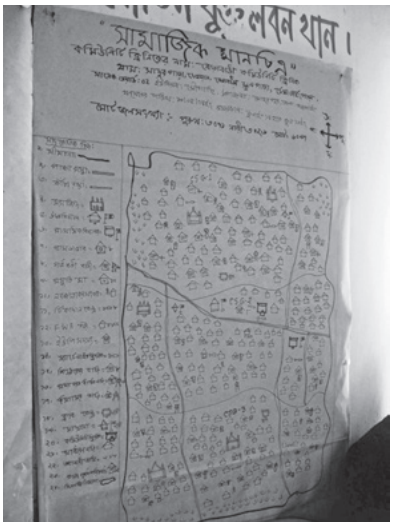
3.4 MCH case management

The major issues of the MCH case management were antenatal care, postnatal care, use of ANC and PNC cards, and proper maintenance of maternal and family health registers. DASCOH's project team organized 26 batches of training at Upazila in which 568 health services (CHCP, HA, FWA) and 154 first line supervisors participated. The training also covered the issue on child health such as diarrhea, pneumonia, malnutrition and immunization. The training conducted hands on practice on how to fill out the growth monitoring card and ANC/PNC card. All 26 MCH training were organized at UHC training room. A group of Training of Trainers was organized in the project office and later those trained people (all MO) conducted MCH case management training at UHC. This training enhanced the knowledge and skills of the health service providers.

3.5 Strengthening the management of CCs

Priorities are focused on supporting the formation and reformation of CGs and CSGs in every CC, their training on roles and responsibilities, coordination and communication among the communities, the CCs and the authorities. DASCOH PHIIR initiated several training to enhance the skills of the committee members. It also contributed to the increase in health seeking behavior of the community people. The transversal themes of gender mainstreaming, do no harm, and Linking Relief Rehabilitation and Development (LRRD) is emphasized throughout the project, focusing on women, children, poor and indigenous people.

The Community Facilitators Group (CFG), who are mostly female, supported the CG and CSG in preparing their annual plan, health education plan and social map. The CFGs are regular members of the CG working as volunteers. They assisted the project team in organizing regular CGs and CSGs activities. CFGs are working closely with the project team and hold monthly meetings to share progress and tactical plan.



Community map in the CC.

Social maps and annual plan are completed by CGs and CSGs, and shared to their respective UPs to identify needs and plan of actions to address them. This process strengthened their ability in making participatory decisions particularly in the management of CC.

The CSG members preparing the community social map.

3.6 Major results achieved in 2013 to 2015

Five major outcomes were achieved within the implementation period 2013 to 2015 as below.

- 50% of the health service providers applied diagnostic tree (Tree-Diagram Diagnosis) and treatment protocols correctly for 10 most common ailments,
- 50% of the FWA applied correct treatment protocols for ANCs and PNCs,
- 90% of the CCs are well equipped based on CCs' guidelines,
- 91% of the CCs are managed according to CCs' guidelines by the CG, and
- 50% of the project participants raised their knowledge and awareness on five selected topics and available services at the CCs.

4. Case story: Sukhandighi Community Clinic

Countrywide CCs are designed to replace home-based and other outreach services at the community level provided in a fixed point. However, many CCs were not fully functional. For instance, lack of sanitation, out of stock medicines, and absence of health care personnel. This led to poor use of health care services. Before the RCHCIB, the rural population was rather entirely dependent on traditional healers, village quacks, traditional birth attendants and drugstores to address their health problems.In addition, the formation of CGs and CSGs was insufficient, and there was lack of people's trust and ownership of the CCs. People had to shoulder very high health costs.

The Sukhandighi CC is one of the 233 functioning CCs in Rajshahi. During the last three years, Sukhandighi CC has made tremendous developments in terms of quality of health care, community involvement and local government institution participation and thus has emerged as a model CC in Rajshahi District.

By doing different training, organizing regular meeting, personal interaction, linkage with the health department and strengthening supervision, Sukhandighi Clinic has overcome its deficiencies.

Sukhandighi CC is now open from 9 am to 3 pm for six days a week. It delivers family planning, preventive health services, and selected curative services as required by the national initiative. The CC serves 10,485 people, and is accessible for the population within a 30-minute walking distance. The community as well as the local authorities show great ownership of the CC.

The Mid-Term Review panels composed of DASCOH, Swiss Red Cross, Ministry of Health and Family Welfare.

A Mid-Term Review (MTR) conducted in mid-2015 showed that the people are highly satisfied with the services provided at the CC. Furthermore, MTR results showed that the knowledge of the health service providers at the CC has increased.

Nowadays, Sukhandighi CC is well managed; drugs are used rationally and are obtained before supplies run out. The infrastructure is constantly repaired; it has been painted and fenced; a small garden adorns the premise; a submersible pump has been installed to ensure regular supply of safe water; toilets have been repaired, adequate spaces have been carved out for nutrition counseling and breastfeeding. Electricity connection has been obtained. All this would not be possible without the support and participation of the community and the local government institution (UPs). To fulfill the community demands by themselves and ownership, people participated at will spontaneously.

In a true sense, the CGs of Sukhandighi served as link between service providers and users, and motivated the community to assist in maintaining the CC. This has led to a high degree of ownership as revealed in the words of Abdur Rahim, DASCOH's local social worker who supports CGs and CSGs, "Sukhandighi CC has earned the trust of thousands of villagers. It has become a go-to place for primary health care services."

Through DASCOH in collaboration with the government, high level of trust emerged. The credibility of all local stakeholders was a major catalyst in transforming the health situation of Sukhandighi from extremely bad, a few years back, to an improved health and well-being of the rural population. Akram Hossain, the vice president of CGs, shares that "thanks to the training and supportive supervision of DASCOH that enable us to create a positive attitude towards health, where preventive care is deemed as important as curative health care."

On the other hand, the local government got increasingly involved with the management and maintenance of CCs, and installed a solar panel on the CCs. The UP chairman and the ward members said that their roles and responsibilities became clear and they were highly encouraged to ensure delivery of quality services at the CCs.

The Universal Health Coverage (UHC) and the NGO's Role

Ms. Kagumi Hayashi, AHI

Alma-Ata Declaration in 1978 called for "Health for All by the year 2000", when Primary health Care (PHC) came out as a strategy for assuring health with the grassroots people, by promoting community participation and utilizing local resources. Since then, a lot of efforts have been made. However, we still see a lot or even more to be done.

Universal Health Coverage (UHC) is now another terminology in front of us. It means a state in which everyone can access the quality health services they need without financial hardship. UHC does not refer to a specific system or mechanism, but systems and mechanisms need to be built in order to realize UHC. The basic concept of UHC is that it enables all people to access health services according to their needs, and not their ability to pay.

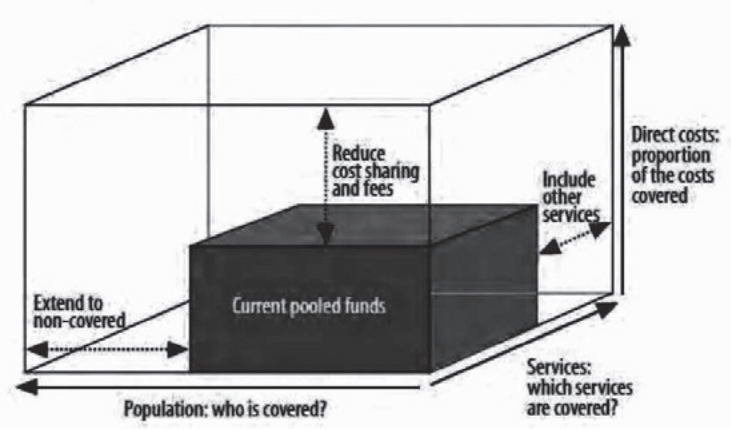
The World Health Report 2010 of WHO whose theme is "Health Systems Financing – The path to universal coverage" says that "There are many ways to promote and sustain health. Some lie outside the confines of the health sector. The "circumstances in which people grow, live, work, and age" strongly influence how people live and die. Education, housing, food and employment all impact on health. Redressing inequalities in these will reduce inequalities in health." It continues that "But timely access to health services is also critical. This cannot be achieved, except for a small minority of the population, without a well-functioning health financing system."

The following three questions emerged:

1. Who are covered? It should be ALL PEOPLE including the marginalized and most vulnerable.
2. What are covered? It should cover essential health services, including prevention and treatment.
3. How is it financed? Public health insurance or tax-based public health system where costs are shared among the entire population through fund-pooling.

UHC from the viewpoint of service users is sometimes discussed with 4As, that is, Availability, Accessibility, Affordability and Acceptability. Health services should be available as supposed to

be at health facilities, and should be accessible physically and socially for the people. They need to be affordable without any heavy financial burden. They also need to be acceptable culturally and socially for the people, otherwise they cannot be relevant and useful. Unless all these are assured with them, health services cannot be reachable.



Three dimensions to consider when moving towards universal coverage. (The World Health Report 2010)

In fact, public health insurance has been introduced in different countries. In most of them, there are only limited coverage in terms of services, population or financing. Difficulties lie as below.

- System does not fit well the needs of the people. People may see it not useful, as only admission is covered while consultation at out-patient clinic is not.
- Resources are lacking, either human, material or financial. Medicine may be only available in a limited period because of shortage of fund.

Difficulties also lie in the situation of service users. Many of them belong to the so-called informal sector, not belonging to any corporation or other institutions. Collection of premium would need higher cost.

Along with the public health insurance in the Philippines, many of the NGOs' interventions and efforts of the people themselves try to improve accessibility and acceptability. One of the AHI's Philippine counterpart organizations called Integrative Medicine for Alternative Health Care Systems (INAM) promotes community health care financing scheme as part of their strategy towards community-managed health program in collaboration with the local government. In one village where they work, around 100 families joined this financing scheme called in Filipino language "Saknungan" (helping each other). This could provide transportation and other necessary costs for the concerned families if they need to go to the health facility, which is located in the central part of the municipality.

Another NGO, the Institute of Primary Health Care-Davao Medical School Foundation or IPHC has been promoting participatory local governance. In the framework called the Sustainable Integrated Area Development (SIAD), people participate in decision-making to draft the village development plan and programs. They also have the program where people could ask for accountability of the village officials and other concerned bodies. IPHC has facilitated the process of SIAD which contributed to local governance in health. Thus, improving accessibility and acceptability for the people.

NGOs work in order to cover the uncovered areas, and to make-up for deficits or gaps in different ways. Shortage of resources with the public scheme is oftentimes complemented by NGOs. With all these complementary interventions by NGOs, the system would work as it is supposed to do. However the systems need to be changed, if they are not relevant. Advocacy should come in as another role of NGOs.

Policies and programs towards UHC are enhanced only with political commitment of governments. The central government has its UHC strategy, and approaches. In order to achieve "to leave no one behind", inclusiveness is critical. Insurance scheme has to be inclusive for different social and ethnic minority groups and should be easy to understand for the people. Policy and system advocacy are much expected by the NGO community.

In the preceding article, the Development Association for Self-Communication and Health (DASCOH) has facilitated communities to enhance their capacity in resource mobilization and management. Community clinics are to be managed by community groups with the clinic premises donated by communities. The government provides health personnel and medicines. Although services and medicines available at CCs are very limited, they contribute in improving accessibility to health services and also in providing the people with a venue and opportunities of collective efforts for community development.

A Japanese NGO Asia Arsenic Network (AAN), which has been working in Bangladesh since 1998, that has finished its 3-year project for Risk Reduction of Non-Communicable Diseases (NCD) there, have recognized the growing needs to respond

NCDs such as diabetes, based on their long experiences of preventive care for arsenic health problem. They worked with CCs, and did related trainings for health personnel at CCs on NCDs. They also functioned as a basis of community participation.

A person of AAN says "It is very important to see the fact that more than 70% of CC users are poor women and many of them cannot see qualified doctors for socio-economic reasons. The CCs are set up at the community level. They are the only health facilities which are available and accessible for those women. AAN's intervention provides health care (except medicine) for NGOs which is given by the CC staff whom they feel reliable. It contributes in ensuring 4As for the people.

Discussing UHC would raise the questions on equity and inclusiveness, and hopefully may help us to identify who are, if any, left behind and what to be done.

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PhilHealth for All Filipinos

Ms. Joy A. Bastian, AHI

1. What is PhilHealth?

The Philippine Health Insurance Corporation (PhilHealth) was created in 1995 by the virtue of Republic Act 7875 to create a universal health coverage (UHC) for the Philippines. It is a tax-exempt, government-owned and government-controlled corporation (GOCC) of the Philippines, and is attached to the Department of Health (DOH). Its goal is ensuring a sustainable national health insurance program for all. This social insurance program provides a means for the healthy to pay for the care of the sick and for those who can afford medical care to subsidize those who cannot. Both local and national government allocate funds to subsidize the indigent people who are living below the poverty line.

Employed members pay their contribution monthly which is automatically deducted by their employers. Whereas, the self-employed and voluntary members can pay monthly or quarterly. According to a survey, the enrollment of PhilHealth has increased to 88% (89,417,720) as of June 30, 2015.

Since its implementation in 1995 up to present, PhilHealth have achieved remarkable milestones such as:

- ensured universal coverage for all Filipinos, indigent program, turned over the medicare program from the Government Services and Insurance System to PhilHealth;
- introduced the outpatient package for indigent families enrolled under the regular sponsored program called Pantawid Pamilyang Pilipino Program or 4Ps (conditional cash transfer for the poor) of which both local and national government subsidize. Membership was later expanded to people with disabilities and indigenous peoples; and
- institutionalized the non-paying program, newborn care package, malaria package, HIV package, implemented the 23 case rates and the no balance billing (indigent patients' hospital bill is 100% covered).

The members of PhilHealth feel its use since the new range of services and higher amount of coverage started. Wider range of health packages enabled the members to avail of them and the amount coverage is much higher than before. This means lesser financial burden for those who do not have enough money to pay for health treatment. As a result, members now have better peace of mind when they are sick and confined in the accredited hospital.

Nevertheless, there are still many things to do in order to improve the features of PhilHealth. Vigorous effort is needed to reach a 100% membership and much better benefits. Creative initiatives at the local government unit level is also necessary to augment the efforts of the national government. The no balance billing through PhilHealth is still far from real.

2. The Supportive Role of Puan Barangay Health Station in Davao City to PhilHealth

How does a local Barangay Health Station (BHS; government health station) support the PhilHealth program? A BHS provides preventive and curative health care and other basic health services that leads to the aim of health for all Filipinos. The Puan BHS, located 14 kilometers from the center of Davao City, serves as PhilHealth's point of care enrollment. Non-PhilHealth members who go there are enrolled right away which improves the number of coverage. The case of barangay Puan exhibits a

good model to fast track PhilHealth enrollment at the local level.

With the strong political and financial support of the local government units (LGUs), the Puan BHS is well-functioning. It is open from Monday to Friday at 8:00 am to 5:00 pm, offering various health programs and services regularly. The health staff of the Puan BHS (a doctor surgeon, a dentist, a nurse, and a midwife) and the Barangay Health Workers (BHWs) are actively ensuring the quality of health care. For example, the follow-up program for TB patients who skip going to the BHS is very effective. The BHWs as health promoters visit house to house to those TB patients who missed to go to the BHS. They remind and persuade the TB patients to continue taking the TB medicine. As a result, these TB patients again regularly go to the BHS for health check and get some TB medicine. The people in the area are highly aware of the importance of health because of the service providers' effort at the grassroots.

Puan BHS constructed by the LGU.

The Puan BHS is thus functioning with the provision of free medicine. However, the DOH sometimes cannot replenish the supply of medicine on time due to high demand in a highly populated area. There are many takers of maintenance medicine because of the effective advocacy and information drive by the health personnel and BHWs. The DOH is trying its best to resupply the medicines on time in order to cope with the high demand.

3. Political Will to Augment PhilHealth's No Balance Billing through "Lingap Para sa Mahirap" Program in Davao City

Momentarily, PhilHealth can only offer partial coverage of hospital bills. It needs a huge amount of liquid funds. In many instances, the bottom 40% of the population cannot afford to pay the excess hospital bill because PhilHealth can cover only up to a certain extent depending on the medical case. There was a case where a poor patient has to pay his hospital balance of 60,000 pesos (USD 1,286) in excess of PhilHealth. It was impossible to pay.

Recognizing the inability of PhilHealth to achieve "No Balance Billing", the former city mayor of Davao City Atty. Rodrigo R. Duterte (the present president of the Philippines) created on its own will the "Lingap para sa Mahirap Program" (Support for the Poor) or simply Lingap. Lingap is mainly funded by the fines collected from traffic defiant people, anti-smoking offenders, and other violators of law. Lingap pays the remaining balance of the hospital bill of the indigent patient and go home worry-free. Only indigent patients can avail of this assistance. There were cases that even those who were non-residents of Davao City were able to avail of this financial assistance. Other cities and LGUs do not have such support service as Lingap. Strong political will and creativity is necessary in order to establish such kind of assistance that benefits the poor.

4. Challenges

Like other public services, the implementation of PhilHealth is still far from perfect. The amount needed to achieve No Balance Billing at the hospital level and free medicine at the BHS level is enormous that the government cannot cope. In case some paying members stop their contribution, the funds decrease affecting the availability of health care services provision. Another challenge is the negative impact of giving free medicine and hospitalization as it might encourage dependency. In order to enhance the credibility of the system, the proper local authorities must work harder to ensure proper screening of true indigents. An efficient monitoring mechanism should also be installed to ensure that the health facilities and services are optimized.

Each LGU must improvise alternative sources of funds in order to augment PhilHealth. The "Lingap Para sa Mahirap " of Davao City is a good practice that benefits indigents to avail free services. Indigent members might as well be given some income generating activities so that they can also pay the PhilHealth quarterly contributions. We must look at the strong and legal potential of LGUs to play a critical role. If we mobilize those LGUs for UHC, its activity becomes sustainable and beneficial to people.

Someday, PhilHealth for all Filipinos might be a dream come true. After all, health is wealth.

FLASH ARTICLE

Participants' Report and Reflection on the Bangladesh Reunion Seminar 2015

Sharing Good Learning and Best Practices
Mr. Md. Rafiqul Alam Mollah, ILDC 1991
Unnayan Sangha (US), Bangladesh

Mr. Mollah

The AHI alumni in Bangladesh were waiting with deep eagerness to meet each other those who participated ILDC and other international training courses organized by AHI, Japan during 1980 to 2015. We were also counting days to get together with the AHI staff to strengthen the development journey for the people of Bangladesh as well as in Asia. A total number of 37 participants including AHI alumni, AHI representatives, interns and observers attended the seminar. It was really needed to share activities, experiences, learning and practices of the alumni's organizations to make better contribution to socioeconomic development of the community, especially the disadvantaged people in Bangladesh. Finally after a long endeavor, the AHI Alumni Reunion Seminar 2015 was held on November 20 to 23, 2015 at DASCOH in Rajshahi, Bangladesh with the theme "Appreciation, Connection and Cooperation" after 15 years gap which gave us scope to improve development effort in Bangladesh and in Asia.

The arrangement of reception and registration for the participants on November 20, 2015 by the organizing authority was attractive and first eye contacts among all the old friends after a long gap really created an emotional situation. The seminar started with introduction of individual participants memorizing happenings, learning and moments in the courses participated in different years by the alumni.

A welcome address was given by Mr. Akramul Haque, Chief Executive Officer of DASCOH, as well as the objectives and outputs of the seminar. The expected outputs were a) to build relationship with each other for a way forward to develop and uplift the poor and marginalized people of Bangladesh b) to create a communication network among the AHI alumni in Bangladesh and c) to devise prospective plan of action for each participant to replicate good learning and practices. Formation of platform for AHI alumni and decision regarding next AHI alumni reunion seminar were also laid.

At the inaugural session, participants took part in a prayer keeping one minute silence for the peace of the departed soul of Dr. Hiromi Kawahara, the founder of AHI who passed away in May 2015. AHI's General Secretary Ms. Kagumi Hayashi expressed her happiness to attend the seminar and welcomed all participants. She also thanked DASCOH and other organizations for the big effort in organizing the seminar. A presentation on ILDC 2015 was given by Ms. Kyoko Shimizu of AHI with two participants of the said course. Mr. Shukuruddin Mridha, Chairman of DASCOH, opened the seminar with his speech expecting a successful event with fun and sharing of knowledge and practices which can play vital role in ensuring "appreciation, connection and cooperation" among all the alumni.

Participants drawing out learning and good practices.

On the 2nd day of the seminar the participants shared their organizations activities, good learning and practices. Then on, the best learning and practices were identified through voting by the participants. The top learning and practices were the facilitating role of NGOs for functioning Community Clinic (CC), use of growth monitoring chart, school-based health awareness program, establishing social

entrepreneurship by farmers group, collaboration with local government, community participation in health, Gram Unnayan Parishad (People's Organization elected through women's group), community based rehabilitation of disabled, people managed savings and credit program, awareness campaign against cancer and voter education and election monitoring.

On the 3rd day of the seminar the participants visited six CCs and three Union Parishads of Paba and Tanor sub-districts of Rajshahi district dividing them into three different groups. During field visit the participants talked with the CC staff, Community Group (CG)/Community Support Group (CSG) members and the UP chairman and members regarding service delivery status, knowledge and skill of service providers, CC management process, role of CG/CSG and local government. In the afternoon the participants enjoyed a cultural program performed by a tribal group at Safina Park, Godagari sub-district of Rajshahi, where daily life including lack of food, cloths, employment, social dignity, security and other problems of the tribal community were highlighted.

Group discussion on learnings.

At the start of the 4th day, the findings of the field visit were presented by three different groups of the participants analyzing observations through small group discussions. The findings are: a) CGs and CSGs are active with regular meeting, participation in discussions and actions, fund raising, communication with health and family planning staff, local government and community, b) CG bank account opened and transactions are continuing properly c) service providers are knowledgeable and motivated, d) CG and CSG members are united, e) information displayed at CCs, f) CCs are clean, g) breastfeeding corner and waiting space with television established, h) well-organized reception, i) regular presence of service providers and CG members, j) documents maintained, k) local resource mobilized, l) there is space to develop further plans, m) UP representatives are positive and cooperative, n) introduced disability issues in counseling, o) CG has action plan, p) UP allocates budget for CC, q) CC monitoring tools exist, and r) monitoring and supervision by CG is in place.

The project has achieved significant result by this time. Some of the NGOs including DASCOH and our organization (US) are also working for building the capacity of CG and CSG, providing orientation to CC staff, supplying different logistics or items and developing community health volunteers. The participants learned about service delivery, referral, community engagement, community action plan, local resource mobilization, fundraising, and cooperation of local government among others during the visit to CC and UP.

The participants prepared action plans to replicate best learning and practices to strengthen their own organizations' development initiative. The action plans prioritized the inclusion of a) facilitation role of NGOs in functioning CC, b) CG strengthening activities, c) voter education and election monitoring, d) referral system strengthening, e) health education session, f) school health activities, g) introduction of growth monitoring chart, h) community based rehabilitation of disabled people, i) inclusion of disabled in CG, j) social entrepreneurship, k) facilitation of self-help-groups, and l) collaboration with local government.

With due consideration to the existing activities and organizational capacity, I developed an action plan to replicate the "community based rehabilitation of disabled people" through group meeting, identification of disabled people, referral and provision of income generating activities support and continuing follow up for further assistance. For the purpose, I required technical support from other organization. By this time we have signed an agreement with the Center for Disability in Development (CDD), an AHI alumni's organization, to work as technical partner for supporting disabled people in Jamalpur district. Staff training is going on by the CDD and we would start activities strongly for the disabled people very soon. I would like to say that the AHI alumni reunion seminar 2015 gave me a wider view to plan this activity and to make partnership with CDD.

My participation to the ILDC in AHI, Japan in 1991 inspired me to start the development of Community

Health Volunteer (CHV) for improving health awareness among the rural community. During the last couple of years we have developed more than 6,000 female CHVs providing foundation training and three times refresher training under different health-nutrition and family planning projects that each phases out after two to three years of implementation. The CHVs received transportation allowance only from our organization to perform their tasks in rural areas. A 60% of the total CHVs continue their counseling, referral support and home visit for motivating people especially mothers/ family members on home based care, visit health facilities, consult physicians and regular health check up. Some of them are getting very minimal support from the local government health and family planning department.

We are thankful to AHI, Japan and DASCOH Bangladesh for organizing the reunion seminar that enabled us to join in "Appreciation, Connection and Cooperation" among all AHI alumni in Bangladesh as well as in Asia for developing socioeconomic condition of the community especially the disadvantaged people. Yes, it is time to go further with our learning and experiences gained through the reunion seminar which is hoped by Ms. Kagumi Hayashi in her closing speech.

I learned a lot from the reunion seminar that enriched my knowledge and experience. Each

Mr. Shankar Kumer Nandi, ILDC 2009
The Salvation Army, CHDP, Jessore, Bangladesh

Mr. Nandi

organization is doing its work effectively to uplift the underprivileged people. I learned new techniques and approaches from the Disabled Rehabilitation & Research Association (DRRA), DASCOH, CDD and Unnayan Shahojogy Team (UST). DASCOH has vast experience on community mobilization and empowerment, primary health care, water supply and sanitation and local governance. DASCOH developed 233 CCs and raised people's awareness to receive health services. I visited two CCs and talked to the service providers who are skilled and experienced. If such service delivery is done nationwide, I believe it will reduce the incidence of morbidity and mortality.

I will apply my new learning in The Salvation Army particularly the new three years Comprehensive Community Capacity Building Project in eight areas of Khulna Division. This project focuses on tapping resources from the community, government health and academic institutions and like-minded NGOs.

Ms. Talisma Akter, ILDC 2015
Center for Disability in Development (CDD), Bangladesh

Ms. Akter

One of the main objectives of the reunion seminar was to establish a strong relationship among the alumni. Also, to share and exchange learning among organizations where AHI alumni are currently working. Finally, it aims to develop an action plan based on the learnings from the three-day long activities. From CDD, I and my colleague Mr. Rasadul Hassan (as an observer) participated in the seminar. There are many ILDC alumni who are currently working in various development sectors in Bangladesh. This reunion seminar created a platform for getting together all the AHI alumni, and shared their experiences, good practices and learning in their respective areas and organizations.

This seminar helped the alumni make effective action plans based on the learning and objectives of AHI in collaboration with the activity of each organization which they represent. Sixteen participants including DASCOH shared their individual presentations.

There was a broad session on CC in Bangladesh which is one of the excellent initiatives that has been taken by the Government. CC is playing an important role to ensure primary health care for the peoples of rural area especially in the village. The community people and the local government collaborate in running the CCs. We visited two CCs and Union Parishad to see how they incorporate sustainability and linkage-building.

In each session, salient learning points such as innovative concepts, creative practices and success factors were documented.

I learned that an empowered community can play an important role in the government service delivery

mechanism particularly in ensuring transparency and accountability. The CG and CSG of the CCs can persuade the staff to become accountable of their actions and to ensure efficient services for the people. It is an important factor for sustainability.

Monetary contribution from local elites and allocation from the Union Parishad is the major bloodline in supporting the development of CCs. The funds derived from these sources are used in renovating the waiting room, constructing tube wells for safe drinking water and the likes. The contribution from the community people and the Union Parishad for the CCs is taking off as they learned to recognize that they own them. Therefore, it is essential for the community people to feel their ownership of the CCs including the corresponding activities.

The staff of the CCs conduct different topic-based awareness sessions by using Information Education and Communication (IEC) materials related to health. However, disability issues are not part of their interventions. The role of the CCs is vital in disseminating information and raising awareness on disability among the community people through the staff, CGs and CSGs. Disability issue must be given attention. but it need to be noticed the disability issue. The society must know the different types of disabilities, causes, prevention and referral mechanism so that they can offer the best support as need arises.

During the field visit, I noticed that the community clinic centers are not accessible for persons with disabilities (PWDs). There were no ramps. Ramps are very helpful not only for PWDs but also for aged people, pregnant women and the very sick.

As we are working through Self-Help-Groups, we can develop the capacity of the CC staff on disability issue. In this way, they can provide appropriate services to the PWDs. As a result, it is expected that more PWDs would avail of the services available in the CCs.

The reunion seminar was instrumental in helping us identify innovative ideas and concepts. It also facilitated interactive sharing of knowledge and learnings among AHI alumni who were representing their of organizations. For example, the presentation of CDD regarding disability issue was included in the action plan of three organizations. In my case, I decided to incorporate the community clinic in my action plan which I got from the sharing and field visit of DASCOH.

Reflection as an observer of the Reunion *Seminar*
Mr. Rasadul Hassan, CDD

Active participation process was very effective in developing leadership skill among all the participants in the international course offered by AHI. Their level of satisfaction about the course was also very high that was reflected in the speeches of different alumni who attended since 1981 to 2015. In the seminar, observers were allowed to participate in the reunion along with the alumni. It was a great opportunity for the observers to get involved in the whole process including exposure visit, action plan development, learning and sharing that will hopefully increase their capacity to contribute in community health service in the future.

The seminar was really a big learning mechanism for all participants. I have learned and gather a lot of knowledge from the seminar. I believe that every learning will be effective when we utilize it in our own organization or activity. I my action plan, I incorporated my learning on CC and very hopeful for it to start functioning in the field.

I would like to thank the AHI alumni and the AHI staff. Thanks to the personnel of DASCOH for their support and hospitality. We all will be waiting for the next reunion seminar in 2017 with the effort of AHI, Japan and AHI alumni Coordination Committee formed during the seminar.

Members of the coordination team for the next reunion seminar. Ms. Akter, 2nd from right.

My Precious Learning Experience at the AHI Reunion Seminar in Bangladesh

Ms. Eiko Adachi, AHI Intern
September 2015 to March 2016

Ms. Adachi, right.

Background

When I was 15 years old, I visited Cambodia and saw some boys and girls on the street. They were selling postcards, boxes and other stuff. They did not go to school yet they speak English by talking to tourists. I respected them. I was also concerned about their future. From that time, I asked myself a basic question: "What can I do for the children to contribute to their better future?"

My major is social welfare. I visited Bangladesh for my field study. After graduation, I worked at a private company for four years. This company's motto is "Create opportunity by yourself, change yourself through opportunity". I like this motto. Then came a chance to go to Bangladesh as a JICA volunteer for two years. My role was to help improve the school health program and capacity development.

My New Learning

What is the key point to develop human resource? This is my interest. So, I joined AHI to learn the concepts and methods of participatory training. I visited Bangladesh on November 2015 to observe in the reunion seminar. I was surprised how active and cooperative they were. Everyone was manifesting good leadership. Then I visited the work field of Ms. Archana Biswas (ILDC 2013). I met many women self-help group members. They were also very active and were proud of their activities. I curiously asked Ms. Archana: "What is important to develop leadership?" She answered: "Give responsibility!" It was a simple keyword but I was really impressed. "Give responsibility!" It means "I believe you". People got self-confidence and felt proud to be trusted. In turned, it made them more active. It is easy to say but not easy to do. But, Ms. Archana and many other AHI alumni keep doing so.

Citizens' Participation in Constitutional Reform

Mr. P. P. Sivapragasam, ILDC 1997
Human Development Organization (HDO), Sri Lanka

Mr. Sivapragasam

Constitution is a document that contains the fundamental principles of the state government and the fundamental rights of the citizens.

It is well noted that in a country like India, the constitution created after independence remained intact to date. At the time when Nepal as well as South Africa returned to democratic rule from monarchy, the constitutional reform were being undertaken with the participation of the people and the civil organizations.

In Sri Lanka today, it is essential to change the fundamental laws and systems for a new social structure in the verge of new challenges in the process of transition following the end of internal conflicts.

In every country its people are sovereign. However, they cannot meaningfully participate in the governance because of the absence of enabling structure. To some extent, they only participate in electing their representatives to the legislative bodies or parliaments. The people retained their sovereign power and the right to choose a government or change it. They can amend their constitution to exercise their sovereign right.

As far as Sri Lanka is concerned, the minority community especially the up-country (plantation) people have to participate in the constitutional amendment.

However, the phraseology people's participation shall not be construed as unlimited right of the people to intervene. Therefore the citizens are subjected to certain limitations. Preceding from this fact, the up-country people as an emerging community have the duty to participate in the constitutional reforms which will decide their fate.

Citizen Participation can be in the form of discussions, seminars, workshops and public statements. These events have been organized by Human Development Organization (HDO) in the

main cities of the Up-country plantation areas under the theme People's Participation in Constitutional Reform.

The Organizing Team of public dialogue. Mr. Sivapragasam (center, left).

Proposal for constitutional reform from the members of parliament, provincial councils, political leaders, lawyers, business community, academes, media personnel, plantation workers, young men and women and the general public is being prepared by HDO. This document will be submitted by the people's representatives to the Public Committee on Constitutional Reform in Kandy.

Proposal Submission to The Public Committee on Constitutional Reform

Some Keypoints are as follows:

1. Restoration of Parliamentary System

Executive presidential system will be abolished and replaced by Westminster system, a parliamentary form of government modeled after the United Kingdom. We believe that this will uphold transparency and accountability of the parliament to the people.

Citizen participation in public dialogue.

Strong demand for constitutional change pressured the status quo and its now on its momentum. The current government system typifies corruption, inequality and violence. There is no equitable representation. The minorities (up-country Tamils and Muslims) are excluded. The civil organization proposed that the parliamentary and political system under the new constitution should be an electoral proportion representation system.

We believe that this reform will enable the up-country Tamil, the Sinhala and the muslim people who live scattered in the northern province and rest of the country to uphold their political rights.

In order to ensure credibility in the political culture of Sri Lanka and to maintain check and balance in the democratic good governance, we suggest that the senate system (second chamber) be re-introduced with an equal minority and professional representation. Any bill introduced to the parliament be transmitted to the senate for its approval.

2. Fundamental Rights

Ms. Logeswary Poniah (ILDC 2008) emphasizing on women's rights.

The new constitution shall guarantee the rights to life irrevocably and inviolably (never to be broken or fringed) by any legal arrangement. These are the rights to livelihood, to own a land, employment suitable to qualifications and living wage of all people especially women, and education and primary heath. Furthermore, the special rights of women and children for freedom from torture, gender bias and domestic violence, equality in possessions and opportunities, and cultural, ethnic, and religious freedom shall be guaranteed.

3. Devolution of Power

Power rested in the provinces shall be devolved in an equitable manner. Power sharing between the provincial and local authorities should be observed. While continuing with the present practice of electing representatives to the provincial and local levels, expertise, social welfare, ethnicity, equal number of male and female members must be considered. This system will help ensure transparency and accountability.

4. Right to Development

Human and physical development of the people living in the plantation areas, conflict affected areas, border villages and urban slums are far from reaching the international standard. It is not even comparable to the least developed and backward areas elsewhere. It is therefore proposed that the constitution shall guarantee inclusive development with specific reference to the up-country plantation people.

5. Language rights

Sinhala and Tamil languages which are used in Sri Lanka shall be given an equal status. On the other hand, English is considered as the linking language.

Conclusion

The new constitution to be created in Sri Lanka should lead the Sri Lankan society as one capable of meeting and winning future challenges. Respect of plural democracy, people-orientation, rule of law, good governance, and sustaining human rights. It should cater to the welfare of every citizen, citizen participation in every stage of constitutional reform is strongly desired.

NEWS FROM FRIENDS

Ms. Weliweriya Liyanage Sumika Perera, ILDC 2001, Women's Resource Center, Sri Lanka

Ms. Perera

Thank you for sending the birthday wishes and the AHI Newsletter continuously. AHI friends' friendship is very deep. Every time I receive the AHI Newsletter, I remember the happy time at AHI. AHI Newsletter is also very useful as a means of updating about AHI itself and our friends' work.

Here is the newspaper article about me and my work. I mentioned AHI-ILDC in it. Actually, ILDC is a very useful training which I have got in my working life. My husband, Mr. D.R. Jayathilake Banda (ILDC 2003) and I still refer to the notes when we need to.

Thank you very much for giving that knowledge.

Loving regards,

Sumika

Sacrificing Her Life for the Welfare of Women

Excerpt from the source, The Sunday Leader local newspaper written by Ms. Ashanthi Warunasuriya and published in Sri Lanka, 2016.

During childhood, she did not have a clear vision of her future. However, she liked reading books and writing and has been with these activities for most of her time dreaming to be a writer one day. Even today, she has not got away from her childhood dreams. "I want to write down my life experiences before I die. That is my dream," said Sumika Perera, our memorable and inspiring character this week.

She has been a social activist for over 25 years. Once, she has been a writer and then a lecturer. A founder of many organizations for women, Sumika is resolute to sacrifice her whole life for the welfare of women. Even though there is an inherent

misconception in society that feminists have no family life, Sumika's social as well as family life is equally successful. We asked her as to what is her view on this backward social perception. "It is an utter misconception and mudslinging. I have two sons in their prime age. They are very sensitive. One must select a spouse that he or she can live with. My husband also engages in my field. We need our spouses and children help in our activities. Today, we have many female activists, but balancing the family and working life is paramount to them.

At present she works as a coordinator of the Women's Resource Centre where she works with grassroot level people, especially with women focusing on human rights issues. According to Sumika, women in the Kurunegala District in Sri Lanka mainly focus on women's rights. They oppose all forms of discrimination and violence against women. Sumika added that they are dedicated to building a society empowering grassroots level women economically, socially and politically by increasing their awareness, helping develop their capacities for self reliance and by ensuring their rights to land and livelihood.

Ms. Perera (right) in a dramatization during the ILDC 2001.

She has completed various leadership training programs locally and internationally which include an international leadership development course at the Asian Health Institute in Japan. She also holds important positions in various social organizations where she is committed to work for peace and democracy. She has also worked as a member for the North Western Province Committee of Sri Lanka Human Rights Commission and as the coordinator of CATAW, the coalition for assisting Tsunami affected women where she has gained a lot of experience as a community worker. Sumika has conducted several community level leadership training and workshops throughout many parts of Sri Lanka on topics ranging from women and gender, gender and disaster, gender and development, gender equality and community development, sexual and reproductive health, gender and mass media, gender and good governance, women and peace, and women political representatives' human rights.

According to her, the Kurunegala District also has the highest number of soldier and police officer recruitment, and it is the district with the highest number of widows in the South of Sri Lanka. Sumika noted that, issues were raised regarding unemployment, lack of access to livelihoods, inability to continue with existing livelihoods, lack of raw material, difficulty selling their products and transport problems.

She believes that the situation of women in Sri Lanka have been going forward with the development of health and education. However, the problems they face now have changed. In whatever position and situation, women face numerous problems, she says, talking about the present day woman. "In the past too, a woman faced numerous problems if she had to walk away from home at night. Today also the situation is the same. Females are being raped by their own fathers, grandfathers, and brothers. Our grandmothers may have not heard such sexual violence in the past. Even though people are educated today, some aspects of society have been deteriorating rapidly, she said.

"The women in the North suffered very much during the war. They lost families, employment, and many of them became prostitutes. During the era of 1989, our sisters and brothers were killed. These are very sad occasions that I remember. I also feel very sad that women activists like Sunila Abeysakara, Monika Ruwan Pathirana were not among us anymore," she said. She feels happy that women have become more educated and sensitive to their problems. She also feels very happy about the achievements she has done towards the welfare of women in the country.

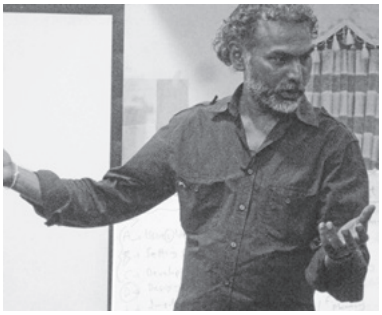
Even though she began working as an activist influenced by politics, she never wanted to be a politician. She did not take any side or any political views. On the other hand, prevalent political parties did not represent her policies and ideas either. Sumika says Sri Lanka has no women activists representing the present or next generation. It is a challenge. At this crucial point of Sri Lanka's politics, Sumika now engages in gathering people's views on the new Constitution and reconciliation attempt of Sri Lanka.

She has some regrets that she had very limited time to explore inner happiness and soul. Commercialism running over humanity and neglect of environments etc, too make her sad. However, she is committed to sacrifice her knowledge and strength towards the welfare of women in the future as well.

"Study, be enlightened in society, be brave, and come forward, (footing myths and wrong social concepts??). You should be educated and become female leaders one day to achieve justice for our gender," she advises the present day women.

CONDOLENCES
The Passing of Mr. Francis Rufi Sardar

Ms. Kyoko Shimizu, AHI



The late Mr. Francis Rufi Sardar.

On the 30th of April 2016, Mr. Francis Rufi Sardar, a great facilitator in Pakistan, passed away at a mere 52 years old. He was the founder and general secretary of an innovative NGO named Research, Advocacy and Social Training Institute (RASTI), Pakistan working for empowerment of children, youth and women and had been taking leadership for development and social change in the said country. He is also one of the facilitators of the Participatory Community Leadership Development Course (PCLDC) in Lahore, Pakistan, which has been conducted by Mr. Hector Nihal, AHI alumni (ILDC 2013), the director of Aids Awareness Society (AAS), in partnership with AHI, once a year beginning in 2014.

The news of his death was surely sudden and unbelievable for everybody who knows him. I, too, was not able to believe it because it was just two weeks ago when we discussed the future plan of PCLDC with full of dream and spirit, after finishing the course in 2016.

"If you can't find a way, create one!" These are the words that always appeared on Rufi-san's desktop wallpaper during PCLDC. (I always called him "Rufi-san," adding the Japanese honorific suffix "-san," which is similar to "Mr." or "Ms." in English.)

Mr. Francis Rufi Sardar facilitating the group workshop in Pakistan, April 2016.

The course's participants were all young NGO workers in Pakistan, and the idea of creating a path where none existed was Rufi-san's compelling message to them. He may not have come out and said this directly, but the participants all understood this from his facilitation style and felt encouraged to become change-makers in the society, like him.

Every time I saw this line on his computer screen, I tried to imagine how Rufi-san's difficulties and limitations to live his life and go about his activities as a community worker and social activist. I remembered him telling me how he started out going around villages with his backpack and talking with people. He seemed to trust in the power all people have to create, and he loved to be a part of that process. "If you can't find a way, create one!" was the essence of his life. He was a proof that the line was not just a line. We were motivated by him and moved to action.

During the three years I knew him, Rufi-san inspired me in his role as a facilitator and as an NGO worker on many occasions. Though we only knew each other a short time, it was enough for AHI to share and pursue a dream with Rufi-san, the great facilitator in Pakistan. He also helped me know the strength and richness of the Pakistani people, even in the face of difficult circumstances, and helped

AHI understand the value of getting involved in the Pakistani people's struggle for change.

AAS and AHI unfortunately lost such a great partner of PCLDC and our challenge and dream we discussed together with him is ongoing, but we have over 60 PCLDC alumni now who are change-makers—heirs to Rufi-san's spirit—and who will be our new partners to move forward with. There are surely many more people in Pakistan who were empowered by him. From now on, too, AHI would like to continue carving out a path with AAS and the people whose lives were touched by Rufi-san and learning in and through the process. His spirit will live on and grow. And he shall always remain by our side.

I deeply hope his soul, which ran and soared through life at full speed, can now rest in peace.

HINTS in Writing Articles

Ms. Joy A. Bastian, AHI

Background

Many stories in the field left untold. Why is it so? More often than not the main reason is the lack of skill to write. As community development workers, advocacy is one of the most important tasks at stake for us. Effective advocacy lies on the how we do it. There are many ways to do advocacy of which one is through written form. The AHI English Newsletter is a good venue to inform, influence and advocate for the principles that we believe essential for the welfare of our constituents, the disadvantaged people in the communities. Here are simple hints for you to write.

Simple Framework to Write

The WH questions as a framework is good enough to start writing. WHAT is the story? This gives you the title and the structure of the story. WHERE did it happen? You can write briefly about the community or location that the experience took place. WHEN did it happen? Make sure the data is reliable and accurate. WHO were involved? Introduce the people who were frontliners of the action including their titles, affiliation, and their roles in the endeavor. HOW was the process? Elaborate on the critical steps undertaken including the challenges, victories achieved, failures and actions taken. You may also write on who were against and why, as well as who were supportive including the underlying reasons. WHY the endeavor was initiated and by whom? You can include all points concerning why.

Some writers keep on writing the steps of project implementation. To some extent it is fine. However, in most cases, they forget to write the results of these steps undertaken. Without elaborating the results, either positive or negative, the steps of project implementation written in details will be meaningless. It is only a shop list.

The writers must remember that the readers are not all experts in your specific experiences. Be clear of what you want to say at all times. Avoid using all the beautiful words in one kilometer long sentence. Remember the KISS principle in writing: **K**eep **I**t **S**hort and **S**imple. Some writers use wording overdose. Redundancy must be avoided at all cost. What is redundancy? It happens when the writer repeats a word in a sentence.

For example:

1. Redundancy

The <u>people</u> in <u>village</u> A must ensure that the <u>people</u> living in <u>village</u> A are qualified. *(<u>redundant</u>)*

versus

The people in village A must ensure all residents are qualified. *(not redundant)*

2. Clarity

The community or village people gathered together in order to talk and discuss about the programs and projects that the community are planning to implement. (*Too long.*)

versus

The community people gathered and discussed the planned projects. (*Short, simple, clear.*)

There are cases that it is necessary to write long sentences. But that should be an exception rather than the rule.

Remember that the main purpose of writing an article is to give a clear message to the readers. Why complicate it by writing too long?

Happy writing!

SPECIAL CALL!!!

Call for Articles on Your ACTIVITIES FOLLOWING DR. KAWAHARA's SPIRIT of SHARING FOR SELF-HELP

On the occasion of the memorable 100th issue of the AHI English Newsletter for publication on November 2016, we are pleased to call for the articles of your activities following the philosophies and aspirations of Dr. Hiromi Kawahara, the founder of AHI, who passed away in May 2015.

Description:

- *GUIDELINES for Writing the Articles:*

1. Your learnings of ILDC/OMC at AHI
2. What kind of idea or inspiration you got from Dr. Kawahara?
3. Based on your learnings at AHI, what has changed and/or been applied to your activity (concrete case)?
4. What outcome has been and/or is expected to be brought?
5. Challenges which you are currently facing with and your plan to solve them.

- Size: A4 1-2 pages Font: Times Roman, size 11
- Photos: Your face photo and field action photos with caption
- Deadline: September 30, 2016
- Send articles to: AHI (info@ahi-japan.jp).

We are looking forward to your articles!
Ms. Joy A. Bastian and Ms. Yuko OKUMA
The Editors, AHI

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 a 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.

1. **Supporting Member**

   Annual Membership Fee:

   Organization (S): $300 per year

   Individual (A) : $100 per year

   Individual (B) : $50 per year

   Individual (C) : $30 per year

2. **Donation: Anytime, Any Amount**

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.**

REGULAR CALL FOR ARTICLES

* Participatory Techniques for Self-Sufficiency
* Alternative Awareness-Building Strategies
* Health and Peace-building in Conflict Areas
* Community-based Inclusive Development
* Disaster Prevention, Response and Management
* Case Stories on Women Organizing
* CSO Development
* Community Health Financing
* Ability Behind Disability
* Information Education Communication Tools

NOTE: Please write your articles using simple format. Do not indent, underline, italicize nor highlight your text. Special effects will only delay the editing process. Send us high your face photo, and high resolution field photos with caption to support your articles.