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Health Promoters Making Progress in the Quest for Better Health Care System and Policies

From your Editor Ms. Joy A. Bastian

At last, after many decades of trial and error, hardships, struggles and frustrations amidst poor health due to the governments' failure to adequately provide better health care services and sound policies, we are now seeing more progress. This progress is attributed to the endless efforts and innovations of the health promoters in all parts of the world. In particular, the collaborative action between and among the government organizations, non-government organizations, private sectors, and peoples organizations in the Philippines and Thailand is a role model. The case of the Katiwala Program by Ms. Josephine L. Quianzon which started even before the Alma Ata Declaration 1978 speaks for the long decades of health care innovation. The Healthy Lifestyle Program in New Corella by Ms. Shiori Ui gained national recognition, an offshoot of the endless pursuit for local governance that eventually benefited peoples' health. The experience of INAM Philippines by Ms. Maricris Paruñgao is a clear example that all sectors can work together towards a common end. In Thailand, their innovation on pushing better health policies at the national level through multi-level approach is quite a leap. In fact, MHCO is now gaining recognition in leading the Thai National Health Assembly. A veteran health volunteer's testimony written by Ms. Mela Berkowitz shows what motivates her to selflessly devote her time for the people.

Ms. Mila Chavez with hat, (ILDC 2011), nutritionist, judging the healthy food contest at the Healthy Lifestyle Fiesta on March 2013 in New Corella, Philippines.

Benchmarking on the successes that are highlighted in the articles in this issue, we, health promoters can claim that our efforts paid back. The wait was too long, but it was worth waiting. Because it has been proven that the quest for better health can be achieved through continuous collaborative actions.

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Capacitating Community Health Volunteers

Ms. Josephine Littaua-Quianzon
Executive Director, Institute of Primary Health Care-Davao Medical School Foundation (IPHC-DMSF), Philippines

1. Early Beginnings


Ms. Quianzon

Thirty six years ago the Institute of Primary Health Care (IPHC) was created as the community extension arm of the Davao Medical School Foundation (DMSF). Viewed as the venue where medical students would get first hand experience on the health needs in the rural areas and in the promotion of preventive community health care. It aimed at creating an alternative system of education that fosters a greater sense of social responsiveness and a more holistic understanding of health.

The late Dr. Jess and Dr. Trining de la Paz had untiringly worked for preventive health care even before the 1978 Alma Ata Declaration on Primary Health Care (PHC) through the Katiwala Program. The Katiwala Program, short for Kauna-unahang Katiwala ng Kalusugan (primary trustee of health) was an alternative approach to decongest and provide better health services to a church - based charity clinic which later evolved into a medical cooperative managed by the Development of People's Foundation (DPF). These Katiwalas rendered preventive and simple curative services to people in their homes.

2. Institutionalizing the Katiwala Program

Two years after DMSF was established in 1976, the de la Paz couple, one of the founders of the DMSF, worked for the institutionalization of the Katiwala Program through the IPHC. While DPF continued promoting the Katiwala Program in the urban areas of Davao City, IPHC on the other hand, promoted the program in the rural areas of Southern Mindanao and trained more than 1,200 Katiwalas in partnership with the regional offices of the Department of Health (DOH). Thus, when the DOH started to implement its PHC Program by training Barangay Health Workers (BHWs), most of the Katiwalas became BHWs. Barangay is the smallest political unit under a municipality.


BHWs of Sta. Maria, Davao del Sur organized Safe Motherhood Health Events.

In the course of institutionalizing the Katiwala Program, IPHC learned the essential role of the government, other sectors and the community in the development process considering that it has limited resources. Thus, in the 80's IPHC took the risk of working closely with the Local Government Units (LGUs) and involving them in project activities. At this time, LGU partnership was almost impossible. Partnership mechanisms were explored to further improve the delivery of basic health services. To solve the lack of human resources, the Community Health through Integrated Local Development (CHILD) Project was implemented in Southern Mindanao (South Cotabato, Davao del Sur , Davao City, Davao del Norte, Davao Oriental). PHC training were focused on health skills (vital signs, water testing using PHC bottles, preparation of oral rehy-


Family Health Fair in Montevista, Compostela Valley.

drating solution, herbal preparation), leadership skills, facilitating skills and values clarification. Eventually, the BHWs were organized into associations and became active development partners in their communities. Some BHWs were even elected as barangay officials and have continued to advocate health concerns in these special bodies.

BHWs' PHC Training in Tabango, Palo, Leyte.

3. Evolving Roles

In the 90's, IPHC have continued to assist the Rural Health Units in the training of new BHWs on basic health skills, how to manage their Barangay Health Stations (BHS), Botika Ng Barangay (village pharmacy) and health care financing (establishing of community managed health insurance or a health emergency fund) were also introduced. The concept of wellness was introduced in 2010 in selected areas (Marilog, New Corella and Talaingod among elementary school children through the child to child program). Promotion of home remedies, practice of traditional and alternative health care modalities and herbal preparations were promoted. The BHWs and leaders of people's organization which acted as support groups to the BHWs, were given skills in the conduct of Inter-Personal Communication and Counseling (IPCC). As a result, the BHWs organized creative health events, health classes, health circles and the like.

Lately, as part of the DMSF Humanitarian and Medical Mission to areas affected by recent calamities (Typhoon Bhopa/Pablo in 2012 and Typhoon Haiyan/Yolanda in 2013) inputs on PHC and psycho-social support were given to duty bearers (BHWs, elementary school teachers and community leaders). It gave these duty bearers the knowledge and skills on how to do stress de-briefing and when to refer traumatic cases in two Barangays of New Bataan, Compostela Province and in three Samar municipalities (Albuera, Tabango and San Isidro).

Through the DMSF-Community Extension and Service activities, the College of Dentistry trained the BHWs and members of the Barangay Council on oral health. The BHWs assisted in the conduct of an oral health profiling in the community.

4. DMSF Renewed Commitment to PHC

DMSF renewed its commitment to the promotion of PHC in all its units guided by the WHO's People Centered Health Care. This framework is focused on four domains namely: 1.) Informed and empowered individuals, families and communities; 2.) Competent and responsive health practitioners; 3.) Efficient and just health organizations and 4.) Supportive and humanitarian health system.

After three decades, the role of IPHC has evolved from capacitating the village health workers, to capacitating the health providers (doctors, nurses, midwives). Recently, DMSF through IPHC was tapped as the academic partner of three Regional Health Offices (Region XI, XII, XIII) in capacitating Local Chief Executives (mayors) in health leadership and governance.

IPHC in the coming years will intensify its effort to make its Marilog area as a Center of Excellence in Primary Health Care with emphasis on Community Managed Health Care and sustain New Corella as its Center of Excellence in Participatory Local Governance.

PHC Training in the Municipality of San Isidro, Leyte.

A Lifetime Volunteer Speaks on Volunteer Motivation

Ms. Mela Berkowitz, AHI

Veteran New Corella Health and Development Volunteer Ms. Cresencia Gumela, usually called Nanay Ising, was invited as a guest speaker for the west region assembly of Japan Association for International Health (JAIH) at Aichi Medical University by Ms. Mariko Sakamoto (AHI supporter and organizer of the assembly). She also attended the AHI discussion meeting and visited Owari Asahi City and Shidara-cho in Aichi Prefecture, to meet the local government staff, health volunteers and senior citizens for mutual learning. Nanay Ising started her volunteer career as a Katiwala (neighborhood health promoter as mentioned in the preceding article by Ms. Quianzon). Then later she became the president of 210 health volunteers in the municipality of New Corella, and once served as a barangay official. She is also a key member of ANAK-NC mentioned in the succeeding article by Ms. Ui. On her first trip overseas, she shared her rich experiences to various groups and audiences.

Below she responds to an interview at AHI.

Nanay Ising at the assembly of JAIH in Japan.

Q: What was your impression of the meeting with the health volunteers in the remote area of Japan?

Nanay: First, the volunteers' age! Many are over 70 years old! But they are very active volunteers, and very kind to me.

Q: How about your stay in the mountain area?

Nanay: We stayed in a Japanese hotel. Many things were so new for me. When I used the high tech toilet I was so surprised. I had to ask Ms. Kyoko Shimizu (AHI staff) how to use it. First time!

Q: And this was your first time flying out of the Philippines. How was your experience?

With Shidara group, Nanay Ising (center) and Ms. Mariko Sakamoto (sitting, second from right).

Nanay: In the airport, when I was going through immigration, I felt so embarrassed because I did not understand their Japanese English. They thought I could not speak English. I was so happy that Makiko, Kagumi, and Mariko (AHI staff and AHI supporter) were waiting to meet me.

Q: You have been volunteering in your village for more than 30 years. Can you tell me just one or two happy memories of that long experience?

Nanay: I always feel so happy to help people, especially the indigents. I remember when I did my first training at IPHC as a *katiwala* (village health volunteer, literally "trustee"). We learned to prepare herbal medicines using the 10 herbal plants accredited by the Department of Health. They are common plants just growing around the village. I felt so happy to teach this to people who have no money to buy commercial medicine. The herbs are so effective and easy to prepare, and people can meet their immediate needs, like treating diarrhea, worms, cold and fever. After the training, I went back to New Corella and we held a meeting in our *purok* (cluster of houses in a barangay) to share what I learned. Many people attended.

Q: After you became a Barangay Health Worker (BHW) you had responsibility to help people in your village access health services. Can you share some episodes?

Nanay: I have many episodes. I remember one mother, an IP (indigenous people, ethnic minority) who came to me for help. Her two small children had high fever for a week. She knew she had to take them to the main hospital, but she had no money for transport. I paid it from my pocket. Another one is, when the midwife referred pregnant mothers to hos-

pital. We have an insurance system, but some mothers need help to do the application. I helped them.

Q: You were the president of 210 BHWs in New Corella for several years. What were your challenges during that time?

Nanay: The main challenge was time management because I was also the blood coordinator and nutrition coordinator. It was hard to manage my schedule. And it was hard to write up the reports. But no report, no honorarium.

Q: As BHW president, how did you encourage the volunteers to continue contributing?

Nanay: The main point was regular updating. We called all BHWs heads for quarterly updating meetings at province level. Then we made plans so they could disseminate and share the information in their own barangays. We send text messages or letters to the BHWs and barangay captains to coordinate. But sometimes BHWs lose motivation because they are too busy with childcare, or with their family farm, or because they do not have enough money for transport. When a BHW did not go the health activities, the midwife informed me. If I have time, I go to discuss together with them and the purok chairman. But in our area it is easy to recruit and replace BHWs.

Farm produced displayed at the Nutrition and Healthy Lifestyle Fiesta on July 2014.

Q: Finally, can you tell me about the IPHC support?

Nanay: I stayed at IPHC for a two-month training and has been working with them for more than 30 years. So they know about my service to my community. This time they supported me to get my passport and visa for this trip. They have always been kind and approachable.

The Healthy Lifestyle Promotion Program (HLPP) in Mindanao Wins Department of Health Award

Ms. Shiori Ui, AHI

1. Introduction

The Healthy Lifestyle Promotion Program (HLPP) run by ANAK-NC in the municipality of New Corella, Mindanao, the Philippines was recently awarded finalist in the NGO category by the Department of Health's Outstanding Healthy Lifestyle Advocacy Awards (OHLAA) 2013.

ANAK-NC is a voluntary group formed by a group of alumni of AHI ILDC and AHI National Course conducted by IPHC-DMSF. It is composed of about 40 members who are leaders and staff of People's Organizations, Local Government Units (LGUs) at the barangay and municipal levels, and NGOs working in New Corella.

(left to right) Victorious and proud ANAK-NC Mr. Joel Quinanahan (3rd), ILDC 2000, and Ms. Nancy Obra (4th), ILDC 1996, received the OHLAA award at PICC, Manila, Philippines.

Mr. Joel Amita Quinahahan (ILDC 2000) and Ms. Nancy Ulanday Obra (ILDC and OMC 1996), both municipal officers as well as ANAK core staff, participated in the awards ceremony in Manila on October 16, 2013. OHLAA awards are given to outstanding programs for five categories of implementing agency: city, municipality, workplace, school and NGO. The criteria is program design, impact/results, sustainability, and innovativeness.

Mr. Quinanahan reflects that while the program scored well on program design and innovativeness, it is still too new to show impact or sustainability. OHLAA organizers encouraged ANAK to run for the top prize in the next awards contest in 2015.

2. How HLPP Started

In New Corella, for 11 years (1999 to 2010), participatory area development and human resource development was promoted through multi-sector collaboration among People's Organizations (POs), LGUs, local business, and NGOs (IPHC and AHI). While issues of poverty and malnutrition gradually improved, traditional life and dietary style faded out, and the increase of lifestyle related diseases has become an emerging issue even in rural and mountainous villages. It is caused by the easier access to high-fat, high-sugar and high-calorie food and drinks at low price, and the insufficient knowledge and consciousness on healthy life and dietary style.

Spaghetti and white bread is a trending snack even in the rural Philippines.

To tackle this emerging issue, in 2010 the Municipal Health Office and ANAK-NC started the HLPP based on their existing system and human resources nurtured through the participatory area development process with support from AHI and a Japanese business corporation, TOKAI RIKA*.

A barangay health worker, who is a healthy lifestyle advocate, is holding health education in New Corella.

In each barangay, the barangay health workers (BHWs) serve as healthy lifestyle advocates designing and running activities to prevent chronic disease.

The impacts of various efforts have started to be seen gradually. In food menus at the occasions of barangay and municipal events contain more vegetables and oily foods are consciously reduced. We can observe mutual control of over-appetite by greeting to each other "Healthy Lifestyle!"

Snacks at various meetings are reviewed, and more traditional and handmade snacks are served. Sometimes, people miss pop drinks, but it is OK, they are moving forward.

Suman, a nutritious typical Filipino snack made of cassava or sticky rice and coconut milk wrapped with banana leaves.

3. March 2013, the First Healthy Lifestyle Fiesta in New Corella

Brisk walking on the Healthy Lifestyle Fiesta.

The challenge of this program has been "How to involve more people?". Two participants to AHI ILDC 2011 (1 ANAK-NC, 1 IPHC) included "Health Fiesta" as part of the action plan at the end of the course. Then, one and half years later in

March 2013, this event was realized.

In planning, preparation, and implementation, various sectors worked together maximizing the experience of participatory development. More than 100 people participated in the Fiesta. They enjoyed walking, cooking contests, dance contest, speech contest, etc.

Even children are involved.

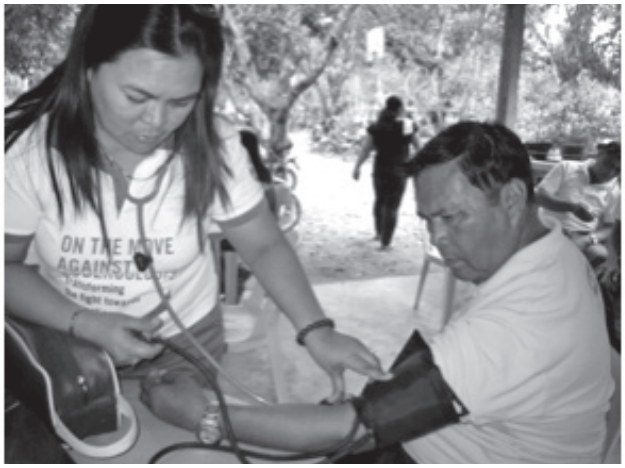
In the speech contest, speakers shared their experiences trying to practice healthy lifestyle. One spoke that "Before, I used to spend 1,500 pesos (US$35) a month to buy tobacco. Now I stopped smoking, and I do not feel tired like before. Now, I am encouraging my sons to quit smoking." Sharing by seven healthy elders from the age of 61 to 91 inspired and stimulated many youngsters.

Testimony to quit smoking at the speech contest.

The trial of HLPP started in two villages in 2012. It was expanded to another village by the time of the Fiesta. One more village joined in 2013.

4. New Innovation in 2014: Integration of Nutrition and Healthy Lifestyle Fiesta

This year, ANAK-NC and four barangays decided to merge the Healthy Lifestyle Fiesta and the Nutrition Fiesta in July, the Nutrition Month. The Philippine government, mainly the Department of Health (DOH) and the National Nutrition Council promote nationwide campaign in July as Nutrition Month and conduct various programs in every level of government. It is good for the residents and officials since both have almost the same target and purpose. This time, not only ANAK-NC members, but also the municipal and each barangay's officials and BHWs work together to prepare programs such as poster making, food agri-product display contest, cooking contest, dance contest, big loser contest, and senior award among others.



Blood pressure monitoring as part of health consciousness raising to prevent or manage lifestyle diseases.

Furthermore, this June, the Municipality of New Corella was recognized as White Orchard Awardee for its good performance in anti-smoking activities promoted by the DOH. ANAK-NC led the municipal wide anti-smoking campaign.

Along these activities, the mayor of New Corella decided to set up a Municipal Healthy Lifestyle Promotion Team to expand HLPP to all 20 barangays through an Executive Order on April 14, 2014. ANAK-NC members and LGU officials are now busy preparing the plan and budget proposal for the next fiscal year 2015.

Challenging for the national award, OHLAA became a big boost to further motivate volunteers and program participants, as well as encourage collaboration with the local government.

* TOKAI RIKA Company, Aichi Prefecture, Japan supported this program through the donation of workers. Workers would contribute 10 yen per dish when choosing a side dish from the daily health menu of their canteen.

Establishment of Community Managed Health Programs by Community Health Workers in Collaboration with Local Government Units

Ms. Maria Cristina C. Paruñgao, ILDC 2006
Ms. Anicia O. Solestre, ILDC 2008
Ms. Jennifer S. Manamba and Ms. Teudelinda G. Paduada, INAM Philippines

Ms. Paruñgao

Ms. Solestre

1. About INAM Philippines

Integrative Medicine for Alternative Healthcare Systems (INAM) Philippines, formerly known as Acupuncture Therapeutic and Research Center (ATRC) Inc. is a non-stock, non-profit, non-government organization on traditional and alternative health care services founded in September 8, 1984. For almost 30 years, ATRC-INAM has been providing both clinic and training services on alternative healthcare to the poor and marginalized sectors of our society and to our partner organizations in different parts of the country. ATRC-INAM has provided training on Traditional Chinese Medicine (TCM) acupuncture to almost 100 partner organizations mostly community based health programs, peoples' organizations and non-government organizations.

At present, INAM promotes Philippine Integrative Medicine (PIM) and continues to provide PIM training to partner organizations and communities in different municipalities and provinces nationwide. Since 2008, INAM have reached 244 barangays and communities in 68 provinces/cities spread over Luzon, Visayas and Mindanao. In these communities, we have trained 1,144 individuals in community organizing, 727 of whom are now Community Health Workers (CHWs) implementing their respective Community Health Programs (CHPs) in 155 barangays. After PIM level 3, there are 37 Community Managed Health Programs (CMHPs) being managed by 128 Community Health Program Managers (CHPMs) in 49 barangays and giving services to 7,697 households. Four provinces are now expanding the setting-up of CHPs to other barangays after having trained 35 CHP Managers as local PIM Facilitators. Meanwhile, six barangays in Luzon are currently preparing for the establishment of their Community Health Care Financing (CHCF) after going through an orientation on CHCF.

Community Health Care Financing Training

ATRC- INAM, together with the advocacy efforts of its partner community based health programs, is instrumental in the passage of the Traditional and Alternative Medicine Act of 1997. INAM is recognized as an accredited training center for Traditional Chinese Medicine (TCM) and acupuncture and being tapped by the Philippine Institute of Traditional and Alternative Health Care (PITAHC) of the Department of Health (DOH) as resource organization particularly in the development of the competency standards and training curriculum on acupuncture for medical and non-medical practitioners in the Philippines.

Alternative health care skills training.

INAM is a founding member of the Coalition for Health Advocacy and Transparency, a coalition of civil society organizations advocating access to health care through transparency and good governance. INAM is also a member of the Primary Health Care Coalition, a network of non-government organizations involved in the revitalization of Primary Health Care in the country. For almost nine years, INAM has been an accredited non-government organization by the Local Government Unit of Quezon City and has been a member of the Quezon City Development Council.

2. About Philippine Integrative Medicine (PIM) Training

The conduct of PIM Levels 1 to 3 training in communities who have requested and have expressed the need to address their health problems in their respective communities paved the way in gradually organizing the families into family clusters. The experience in the implementation of the Community Health Programs (CHPs) in the communities and other enhancement training needed by them will eventually strengthen the CHPs and the family clusters. Depending on their development and collective decision, the family clusters shall hopefully lead to the formation of Community Health Organization (CHO). The CHP shall be managed by trained CHWs who provide basic health services to family clusters and refers patients beyond their capacity to the nearest government health care facility which may be a Barangay Health Station, Rural Health Units (RHUs) and District or Provincial Hospitals. The CHPs provide accessible, acceptable, available and affordable basic health care services at the family and community level and complements the existing local health care system.

One of INAM's strategies in the promotion of PIM training is partnership with the local government units (LGUs), non-government organizations (NGOs), peoples organizations (POs), etc. INAM values solidarity and working together with the different organizations especially with the LGUs through the Municipal Health Office (MHO). Together with the LGUs and MHOs, communities in the Geographically Isolated and Disadvantaged Areas (GIDA) are identified and prioritized for the conduct of the PIM Levels 1 to 3 training. Barangays located in the GIDA oftentimes do not receive basic health services due to geographical inaccessibility and lack of government assigned barangay health workers (BHWs), midwives and other health care professionals to provide health services. The BHWs work under the supervision of the rural health midwife and with the municipal health officer and provided by the local government with monthly minimal allowance. The CHWs trained under the PIM curriculum are community leaders identified by the community and working as volunteers with their commitment to serve their family clusters. There are times when BHWs can also be CHWs especially when they are chosen to participate in the PIM training.

3. Details of the PIM Training: Tanay Case

In Tanay, Rizal, 429 Dumagat (one of the indigenous peoples or IPs) farming families from six barangays are presently formed into family clusters

Community Health Workers in Tanay

and organized into six barangay level community health organizations with each CHO composed of several family clusters and assigned CHW per cluster family. The CHO in each barangay has a Community-Managed Health Program (CMHP) that provides health services to cluster families.

1.) Capacity Building of Community Leaders/Indigenous Peoples for Health by Level

a.) PIM Level 1: Community Organizers (COs), May 31 to June 3, 2010. Thirty seven IPs (Dumagats/Remontados) became COs. The IPs learned basic health skills on 18 common community diseases affecting their barangays and develop their own survey form for gathering household data in their assigned family clusters.

b.) PIM Level 2: Community Health Workers (CHWs), July 26 to 30, 2010. Thirty eight Dumagats from nine municipalities of Tanay became CHWs. Participating barangays are San Andres, Mamuyao, Tinucan, Sta Ines, Laiban, Sto Nino, Cuyambay, Daraitan, Cayabu. The participants gained experience and skills on how to collate and analyze their household survey; identified the major problems in their respective communities and understand the importance of managing common community diseases in order to prevent them from becoming emergency cases; learned how to refer and coordinate with the MHO during emergency situations. They understood the importance of immunization for their children and are willing to participate in immunization campaigns, identified their responsibilities as CHWs.

c.) PIM Level 3: Community Health Program Managers (CHPMs), September 12 to 17, 2011. Twenty eight CHWs (including five from the partner organization) from eight barangays in Tanay became Community Health Program Managers. IPs became confident in their knowledge and skills on how to manage their community health programs. Using the monitoring records, plans and previous experi-

ences, the participants evaluated their community health programs after one year of implementation.

d.) Training of Facilitators: PIM Facilitators, October 15 to 26, 2012. Twelve participants graduated as PIM facilitators and nine are CHPMs from barangays Laiban, Daraitan, Cuyambay, Sto Nino, Mamuyao and San Andres, and three RHU staff. The IPs developed their own facilitator's guide to be used in the conduct of PIM training in nearby barangays and to expand the number of CHPs and CHWs to provide more access to health care services. They also facilitated the PIM Level 1 training last October 2013 which was attended by almost 30 participants coming from other barangays and the PIM Level 2 training last June 23 to 27, 2014 with almost 20 participants.

2.) Establishment of Community Managed Health Programs (CMHPs)

At present, there are nine functioning CMHPs from six barangays (Laiban, Daraitan, Cuyambay, Sto Nino, Mamuyao and San Andres) providing basic health services to 387 families organized into 28 clusters or approximately 1,935 individuals

3.) Documentation of Good Health Practices

Community Health Program Managers participated in the Community Participatory Research – Writeshop for Documentation of Best Practices Guidelines last January 2014. The CHWs documented the treatment, health education, herbal plants used for common conditions for the patients/ family members who availed of their services. The records of the CMHPs became the basis for developing the Best Practices Guidelines for Common Community Diseases which was presented during the third National Community Health Workers Assembly held last February 27 to March 1, 2014.

4.) Patient Referrals and Health Improvement

Out of the 597 IPs who sought the health services of the CHWs and CHPs within a one-year period, 547 (92%) were cured and only 50 patients (8%) were referred by CHWs to Barangay Health Stations, Rural Health Units and/or Hospitals. There's marked improvement in the health situation of the families with increasing numbers of Dumagats having their children immunized, more pregnant women availing of pre-natal check-up and more health cases appropriately referred to health centers.

5.) Development of Community Health Care Financing Scheme (CHCF)

From October 9 to 11, 2013 and February 10 to 14, 2014, 12 CHWs and 2 RHU staff participated in the CHCF Training Parts 1 and 2. The IPs were able to develop their benefit package, policies and guidelines and a 1-year plan for their CHCF scheme (Saknungan Para sa Kalusugan) wherein approximately 100 families have joined.

Meeting at the grassroots level.

Community/family cluster assemblies during health education and for consultation if families/community members shall decide to participate in the community health care financing scheme.

6.) Creating venues for Community Assemblies

On May 2014, the MHO through the support and cooperation of the local barangays, agreed to have their barangay local health board established in six barangays, which ensured the representation of the CHWs/CHPM. This development shall make the CHPs sustainable. The plans of the CHPs, in line with the thrust and direction of the barangay local health board, can be presented and included in the programs for health of the barangay. This shall in turn provide financial and political support in the implementation of the health programs. In February 11, 2014, INAM was selected by the Tanay Municipal Local Health Board as its non-government organization partner who will represent the NGO sector.

Sustainability of the community health programs is ensured even if there will be changes in the local government administration. So the people shall take ownership and responsibility for sustaining their respective community health programs/ community health organizations in the different barangays of Tanay. People's empowerment and participation are also ensured through increasing participation of the people particularly the indigenous peoples so that their voices and needs can be heard and addressed by the local government.

The Thailand Case

The National Health Commission Office (NHCO) is AHI's partner in Thailand since 2009. It started from an unexpected meeting of me and Mr. Ugrid Milintangkul (ILDC 1987) in an international conference held in Bangkok in 2006. Mr. Ugrid talked about an upcoming event in a passionate manner, which remained as a good memory to me. In 2008, AHI received an invitation from Mr. Ugrid, then the deputy general secretary of NHCO, to observe the first National Health Assembly (NHA) of Thailand. Since then, yearly from 2009 to 2012, AHI selected and sent two alumni from other countries to join and learn from this progressive Thai experience. NHCO reserved special seats for the AHI alumni.

Meanwhile, NHCO sent its staff and their local partners to AHI International Leadership Development Courses (ILDC). Now in NHCO alone, there are five AHI alumni working as core drivers for participatory democracy through developing healthy public policies. In 2013, two NHCO staff, including Mr. Ugrid and his colleague joined the AHI Reunion Seminar in India as resource persons, in order to share the Thai health system and experiences of solving health and health related issues through the National and Provincial Health Assembly.

I visited NHCO and its site on June 3 to 6, 2014. Rather than sending AHI alumni to the NHA at the national level as previous years, NHCO and AHI are now finding ways to facilitate experience sharing and mutual learning among neighboring Asian countries, further at the grassroots level. (by: Ms. Shiori Ui, AHI)

AHI's Ms. Shiori Ui (front left) meeting the health volunteers in Trang Province.

The succeeding article is from the NHCO team.

The Quest for Public Participation

Ms. Nanoot Mathurapote, Specialist International Affairs, National Health Commission Office (NHCO), Thailand
Ms. Prangtip Netnoy, ILDC 2013, Professional Officer, National Health Assembly
Mr. Jaruek Chairuk, ILDC 2013, Specialist, Provincial Health Assembly

Ms. Nanoot

Ms. Prangtip

Mr. Jaruek

1. Public Participation in Decision Making

It is widely accepted that public participation is a fundamental contribution to development. In the field of health development, community participation was listed together with appropriate technology, intersectoral collaboration and reorientation of basic health services, as key strategies in the implementation of Primary Health Care (PHC) policy in 1970s.

Thailand has set up a village health volunteer to conduct health development activities in rural area. They play a big role in bridging between the health officers and the people. It is in this rather initial movement that lay people are acknowledged and involved in health development. However, their role is limited to implementing activities which have been decided by the health officers, but they are not involved in decision making on health development for their community.

The public growingly called for participation in decision making and policy process in health development in the 1980s. This movement has come along with the concept of health promotion. Health of the population does not depend on health policy solely, but also on non-health policy. Economic led growth development may also possibly affect the population's health.

Ottawa Charter gives importance to health promotion as a way to enable the improvement of their health. Building healthy public policy along with creative supportive environment, strengthening community action, developing personal skills and reorienting health care services were identified as action areas to achieve health promotion.

For Thailand, healthy public policy is not sufficient for our context. Public participation in the policy process is indispensable. Consequently, the National Health Act in 2007 was designed as a tool to promote and facilitate the process of building participatory healthy public policy.

District health promotion hospital.

2. National Health Assembly

Thailand has innovated health assembly, under the National Health Act, as a process and space for public deliberations and participation in the policy process. The National Health Commission chaired by the Prime Minister is mandated to convene the National Health Assembly (NHA) at least once a year. As of now, six NHAs have been convened with a total of 59 resolutions.

Issues to be dialogued at NHA are open to any organizations or networks to propose. Since health in Thailand has a broader sense as the well-being, the proposed issues consequently vary from health care, and health financing, to natural resources, education and social justice. This shows that health has become an integral part of development.

Once the proposed issues becomes NHA agenda, the working group of each agendum is set up, consisting of all possible stakeholders, to draft the resolution. The first draft of the resolutions are distributed nationwide for public consultation. The working groups revise their draft according to feedback and recommendations of the public and then the final draft is brought to be dialogued at the NHA. Around 200 NHA constituencies, or around 1,500 people, attend the NHA and consider the final resolutions. NHA does not use a voting system like in a parliament. Only a consensus of the constituencies can pass the resolutions. The adopted resolutions are finally submitted to the National Health Commission for further action.

The National Health Commission is not a government board, but an intersectoral one, comprising government agencies, academia/health professional institutions and the people sector including civil society, NGOs and the private sector. As a result, the commission cannot apply hard power to enforce the resolutions or force anyone to comply with. The meaningful participation of all sectors in the NHA process is one of the success factors that can put the resolutions into action effectively.

Although some resolutions necessitate authority of government agencies to accomplish, the idea of NHA has created a sense of self-reliance and management. The resolutions do not call for only government agencies to implement; the health assembly network is also obliged to practice the resolutions. Soft power of the National Health Commission has generated intersectoral action rather than disruption.

3. Provincial Health Assembly in Trang Province

Thailand has not only the NHA, but provincial health assembly (PHA) has been convened throughout the country as well. Quality of NHA at the national level cannot succeed unless public participation at the community and provincial levels are strengthened. In addition, provinces have different kinds of health related problems. PHA is hence applied as a tool to solve their specific problems and empower the public.

With the visit of Ms. Shiori Ui to the National Health Commission Office (NHCO), two AHI alumni from NHCO - Mr. Jaruek Chairuk and Ms Prangtip Netnoy – arranged the field study for Ms. Ui to learn about PHA in Trang Province, which received the Health Assembly Award in 2012.

Trang Province is located in the southern part of Thailand. This province is considered rich both in terms of economy and resources. The upper province is mountainous, while the lower part is lowland having two main rivers run through it. The western part is a coastline of 119 kilometers. The different resources create different cultures, among them the rubber farmers in the mountains, rice farmers in the low

land, and fishermen by the sea. Trang is also an important seaport city where Chinese, Indian and Malay have migrated to do business there. They all live in harmony.

With no need to worry about the economy, the people turn to an interest in politics. Social movements have been active since the student revolution in 1973. Social activities have occurred continuously since then such as public protests against dam construction and usage of fishery equipment that destroys natural resources. Trang people also joined in pushing the National Health Bill into promulgation during 2000 to 2007. Public mindedness and a sense of ownership by the people is a high social capital of the province.

When NHCO introduced a health assembly to Trang people, the concept was quickly accepted, but still was not easy to implement. Government agencies, academia, and the people rarely collaborate, although they have the same goal for health. Gradually provincial health assembly has been acknowledged as a tool to build intersectroal collaboration and public participation in a policy process. The first PHA was convened in 2010 following the working structure and process of NHA.

4. Resolution in Action

One of the resolutions of Trang's PHA is on consumer protection. This issue came up to the PHA from a grassroots level, where village health volunteers, hospitals at a sub-district level, and consumer protection networks had been working on it in some places. It is a common practice at funerals and cultural festivals to find hosts/sellers serving hot food in a plastic bag, not on a plate, to guests/customers. This shows that the people are not aware of dangers from melted plastic bags. Furthermore they always use cooking oil repeatedly, which can cause cancer.

This might be a small issue in the eyes of the government but the people are highly concerned. Because PHA opens a chance for every network or organization to propose an agendum, these people united to drive this agendum into a provincial policy. Once the resolution was adopted, the provincial public health office put this issue into their provincial strategy on public health as the office saw the benefit of it, not by force. The campaign to ban plastic bags have therefore been made in parallel with building an understanding of this issue to 6,000 health volunteers of all districts.

After listening to a brief on Trang's PHA, Ms. Ui and three NCHO staff visited the hospital at Ratchada District to follow up on the implementation of the resolution on consumer protection. We reached there about lunchtime. Though we had not yet talked with them, our eyes saw many lunch boxes of the villagers. They brought them up to share food with us. No plastic bags are used.

While having spicy southern food, the public health officer said that all the vegetables that we ate were organically grown by the villagers. Twice a month, they bring the organic agriculture products to the hospital to exchange with other villagers. This district is also campaigning to change the villagers' behavior by educating them on the benefits of eating half a kilogram of vegetables a day and of exercising at least three days a week. Those who do best get an award as an incentive. Edible fruit bearing trees are also grown along the street with no use of chemical fertilizers or pesticides. The resolution has been implemented widely on a voluntary basis. It depends on the creativity of each local government on how to implement the resolution in the most effective way for their context.

Eating southern spicy food.

Beyond changing consumers' eating behavior, PHA can change people's attitude from being recipients of the government projects and services to policy drivers. This is a long-term goal of empowering our people and strengthening participatory democracy that Thai people are proud of.

Organic vegetables for exchange.

FLASH ARTICLES

AHI Support to Typhoon Yolanda Victims in the Philippines

Ms. Rosanna Pandes, ILDC 2005
I-CODE, Philippines

AHI has no regular scheme for emergency support to natural disasters. At the time of the calamity caused by Typhoon Yolanda in the Philippines, some Japanese individuals and groups offered voluntary donations to support the victims through AHI network. AHI contacted the alumni living and working in Panay Island, one of the heavily affected areas, and channelled the donation. Ms. Rosanna M. Pandes coordinated the relief work for children in collaboration with other AHI alumni. The following is the report from Ms. Pandes.

Ms. Pandes

Iloilo, Philippines. Last November 8, 2013, a super Typhoon Yolanda hit the Philippines particularly in the Visayas Region. Thousands of people died and worth billions of pesos of properties were destroyed. Thousands of families were homeless and lost their livelihood.

Boxes of goods for distribution.

In the Province of Iloilo, Western Visayas, several towns were severely affected of the typhoon. Majority of houses in coastal and island villages were totally damaged due to storm surge. Fishing boats were damaged and lost and some fishermen died. With these, the government both local and national and even international organizations immediately extended assistance to victim families in the form of food, potable water, clothing, medicine and shelter.

On the other hand, classes in all levels were postponed until December due to damaged infrastructures. Classes formally resumed only January 2014. In Bingawan, some classes were held in makeshift structures with at least four combined grades in one room. Others temporarily hold their classes under the shade of trees, community chapel and tents provided by international NGOs. This situation is difficult for the students and teachers since it is not conducive to learning but they diligently continue and hardly cope-up on the days that they were not able to go to school for several months.

Daycare Center kids got kits.

AHI with the help of kind Japanese supporters extended calamity support to victims that made the people smile especially the children. AHI through its alumni who belonged to Iloilo CODE-NGOs (an umbrella of NGOs) provided school kits in selected schools in Bingawan, Batad and Carles, Iloilo. School kits include umbrella, water tumbler, waterproof envelope with handle, pencils, toothbrush and toothpaste. In the first batch, Ngingi-an Primary School and Quinangyana Elementary School in Bingawan received 142 kits. In Batad, 158 kits were given to Malico Primary School, Calangag Primary School, Banban Primary School and Quiazan Florete Daycare Center.

In the second batch of assistance, the AHI alumni bought 600 sets of school kits. In March 30, 2014, 120 kits were given to school children in Barangay Barosbos, Carles, Iloilo. They are siblings of small fisherfolks and jobless families in the village. On April 7, 2014 Batad's Alapasco and Cabagohan Elementary Schools received 280 kits. Distribution in Bingawan was facilitated in June after proper coordination with the school heads and supervisor.

The students were greatly thankful for the gifts they received from AHI. According to one school head, their school did not received assistance from any organizations. She cried for joy as she felt that

someone remembered them. They considered AHI as brother/sister and unconditionally gave assistance to their students which is very useful in their daily lives. The parents, children and teachers from Batad, Bingawan and Carles, Iloilo heartily extending their deepest gratitude to AHI and Japanese individuals who contributed for the typhoon victims in the Philippines.

"Now I can protect myself from rain."

Thank you to Iloilo CODE-NGOs, school heads and to my fellow AHI alumni, Mr. Jojo Rubrico (ILDC 2003), Mr. Marvin Saladar (ILDC 2005), Mr. Elphin Celeste (ILDC 2003), Mr. Russel Gardose (ILDC 2005) and Mr. June Jordan (ILDC 2003) who assisted in facilitating this project.

Grateful smile for AHI and all the Japanese.

Historical Speech by the Thelingu Community

Ms. Marie Princy Henarath Arachchige Dona, ILDC 2009, Janawaboda Kendraya, Sri Lanka

1. Background

Ms. Princy

The Thelingu (tribe) community was among those who came to Sri Lanka from India about 200 years ago. Among them, one group became members of the Negombo United People's Organization (NUPO) in 1992. They qualified as NUPO members because of low income, illiterate, and oppressed class. Joining NUPO eventually improved their knowledge, skills, talents, and social status. They are living in their own world until after the Tsunami disaster that they have to share houses. The scheme of sharing houses enabled them to experience living with other community group which created many difficulties.

Their constant participation to Suwa Sawiya Health Program under NUPO had enhanced their awareness on the value of getting organized to win their rights. They got their leadership and skills developed. It has helped them to identify the social problems and human rights violations. Though with developed leadership skills they had stage fright to express their ideas before a gathering of people. Though, some of them raised their ideas derived in the meetings to their mother organization, NUPO.

Surprisingly, during the People's Health Movement (PHM) meeting conducted to commemorate the World Women's Day on March 17, 2014, Ms. S. Meenachchi delivered a speech for the first time representing the Thelingu community. She was one of the 50 to 60 representatives of around 50 organizations in various fields. In her speech, she presented the problems faced by the Thelingu community. We were amazed to witness Ms. S. Meenachchi came forward instead of the representative animator, who unluckily failed to come. The conveners gave her high complements.

2. Ms. S. Meenachchi's Speech

Ms. S. Meenachchi

"Chairman, Ladies and Gentlemen: Today we are very delighted. First, I am grateful for this opportunity to forward our ideas on women rights. To recall, our ancestors visited Sri Lanka seeking employment many years ago. But they were not able to find jobs as they wished. They had to get involved in various jobs like fortune telling. Some of our members follow the same path even today.

Presently, our community is in the east, north, south and west districts. There are villages which are named after our community like Tellingunager in Trincomalee District. About 75 to 100 families are living in this area, and 2,000 to 3,000 families Sri Lanka-wide. Though some of us were born in Sri Lanka, contributing to the national income, we have no identity. We are not recognized as Sri Lankans. In our birth certificates, we are identified as Sri Lankan Tamils or Indian Tamils.

Only the new born babies are identified as Thelingu nationals. In wartime this was a severe problem to

us. The police and the armed forces could not identify us as a different community because of our language. Our names and language are similar to the Tamils. Lack of good education is also a problem. Education is necessary to get a driving license. We are compelled to spend more money to obtain one.

We are the members of Suwa Sawiya Health Network and the Landless Peoples Organization of Gampaha District. We benefited a lot by working with those organizations, like the shelter that we are living now. Our former shelters were completely destroyed by the tsunami. We had to struggle hard to get shelters of which the government failed to provide since our community is different. We met the Grama Niladarhi (village level government officer) and the district secretary requesting them to give us houses. Our organization turned to be our great strength. We have organized communities in Colombo, Gampaha and Trincomalee District. These organizations emerged not without problems.

We may be addressing the problems of women today. We know that we, women, are gravely oppressed and harassed. We have to suffer a lot. Women must seek jobs. When the economy of family declines, some of our Thelingu women start selling fish, fancy items and even preaching fortune. Because of poverty, cast and by being women, we have to face difficulties. We know that cast oppression is higher in India than in Sri Lanka. But in Sri Lanka too we are being look down upon as fortunetellers. But the situation in Negombo in Gampaha District has gone down presently. We are poor, undereducated, and not represented in the government.

Our people living in Colonnawa suffer a lot when the area get inundated. They cannot get out of their homes and compelled to stay. No one came to check if a child dies of starvation. We can go to the boutiques when the rain ceases and the flood subsides. Only then we can get something to eat. But many come to hear our grievances during election campaign periods. And they naturally disappear after winning the elections. Vicious cycle. We now realized that the only solution we have to get rid of this situation is to educate our children. We must give them good education. Unfortunately there are some instances where our children are being harassed.

On this memorable day that we commemorate the International Women's Day, we request the honorable participants here to protect our rights and accept us as humans. We thank you sincerely for allowing us to present our views after 200 years. This can be considered as a historical day. Thank you!"

HERE AND THERE

From Reconstructing His Own Country to Assisting Neighboring Countries: Mr. Tan Try, The First Alumnus from Cambodia

Ms. Shiori Ui, AHI

This article is taken from the AHI Japanese Newsletter focused on Mr. Tan Try, December 2013. Ms. Shiori Ui translated it from Japanese to English.

Mr. Tan Try (ILDC 1991) was standing outside his organization's office after work, with a calm smiling face. "I just came back from Myanmar." "Really? What did you do there?" "I went there for technical cooperation in health communication as an expert. It is just like what you have been doing here in Cambodia."

Mr. Tan Try

Mr. Tan Try, a very gentle man with a peaceful voice, was unusually excited and started to tell his experiences in Myanmar one after another as he was driving. "Wait a minute! Please slow down and let me listen to your stories at the restaurant." It was the first time in our 23 years of friendship that I requested him to talk more slowly.

It was the year 1989 when AHI started its collaborative work of health education training with one unit of the Ministry of Health of Cambodia. That time, there was an absolute lack of human, material, and financial resources, and no diplomatic relationship between Japan and Cambodia, which was still under internal war. The counterpart person of this initial AHI work in Cambodia was Mr. Tan Try, a medical doctor. He joined the AHI International Course in 1991, as the very first participant from Cambodia.

Soon after the end of the Pol Pot Regime while the internal war was still continuing, he struggled to complete his study at the faculty of medicine. He was assigned to the health education section of the ministry, a very unpopular work for medical school graduates who usually expected to work in hospitals. According to him, originally he was shy and rather quiet. But soon he developed himself to become a top level trainer, and trained many junior colleagues. After serving for 10 years in the government, he left his ministry position and joined

UNICEF Cambodia in 1997. He continued to be

Mr. Tan Try explaining on communication at the Ministry of Health, 1992.

actively engaged in health education and communication work, as one of the top experts in the country.

From December 2012, for one and a half months, he was sent to UNICEF Myanmar as an expert on communication for development. His task was to assist UNICEF Myanmar that works closely with officials of Myanmar's Ministry of Health in developing two training manuals for health center staff and health volunteers – a participant's manual and a facilitator's guide. "Many theories or programs have been introduced in the area of health education/ communication, but the very basic principles and skills in participatory training have not changed. Many things I shared this time in Myanmar were what I learned from AHI 20 years ago. They are still useful and meaningful."

In Myanmar, it took longer to translate the manual into the local language. He completed his term before the manual was tested. The pretest was left to the officials of Myanmar's Health Ministry. "I thought I could do more in one and a half months. But, I did not know their language. I heard people in Myanmar were educated and understand English. But under the military regime, the country was closed, and the number of people who understand English decreased, even among UNICEF staff. I had some difficulties in making stories for health education because I do not know their culture well. It is not easy to put theory into practice under a different culture. I understood the need for time and patience in international cooperation."

Mr. Tan Try visited villages as a foreign expert guided by the translator from the Ministry of Health. "I had to explain to the translator first, then he explained to people regarding what was about the participatory approach. Participatory training methodology is not totally new in Myanmar. However it is not easy for general people to raise their voices and express their opinions to government health workers in a society where freedom of expression was tightly controlled. Cambodian people experienced the same, that people did not like to speak out but just follow the decisions from the top." He experienced a similar situation in his country for many years, so he could easily imagine the difficult situation Myanmar people were in.

He told me before that he was not interested to work in other countries, since he was satisfied with his work in Cambodia up to recent years. "This time, I felt that my skills and experiences were useful in other countries. I built my confidence. I think I achieved 90 % of my task. I never imagined 20 years ago that I could go to another country to give assistance." He was very proud that he could now offer help to people in a neighboring country.

"What would you do if they ask you again to go there to help?" I asked. He replied, "I would like to accept such work in neighboring countries close to mine. Working in own country and working in other countries are different. I would like to develop myself by working in new environments. If there is a request, I would accept it again." We both nodded.

I remembered when Mr. Tan Try was put in charge of participatory health education training in 1991. While he was facilitating a 10-day course for local government health education workers, he was always holding notebooks from AHI's international course. After the first course was over, he said that he got so nervous that he could not eat properly during the course. I asked, "So, you do not want to do it anymore?" He replied with sincere attitude that he wanted to make this course a better one next time.

What a joy for me to talk about the challenges and rewards of developing participatory training together with people from different cultures. Many years have passed and times have changed indeed. But Mr. Tan Try's sincere and positive attitude remained the same. I heartily enjoyed this special evening over crispy fried frog legs with spicy garlic, grilled freshwater fish with green mango sauce and much more.

Recently, we received a wonderful message that Mr. Tan Try became an annual supporting member of AHI through PAYPAl system. His kind assistance to AHI is highly appreciated.

Friends who know Mr. Tan Try could contact him through: Email: trtan@unicef.org

AHI Study Tour 2014 to Bangladesh

Mr. Takahiro Nakashima, AHI

Mr. Nakashima (first left standing) with the Study Tour participants and JCF staff, Mr. Mazed (extreme right standing).

1. The AHI Study Tour

Since 1981, one year after AHI was established, we have been organizing study tour every year. Education program for Japanese has been one of the core missions in AHI, and its basic concept is to let Japanese reflect themselves by learning from Asian people's reality and struggles. Study tour has been the most effective educational program for Japanese.

2. Purpose of the Tour

The threefold-purpose of the study tour is: 1) to know the reality of the marginalized and their issues, and NGO's interventions, 2) to expose Japanese participants to the reality and the issues, so that they could reflect their values and lifestyle, and hopefully, in the near future, they take actions in their respective places toward a better society, and 3) to build solidarity between the marginalized and the Japanese. Our target participants would be AHI supporters including high school students as well as health workers.

3. Outline of the Tour

On March 20 to 29, 2014, we conducted study tour in Bangladesh, and the host organization was Jagorani Chakra Foundation, Jessore. In the organization, we have four AHI alumni, namely, JCF Founder Mr. A. K. Arzoo (ILDC 2003), Deputy Director Mr. Kazi Mazed Nawaz (ILDC 2007), Project Manager Mr. Shailendra Nas Das (ILDC 2013), and Ms. Archana Biswas (ILDC 2013), the former JCF staff as well as director of Joyoti Society (Women's Federation). The alumni were most effective and committed to host AHI Japanese participants. The rest of the JCF staff and the high ranking officers also welcomed us wholeheartedly. The participants were nine senior high schools, four university students, and four adults. Ms. Kaori Tabata, a university student was an intern who was always vigorous and responsible in taking new and challenging roles.

Itinerary was a bit hectic. We stayed in the town of Jessore, which is an administrative center of Jessore District in the of southwestern tip of Bangladesh on March 21 to 22 as well as after rural homestay on March 26 to 28. During rural homestay, each Japanese participant was hosted by a women leader of Self Help Organization (SHO). They enjoyed rural life in Bangladesh and got new insights on people's reality, issues, and their efforts to overcome. In Jessore, they also stayed at the home of JCF staff. This tour is very unique since all accommodations were homestay in Bangladesh.

4. Outcome of the Tour and Its Vision

The participants really enjoyed the tour and gained lots of insights that JCF especially Mr. Mazed arranged with deep thoughts based on our expectations. Quoted from the evaluation meeting during the tour, the participants were impressed knowing that: 1) JCF facilitates genuine sustainable development among ultra-poor women, 2) JCF made a difference, in terms of self-reliance of poor women, 3) Ultra poor people are just equal human being like us, Japanese, who are smiling and crying, 4) Bangladesh people help and share with one another, 5) Bangladesh people have strong human ties among family members, especially brothers and sisters, and 6) Bangladesh young people have more ambitions and aspirations than Japanese youth, etc.
Pastor Tetsuji Saotome of the Christian Church, one of the participants, said that this study tour was almost perfect in terms of programming. From the participants' comments, we could know that this tour has improved and very much successful based on previous year's experiences.

We deeply appreciated the genuine hospitality, and meaningful arrangement of JCF and the women's groups. JCF made untiring efforts to give us all the supports to achieve our goals. Through equal partnership, I do hope that AHI and former participants' NGOs are collaborating to develop the leadership of Japanese youth who could bring about lasting peace on earth together with other Asians as well as the rest of the people in the world.

Wonderful Time in Bangladesh

Ms. Kaori Tabata, AHI Supporter

It was my first time to visit Bangladesh. The bus was running in the dark to Jessore. I was looking outside, wondering what kind of encounter there will be.

Through the tour, we had a chance to visit many kinds of actions. JCF's actions were much wider than I thought, many people there were influenced by it and I was so impressed. The JCF building was already completed, which I heard it was still under construction last year. I felt everything is changing remarkably. We had a 3-day homestay in a village. The time was short compared to life. But there was an encounter which I can never forget. Her name is Ms. Azmin. She invited me as a host family. I felt some powerful energy from her since we met. Through the stay, Ms. Azmin, her family and neighbors were very kind to me. What a surprise, I was never alone through the stay. One day she went out to participate a meeting "Ekku Musti Char". She is a SHO leader and a Community Based Organization (CBO) worker. We were invited to the meeting. They started to collect rice and she was writing something to the notebook. She can speak English but sometimes there is a communication gap between us. Even that, she looked to my eyes and explained politely what she was doing in every action. What I saw was they were opening the way to the future with their own hands, helping each other. Ms. Azmin was behaving strong while staying outside.

Ms. Kaori Tabata in Bangladesh, (center).

Afterwards coming back home, she returned to her usual pace; taking care of her brother's baby and helping her family. One day one of our participants lost her phone. They were very worried about it and encouraged her. They were very powerful, joyful and so kind. I could not believe that this village was suffering an ultra-poor life before.

Sad to leave the village. But I was full of energy and inspiration after I met these wonderful people and life here. After my homestay, I thought that Japan is full of useful things. But many people (including me) do not have enough time to stay with their families and friends. Many of them keep searching for more useful things and services that eventually lead to physical and emotional stress. But in Bangladesh people build on deep relationship among each other.

Through this tour I had many chances to know the activities of JCF. We got used to the environment, met people, and began to change our outlook. To hear the participants' stories was one of the most exciting parts. They talked about the sense of belongingness. The members of the study tour proudly talked about their experience in Bangladesh to the people around them. I was happy that some of them were thinking of going to Bangladesh again.

I am thanking Mr. Mazed, JCF staff and all the people who helped us experience such a wonderful tour. I loved the south Asian culture and wanted to feel the countries closer. Hopefully there are more others who could get a chance to immerse in local simple life yet full of love, kindness and togetherness. I love Bangladesh!

NEWS FROM FRIENDS

Yoga Nidra Making Mothers' Day Cards

Ms. Sopa Tamachotipong, ILDC 1985
Association of Himalayan Yoga Meditation Societies International
(AHYMSIN-Thailand Center)

Ms. Tamachotipong, 2nd right.

On Mothers' Day, August 12, Himalayan Yoga Samadhi (Thailand) held an activity "Loving Mom with a card from child's hand and heart". It aims to strengthen the bond between mothers and children, especially those who are living separately. The card conveys the feeling of love and care from children to mothers. Nine participants and I started with basic yoga and enjoyed making cards. Thanks to Khun Thaniya Kevalee, Swami Veda Bharti, and AHI.

ATTENTION: Exclusively AHI Alumni

INTERNATIONAL WORKSHOP (IWS) ON EMPOWERMENT OF INDIGENOUS PEOPLES THROUGH COMMUNITY PARTICIPATION FOR SUSTAINABLE LOCAL HEALTH SYSTEM:
The Case of Tanay, Rizal, Philippines
March 3 to 10, 2015.

Objectives:

1. to learn new ideas and insights through sharing experiences on empowerment of indigenous peoples through community participation for sustainable local health system from various areas/countries;
2. to learn from the community health programs experience of Tanay, Rizal; and
3. to build solidarity and network among participants towards developing sustainable local health system for indigenous peoples' communities

Target Participants: **22 maximum**

Basically **TEAM** participation from several countries: AHI Alumni with partner health volunteer leaders and/or local government officers who can bring concrete cases on the theme.

Financial Sharing Requirement: Refer to the workshop outline* for details.

*Workshop outline and application forms are downloadable from the AHI website or send inquiry.
http://ahi-japan.sakura.ne.jp/english/html/
E-mail: info@ahi-japan.jp

Contact Persons:

Ms. Shiori Ui and Mr. Eichi Shibata
IWS 2015 Coordinators, AHI

DEADLINE FOR APPLICATION:
OCTOBER 22, 2014

REUNION SEMINARS
Reminder for Registration

INDIA 2014

The **Reunion Seminar in India** will be on **November 17 to 20, 2014** at AYUSHYA, Kottayam, Kerala organized by the AHI alumni in AYUSHYA, Kottayam, Kerala organized by the AHI alumni inAYUSHYA and Kerala in collaboration with AHI.

Theme: **Holistic Health for People and Ourselves**

For inquiries, please contact the coordinator **Ms. Eliza Kuppozhackel (OMC 1992)** through any of the following methods:
a.) by **phone:** 0481-2720544
b.) by **mobile phone** (+91) 9961752903
c.)by **Email:** ayushyamms@gmail.com
elizakup@gmail.com

Website: www.ayushyamms.org

BANGLADESH 2015

The **Reunion Seminar in Bangladesh** will be held on **January 17 to 21, 2015** at the DASCOH, Lutheran Mission Complex, Dingadoba, Rajshahi, organized by the AHI alumni in DASCOH, organizations in Rajshahi area in collaboration with AHI.

Theme: **Appreciation, Connection and Cooperation.**

For inquiries, please contact **Mr. Modon Das (ILDC 2011)** through any of the following methods:
a.) by **phone** 0721-776305
b.) by **mobile phone** (+88) 01730072822
c.) by **email**: php.dascoh@gmail.com.

Website: www.dascoh.org

PLEASE CHECK!!!
http://ahi-japan.sakura.ne.jp/english/html/ for News Updates, Be a Supporting Member (PAYPAL SYSTEM) and more! Your comments, suggestions and article submissions are welcome.