ASIAN HEALTH INSTITUTE August 2009

Series No. 83

987-30 Minamiyama, Komenoki, Nisshin, Aichi 470-0111 JAPAN
Tel:+81-561-73-1950 Fax:+81-561-73-1990 E-mail: info@ahi-japan.jp
Homepage: http://ahi-japan.jp/english/english.html

FOCUS: DISASTER RESPONSE AND COMMUNITY DEVELOPMENT INITIATIVES

AHI's Disaster Assistance Program

A family struggling for life during disaster. (Photo by: CBR-DTC, Indonesia)

Editor's Note...

"Tsunami" or tidal wave is a disastrous natural calamity that yet no science can precisely predict when and where to happen. To recall the malady brought by the huge *tsunami* in 2004 still makes many people feel the scare particularly those affected. Thousands of human lives were wasted. Animals, plants and shelters were devastated. The damage it brought to those villages and the villagers were enormous. The usual life pattern, social interaction and economic activities ceased for some time as they had to find temporary shelter at the evacuation sites which could impossibly offer comfort. Time has come to move back to their respective villages to start all over again from zero. There is nothing more devastating than this.

"It's not the end of the world", the optimists say. The worst was turned into a big opportunity through the concerted efforts of the villagers, their leaders and governments, churches, NGOs and international supporters like the Asian Health Institute, Japan. Emergency response teams were created locally. All sorts of resources like human support, in kind and money were mobilized locally and internationally to assist the *tsunami*-affected people .

This issue put forward the experiences of Indonesia and Sri Lanka told by Mr. Maratmo and Ms. Perera, respectively. Ms. Kagumi Hayashi, AHI's General Secretary, depicts in her article the international cooperation and support to the unfortunate people who suffered much from those disasters. Strategies pertaining to resource mobilization and utilization was explicit with special mention to precautions.

In this issue...

AHI and Disaster Response

Ms. Kagumi Hayashi, General Secretary, AHI

Tsunami on December 26, 2004 brought a huge scale tragedy to many different parts of Asia, including those where some of AHI alumni were working. Actually the first news brought to AHI was from the one in Sri Lanka in the evening of that day.

Responding to this, we set up the special fund raising campaign two days later. As a result, we were able to raise funds, which is the amount of 25,084,993 yen (about US$270,000) from 1,441 donors, much larger than we had expected so as to make the financial support to 15 different organizations in India, Indonesia and Sri Lanka, including housing, livelihood support, mental care, special care for female victims, and so forth. Many voices of caring and sympathy from Japanese people sent to AHI, along with high expectation that AHI would be able to bring the support to the needy people through its alumni.

Our second experience was with the earthquake in Central Java in Indonesia, which occurred on May 26, 2006. This time, one of the alumni sent the news immediately expressing his plan to do some relief work. We also organized fund raising campaign, so as to support him to carry it out. He organized the team of volunteer healers using traditional medicine, including acupuncture and herbal medicine. It was the challenge for those health workers to maximize their skills and knowledge.

As for Central Java earthquake, we raised 1,653,636 yen (about US$18,000) from 153 donors, and it supported two different projects.

All hard work involvement from relief to rehabilitation, our friends draw out some learning which are very critical for support intervention. We quoted a few of them from the questionnaire that AHI had instituted in May 2008. Sri Lankan Mr. Herman Kumara said, *"We do not want to jump into a situation where communities, organizations and government or responsible authorities can handle the situation. Then we need not to intervene there. Some rehabilitation activities created a lot of damage to the victimized sectors, than do the best out of their involvement."* Mr. S.J. Prabhu from India also stated that, *"Mushroom of foreign NGOs poured hell of money to the Tsunami affected people. Sometimes people not directly but yet deeply affected were neglected."* Some mishandling or mismanagement of resources was observed, as what and to whom was all in the hands of relief agencies.

In such situation, involvement should be done towards earlier restoration of daily life. *"The new gifts should not overwhelm you, but should help you to build a new strong and vibrant community of self sustainability."* , Dr. Felix N. Sugirtharaj, India.

Throughout all the practices of our friends in these two unfortunate experiences, we have learned that:

1) Right after the emergency stage, there comes a long process of rehabilitation, that is, development starting from zero;

2) Rehabilitation process will much depend on community potential, which is to maximize both internal and external resources. Emergency intervention should be done in such a way not to distrust social networking in respective communities.

It is a challenge for development agencies that development efforts before disaster would provide the basis for rehabilitation. In other words, disaster management should be integrated with day-to-day basis development efforts. *"From affected to be healers is our motto"*, Mr. Siswo Pranoto, Indonesia said. He initiated health volunteer training after the first intervention of health care service delivery utilizing traditional medicine. Then they offered training to those affected. They said that it is a long process for them to be agents for health and development.

In this issue of the AHI newsletter, two articles in relation to Tsunami disaster 2004 are introduced. Both of them deal with vulnerable sectors in communities. They became even more fragile in disaster situations.

In the case of CBR project in Indonesia, the tragic experience and consciousness for disaster management of all community members nevertheless with or without disability, functioned in a common platform in terms of disaster issue. Another one is from Sri Lanka which implies the importance of giving special attention to the vulnerable sectors in disaster management, and moreover should be focused on day-to-day basis efforts of development.

"Disaster preparedness is yet the best arm we have in the midst of natural uncertainty."

Implementation of Post Disaster CBR

Mr. Maratmo Sukirman, CBR-DTC, ILDC
2001

1. CBR in Indonesia

The concept and implementation of CBR in Indonesia differ because of different situations, cultures, and local social context. It is also due to different philosophies and paradigm of disability issues among initiators of CBR itself. And finally due to evolution of CBR itself. Today, mostly CBR implementation in Indonesia is still project oriented. These projects are initiated by GO, NGO and DPO. DPO means Disability People's Organization. The promotion of CBR is from project-based to national program. In this sense the role of PWDs and their organizations/groups (DPO and SHG) increased in promoting and implementing CBR. Approaches and strategies of CBR has been adopted by organizations to respond disaster like the Tsunami in Aceh, North Sumatra and the Java earthquake.

2. Why CBR?

The reason of using CBR is because it provides comprehensive perspective of solving disability issues rather than traditional rehabilitation. Traditionally disability issue is viewed as individual issue faced by individuals with disabilities. Therefore, rehabilitation service is viewed as a medical, educational, vocational and social service that is delivered directly to individuals with disabilities. In CBR, disability issues are more viewed as social problems faced by individuals with disabilities. Therefore, rehabilitation service should be focused on behavior change of community to fulfill the rights of people with disabilities. The table below shows the above statement and what was lacking in traditional rehabilitation is supplemented by the CBR paradigm.

Traditional Rehabilitation	CBR Paradigm
◊ Individual issues	◊ Social issues
◊ PWD's change	◊ PWD and community's change
◊ Short-term program	◊ Long-term program
◊ Practical needs	◊ Practical and strategic needs
◊ Partial solution	◊ Integrated solution
◊ Exclusive program	◊ Inclusive program

3. CBR Post Disaster

At the occurrence of disaster is a devastating sight. And after it can be worst that triggers various questions. What can CBR do to respond disaster? What kind of approaches, strategies and appropriate actions must be taken? Does CBR really work in post disaster situation? How to sustain CBR post disaster?

Tents and mobile rehabilitation unit.

Rehabilitation institutions are set up to provide services for PWDs. But due to Tsunami and earthquake most of these facilities were badly damaged and dysfunctional. So in our case three approaches to CBR response were employed namely the 1.) community-oriented approach, 2.) community-based approach, and 3.) community-managed approach.

The first approach (emergency phase) delivers services for communities and PWDs in solving their problems. The professionals bring their services to tents, barracks and temporary houses. Mobile rehabilitation unit and outreach program are on site. The second approach (rehabilitation and reconstruction phase) is to facilitate community and PWDs so that they are able to analyze their problems, define their needs, identify community resources, develop priorities, make plan of action and monitor and evaluate action. The third approach (empowerment phase) ensures that the owner of the programs is the community and PWDs. They are able to organize and implement CBR by themselves using their own resources. If they need other resources, they initiate to mobilize from outside or create new if possible.

The role of the community and the PWDs as compared to that of the CBR initiator changes. Over

The PWDs as program owners.

time the former assumes more control and ownership of the program as the latter slowly phases out from the system. At a certain point of time the community and PWDs take full responsibility in managing and sustaining the programs implemented.

4. CBR Strategies

Five distinct strategies are applied in CBR. These are 1) training, 2) working with local people or grassroots, 3) develop self-help groups (SHGs), 4) working with local GO, NGO and PO, and 5) patchwork. The 1st strategy revolves in developing training for trainers and training for users, developing participatory training methodology, and developing training manuals. The 2nd strategy ensures that the community and PWDs are the main responsible as well as resource persons for CBR implementation, set-up CBR cadres, and that programs must be relevant to their needs in accordance to their own resources, culture and values. The 3rd strategy supports to set up SHGs (cross-disability group), empower leadership and group capacity, and role modeling. The 4th strategy is about coordination with local government and related institutions, special bodies for rehabilitation and reconstruction of disaster, working with POs, community health post (posyandu), women organizations, religious organizations and local NGO partners. The 5th strategy works on integrating the CBR programs to existing ones in the community. It aims at making the program cost effective, as it does not need to establish new infrastructure. Finally, it promotes inclusion of disability issues in the mainstream programs.

CBR Steps of Implementation

Steps	By Whom
1. Capacity building of local NGO partners	CBR Center
2. Community awareness	Local NGO Partners
3. Situation analysis	Community, PWDs, Local NGO Partners
4. Definition of the Needs	same
5. Community Organizing	Community
6. Establish SHGs	PWDs
7. Training for CBR Cadres	Local NGO Partners and CBR Center
8. Training for SHGs	same
9. Planning	Community, PWDs facilitated by NGO Partners and CBR Center
10. Program Implementa-tion	same
11. Monitoring and Evaluation	same

5. The CBR Action Programs

It starts from relief work supporting basic daily living such as nutritious food, fresh/clean water, clothes, medicine, kitchen kits, temporary shelter/ simple dormitory, school kits, and books. Community awareness and sensitivity on disability is done to create positive attitude among community members towards PWDs. The training workshop on the impact on Tsunami on vulnerable groups and women for GOs, NGOs, INGOs, POs and related institutions working in Aceh and North Sumatra was organized. It covered capacity building, training management on CBR, approaches and strategies, early detection and intervention, play therapy and trauma healing, leadership and SHG, and income generating and entrepreneurship. The SHG of PWDs holds capacity building, leadership and management, peer counseling, campaign, advocacy and IGPs. These IGPs lead to the development of group entrepreneurship, access for capital, set a revolving fund system and support for marketing of products. Finally, the new building of the Rehabilitation Center with its facilities in YPAC Foundation Aceh was established for medical, educational and psychosocial use and pre-vocational rehabilitation including CBR activities.

Primary Rehabilitation Therapy

6. Lessons learned

CBR can be sustained if it is anchored on existing local culture, wisdom and values; integrated in existing community programs (Patchwork Strategy); local partners and local people work together to continue the programs; various approaches and strategies to facilitate the community are used; training for trainers is developed; SHG are formed and developed; and CBR cadres and volunteers are organized and trained.

***Note:** This article which is based on the CBR Seminar held by the Japanese Society for Rehabilitation of persons with Disabilities (JSRD) on March 8, 2009 in Tokyo, Japan*

- -

Post Tsunami Response Initiatives

Ms. Weliweriya Liyanage Sumika Perera,
CATAW, ILDC 2001

1. Background

The Coalition for Assisting Tsunami Affected Women (CATAW) was established in the immediate aftermath of the tsunami disaster in January 2005. It was by the women's groups and activists, who recognized the urgency of responding to the needs of women in the affected districts. CATAW is an alliance of women's organizations working towards the well being of tsunami-affected women. CATAW consists of 55 women's organizations from four networks of the same that have functioned for about 20 years in various areas of Sri Lanka. The main objectives of CATAW are to identify the specific challenges experienced by tsunami affected women, provide assistance, and advocate at policy making levels for measures and programs against sexual and gender based violence and discrimination. CATAW has worked in seven districts which have been the most affected by the tsunami, namely Ampara, Batticaloa, Galle, Hambantota, Jaffna, Matara, and Trincomalee.

2. Training Workshops Organized by CATAW

Six residential workshops for district female activists who are working with Tsunami affected women were held by CATAW. These workshops focused on how to promote the rights of the Tsunami affected women. In each workshop 20-45 women participated. Participatory Training Methodology was used. Numerous issues of Tsunami affected women emerged in these training workshops such as:

1) Violent conditions they encounter while living in camps and temporary houses and the failure to fulfill their basic requirements.
2) Discrimination against women when redistributing property and land.
3) Health and reproductive health problems.
4) Young woman servants, sexual abuse and forced marriage at very young age.
5) Rape, suicide and murders.
6) Domestic violence and sexual harassments by the husbands and the officers.
7) No voice for women in the process of rehabilitation and reconstruction.
8) No assistance from the government to re-establish their own livelihood.
9) Inability to engage in their livelihood in the areas where they have been forced to live.

After these workshops the district network was established by the women activists of these organizations to promote women's rights. This network is functioning very effectively. Nonetheless, many problems occurred in Trincomalee, Baticoloa, and Ampara districts due to the prevailing war.

3. The Advantages of the Training Workshops

District level female activists became well aware of the problems that the Tsunami affected women have encountered. They focused on influencing the authorities at the district and national levels and encouraging women to seek solutions for their own problems. CATAW has positive results in its advocacy work by providing necessary information to the National, Asian and International organizations.

Women's Day demonstration in Hambanthota organized by Ruhunu Rural Women's Organization, one of CATAW members. Ms. Sumika Perera,3rd person from left.

Documentation Project

CATAW is doing documentation projects in order to document the experiences of women after the tsunami and enabled them to tell their own stories. Also to raise awareness of these issues, sexual and gender based violence, and to lobby and advocate for changes in supporting tsunami affected women and to work towards increasing their safety.

Livelihood Assistance

The objective of providing assistance for livelihoods was to assist tsunami affected women to be financially independent. While most government and other organizations in these areas focused on immediate relief and rehabilitation programs, CATAW recognized that women had special and specific needs and concerns in terms of both social and economic security. Women are required to complete application forms to receive financial assistance in re-establishing livelihood activities they had engaged in prior to the tsunami. Applications for assistance are submitted through women's groups and networks that are linked to CATAW. Applications issued by CATAW need to be completed by each applicant and approved by the related organization.

CATAW has developed criteria for providing economic livelihood assistance, which focused on the most vulnerable groups of women. The main criteria are: 1) Female headed households-families headed by widowed women, due to war or tsunami, and single mothers, 2) Low income earning women, and 3) Women who financially support and take primary responsibility for looking after their families, although their husbands are still living

The CATAW Working Committee assesses each application and allocates funds. Livelihood funds have been disbursed either directly by CATAW to women through the involvement of coordinating organizations, or through district level organizations which belong to one of the networks of CATAW. When funds are distributed by CATAW, the staff visits the district areas and distribute the livelihood funds directly to the applicants. When funds are distributed by district level organizations, CATAW disburses the money to an organization which has agreed to take responsibility for the money and to distribute the funds directly to the women. Agreements are signed by each organization and by each woman applicant.

District level organizations have agreed to prepare reports and monitor the distributed funds. There is also a separate agreement between CATAW and each woman who receives money. Women are encouraged to form small groups to work with, and 20% of the amount of money received by each woman should be invested into a bank account for the group.

After six months of providing livelihood support, women who received funds from CATAW have formed small groups in their villages. These groups have been successful. For example, women in the Galle district who have invested money in fruit stalls have started to deposit their small group funds into bank accounts. Women in the Hambantota district who have received money to produce coir ropes are now working together in small groups to obtain raw materials and sell coir products.

Women who have received livelihood funds are now able to have more control over their economic situation. CATAW has received positive feedback from the women, including comments such as no one except CATAW has given support to 630 women to build up their income which was destroyed by the tsunami. Positive impacts of livelihood assistance for tsunami-affected women are many. For example, Women were able to re-start their economic livelihood activities which were destroyed by the tsunami. Livelihood activities include: poultry farming, selling vegetables, selling fruit, burning (cooking) hoppers, cooking food, fish processing, running small cafes, running boutiques/ small shops, producing coir ropes by hand, making

brooms, selling fish, producing rice, dressmaking, selling textiles, and handicraft work.

The economic status of women has been strengthened through engaging in livelihood activities. Women have been able to establish good social networks through forming groups, and are gaining leadership roles within their families and the wider community. Widowed women with children (female headed households) in particular, have been economically strengthened and are therefore able to better provide for their families, which includes looking after their children's needs.

Previously these women had not received any livelihood assistance. Through the funds received by CATAW, either as donations or as targeted funds from a donor, CATAW has been able to provide financial assistance towards strengthening tsunami-affected women's income earning capabilities.

Women's group attending a meeting.

By consulting with these women on what type of economic activity they would like to do and have the skills to engage in, CATAW has endeavored to provide assistance which women have acknowledged they needed. This has often resulted in women being motivated to also develop wider social networks through their small groups.

Summary of other activities carried out by CATAW

- Issued two observation reports after visiting tsunami-affected areas in January 2005 that were presented to responsible people and authorities in the government including the president. The reports focused on gender-based violence that tsunami-affected women have been subjected to.
- Issued two statements to the press based on those reports in January 2005.
- Involved groups of tsunami-affected women in five radio programs and five television programs representing CATAW from May to August 2005. Specific problems faced by women were presented in those programs. Although those programs were organized by other organizations, including the women and Media Collective, CATAW could provide a major contribution.
- Liaison with TAFREN and presenting related reports to and participating in some meetings and discussions organized by TAFREN.
- Taking part in pressuring activities organized by women and Media Collective and by other such organizations.
- Coordinated training programs to assess the situations that tsunami-affected women experience. Two workshops were held in Colombo and Polonnaruwa. Two women lecturers from the University of New South Wales University, Australia, Dr. Eileen Pittaway and Ms. Linda Bartolomei, conducted those workshops. The training programs were organized by the women and Media Collective and CATAW, and funded by the United Nations population fund (UNFPA)
- A five day Training of Trainers (TOT) was held in Colombo by CATAW, the National Committee on Women (NCW) and UNFPA. CATAW coordinated to include 12 participants who were activists from NGOs at district levels. After the TOT, the participants conducted district level training workshops in two stages. Four-day district level were held to train governmental officers by NCW and UNFPA, and two-day workshops for women activists of NGOs were held by CATAW funded by Austcare. Those training workshops were held from August to October 2005. We identified and assessed the specific problems faced by tsunami-affected women. In each district, women activists from all NGOs of the area participated in the training workshops, which were very successful.
- We have been involved in lobbying and advocacy work through participation in meetings organized by NCW and other organizations. CATAW has presented specific issues and problems experienced by tsunami-affected women at meetings and to various authorities including district secretaries, government officers and Grama Niladhri (village officers)

Note: Press releases in Sri Lanka had been issued in relation to post-tsunami initiatives with special mention to CATAW

AROUND JAPAN

A Challenge for Village Reconstruction and Development with CBR

Ms. Kyoko Shimizu, AHI

On March 10-11, 2009, I visited Izumizaki as one of the participants of the exposure tour to the village held by JANNET, Japan NGO network for Disabilities. Nowadays in this village, various activities for community development are implemented by people with the innovative policy of the mayor being fused to issues with people with disabilities (PWDs). It would be worthy of special mention that the PWDs in this village are confidently working as important actors or providers of development, beyond the recipients or supported persons.

1. Situation of Izumizaki Village

Izumizaki village ranked 2nd worst deficit in Japan. It is in Fukushima prefecture, northern Japan, buried under deep snow in winter. The land area is 35 sq. km with 6,700 people (May 1, 2009). Most of them are farmers and there is no other special industry. The village has a low birthrate (15% is under 15 years old) and a high aging population (20% is over 65 years old). Its income depends on residence tax which is decreasing year by year. Also, there were many useless public works. As a result, the village is buried in debt deeper and deeper but no villagers know. Hideo KOBAYAHI was elected as new village mayor in 2000. He did not know the financial crisis before then at all. He noticed that the debt reached $680 billion, thrice as much as one annual budget. His efforts for the reform and development of his village started at that time.

2. Agenda of the new Mayor

First, Mayor Kobayashi reduced the number of public works for budget cutback. Simple constructions were done by the villagers voluntarily. In order to get their understanding and cooperation, he set a regular meeting with community leaders, disclosed information and shared the problems. On the other hand, he focused on the assistance for the weak, such as aged, child and disability and increased the budget for public service; health, welfare and education. Medical fee was set cheaper than other villages. Health and Welfare Integrated Center and Welfare Center for Disability and Support Center for Child with Disability were opened. Elementary school was rebuilt and some day care centers were added. Yet the village office made of wood is old and has holes that remained as it is.

Mayor Hideo Kobayashi

The Mayor recruited firms and factories to get tax. To increase population, he promoted immigration from urban areas into two new towns in the village. His policy which set high-priority on health and welfare, various festivals and experienced-based events about agriculture, attracted urbanites who are interested in living with nature and security. The mayor went around Tokyo TV stations and got a lot of media exposures to promote tourism in Izumizaki. Today, 500 families (1,500 people) are newcomers and the deficit is reduced to $200 billion.

3. Fusion of Volunteer Spirit from Urban and Traditional Self-help philosophy succeed

Urban newcomers participated in volunteer activities and community programs. Key leaders emerged and suggested ideas for community-based activities initiated by them, and inspired pioneer residents to join (who then welcomed this movement). This is because, in this area, “Yui”, the thoughts and system of self-help in community, still remains. This is a traditional custom of mutual cooperation or exchange labors among neighbors when they plant or harvest rice, have funerals or family celebrations in

families, hold community festivals, and build or maintain facilities which people share (temples, shrines, channel, road). Recently, this custom is disappearing along with modernization and urbanization in most areas in Japan but not Izumizaki.

4. "Kokoron": Inclusion and Mainstreaming of Disabilities in Community Development

Kokoron was founded in 2002 as the first support facility for people with mental disabilities in Izumizaki. It provided job or living support and consultation programs. People in Izumizaki welcomed to build it and many community volunteers supported. *Kokoron* comes from a Japanese word *Kokoro*, which means *heart* in English. There are 60 users now and most of them work for training. Some are in charge of cleaning towels used in a hospital while others work in a horticulture center and at *Kokoro-ya*. *Kokoro-ya* is a direct sales store with a restaurant aiming for safe food and local production for consumption. People buy rice, vegetables, fruits, additive-free seasonings and some processed foods and enjoy lunch here. All products and lunch food ingredients are locally and organically grown, mostly brought "directly" by neighboring farmers and local businessmen. Some products are from other areas which are quality tested & "directly" traded with producers. Only few quantities are brought in the store. When a product is sold out, *Kokoro-ya* contact the producers and they bring it again on the same day. "Face-to-Face" relation between and among producers, sellers, customers, and producers is salient. It is not only a business linkage, but also a communication linkage. In *Kokoro-ya*, PWDs buy and sell the products, cook and serve lunch.

5. Testimonies

"When I started to bring the mushrooms I grow to *Kokoro-ya*, my father was anxious to trade with PWDs", a young mushroom farmer said. "Such prejudice disappeared soon. I realized they can trade and are good business partners. It was usual for me to work with them now." He was an office worker who quit his job and started growing mushrooms with his father a few years ago. Now, he enjoys selling his products to *Kokoro-ya* as he receive response from customers. They energize him to go on and keep high motivation to harvest better. He is so proud that his mushrooms are in the shelves of *Kokoro-ya*. Why? "Because this means my mushroom is certified as excellent quality. *Kokoro-ya* is accredited by the Fukushima prefecture government as a store, which contributes to the development of Fukushima and Izumizaki.

Inside the Kokoro-ya

Kokoro-ya holds producers' meeting twice a year with PWDs who work there. They talk about business, community development, management skill, new business ideas and disability problems. The Forest Recovery Project came from these talks. It is a collaboration project of *Kokoron*, farmers, local association of commerce and industry, and community. They started to crop organic rice to make *sake*, a specialty product here and sold in *Kokoro-ya*. People experience cropping and brewing, work with local farmers and PWDs of *Kokoron* and deepen exchanges among them. This is a chance for people to be in close contact with nature in Izumizaki and raise awareness for forests conservation. People's attitudes for disabilities are changing. A participant of the project who runs an organic store in Tokyo finally welcomed to buy products from *Kokoro-ya*. Last year, *Kokoro-ya's* income was doubled and the number of job finders increased to 5 from 1 in 2003.

"Working is enjoyable", a *Kokoro-ya* PWD staff said. Before, he did not talk to anybody. When he went to another facility for PWDs, he worked in a hospital. "I did not have opportunity to talk with others except the PWDs there". He moved to *Kokoron* and now is able to continue to work as a seller in *Kokoro-ya*. "I knew that I can take my role in *Kokoro-ya* and community and challenge others".

6. Insight

In Izumizaki, PWDs work as important promoters of development. They are not just supported persons, but also supporter for villagers. The villagers are not just supporters for PWDs, but also supported for their better living in the village. This might be a key for sustainable programs.

FLASH ARTICLES

Orphan Vulnerable Children (OVC) Living as Normal Children, Cambodia

Mr. Chea Thy, PLAN International, ILDC 1995

'If we believe in OVC living as normal children, then we help them to enjoy the fulfillment of their basic rights.'

In recent years, in a community in Srei Santhor, Cambodia, there were five young orphans whose parents died of AIDS. Their father passed away first and then the mother did the second. All their money was gone as used for their parents' health care and funerals. Nobody took care of them. Their lives were encountering a lot of difficulties. They were hungry as they had little rice to feed in their daily life. They could not go to school. But two of them went to sell their daily labor for a rich family and got paid very little money, another went on as a beggar to get rice and money, another was at home to take care of their youngest. Day after day, their lives become worsened because what they had got could not fulfill their stomach.

Their situation was very regretful and terrible. A piece of land left by their parents was grabbed by their neighbors. The two of those five children were lured by the middle woman to leave their community to work at the city. The third become street child and walked away without home. The four and the fifth children, as lack of care and support, died of ailments. The local authority and community as the whole were well aware of that particularly miserable issue occurred and they came to take part in the child funeral.

Later on, other parents of a family in the same community also died of AIDS: the husband was away first and his wife followed him after. They left three young children behind. Learning from the above experiences, local authority together with local elders organize supportive activities as they concerned of the children and decided to take some action such as locally collected rice to raise their children, encouraged neighbors to provide care and follow up care for them, linked them with school. As warmly emotional and socio-economic support from community members made, their lives were getting better day after day. More luckily, their land left by their parents was hired by one of their neighbors under the agreement from local authority. Under the eyes of local elders' supports, the local authority made tenure paper on the house and land for the children. The children became to enjoy their lives as they could survive, learn and play with other children in their location.

The above story reflects the valuable community's participation and supportive environment made in helping vulnerable children in one of the rural areas in Cambodia. As learning from the miserable experiences; leaders, elders and community members as key local resource persons took part to support orphans, who were affected by HIV/AIDS, to be able to survive as human being in their community.

The Philippine Integrative Medicine (PIM) Experience as an Indigenous Approach in Building Community Managed Health Programs

Ms. Carmenchu B. Badilla, R.N., INM Philippines, ILDC 2007

After my participation to ILDC, INAM launched its PIM curriculum through a series of Regional PIM Consultations last November 2007. Learning this new concept encouraged NGOs and POs to try this new approach in re-energizing communities and POs to revive and set-up their Community Health Programs that is community-managed through collective action towards the building of their alternative health care systems. Thus PIM training commenced in January 2008 as a response to the invitation of interested NGOs and POs.

1. What is PIM?

INAM's concept of PIM is that it is an awareness, a consciousness of viewing health as a state of total well-being resulting from the interplay of socio-economic, political, ecological and spiritual aspects of life and understanding that health is a fundamental human right and a responsibility of the individual and, collectively, of the community. It is characterized by partnership, being interdependent and mutually transformative of each other. The practice

of PIM is expressed with the values of respect, equality, participation, responsibility, interdependence, solidarity, mutuality and openness. This PIM consciousness adheres to the integration of different systems of medicine based on empirical and scientific knowledge, rooted in the culture of the people. Such an integrated system addresses the health problems in the community through promotive, preventive, curative and rehabilitative services, which are accessible, affordable, available, effective and acceptable to the people.

PIM, as an evolving consciousness, emphasizes the direct, responsible and sustained participation of people in the development of their alternative health care systems, an indicator of the fulfillment of their aspiration for self-determination. And the work ahead can be realized through INAM's partnership with non-government/civil society organizations (NGOs) that assist People's Organizations (POs) and their communities.

This concept was translated into PIM curriculum which serves as a tool for PIM promotion adopting process-driven adult learning which is pro-action and stimulating people to think more deeply for themselves through asking questions that don't have right or wrong answers and motivating people to see the difference that they can make. What are their options? What are their choices?

Within 18 months, INAM through its Advocacy, Research, Networking and Training (ART) department had conducted PIM training levels 1,2 and 3 in 15 provinces nationwide: Luzon-4, Visayas-6; Mindanao-5. This distribution provided a national character to PIM and making PIM take a root towards sustainability. Aside from geographical scope of engagement among partner NGOs, it had also established partnership with two academic institutions with community extension programs, church based health programs, and two local government units (LGU) through its Municipal Health Office. Out of the total 587 participants trained in level 1, 37 of it has evolved community managed health programs in 10 municipalities in the province of Negros Occidental (Visayas). The PIM training had also been experienced among the tri-people: the Muslims, Christians/Settlers and Indigenous Peoples and different groups had been represented; the barangay health workers (government community health volunteers), traditional/indigenous healers, urban and rural based sectors, academe, church-based programs, and NGOs who all validated the PIM relevance in different contexts.

Plenary Workshop in Aklan, Visayas (Menchu standing, right).

2. Effect of PIM Training to the communities

The training challenged their way of thinking and methods of work as health workers, thus, created tangible steps toward changes on their previous approaches in order to gain trust and participation from other community members. As the participants realized how valuable was the training and the process they experienced made them proud, confident and motivated to share to their barangays (communities) what had been learned from the training. There were changes in attitudes and perspectives on planning and managing community conditions/disease and valued the self-learning as something they need for self-development and learned to open up the self more. From the process, they realized the importance for exact information in identifying real community problems using the information gathered from the household survey as basis for their community health plan, learned appropriate approaches on community organizing, realized the importance of health education in understanding the concept of health and diseases and their capacities gained from basic health skills training inspired them to provide health services to their communities, however, realized one's limitations in managing common conditions and which needs doctor's referral. They also realized the maximization of appropriate local resources including the LGU and RHU support, the recognition on the value of cooperation/collective work to pursue tasks and the need for tri-people cooperation to achieve peace in their areas. Aside from learning more appropriate approaches to care for the environment, the process also opened opportunities to strengthen relationship within the family and among families. Interaction of the youth trainees with more adult participants helped bridge experiences among generations.

Such level of people's experience, rekindled their sense of responsibility to fellowmen and their spirit of volunteerism was enhanced to service the majority poor and embraced it as an integral part of oneself. They realized that such spirit shall guide them for better choices to improve their community's quality of life towards the realizations of their dreams through their own approaches.

3. Effect of PIM Training to the NGO/LGU/ Academe/Religious

The PIM process paved the way to revisit their own management practices and approaches for efficiency and effectiveness of their own programs, including community organizing aspects. It provided venue for health professionals to recognize their limitations in community development and shift on new perspectives including key personnel that have extensive experience in community development and realized the need to go through a reorientation process on community work to harmonized approaches. The process facilitated to draw learning on new approaches on educating patients and co-health workers on the efficacy and efficiency of alternative medicine (like the use of herbal medicine, massage and others) as complementary to western medicine and new organizing skills which can motivate people to rely on their capacities and resources for their development. The process also brought to realize the interrelatedness of health to environment and sustainable agriculture, and the realization among the health professional that there are other ways of approaching community conditions that are more appropriate, accessible, acceptable and affordable by the community.

They saw the significance of health education in enhancing the academe's community extension programs and opened opportunities for further collaboration and reorientation of local health care system. And their participation provides opportunities for changing the mindsets of the municipal health office/rural health unit (MHO/RHU) personnel to complement the outcome of the PIM training to their community programs.

4. Effect of PIM Training to the ART Staff

Our level of understanding of the PIM concept reflects our understanding of where we are as development worker and it keeps reminding us at the consciousness level to be mindful of our tendency to slip back to our "old way of thinking".

When we started, our full understanding and integration to the PIM concept is in question and such reality did not qualify us as expert facilitators for PIM training. However, we strongly believe and confident that engaging ourselves in the learning process with the PIM framework as our guide is the key to be effective and efficient facilitators. Strategies adopted were systematic approach to facilitation and team work whose dynamics in every experience is improving until it became more natural and spontaneous. With every experience in facilitating PIM training, we gained more and more confidence as to the mastery of the process and content and have a feel of what to be emphasized in every PIM level and every group (as our recognition to the uniqueness of each group who participated to the training). The experience molded our values and attitudes, developed individual facilitation styles, and deepened the understanding to the PIM concept, thus affirmed the importance of trusting the people, respect for the person, fellow individual and the community and slowly translating and integrating lessons learned in our lives. The activity also served as training ground on how to "pick up" issues on attitudes and values which becoming more conscious of being able to process with the participants, stressing the importance of exact and appropriate information shared, and the need for all participants to be involved in all aspects of the process as an exercise to genuine participation for decision making. In the process we also realized that literacy is not a hindrance in PIM processes to convey messages between the participants and the facilitators as we had experienced among the participants who cannot read and write. The development of the Facilitator's Guide for PIM 1, 2 and 3 in conducting the training was translated from our experiences.

5. What is at stake of integrating PIM in our lives?

The PIM concept is holistic and shapes values of an individual, the family and the community which can be translated into principles that will guide us to live harmoniously with our environment. However, fully understanding the concept can only be realized by continuously engaging in its process and by translating this in our lives.

In the community context, PIM can be a seed to help the people develop and evolve their own Alternative Health Care System, a sustainable and people-driven through their collective efforts. When people are willing to come together to change their situation, their collective experiences in their health program empowers them in managing change.

HERE AND THERE

Rediscovery of Indian Friends

Mr. Taka Nakashima, AHI

Study tour member talks to the SHG.

"Namaskar! Namaskar! Where are you now?" Over the mobile phone, the shout of Oriya accent English came into my ear. It was in the bus on the way to Deenabandu village. The owner of the voice was Narendra Kumar Biswas who participated in ILDC 1988. At that time, he was 25 years old, and had been working as NGO worker in Calcutta for three years since graduation at a University. There was an unforgettable incidence for me during his participation to ILDC. When Dr. Ishikawa, the resource person, showed his South Asian map, Narendra insisted that the map was wrong because Kashimir's border was drawn based on Pakistan government's claim, and he got out from the session room. He used to be a member of Hindu Nationalists Party until before coming to Japan. He has a critical mind that he even criticized the overall facilitator's analysis.

After ILDC, he worked for the Asian Network for Innovative Training and Research (ANITRA) Trust and the Asian Community Health Action Network (ACHAN) until 1998. Afterwards, he went back to his home village in Orissa state, and established a middle school to educate boys and girls in his community and managed it well. In April 2006, Dr. Hari John, the founder of ANITRA, called him back to manage the field office in Deenabandu village.

I, myself, was an alumnus of the AHI-Deenabandu Training in 1988, and felt Deenabandu as my second home. Therefore, I grew the hope to return to Deenabandu again and see my old friends,especially Narendra, and witness the changes in India where there has been rapid economic and social development. In the window of our bus to Deenabandu, in-between the green banyan trees along the road, various sceneries came in and went away such as, red color soil of Indian subcontinent spreading on the earth, workers building up bricks, herds of cows or goats walking on the road and farmers harvesting groundnuts. We could see the changes due to economic development, such as Korean Automobile factory, estates for sales for middle classes, widened highway with branded cars. As we arrived at the Deenabandu Training Center, Dr. Hari and Prem John and Narendra with other staff welcomed us warmly, and firmly shake hands with happiness to re-union with my admirable old friends after 10 years.

At the welcome ceremony, ANITRA field workers showed us the popular theater and Dalit liberation songs, which were presented yearly for awareness raising among 60,000 Dalits & tribal people in 262 villages in 2 districts. Dalit is a group of oppressed/ disadvantaged people traditionally regarded as "untouchables" or scheduled caste. This popular theater is one of the programs improved and enhanced by Narendra. After his taking over the management of the ANITRA field office, he increased the number of the field workers and other staff to 50, and extended the activities in additional 190 villages.

AHI hospital staff (center), study tour.

They do Right Based Approach with activities like training, organizing different sectors (landless, tribal

people, TBAs, Women, Youth), PO formation, networking among NGOs & POs and advocacy. As we dialogue with the Self-Help Groups (SHG), they expressed how they became more equal in partnership with their husbands, or how they could plan for their own families and SHGs. They even could demand their local governments to get services.

Though Narendra, himself, belonged to higher caste, he fought against exploitation and oppression against Caste discrimination by taking side of Dalit and tribal people. He facilitated larger process of changes among those weaker sections of Indian society through teamwork with his subordinates, who were Dalit Christians despite different Castes and religions. When I interviewed Narendra about his participation to ILDC, he said, "Before participating ILDC-Japan, my view was limited in my village in Orissa. Though it became expanded to the world after ILDC. When I came back to India, birthday cards and AHI newsletters always kept in touch with me and reminded me of my learning in ILDC. Once those communications were cut when I came back to home village, but I borrowed the AHI newsletters from my friends in the next state." His supervisor shared with us that he concentrated to prepare for the AHI study tour for last three months.

Narenda (left) & study tour member (right).

He used to be a Hindu Nationalist, however, he has been supporting the liberation movement and activities by the Dalit and tribal people in order to regain human rights and dignities. On top of these good news for me, the happiest thing was he became AHI supporters together with other eight staff. He said the membership fee like US$30 per year was not a heavy burden for NGO workers in India. This trip gave me a special opportunity to rediscover his deep sense of trust and friendship with AHI.

NEWS FROM FRIENDS

AFGHANISTAN
Dr. Said Habib Arwal, Ministry of Public Health
Community Based Health Care, ILDC 2008

Community Health Workers National Day

We are doing well with our activities (planned and unplanned). My main activities after returning from Japan was conducting first Women Action Group workshop. All Kabul NGOs and UN agencies women representative attended this workshop which I have chaired. Action Plan for the next steps of women action group is going on very well. We conducted different training for 400 Community Health Supervisors in all country especially on Post Partum Family Planning. This was first time to be approved by government Community Health Workers National Day. On May 21st we celebrated National CHW's day all over the country. Recently I have started the plan for Community Based Initiative program of the World Health Organization under stewardship role of Community Based Health Care Department of the Ministry of Public Health, which is my department.

BANGLADESH
AKM Abul Kashem, Bikrampur Legal Aid Organization (BLAO), ILDC 1992

I participated in ILDC of AHI in 1992. Since then I have been rendering my services for promoting the Peoples Health Movement (PHM) with the rural and

urban poor. I use role plays, folk songs, campaigns, posters, billboards, and publications. I also provide consultancy services to other grassroots movements and network partners for upholding the HEALTH RIGHTS issues of the helpless and destitute people.

I never forget AHI's friendly hospitality and beautiful atmosphere during the ILDC 1992. Thanks to AHI friends for remembering me through AHI Newsletters and birthday greeting cards, which reminded me of my memories at AHI. I had remarkable days during the ILDC with which the last day was culminated by a festival. This was really unique to recreate new sensation and beautiful lives. I cannot forget the people whom I am very grateful especially to Mr. Ikezumi, Mr. Taka, House Mother and others. But I am extremely sorry to see the Sayonara Massage by Mayumi Yamazaki.

Mayumi-san is a very good friend of mine. She is one of the pioneers of AHI. Her smile and behavior for open hearted cooperation and style of animation inspired the participants to share and learn some empowerment related issues. I want to thank Dr. Hiromi Kawahara for his leadership in AHI for the past decades.

PHILIPPINES
Ms. Maria Welsita Fuerzas-Flores
Freelance Consultant, ILDC 1999

You never stop caring and sending greeting cards and copies of the AHI newsletter. I have been through the different projects, places and meet different people, yet you are the best people I have ever met, the kind heart and love for the people in need of true development and genuine service. You at AHI, made me humble and fortunate to be part of your program, the ILDC. My work now reminded me most of what I have learned from ILDC.

I am now working as a Consultant on health advocacy and legislation, helping the Local Government Units of Compostela Valley province in the implementation of Family Health Book. The Family Health Book (FHB) - a behavior change communication package designed to improve family health by increasing utilization of a critical set of family planning and Maternal Neonatal Child Health and Nutrition (MNCHN) services. The FHB provides information to families in a way that allows them to understand and recognize health risks, determine the services needed to address such risks, and plan for the eventual utilization and financing of such services. This covers the conduct of an FHB operations research which aims to generate evidence for determining which features of the initiative effectively contribute to intended MNCHN outcomes, guiding the finalization of its design and the development of operational guidelines for possible FHB rollout. It involves the following major intervention areas: the Family Health book and the navigator's kit, the navigators, support to Philhealth enrollment, assistance to facilitate Philhealth accreditation, emergency transport and communications network, outreach programs, support to Compostela Valley Provincial Hospital as well as monitoring and evaluation. Philhealth is the national health insurance scheme in the Philippines.

PHILIPPINES
Mr. Zaldy Oroyo Abainza, Child Sponsorship for Community Development, ILDC 1987

Reading the names and addresses of my classmates brought me good memories back to 1987, which is 22 years ago. Wow! I remember a comrade of yours, a Japanese guy whom I showed a piece of paper at the Tokyo Train station indicating instruction in Japanese character that I need to get to the train to Nagoya. This guy who never spoke any English brought me to the station, escorted me with my heavy luggage and boarded the train with me to Nagoya. Along the way, he would make signals (gestures) to me to check if I am OK, if I am hungry and from his signals, I could understand that he was telling me that it will still be a long way. While in the train, I showed him another instruction, which tells about the address of AHI, the contact person and the telephone number.

When we got off the train, he made a phone call and in 15 minutes Kiemi showed up. Later I learned that he was north bound (Sapporo side) but for fear that I may get lost, he accompanied me to Nagoya. I cannot thank him enough when we parted ways. He was indeed a Good Samaritan.

This experience which I think an encounter with God had changed a whole lot of my faith especially when traveling and I know that God is always with me and that I shall always be kind, accommodating and helpful to every foreigner or to anyone wherever I may be. This experience I have "paid forward" to over a 100 travelers in the Philippines and elsewhere.

PHILIPPINES
Ms. Aida Conception Ishikawa, ILDC 1980

Thanks so much for your birthday greetings! I was one of your first students. I was with Ramon Castaneda when we learned Acupuncture in the clinic of Dr. Kurono in 1980. Dr. and Dr. Kawahara hosted us in Hara Hospital. At that time, there was no AHI building yet. I treasured that moment of learning acupuncture and at the same time, I met with Japanese organizations which are involved in the campaign to boycott bananas from the Philippines in support of banana plantation workers in Mindanao who are victims of chemical pesticides, and issues on poverty as reflected in the case of sugarcane plantation workers in Negros. I felt the real meaning of solidarity between the Filipinos and the Japanese people. In the hospital, I was able to witness the actual operation by Dr. Hiromi Kawahara. I felt the warm reception of the staff in the hospital and in the clinic where we had the training. Dr. Kurono and Dr. Kagami shared with us their knowledge in acupuncture. We also had a tour in the clinic where "shiatsu" was being practiced.

This experience has challenged me to commit myself in development work although not with health organization but with disaster response organization called CONCERN. CONCERN stands for Center for Emergency Aid and Rehabilitation. Here we give services in the form of relief delivery operations, medical missions with the support from health organizations during disaster events, for example, flood, landslides and eruptions like Mt. Pinatubo. We render training on disaster preparedness to minimize its effects. Following these training, we form grassroots machineries for self-help initiatives at the community level. We facilitate funding of rehabilitation projects such as provision of irrigation facilities for farmers, seeds dispersal and other livelihood programs. We support community based health programs where preventive aspect of health care is given premium attention more than the curative ones.

The communities are the ones doing the planning how to deal with different types of disasters. Information dissemination, advocacy addressed to the government's giving priority to disaster preparedness and response, resource mobilization are basic components of disaster response work where the principle of empowerment of the victims is at the core of our services. The grassroots formations enable the organized victims capable of planning and deciding for themselves how they respond to the disasters to come.

INDONESIA
Mr. Yahya Wardoyo, Facilitator of ILDC 1992
Ms. Esther Wardoyo, ILDC 1990

Here are some of our activities in Indonesia. Concerning our Elders Group, we started it by training some cadres from 15 congregations of Indonesian Christian Churches in Purwokerto area. On average, each congregation has some 30-100 elders who are in our scope of work. We asked them to delegate at least four cadres per congregation to be sent to Klampok (my home) for training. Then we expect they can return to their congregation and start their own activities for the elders.

The training includes, 1) how to organize, plan, and evaluate, 2) essential knowledge concerning old age, like problems related to health, psychological, physical, mental, and social, and how to cope with those problems, 3) practical knowledge on taking measurement and monitoring height and weight and how to solve the problem of overweight (and underweight, but we don't have any), 4) how to take blood pressure and giving advice for those who are hypertensive, 5) checking blood sugar level and protein in urine, 6) practical knowledge on how to prevent dementia, through brain training and brain gym, 7) practical techniques on physical exercises like aerobic training, weight bearing, stretching, 8) very simple health care, 9) funny games, ice breakers and jokes that can bring joy and refreshment for the elders.

So far we had trained some 60 cadres, and this year we are about to make evaluation on how well they had done in their own congregation. Besides within congregations, we also activate elders organization in the villages around our area (Klampok). We had eight villages in one district, and every village is to send at least four cadres so they can start their own programs for the leaders in their villages. Once a month we hold meetings with the cadres to refresh and encourage them. This is also a sort of psychological reward for them because they do these programs voluntarily.

We also introduce some simple techniques like how to make soybean milk, virgin coconut oil, snacks and so on. Some of the elders even started their own small groups to make soybean milk as well as virgin coconut oil and sell them through some small shops around Klampok.

These small livelihood activities are very helpful in their day-to-day living and at the same time boost their self-confidence.

INDONESIA
Ms. Yuli Veronica, INTI-YOGYA

(*Yuli Veronica (seated upper left corner, photo) is an architect. She has helped INTI in educating the people to build healthy house and good sanitation. Good sanitation can prevent contagious diseases like dengue fever. A healthy house is a house which is earthquake resistant.)*

I would like to share one of the success stories we have. It is about "Burikan". Burikan was a sub-village (dusun) in the rural area of Sleman District, Yogyakarta Province, Indonesia. It has a population of 775 people of which men and more than women. The annual population growth rate is 20 of which 80 are under five years old. Most people are educated; elementary and high school education. Besides health program and some training programs, the local government as well implemented Arisan (a women organization for collecting money and giving industry to increase the family income), and JPS (Jaringan Pengaman Sosial or Social Safety Network). The people's sources of living are fishery (fish for eating, and pet (koi, gold fish, and louhan), animal husbandry (sheep, goat and cow), and agriculture (rice, coconut and fruits).

Burikan was financially assisted by the Asian Health Institute (AHI) through INTI-YOGYA in health services provision. The health services of Burikan has been delivered to 775 people since March 2008. Burikan was chosen because there are about 100 aged people (60 years old and above) with no income; the there are 44 families who are considered poor and have received direct support from the government; and over 50 old people needed medical assistance due to their chronic diseases such as hypertension and diabetes.

The Asian Health Institute has supported the free medical service which was held once a month by the medical team of INTI-YOGYA from march 2008 to January 2009. The money donated by AHI was used to buy medicines, re-agents for blood sugar tests and transportation. The team consisted of two medical doctors, one nurse, one midwifery student, one laboratory worker and team of pharmacists from the University of Sanata Dharma, Yogyakarta. Some student from moslem universities such as Muhamadiy sometimes helped our program in Kuliah kerjah Nyata.

Our activities include free medical treatment, free acupuncture and other complementary treatment such as massage and pranic healing, free blood sugar test, health and nutrition education and healthy house and sanitation including how to build houses which are earthquake resistant.

After january 2009, the financial support from AHI has finished, but the health post still continued to provide free medical services. At present the pharmaceutical school of Sanata Dharma provides the professionals (doctors and pharmacists) and medicines while the people of Burikan and their leaders provide some volunteers (nurses, laboratory assistants and some health workers) in addition to the place and equipments needed for performing the health post. The health post is now used by the pharmaceutical school of Sanata Dharma for their students' field practice.

During the medical service which was attended by the dean of the pharmaceutical schools and some lecturers, we conducted education on diabetes, examined old patients and dispensed medicine. Dr. Andry Hartono examined the patients and prescribed medicines. Pak Joko, our laboratory assistant and a volunteer from Burikan, checked the blood sugar of patients and bu Woro, a nurse, volunteer from Burikan, measured the blood pressure. The free medical services is carried out at least once a month.

These activities created many good opportunities for the village people as well the supporters.

INDIA

Ms. S. Annapurna, Community Development Centre, ILDC 1993

S. Annapurna receiving her award.

I am glad to share the good news of my National Award on Environment. The content of the citation award is stated as; "The Indira Gandhi Paryavaran Puraskar, 2006 Individual Category, Rs. 2.00 lakhs plus silver Lotus is being awarded to Smt. S. Annapurna in recognition of her outstanding contribution to environmental conservation and awareness generation in Vizianagaram district of Andhra Pradesh. Smt. S. Annapurna, born on 23rd of December, 1964, is founder of the "Community Development Centre", which has done remarkable work in the tribal areas of Vizianagaram district of Andhra Pradesh by providing smokeless chullahs, raising plantations and undertaking watershed development programs with public participation. This has resulted in environmental protection coupled with social upliftment of the tribal community.

SRI LANKA

Mr. Ashoka Kumara Karunarathne, Institute of Community Health Care, ILDC 2006

I am happy to introduce my book "Perani Gorithene Asiri-Siri" (Splendour of Ancient Cultivation). The book is about traditional paddy cultivation in Sri Lanka. Through the knowledge and experience I gained from ILDC course, I hope to help the poor by developing their primary health care.

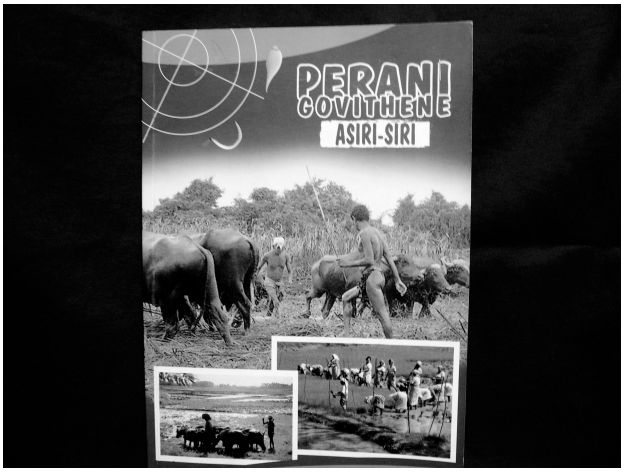
The following was written by Sri Lal Nishantha Hettiarachchi of Sri Lanka Wild Life Trust.

"Splendour of Ancient Cultivation"

"Sri Lanka is famous for its agriculture system in the world. Rice has been exported from Sri Lanka in the periods of Kings. The ancient man had an expert knowledge to cultivate their lands in eco-friendly manner. This book written by Ashoka Kumara Karunarathna has included all aspects of practical, scientific and theoretical knowledge of eco-friendly agriculture system prevailing in Sri Lanka.

He was born in Horadorawwa Village in Haputale and joined the Ayurveda Department after completion of his primary and secondary education. Now he works as a research assistant in the same department.

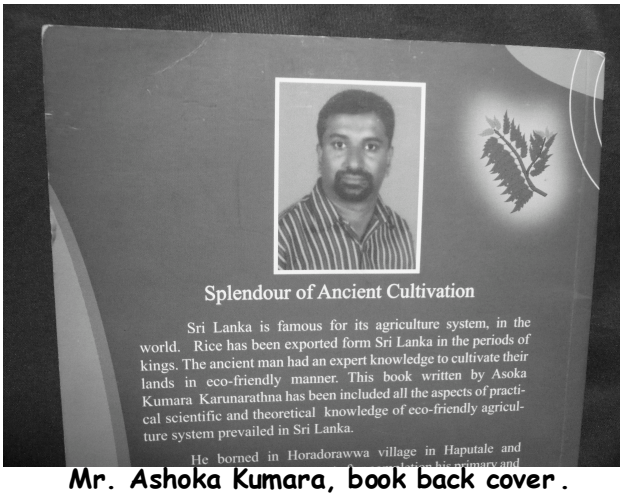
It is a great service to document this valuable knowledge, as they are in danger of extinction due to complicated problems of industrialization in the present day society. Not only the ancient methods but the research findings he has included in this book. The book highlights the ancient properties of agriculture which is diminishing.



The book of Mr. Ashoka

In the Inter-Introduction of this book (above), Piyal Marasinghe wrote,"I am glad that there appear a few examples in this book which explain the way our ancestors, with collective feeling, agreed with the stanzas from "Karaniya Metta Sutta" (Buddhist Incantation) to save cultivation from pest. The meaning of two stanzas are "May all, far away, be in happiness and comfort". Our ancestors, with the knowledge they acquired by peaceful living without being harmful even to an insect and adhering in action to the meaning of the stanzas were wise enough to save cultivation from attack by pest. Today the system of saving cultivation from attack by pest is entirely different. The present day farmer has

acquired a habit of the quantity of insecticide used in recent times one cannot think that even a single insect could be living. What has happened now is entirely different. Attack by pest is on the increase and we realize how best suited was the system adopted customarily by us to save cultivation from pest through practicing kindness to insects. A list containing the names of the varieties of paddy appear in this book. It is due to our misfortune that those varieties are only limited to books.



Mr. Ashoka Kumara, book back cover.

This has happened as a result of the introduction of "Agriculture" over the "customary cultivation" and thereby our children will not get a chance of seeing those various varieties of grains or feel the taste.

But one day or other, our Sri Lankans will realize the importance of adhering to customs and observances relating to cultivation. On that day, undoubtedly not only the farmers but also the learned people of this country will realize how worthy, a book of this type will be.

The value of this book is more and more enhanced through the attraction derived by its contents. When looking through this angle, it can be graded as one of high quality. There appear songs and poems in this book which are sung in the field or in the threshing floor in sweet melody. All that confirms my grading.

If you are interested to buy this useful and practical book, please contact Mr. Kumara by email, karuashoka@yahoo.com.

CALL FOR ARTICLES

We are calling for articles that would be in line with the topics or themes written below. In case you are interested in writing an article but is not in line with these themes, please do not hesitate to contact us for consideration. We are very flexible.

Please **SUBMIT YOUR ARTICLES ON OR BEFORE October 30, 2009.**

- **HEALTH ADVOCACY (New, for NL#85, April 2010)**
- Local Health Board/Local Health Committee or Local Special Bodies
- The Effects of Global Economic Crisis to Community Health & Development
- Children Development Program
- Trends in Development and Self-Help Supporting Groups
- Indigenous Approaches and Mechanisms for Collective Community Action
- Alternative Approaches to Agriculture
- Re-energizing People's Organizations and Expanding their Relevance to Health and Development

IMPORTANT REMINDER!

Kindly follow the following:

1.) Font Style: New Times Roman
2.) Font Size: 11
3.) No indent
4.) single space
5.) No special effects, ex. font style, color
6.) **Photos: JPEG format, color grayscale, write short caption**, email together with your article.

ATTENTION: ALL AHI ALUMNI

1. Call for By Country AHI Reunion Seminar

Do you want to meet and build network with other AHI alumni in your country? Do you wish to continue learning and sharing experiences among AHI alumni? Then, WHY NOT YOU plan and organize a reunion seminar?

AHI will support initiatives from the alumni who are willing to take organizing roles for your country or area (if the whole country is too big to cover). You can send a proposal with concrete plan to AHI by yourself or together with a few other alumni you know as a group.

Example, in Cambodia, three alumni reunion seminars were organized by a group of AHI alumni (about 5-6 persons) with support from the National Center for Health Promotion. In each gathering, more than one AHI personnel attended. The first one was a 3-day sharing of experiences in 1999, including an input session on aid and globalization issue in Cambodia by a guest speaker, and 2-day field visits to some alumni. The second one was in 2005, a 3-day discussion on how to promote community participation in health in decentralization trends. The last one was a one-day meeting in 2008, sharing updated information and work experiences to one another. Styles, scales, and program vary. The plans were made and disseminated to the alumni a few months in advance which allowed many participants to attend.

If you wish to be an organizer, please send your tentative plan/idea to AHI. If you need some information about the alumni in your country/area (total number and a names), please let us know. There is no deadline for proposal, and it is up to you when (but please avoid AHI's busiest September-October period) and how you want to organize. Waiting for your inquiry and concrete proposal!

2. Join the National Health Assembly 2009 in Thailand

The Thai government decided to increase the budget for the universal health insurance by 10%, even though the overall public budget was to be cut by 13%! How could it be possible at the time of global economic crisis?

Thailand has been taking steady steps toward "healthy public policies" (not a sole good health policy, but making other public policies incorporating health aspect consciously) since 2000 involving various sectors and civil society. In December 2008, the National Health Assembly got an official status. See http://www.samatcha.org/. NHA is a movement toward participatory democracy with health as a concrete cross-cutting issue. In the core of such movement, there are several AHI alumni who lead the Assembly. Do you want to learn how AHI alumni in Thailand and their partners are working on this? AHI in collaboration with National Health Commission Office are happy to invite two interested AHI alumni to NHA 2009 which will be held in December 16-18 in Bangkok. Do you want to observe and learn from this exciting Thai experience? Fill out **the application form downloaded from the AHI website and send to AHI on time!**

Date of Visit to Thailand: December 15-19 plus a few days for extra programs

Eligible AHI Alumni for Application:
1) Currently actively involved in health advocacy and/or policy making process at either local or national level
2) A part of network for health advocacy and can share insights/learnings from Thailand through the network after return.
3) Make a brief report on insights, learning, comments in English and submit to AHI and National Health Commission Office of Thailand.

Financial Sharing Condition:
1) AHI: economy return flight ticket cost
2) National Health Commission Office of Thailand: hotel and accommodation, program related expenses, transportation within Thailand
3) AHI alumni: expenses within own country such as passport fee, entry visa to Thailand, airport tax in own country, transportation to/from nearest international airport. Most of the meals and refreshments are included as part of the program. One or two meals during free time, alumni may need to pay by themselves.

Deadline for application: October 20, 2009