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AHI After 30 Years and Onwards

More than 120 participants crowded into AHI's training room to celebrate the organization's 30th Anniversary, at a gathering held on 11 December 2010. The event was moderated by AHI's T-shirt gang, the Open House volunteer organizing committee, and began with their own musical performance.

After opening remarks by founder Kawahara Hiromi, the day's main event, a panel discussion by Ms. Hari John of Tamil Nadu, India, and the Japanese high school students who participated in AHI's south India study tour in 2010.

More than forty years ago, Hari John, with her husband Prem John, opened a clinic in a rural area of Tamil Nadu. However, they soon realized that for the poor residents, health education to prevent illness was more important. They closed the clinic and dedicated themselves to training community health volunteers. In the discussion at AHI, Hari John spoke about this beginning and her 40 odd years of experience. Meanwhile, the Japanese high school students spoke about their visit to Hari John's area of India, and how the experience changed their life views and future plans.

In the second half of the program, AHI alumni from around Asia ***(continued on page 2)***

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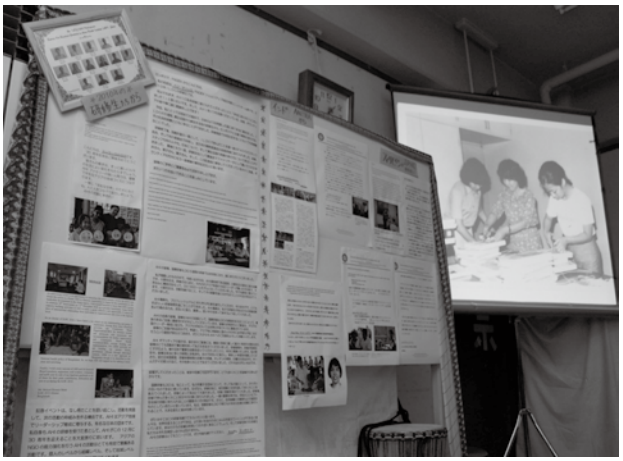
gave video messages on how they are applying their AHI learnings in their current activities. Through the event, old and young, newcomers to AHI and 30-year veteran supporters were able to come together and share their perspectives on community health in Asia.



Messages from AHI alumni exhibited.

Partnership for Inclusive Health and Development
General Secretary Ms. Kagumi Hayashi on AHI's Mission at 30 Years

AHI's Invisible Financial Supporters Voice Their Concerns

Ms. Kagumi Hayashi

AHI alumni may forget the names of AHI staff members, but they rarely forget their host family's name! They deeply appreciate being included in a Japanese family throughout their stay. And AHI volunteers gain great pleasure from assisting participants during the course. Yet there are many more AHI members who, although they do not meet course participants face to face, provide the necessary financial support to sustain AHI's work. As of February 2011, even in the current economic recession, around 4,500 individuals and organizations provide regular financial contributions.

In April 2010, we conducted a postal questionnaire survey to all these financial supporters, focusing on four main areas. First was how they came across AHI and why they began their financial support. Second was feedback on AHI's publications such as the bimonthly members' newsletter. Third was about how they would like to be involved with AHI's activities. Finally, respondents were also asked to give their general comments and suggestions about AHI.

There was an excellent rate of response (almost 20%), indicating the supporters' great concern for AHI and its work, and the data gained is invaluable. However, as general secretary, charged with reviewing AHI's general mission during this 30th anniversary year, I was especially struck by respondents' comments on AHI's role given global changes since 1980. In particular, two common challenges from the supporters stuck in my mind. First, now, as a continent, Africa has more dire needs than Asia, and Japan is also in decline, so why not shift geographical focus? Second, Asian countries have developed tremendously, so isn't it time for partnership not assistance? I'll explain the questions a little more clearly before discussing my conclusions.

Why Asia? What About Mutual Partnership?

The first comment was, why should AHI continue to focus on Asia? It is a sensible question. Certainly, although there is also great need in Asia, nowadays Africa is the continent with the highest rates of poverty and worst health indicators, and poverty is also on the rise in Japan. Besides, AHI's Japanese supporter base is shrinking, and expanding to Africa or within Japan might improve AHI's financial sustainability.

The second comment was, "Isn't it time for more equal partnership?" Some supporters feel keenly that given the expertise and increased wealth in Asia, it is no longer appropriate for Japanese citizens to be giving one way financial and technical support. Financial support for empowerment could also come from wealthy citizens of other Asian countries and through fairer national governance. Technical support should be facilitated through sharing among equal partners.

AHI's Strength---Alumni Networks

After thinking together with the AHI community, I reached a few provisional conclusions, as follows. Most importantly, I came again to the clear understanding that AHI's strength is its network of partner organizations, alumni, and supporters. Given

AHI's limited resources, it must make strategic use of this strength to contribute to global society. Its most effective strategy is not going out to find new markets for its participatory training approach, but working with and supporting the efforts of these partners.

When Training Ends, Partnership Begins

In fact, the "Why Asia?" question led me to a new understanding of the role of training programs in AHI's overall mission of supporting inclusive, fair community health and development. That is, the training programs are like a special courting period, an opportunity for participants and AHI to initiate new networks for future collaboration. The litmus test of a training institute's capacity is after the training ends, because that is when participants go home and more equal relations begin. Post-Open House is the start of long-term partnership.

The 3 Step program also led me to this revised understanding of AHI's mission and strategies as it turns thirty. This program encouraged alumni to analyze their activities as a basis for identifying possible further technical and financial collaboration with AHI. One of the former participant who started the collaboration with AHI, for example, documented the effective village health groups his organization had fostered. Through this, he identified the promising strategy of linking these groups in a formal network with local health centers and village government in Cambodia. AHI was able to serve as a partner to discuss and offer the financial support necessary for a small-scale pilot project. If this project goes well, the organization can apply to funding agencies to cover a larger area. AHI can play a valuable role as a trustworthy partner for training course alumni and their organizations.

Asia---Where Our Partners Are

In fact, providing this small-scale funding for field activities meant a departure from AHI's principle of giving "people, not money," and initially AHI's trustees hesitated. They agreed to go ahead because it would be a valuable new opportunity for AHI to learn new ways to collaborate with alumni. That is, they felt that AHI's role is no longer just producing more ILDC alumni, but responding to them as partners with valid proposals for community health and development.

So my answer to "Why Asia?" "Because that's where our partners are." As AHI enters its fourth decade, its role is to collaborate with its partners, particularly our alumni from throughout Asia.

My Gratitude

Dr. Hiromi Kawahara
Founder and Emeritus Chairperson of the Board of AHI

The Asian Health Institute (AHI) was established in December 1980, as a training institute for workers in the field of health and development in Asia. Based at Nisshin, Aichi, Japan, it started inviting middle level health workers from various parts of Asia. According to the point of view that high level people had more chances to learn in developed countries invited through governmental channel, it was decided at AHI to receive middle level people putting more emphasis on private sectors.

Since AHI was almost the first organization of this sort in Japan, it had to discover the way by its own efforts.

Fortunately in early 1980's, there was some tendency to use community health rather than clinical medicine as a tool in the world of international health. There may have been an influence from "Alma Ata Declarations in 1978.

Been invited by Dr. Prem C. John of South India to join a discussion meeting of starting a spick-and-span group, which works for networking NGO health sectors in various parts of Asia. It was certainly lucky for the early time of AHI to meet international leaders of this sector. Learning from these people as well as training participants from Asian communities, AHI soon was able to establish a new type of training- Participatory Training Methodology (PTM) as a basic concept.

"Gratitude" is the only word I may use now at the 30th anniversary of AHI as its founder. It is grateful to its supporters many of whom have continuously been donating to AHI during these years. It is grateful to former participants many of whom are still communicating with AHI reporting such wonderful and influential work to help people in communities in various parts of Asia. And as a matter of course, I am thankful to the Lord who guided and protected us through the work of AHI.

At this time, it would also be my task to touch upon my dreams on AHI in its future. As it is generally figured, socio-economic situation of the world and also of Japan are now entirely different from the ones in 1980's. Recent vital statistics of Japan shows that people over 65 are 22.7 % whereas under 15 are 13.3 % of total population. (They were 5.7 % and 30 % in 1960). These changes resulted in a decrease of working population and also in an innovation especially among many young people in Japan.

One proposition on programs of AHI in the near future might be to receive more Japanese young people as participants of the training courses, especially in the ones outside of Japan. People from Japan would be able to learn from the situation in other Asian countries of many varieties, and also to understand how to live and work together with others in and out of their own country.

AHI is a means by which people living in Asia bond together and establish a strong link to promote healthier communities. My sincere prayers to all AHI friends and supporters.

AHI: Three decades of dedication for better health and development together with its partners in Asia
Ms. Hari John, Tamil Nadu, India

Synergy, the working together of two individuals for greater effect; when one plus one is not merely two but four, or six or eight or many folds.

Ms. Hari John

"Short case stories of Deenabandu presented in this article are to show the reality of the people who are in a way reflective of those Asian countries which AHI is actively cooperating with. And that these people's indigenous knowledge is an important substance to achieve a self-sustaining health care, thus, AHI aimed for."

1. Looking Back

Sometime in 1979, Prem John, my husband, went to Japan and Korea to explore the possibility of forming a network of community health practitioners in Asia. I went to the Philippines and Ms. Susan Rifkin to India on the same task. At that time Dr. Kawahara took Prem to the area in Aichi where the Dairy Farm is to show the grass covered field where he was planning to build AHI.

During the ceremonial lecture of Ms. Hari John, December 12, 2010.

In 1980 both AHI and ACHAN (Asian Community Health Action Network) were formed. Our relationship too started then. Actually it began when Mr. Masaichi Yamashita, the first general secretary of AHI, then with the Christian Conference of Asia (CCA), attended a meeting of community health practitioners convened by CCA in Bombay where he met Prem and got to know him. This relationship flourished after Prem went to Cambodia and spent time with Mr. Yamashita when he was posted there.

Our partnership deepened when Dr. Kawahara representing East Asia and I, representing India, served together in the Christian Medical Commission (CMC) of the World Council of Churches , Geneva.

Besides CMC meetings in Geneva, we met in several other meetings of CMC in various parts of the world and I came to know the simplicity and humility of Dr. Kawahara and his vision for the poor of Asia and developed a deep respect and affection for him. He was genuinely concerned about the growing western influence in Japan, the slow erosion of basic oriental values such as love, concern, sharing, trust and confidence in each other. He wanted to strengthen the bonds between people of Asia. His unambiguous focus was on the poor, *Putting the last, first.*

His concern was the scarcity of people and programs practicing community health focused on the poor of Asia which he saw when he served in Nepal. It led to the Sub-Regional training program.

It was my privilege to be one of the trainers in 1981 and 1982, in the first and second mid-level workers training held in Aichi. I expressed the view then that the trainees need to be exposed to the reality of the poor which could not be done in Japan. AHI acceded to this request and went into joint partnership with Deenabandu and later ANITRA. This brought us together even more closer in spirit and in action. Together we did this program from 1982 to 1998. Today, having trained around 400 mid-level workers from around Asia in this program – from India, Bangladesh, Nepal, Sri Lanka, Bhutan, Thailand, Cambodia, Vietnam, Indonesia, Malaysia and even from Japan and the US, through this sub-regional program, Dr. Kawahara's plan of producing leaders has borne fruit. Many of our trainees are now leaders and decision makers. In one of the annual sessions of the World Health Assembly in Geneva, a young man approached me asking if I recognized him and told me that he was a trainee in a sub-regional program of AHI and Deenabandu and that he is now the vice-minister for health in Cambodia! The Sri Lankan delegation too had a person trained in this program.

From left to right: Mr. Prem John, Ms. UI Shiori, AHI, Ms. Hari John, Mr. Takahiro Nakashima, AHI, during the ceremonial lecture, December 12, 2010, Nagoya City.

Dr. Kawahara became the Chairperson of ACHAN and Prem was the Coordinator. This gave us many opportunities to meet him, Dr. Satoko Kawahara (Dr. Kawahara's wife), and Mr. Yamashita of revered memory, Mr. Ikezumi and others and discussed matters of mutual interest in meetings and training programs all over Asia.

We believe that the synergy that came about between AHI and us has created a movement in Asia and in partnership with People's Health Movement, around the globe now. Dr. Kawahara's dream therefore has become a reality.

We want to express our gratitude to Dr. Kawahara, and the staff of AHI for giving us the opportunity of being part of their vision and to play a part in it.

It gives us therefore great joy to be here on this auspicious occasion of the 30th Anniversary, to wish all of you God's blessings and together with you we look forward with hope and determination to the next thirty years and for another generation of leaders who will carry the torch that Dr. Kawahara lit for AHI and for Asia.

Partnership with People

AHI was a specific response to the particular context of the poor of Asia in the late seventies and early eighties. Though the UN had adopted the Universal Declaration of Human Rights in 1948 that recognized health as a human right by stating that "Everyone has the *right* to a standard of living adequate for the health of himself and his family, including food, clothing, housing, medical care and necessary social services", though the 1966 International Covenant on Economic, social and Cultural Rights strengthened it by reiterating the "*right of everyone* to the enjoyment of the highest attainable standard of physical and mental health", later reiterated at Alma Ata in 1978, completely preventable diseases of poverty such as childhood diarrhea, infectious diseases, and water borne diseases, Malaria, Tuberculosis and such continued to be widely prevalent. Health systems were either inadequate or insensitive to the needs of the poor.

AHI recognized that health is a reflection of a society's commitment to equity and justice and that health and human rights should prevail over economic and political concerns. They recognized that upstream determinants of health (access to food, clean water, housing) must be tackled if health is to become a reality and this was only possible if communities play an active role in their development.

3. Unending Struggle for Better Community Health

The concept of Community health evolved in the early seventies with several notable examples such as Jamkhed and Deenabandu in India, Gunawan's experiment in Indonesia and several programs in the Philippines and Latin America that grew out of liberation Theology. These initiatives documented in

"Health by the People" by Kenneth Newell in 1975, the key words being equity and community voices were picked up by Halfdan Mahler, the then Director General of WHO resulting in Alma Ata in 1978.

From the beginning of history, access to and control over resources have been vital determinants of health. Alma Ata too was concerned about the gross inequality in the health status of the people particularly between developed and developing countries as well as within countries. More importantly, for the first time, people's right and duty to participate individually and collectively in the planning and implementation of their health care was emphasized.

The late Mr. Masa Yamashita and the training participants in India in early 1980's.

AHI and ACHAN identified and built upon some of the basic principles of community health – access, equity, participation, focus on those most in need, solutions that are appropriate and within the communities' resources, and identifying, refining and building upon people's knowledge systems. What is notable is the changing relationships and changing power equations between the providers and the community since then.

3.a. The Case of Recurring Diarrhea

A five-year old child came with diarrhea and severe dehydration. We used all the skills we had learnt in medical school to save the child. Six weeks later the same child came back with the same problem. This set us thinking. Obviously what we did was not good enough. Something was missing, actually many things were missing. Medicine and medical skills alone were not the solution. There were obviously several factors at work of which we were ignorant – such as what are now termed as social determinants of health – early childhood development, water and sanitation, living and working conditions, housing, wages, general socio-economic, cultural and environmental factors as well as causal factors such as gender and heredity (caste).

3.b The Case of Poor People's Reality on Costly Medicine

When we ran rural clinics, we assumed that everyone could afford to buy the medicines we prescribed, till we came across the man who looked worse after a week of treatment. When asked if he had taken the medicines we prescribed, he said: "yes, but I had to skip several meals to save up and buy those medicines" This was another case of Paul on the way Damascus type of revelations! This brought us face to face with the reality of rural economy and made us think in terms of wages and asset holding patterns.

The evolution of community health has been slow and not time specific. In 1970-80, the approach was intersectoral, and community based health action. The 1980-95 was the Post Alma Ata approaches, which was the involvement of communities, focus on those Most in need, Action-Reflection-Action processes, community organization, and community based action for health. In 1995-2005, the emphasis was on social capital building (trust, confidence in each other, sharing etc.,) and strengthening community-based organizations. In 2005-2010, hailed Health as a basic human right, Rights based approaches, primacy of people's role, use of existing state resources, establishing rights and appropriating entitlements, and intervention into governance, holding duty bearers accountable

Recognizing the need in Asia and the need for action at the community level, AHI and ACHAN made great effort to propagate people-based primary health care. Deenabandu and several South East Asian programs that had traversed similar paths brought some of their experiences to Bangkok in 1980. Keeping in mind the principles enunciated by Ivan Illich and the training methods used by Paulo Freire, plans were developed, among them the decision to train and equip mid-level workers to address community problems and to propagate participatory methods in doing this. AHI undertook to support the training of mid-level workers. The first program took place in AHI but it was realized that it would be much more cost-effective to train in other parts of Asia. Deenabandu then became a partner of AHI.

3.c Training Method Evolved at the Grassroots

We changed our training methodology after realizing what is real for the grassroots, as told by the

Village Health Workers (VHWs). During the VHW training, the topics discussed were not what we had in mind but what the VHWs thought were the most common problems in their communities.

For example, if the topic was Scabies (a skin infection common among the poor), we asked what they believed caused it. They said, eating raw peanuts. Scabies of course is caused by the itch mite. We traced back why they said it. It was usually related to peanut harvest when women and children went to harvest peanuts till late in the evening – the more they harvested, the more they were paid in kind. When they returned home, there was hardly any time to wash or bath themselves and the children (also water was not easily accessible). They went to bed dirty and continued itching. The itch mite finds an entry point in the abrasions caused by nails. This then multiplies and spreads to cause Scabies.

The people in Deenabandu, India, taken during the 1980's.

When it came to treatment, we did not understand why they were using neem leaves and turmeric since we knew that Sulfur ointment was the specific treatment. So we did some research and found to our great surprise that neem (Azadirachta indica) which grows everywhere, has leaves with high sulfur content and that turmeric has been used as an antiseptic for hundreds of years.

Giving a scientific base to their indigenous knowledge boosted their confidence and made them realize that even though they had not gone to school they had a whole lot knowledge and skills which educated people did not have. They started to believe that book knowledge was not everything and that their experiential knowledge and practices were just as good. This confidence also gave them the courage to face up to the upper caste landlords.

This is well illustrated by the case of the lower caste Traditional Birth Attendant trained by us who refused to do an upper caste delivery in their cow shed when the upper caste TBA could not do. She walked away and said she would only do the delivery inside the house. They begged her to come back and do the delivery inside the house which she did successfully being an experienced VHW.

The baton has since been passed on to Asian Network for Innovative Training, Research and Action (ANITRA) which took up training along with AHI. While the methods remained participatory, the context and curriculum have changed. The emphasis now is on organizing communities that would then build community structures, practice representative democracy even at the grassroots, intervene into governance and build solidarity on a large enough scale to make the voices of the poor heard at decision making levels a process that would be wholly owned and managed by the people and would be self sustaining. The case of the Traditional Birth Attendants is a live example.

3.d The Case of the Traditional Birth Attendants (TBAs)

Since many of the health workers were TBAs, we did a special training for them. At that time hospital deliveries were uncommon because of lack of transport and expense, therefore TBAs had a big role. Neonatal tetanus and death were very common because of the unhygienic practices of the TBAs, who, routinely used the sickle meant for harvesting, to cut the umbilical cord without even washing their hands. All that we did was to teach them to trim their nails, wash hands with soap and turmeric water, to sterilize a blade and the string to tie the cord in boiling water and use a square of rubber sheet to do the deliver. In a year's time, there were no cases of neonatal tetanus.

We used to do episiotomies (cutting the wall of the vagina and then suturing it) for difficult deliveries. The TBAs, on the other hand were delivering easily since they applied oil to the vagina and kept massaging the area. To my great surprise, a Swiss midwife who attended on my daughter in a Geneva hospital did exactly that! Another incident was the transverse lie with hand prolapsed and a dead baby. In the prevalent socio-economic conditions, the lack of paved roads and transport this was a big and expensive task which the villagers could ill afford.

This TBA with her long experience was able to deliver the dead child normally. This was humbling!

Several hundred mid-level workers from all over Asia have been trained, both in Japan and in Deenabandu. Many of the earlier trainees have gone on to become effective leaders and have been instrumental in helping communities transform themselves. The newfound economic strength of several countries has not been translated into equity the gap between those who have (money, education, power, opportunities, and resources) and those who don't, has increased. Illness patterns have changed while older diseases such as Tuberculosis and Malaria continue to affect the poor, newer diseases such as HIV-AIDS, SARS etc., along with degenerative diseases continue to target the poor. Even in this age of information and a globalized world, the poor have to be equipped with knowledge and skills to tackle continuing forces of oppression and attain health.

3.e The case of the Village Health Workers (VHW)

In 1973 we heard of a program in Guatemala where village health workers (VHWs) were being trained to handle simple health problems. We decided to do this also. We explained to the community leaders and requested them to select women and send them for training. The leaders being upper caste chose mostly upper caste women. When we started training them, we found there were serious difficulties between the upper and lower caste VHWs. They would not even sit together or eat together. This showed the rigidity of the caste system. We decided to focus our work on the depressed sections since they were the most affected in communities. At the end of the VHW training, they were given a small medical kit for simple illnesses like cold and cough, cuts and wounds, head ache etc., in order to have medicines accessible. A few months later when we checked, hardly any medicines had been used. When asked why, they said that they had their own home medicines which they used and only when they did not work, did they resort to our medicines!

Empowering our reference communities to fight for their rights remained large. The work and relevance of AHI continue to be of great significance.

3.f From Health to Economic Concerns

In 1974 we did a baseline survey and found that the economic condition of the poor was very bad and indebtedness was what kept them in bondage and servitude. Therefore we started working on programs that would increase their income levels such as animal husbandry, improved seeds etc., Also a program of applied nutrition with seedlings of papaya (prevention of night blindness), Murungai (Moringa Oleifera) seedling (iron, Vitamin C) and other seed for kitchen gardens. Incidentally the milk of the raw papaya is used in Scorpion stings and tender raw papaya is used for cleaning suppurating wound as in diabetes and leprosy and raw papaya roasted over a fire is excellent for back pain.

We also started grain banks, where much like a regular bank, people could deposit grains when they had in excess and draw back in lean times, assuring them of a continuous supply of food at a cheaper rate, also keeping them from further sinking into indebtedness. In 1979, to get them away from the clutches of money lenders and to have access to money in times of emergency, we started credit unions riding on the back of people's associations. These credit unions, in course of time, had considerable amounts of capital that could be lent to the community for small economic initiatives like petty shops; street selling, and to buy goats. These unions were owned and managed by people themselves.

We got seriously involved with wage struggles and collective bargaining since their main income was from selling their labor – most of the poor had no land or other assets or any other means of production. After many years, the government recognized the need for this and the Parliament has enacted a Minimum Wages Law.

4. Linking and Working Together

Sharing these experiences with others so that other people, other civil society organizations and NGOs could build upon is useful. We believed that communities with their illness patterns needed not doctors and nurses but community development workers. That made the training of mid-level workers from India and other parts of Asia such as Nepal, Bhutan, Bangladesh, Malaysia, Thailand, Cambodia, Indonesia and Vietnam relevant. Our partnership with AHI, which too believed in this model of development and training, started jointly in 1982 and continued up to 1998.

We moved away from a techno-centric, medical approach to a holistic one, to being part of people's struggles for dignity and justice. During this evolution, our role slowly diminished and that of the people became central to their own development. The highest form of development is the development of consciousness which is what we are involved in now.

Indeed, AHI so believed.

MESSAGES FROM AHI ALUMNI AND PARTNERS IN ASIA

BANGLADESH

Mr. Md. Belayet Hossain Meah
Voluntary Association for Rural Development (VARD), ILDC 2010

An anniversary event is an opportunity to remember the achievements, review the action and dream the action in a frame. AHI is a famous organization in Japan for its contribution in leadership development in Asia. I feel honored to know that AHI is going to celebrate its 30th Anniversary on 12th December 2010. Asian NGOs capacity building activities of AHI is really good, effective and appreciable. It opens the door for international relationship from individual to organizational and even to the regional level.

As an alumnus of ILDC 2010, I learned a lot which we are implementing and going to implement. Among these most illustrated activities are Community Based Organization (CBO) for destitute women and adolescent club assessment and recommendation for further improvement and Community Based Health Insurance(CBHI) concept briefing and implementation. For CBHI activities we are briefing our partner NGOs, government officials through individual contacts. CBHI is a new approach in Bangladesh though it is described in the National health policy of Bangladesh. We hope AHI will support us for making it more clear and enriching. I wish every success of AHI and its honored Board members, supporters, well wishers, volunteers and staff side by side my heartiest gratitude to all of them for their great contribution, dedication and care to us during the ILDC 2010.

Women's discussion in Bangladesh.

CAMBODIA

Mr. Dann Chhing
Cambodian Organization for Assistance to Families and Widows (CAAFW), ILDC 2010

Mr. Dann Chhing and a student in Hiroshima.

I am happy and proud for AHI's talented staff for patience and hard work to coordinate the ILDC course for five weeks. They encouraged and motivated me and other participants to promote cooperation, solidarity and love each other in order to effectively achieve the common goals of the course.

One thing I was so impressed was the wisdom and legacy of Dr. Hiromi Kawahara, AHI founder. He is a big-hearted man who plays role model in honing young generation leaders through the ILDC for Asian people. I still remember Dr. Kawahara's wisdom; continuation of work and share with others.

For the AHI supporters, you have been wisely contributing and dedicating your own resources to support ILDC. Your spirit and money have effectively contributed to produce leaders and build peace in Asia and the World. Your support will bring hopes and positive change for Asian people especially those who are in developing countries. I will always remember your kind heart to support AHI. Please continue supporting AHI.

For the volunteers, my warm respect and love to all. I remarked that all volunteers are very active and committed. I really appreciated the support of volunteers during the course. They played very important role in assisting the course to successfully complete based on timeframe. During my stay, the volunteers spent a lot of their time, spirit, forces, and resources to coordinate in food preparation, teaching Japanese language, cleaning the dining room, and as guides for the free Sunday, home stay, etc. I have brought the supporting activities of volunteers to my family and colleagues. I recognized everything I learned from the volunteers.

ILDC is very helpful. It gave me a lot of knowledge through mutual sharing and interaction. The course significantly changed me. Many of the topics I learned have been applied in my daily work. I became broadminded in mainstreaming peace concepts in communities. AHI should continue this kind of training. I strongly believe that people can change the world and other people toward a better society. Your investment today will give great results in the future, but we need to pursue it.

CAMBODIA

Mr. Heng Sarik
Partnership for Development in Kampuchea (PADEK), ILDC 2010

Congratulations to the 30th founding Anniversary of AHI from Padek Organization in Cambodia! ILDC 2010 is yet very fresh in my memory. Thanks so much to AHI for allowing me to participate in the ILDC 2010 and to the volunteers and supporters who always contribute to support AHI activities. I was so surprised at the first time to go abroad, especially Japan, a developed country. For five weeks of ILDC, I learned a lot from participants coming from different countries with diverse cultures and varying views and context of development. The dormitory life during the course was very useful for me. After the course, I shared what I learned from ILDC to our staff in Cambodia. I shared the same to the community people in the committee meetings. Through it they could learn about Japan and some community development models. Thanks to Ui-san, Yoko-san, and Kyoko-san who tried hard to facilitate the course with good results. Thanks to the volunteers and supporters in this ceremony. Good luck! See you again.

In the meeting, Mr. Heng Sarik, standing.

INDIA

Mr. Narendra Kumar Biswal
ANITRA TRUST, ILDC 1988

Namaskar! Konnichiwa. I wish everybody in AHI very good health. I am very much delighted to know that AHI has become 30 years old.

We all are part of AHI and I appreciated its work all along in facilitating developmental work throughout the world. I wish AHI grows and continues its good work to eradicate exploitation, ignorance, violence, poverty and ill health in the world. Thanking you all my friends. More power!!!

He and his friends in India became AHI financial supporters.

PHILIPPINES

Mr. Jonathan A. Alegre, FPAFP
President, Davao Medical School Foundation Inc

We wish to express our warmest greetings to the Asian Health Institute on the occasion of its 30th Founding Anniversary.

You have contributed much in helping the Davao Medical School Foundation through the Institute of Primary Health Care develop leaders who will work for the development of their communities through our Community Based Development (CBD) training program. Later, we tried to pursue area development through our partnership in promoting the Sustainable Integrated Area Development (SIAD) Approach in the Municipality of New Corella, Davao del Norte. These efforts proved very fruitful and have created greater impact in the lives of communities we served.

We are glad that we are your partner for a long time now. Your commitment to improving human capability has been proven time and again in our various endeavors. We sure wish that we continue to be partners and collaborate in more undertakings of mutual interests to us. Congratulations!

PHILIPPINES

Ms. Josephine L. Quianzon
Executive Director, Institute of Primary Health Care (IPHC), AHI-PIME Philippines 1984

Congratulations to the Asian Health Institute (AHI) on your 30th Founding Anniversary!!! As a long time partner of the Davao Medical School Foundation through the Institute of Primary Health Care (DMSF-IPHC) you have helped us pursue our vision and develop our capability as an organization particularly in creating greater social consciousness.

Together and in partnership with the New Corella Local Government Units and communities, we were able to improve our approaches to community development particularly the Sustainable Integrated Area Development (SIAD). The SIAD process truly empowered communities to help themselves and has tremendously contributed in the delivery of basic services most especially in the health sector. It has also guided community leaders, members and different stakeholders actualize transparency and accountability, an evolving norm in local governance. More importantly, people's participation has improved a lot with communities actively participating in identifying their needs and collectively finding solutions. Working with AHI has been mutually enriching. May you continue to pursue your Vision and Mission with greater passion and commitment. Thank you for your trust and confidence!

PHILIPPINES

Mr. Ruben Santos
Institute of Primary Health Care (IPHC), Philippines, ILDC 2005

AHI's ILDC shaped my leadership in my new position. *Domo Arigato Gozaimashita*! "For your 30th Founding Anniversary, may I congratulate the management and all people who inspired the organization to pursue its vision and mission. I hope that for 3 decades of partnership and collaborative engagement between different NGOs and stakeholders in the countryside especially in New Corella SIAD, it has already explored and fostered its contribution to the continuing work of social capital formation, development and nation building". *Mabuhay kayong lahat!*

PHILIPPINES

Mr. Yokhito Birondo
Institute of Primary Health Care (IPHC), Philippines, ILDC 1994

My sincerest congratulations to your 30th foundation anniversary! Your endeavors are not in vain as we altogether are hand in hand in propagating people's health and development, living a democratic life and self content. Your impact in the lives of people specially in Asia will always be great!

PHILIPPINES

Ms. Josephine B. Alindajao
Institute of Primary Health Care (IPHC), Philippines, ILDC 2000

It was a great joy being part of the more than 20 years of community-based development (CBD) training and in the ILDC. The insights gained from those experiences will always be part of me as a development worker. God bless you more.

PHILIPPINES

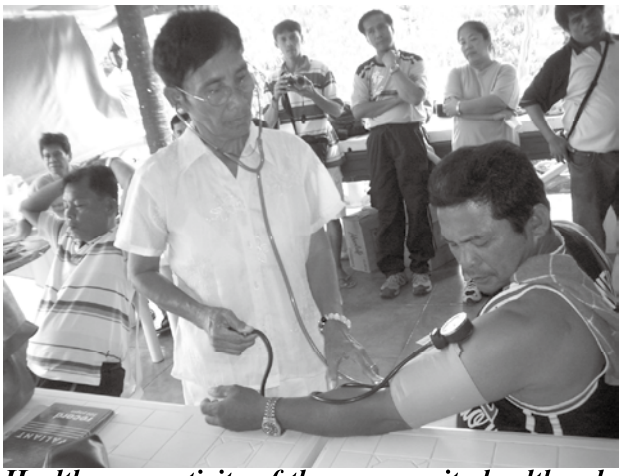
Mr. Joel Quinanahan
President, ANAK-New Corella, New Corella, Davao del Norte, ILDC 2000

Let me extend our heartfelt congratulations to AHI for celebrating its 30th foundation anniversary. The AHI has been like a family to us CBD graduates and for reaching 30 years of doing undoubted service throughout Asia is an accomplishment of magnitude scale. In fact, our decade-long partnership has been a wondrous journey and as New Corellans we will be forever grateful to AHI for the support as well as the memories that we have shared together. It is our earnest desire to go on with the SIAD process in New Corella. In fact, the CBDAO and like-minded allies has coalesced to strengthen and sustain it. Having AHI on our side is a plus factor that continues to inspire us in this arduous lifelong challenge. Again, to all men and women behind AHI, Happy 30th Founding Anniversary to you all!

PHILIPPINES

Ms. Nancy Obra
Rural Health Unit (RHU) New Corella, Davao del Norte, ILDC 1996

Thank God for 30 years of sharing your love to others. We are blessed as your partner of empowering our local communities. May God continue to bless all the members, volunteers, officers of AHI as you go on touching other peoples' lives. Congratulations!



Health care activity of the community health volunteers in New Corella.

PHILIPPINES

Ms. Luz B. Canave Anung
Facilitator of ILDC 1984 and PCHAP 2004 to 2005, former Executive Director of IPHC

Ms. Anung, left, with PCHAP participant.

I greet with great joy the Asian Health Institute on its grand anniversary. May God bless you with more donors and more projects to enable you to fulfill your mission of service. AHI will always hold a special place in my heart. It has molded me in many ways as a development worker, facilitator and peace-maker. Without the experience that AHI provided to me, I would not have honed my skills and widened my perspective. As facilitator of its ILDC and courses in PCHAP (Participatory Comprehensive Health Administration Promotion Course, commissioned by JICA, the Japanese International Cooperation Agency), I have gained more understanding about the challenging contexts which our fellow-workers face in order to improve the living conditions of their people. I am always humbled by their stories of courage and perseverance. I owe the institute a lot for giving me many opportunities to grow professionally and even spiritually.

SRI LANKA

Ms. Yogeshwari Krishnan
Institute of Social Development (ISD)
ILDC 2010

Wishes for the successful event of AHI's 30th anniversary, December 12, 2010. Your hard work will create more positive changes in poor people's lives. The strong human energy of AHI family will build a healthy and peaceful life of Asians. So we work together for a "Peaceful World", heart to heart and people to people.

SRI LANKA

Mr. Niranjan Udumalagala
University Pharmacist Association, ILDC 1995

Congratulations to the 30th anniversary of AHI. It is a great event. Serving as a training institution for 30 years in Asia is a record. Having attended to AHI training helped me personally as well as my society in Sri Lanka through sharing. All the AHI alumni are jointly congratulating the past and current staff of AHI. In fact, we organized a two-day workshop, AHI Alumni-Sathyodaya Workshop, to celebrate the 30th anniversary even if we are far.

NOTICE!

It is AHI's policy to use Ms. (female) or Mr. (male) as a universal title for everyone to promote equality. Thank you very much for your kind understanding.

HERE AND THERE

The Third Annual Health Assembly
Collective Action to Overcome Inequity for Better Society
December 15-17, 2010
UN Conference Center, Bangkok, Thailand

The Thai NHA Conference Hall packed with international participants.

The third National Health Assembly (NHA) was held on December 15-17, 2010 attended by more than 1800 participants, representing 182 constituencies within the National Health Assembly Network, where 19 international participants attended as observers. Among the international participants, Mr. Md. Akramul Haque from DASCOH, Bangladesh and Ms. Maria Cristina Carganilla-Parungao from INAM, Philippines attended as AHI Alumni sponsored by the Asian Health Institute, Japan (among the 14 applicants) to learn good practices from the assembly and replicate in their concern country program. It was realized in collaboration with the Thai National Health Commission Office led by Mr. Ugrid Utilangkul, AHI alumni, ILDC 1987.

The National Health Assembly is a social innovation process of Thailand to build healthy public policies under National Health Act 2007. NHA is a process in which the relevant public and State agencies exchange their knowledge and cordially learn from each other through a participatory and systematically organized forum, leading to recommendations on Healthy Public Policies or Public Healthiness."

The National Health Assembly Organizing Committee (NHAOC), comprised of representatives from the state and other sectors, was established by the National Health Commission (NHC). According to the Act, the NHAOC organizes NHA once a year since 2008.

The NHA is one of the most important social mechanisms to support the participatory, constructive and peaceful reconciliation among all stakeholders towards consensus agreement on specific Healthy Public Policy such as to be concern on the health of the people, to be responsible for the impact on health incurred by the policy, to build enabling environment, and to give people alternatives and access to these alternatives.

The NHA link the 'political power', the 'social power' and the 'intellectual power' to form 'the triangle that moves the mountain'. This is a tripartite powerful strategy to achieve long term and sustainable implementation of participatory healthy public policies.

REPORT 1

Mr. Md. Akramul Haque
Chief Executive Officer, DASCOH, Bangladesh, ILDC 2008

1. During National Health Assembly

All participants of the Third Thailand's NHA 2010 were welcomed by a puppet show focused on rights and justice which all humans deserve from birth to death. The puppets' movements reflect today's society in which all humans are free but have created obligations for themselves. Also, the nominated network representatives analyzed, discussed and comments on the main documents and draft resolutions in several group meetings. These resolutions were adopted through consensus. The final resolutions were printed and distributed among the participants and proposed through national health commission to the national cabinet for approval and execution. The event was graced by speeches from Honorable Guests including Asia's first Nobel Lau-

reate for Economics, Professor Amartya Sen and the Prime Minister of Thailand Mr. Abhisit Vejjajiva.

Sitting left to right: Mr. Ugrid Utilangkul, Mr. Amartya Sen. Standing left to right: Mr. S. Wutti (ILDC 2010), Ms. M. C. Parungao, Mr. A. Haque.

2. Brief Overview of the 9 Agenda of NHA 2010

2.1. Overcome Inequity

The assembly has proposed strategies for a national reform aimed at reducing inequity and promoting justice for a healthy society, namely economic reform (tax, land and inheritance), natural resources reform, social reform and political reform as stipulated by Section 87(1) of the Constitution.

2.2. Control of Marketing for Infant and Child Nutrition

The assembly acknowledges unethical marketing practices by breast milk substitute companies, leading to a decline in breastfeeding among Thai mothers. Legislation to regulate this clear violation of WHO's Universal Code of Marketing for breast milk substitutes should be enacted by 2012. It is also recommended that the Ministry of Labor considers the possibility of extending the paid maternity leave to 180 days, instead of 90 days while encouraging offices to set up daycare concerns.

2.3. Equity in Access to Health Care for People with Disabilities

The assembly recommends an establishment of a society security fund for the disabled by the National Fiscal Committee of Public Health, as well as a better financial system for the disables health development, i.e. regional fund for the disables and a provincial strategic plan for the disables quality of life. Relevant ministries should include the disables quality of life as a development indicator for the next 5 years. The National Commission should also set up a committee for the disables health to coordinate with all parties.

2.4 Problem Solving in Teenage Pregnancy

The assembly proposes that the government and the private sectors should collaborate on national strategies to promote sex education and other preventive measures which should be implemented at local levels as well. All parties concerned should also work towards drafting legislation for reproductive health and a strategic plan for national reproductive health development. The Ministry of Education should put in place a system to address the problem of pregnancy among students.

2.5 Interventions for Non-asbestos Society

The assembly proposes that the Industry Ministry outlaws the material by 2011, both import and export, possession or manufacturing. Building regulations should outlaw asbestos and measures fire safe asbestos disposal must also be implemented. The government should set an example by prohibiting asbestos in future construction of future government buildings.

2.6 Interventions for the Control of Tobacco

The assembly proposed the strategy 2010-2014 to control tobacco should be put into effect. The Finance Ministry should revise tobacco taxes so that tobacco will gradually become more expensive. There should be support systems for tobacco user rehabilitation as well as a participatory approach to support those who want to quit smoking.

Small group discussion during the conference.

2.7 Policy on Self-managing Area

Centralized development has resulted in inequality in self-management and budgeting. Government support should be given to initiatives of this nature as well as collaboration with all sectors. National Committees should have a 60% representation by local administrative bodies and non-government organizations. The National Reform Committee and the National Health Commission should look into developing policies to promote self-management in order to formulate proposals and to reassure implementation.

2.8 Policy on the Medical Hub

The assembly recommends an extensive study of these policies and the possibility of regulation by the Finance Ministry to prevent or reduce negative impact. The Board of Investment should also abide by the 2009 Health Statute, Item 51, which states that the agency must not provide tax or investment privileges to medical service providers which disproportionately seek commercial benefits. A national action plan should also be developed to address shortage of medical personnel.

Discussion and question and answer in small group during the hospital visit.

2.9 Progress Report on the Previous Resolutions

It is recommended that the government and all parties concerned designate as their priority the issue of public health, economic gains, and to take a stand against exploitation of FTA. Health Impact Assessment (HIA) should also be carried out on projects arising out of FTA. Relevant agencies such as the Ministry of Commerce should jointly regulate pricing, investment and intellectual property in order to mitigate the effects on health and society. No obligation not thoroughly investigated in terms of negative impact should be made with FTA signatories.

3. Challenges of NHA

There are five major challenges ahead. First, the selected participants from the networks should represent the needs and demands of the constituency to the assembly and get involve in the execution of policies. Second, to develop state and non-state intersectoral coordination and collaboration to ensure policy implementation. Third, build capacity of the constituencies in proposing the public policy issues, commenting the draft resolutions and translating the resolutions into action. Fourth, cost effectiveness of the national health assembly to develop healthy public policy. Fifth, impact analysis of the policies developed through the assembly.

4. Lessons from National Health Assembly

Before attending the NHA 2010, I had four expectations. First, I wanted to know the roles and responsibilities that the Community Based Organizations (CBOs), Local Governments, and local NGO in the development of public health for the poor and the vulnerable people. Second, I was curious if there exists some mechanisms to ensure community participation in local governance and its application to health. Third, how public-private partnerships can be developed to enhance decision making power of the people to get access to health services as a basic right. Fourth, is to prepare a plan of operation based on learning from the NHA in Thailand. Apart from these expectations, I was also interested in health advocacy topics and issues. For instance, how the health insurance can be introduced and their effectiveness; coordination and collaboration among the government line department, NGOs and civil societies in health programs; and the role of AHI alumni in local and national level health advocacy.

Vis-à-vis my expectations, I learned from the NHA about how to support intersectoral action among civil societies, private sector, academia, professional sector, politician, and government sector in developing Healthy Public Policies together for a better healthy society. I also realized the importance of increasing the awareness and the level of commitment by all partners at all levels in driving healthy public policy through the participatory process of NHA, which creates ownership and support in policy execution. Indeed, it is prime to pursue extensive and long-term capacity building of all partners through the strong evidence based process of NHA, which moves forward to policy reform commission.

5. Recommendations

It has been recommended to disseminate the participatory healthy public policy development process as a best practice of Thailand to the developing countries. International observer participants may select from neighboring Asian countries comprising government, private sector and civil society to replicate the learning in their concern countries. For observer participants, one-day orientation by the NHC is more effective to understand in depth the whole long process of the NHA. One-day field visit may add to understand the health program of Thailand.

6. Replication Plan Back Home

Participatory policy making process will be introduced at Union Parishad level of DASCOH program area on water, sanitation and health. The existing platforms ward shava and Union Coordination Committee under the Local Government (Union Parishad) Act, 2009 will lead the whole process at local level while DASCOH will provide technical and advisory support. DASCOH will facilitate the participatory policy making process at Upazila, District and National level gradually through evidence based learning of local level involving concerned stakeholders.

REPORT 2
Ms. Maria Cristina Carganilla-Parungao
Integrative Medicine for Alternative Healthcare Systems-Philippines (INAM), ILDC & OMC 2006

Amazing Health Care System of Thailand

We spent our first day thru a field exposure arranged by the National Health Commission and Asian Health Institute. We visited Saraburi Province and met the hospital directors of Kaengkhoi and Muaklek district hospitals. We had a glimpse on how the Thai traditional modalities were integrated in the health care system and how the district hospitals respond to the health care needs of the people.

1. Visit to District Hospitals

Saraburi province has 14 sub-districts with 117 villages and around 20,566 households. The province has a total population of 96,084 with 47,139 males and 48,945 females. In one sub-district, 1 community hospital with 60 bed capacity, 1 extended clinic and 19 primary health care centers are available to respond to the health care needs of the people. The ratio of health personnel to health service receivers is as follows: 1 doctor is to 13,726 people, 1 dentist is to 19,217 people, 1 pharmacist is to 16,014 people and 1 nurse is to 1,502 people.

Kaengkhoi Hospital, is a district or community hospital serving almost 400-600 out patients per day. The hospital is clean, equipped with good facilities and with attentive and accommodating staff. Seventy to eighty volunteers coming from the different communities assist the hospital staff in different tasks such as playing the violin and providing good music for patients waiting in the reception area, doing office work, helping in the information system, assist in patient care, etc.

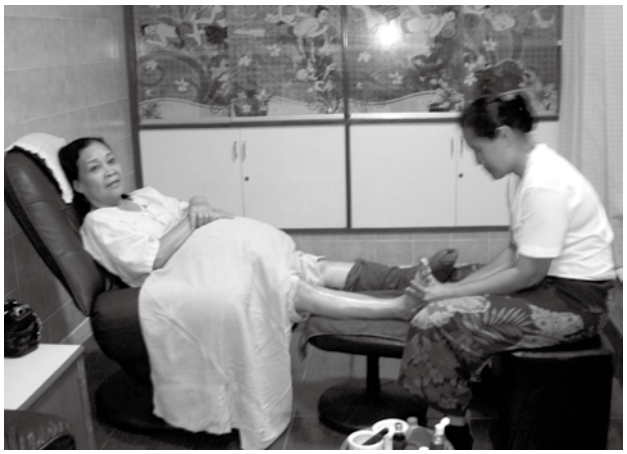
Volunteers playing some music at the reception area of the hospital.

The hospital director, Dr. Prasitchai Mungjit showed us the computerized patient database, the different hospital departments and further explained the role of the hospital through a powerpoint presentation. Kaengkhoi hospital is active in its health promotion policy such as providing healthy food for the patients and the staff, no smoking policy within the hospital premises, no coffee or carbonated drinks sold in the hospital and every staff has to be involved in a project to promote health to their patients, families and communities.

Dr. Mungjit shared some information on their National Health Security Scheme or Health Insurance, the management of their hospital waste and the integration of traditional Thai medicine/modalities as part of the health care system of Thailand.

Thailand's current total population is 65 million and out of which 45 million people (69%) are covered by the National Health Security scheme for unemployed, informal sector, students, elderly, etc. 15 million people (23%) are covered by the Social Security Scheme for the employed people and 5 mil-

lion people (8%) who are working for the government, government officers and royal family are covered by a "special fund" which pays for their health care services. Only one person is entitled to one insurance/scheme. Thailand has universal coverage.



Foot reflexology performed by a trained woman.

All healthcare services of the Kaengkhoi district hospital and Spa are part of the universal coverage of the National Health Security Scheme (National Health Insurance) of Thailand. Thai people enjoy hospital and spa services in the district/government hospitals for free provided that these modalities were prescribed by their attending doctors. The spa offers Thai traditional massage, foot reflexology, sauna and hydrotherapy. Part of the National Health Policy of Thailand is to integrate the Traditional Thai healing/medicine/modalities in the government hospitals. Members from the community who volunteer in the district hospital and primary health care centers are given the opportunity to be trained in Thai massage, foot reflexology, herbal compress and other modalities such as hydrotherapy and sauna. After completion of 330 hours of training, they can be employed as accredited massage therapists in the hospital spa.

Muaklek district hospital and hospital spa has the same services with that of Kaengkhoi Hospital. They also have a protocol for Smoking Cessation which included steam bath and Thai massage. Patients who successfully quit smoking are given recognition by the hospital. For post delivery care, mothers undergo steam bath and Thai massage.

We visited Lungkhao Primary Health Care Center, which provides primary health care services to 330 households and 354 families. They have their own spa, Anamaya Spa, which offers Thai traditional massage, body spa and steam bath. Patients are required to have a medical consultation first before the treatment. For members of the community who are sick, massage will be charged to the health security scheme but for those who wants massage for relaxation, the service is charged 150-380 baht.

2. Learning Insights on the Health Care System

Witnessing the established health care system of Thailand makes me re-think of the possible reorganization of the National Health Insurance of the Philippines which is provided by PhilHealth. The PhilHealth covers the health insurance of the employed, unemployed, indigents, overseas Filipino workers and senior citizens. With its enormous amount of collected premiums, the Philippines has not achieved yet 100% universal coverage and benefit package still needs improvement.

Amazingly, Thailand has one type of insurance for each sector which is funded by several schemes. This connotes better management of the contributions and benefit package or health care services provided to the people. The support of the government through policy development and budget allotment is very important to realize the objective of 100% universal health coverage for the Thai people.

A lot of information dissemination on the importance of health care financing whether government or community initiated should be done by INAM. We need to involve participation of the community together with our partner organizations to initiate discussions on the universal health coverage issue, the next steps and what advocacy work should be done in order to make at least the basic health care services accessible and affordable to our people.

Ms. Maria Cristina Carganilla-Parungao at NHA.

3. Participatory Public Policy Discussion

Participatory public policy is a process of developing sound policies involving collective participation from the community level up to the national level. This involves identification of problems being faced

(continued on page 18)

New Partnership Program With AHI Alumni in Sri Lanka

"Education Improvement Program in the Tea Plantation Area"

This new program was born out of the concern of one lady that rippled to a larger group.

There was an elderly woman who supported AHI with her concern and sympathy with other Asian people, as she herself was a military nurse during the war time. She gave us the newly bought electric appliances that she would not use any longer, as she decided to live together with her daughter in Nisshin City. This is how she started to be related to AHI. Every time she visits our office, she expresses her concern to people who have difficulties in getting the basic needs like safe water. She also enjoys being with the AHI participants during the fellowship parties.

Her daughter is related to one cosmetic company based in Osaka. She is working there. That company has been environment conscious and active in corporate social responsibility or also known as CSR since its beginning in 1980. Almost all companies in various parts of the world are now consciously incorporating CSR in their mandates or policies. They have special concern in contributing to children education particularly in developing countries. They provide fund for NGOs implementing educational programs. The fund is generated from among the 1000 salesladies all over Japan. The woman's daughter is one of those salesladies, who kindly recommended AHI to be one of their possible partners.

After several meetings with the person-in-charge of that company, they decided to contribute to AHI's activities in Sri Lanka. AHI has been inviting development workers working for the tea estate workers, who are mainly Indian Tamil. They are marginalized in the Sri Lankan society. Their unpleasant situation was rooted in the British Colonial era. Even after independence, their condition did not improve much. This prompted AHI to form a network of former participants working for that sector and implement this project.

On March 2010, AHI organized a planning session with its alumni working for the plantation workers in Kandy, Sri Lanka. Based on the discussion and to respond to their needs they raised, AHI and the group consisting three organizations with AHI alumni, have started the project to make better education for children. These organizations are Human Development Organization (HDO), Satyodaya, and Plantation Rural Education and Development Organization (PREDO). HDO is in-charge as coordinator.

The project components vary according to each respective area. They may include training teachers and awareness raising among parents and community people to tackle larger concerns and support. The program offers additional classes for the 11th grade children (15 to 17 years old) to obtain General Certificate in six schools within the six plantation areas.

Overcoming poverty and related problems of the plantation workers (marginalized Tamil people), through improved educational level is the aim of this project. This might bring positive changes to the plantation communities. Collaboration and networking is also expected to occur among various players such as school teachers, parents, and others.

The experiences of this program will be documented and shared among the AHI alumni and others around Asia through the English and Japanese newsletters, online (see AHI website) and forum in various occasions.

(continued from page 17)

by community members, identification of their basic needs, consultations done between community leaders and members, identification of the response of the people on a particular issue and involving other stakeholders in addressing the gaps. Through the process of identifying the gaps, policies may be developed at the community level with the possibility of elevating the issues to the national level. Dialogue between community members and policy-makers is necessary to address the concerns and welfare of other stakeholders.

Communities should be provided with the appropriate capability building to provide them with the necessary reliable information which will guide them in their decision-making process and to be able to participate and voice out their issues and opinions. *(end)*

NEWS FROM FRIENDS

AHI alumnus got an award as "Best Teacher"

Principal Mr. Md. Nazibar Rahaman, ILDC 2008, Bangladesh Slum Development Program (BSDP) was commended as Best Teacher by BBS, October 5, 2010. BBS supports educators and educational institutions in Bangladesh. BSDP manages schools in slum area providing educational support for poor children.

ERRATUM

Our apologies for the clerical errors in the No. 86 issue of AHI English Newsletter published in February 2011 as follows.

- Pages 1 and 11 Post Hiroshima Visit, it should be Karuna Trust (not ANITRA Trust), and Kumar (not Khmar)
- Page 2 Right Based Approach, it should be Mr. Natchathiram Srinivasan (not Mr. Srinivasan Natchathiram)
- Page 16 Around Japan, it should be Mr. S. Wutti (not Ms. S. Wutti).

For the Tsunami and Earthquake Affected People in Japan. *This is for you…*

"Our lives are not determined by what happens to us but by how we react to what happens, not by what life brings to us, but by the attitude we bring to life. A positive attitude causes a chain reaction of positive thoughts, events, and outcomes. It is a catalyst, a spark that creates extraordinary results."

Thank You for Your Messages for the Victims of the Tohoku Region Earthquake

On March 11 2011, a powerful 9.0 magnitude earthquake struck the northeastern coast of Japan, part of the Tohoku region. It was the most powerful since records began, and triggered a devastating tsunami. As of May 11, 2011, 14,981 people died and 9,853 people are still missing. Among the survivors, more than 500,000 people have been left homeless. Until now, more than 1.2 million people are forced to live in government assigned shelters. While those people who are difficult to move such as elders and people with disabilities cannot do anything but to live in their houses without support even to the minimum.

Immediately after the earthquake and subsequent accidents at the nuclear power plants in Fukushima, we received many e-mail messages and phone calls from the AHI alumni and friends expressing their concerns for the AHI community in Japan. They also conveyed their prayers and support to the victims of the disasters. We received more than 100 messages. Some AHI alumni also collected donations for the victims. This is a clear expression of solidarity among us Asians.

Around 50 AHI supporters were living in the areas affected by the disasters. AHI tried to contact to them and was able to confirm that most of them were safe. However, they are now facing so much difficulty in surviving life each day. Many of them have lost their relatives and friends, apart from their livelihood and properties.

Through the AHI Japanese and English newsletters and the website, we are conveying your messages especially to those affected by the earthquake and tsunami, and to share your prayers for the victims together with all AHI supporters in Japan.

All forms of support you bestowed created a lot of synergy, encouragement and inspiration. Knowing that many are one with Japan hoping for it fast recovery is indeed energizing. For all of these, we would like to express our gratitude to all of you from the bottom of our hearts.

From The AHI Board of Directors and Staff Members

A VERY IMPORTANT ANNOUNCEMENT

AFTER 30 YEARS, AHI would like to reorganize efficient mailing system of the English Newsletter and the birthday cards that have been regularly sent to every AHI alumnus.

❖ **FOR AHI ALUMNI who participated in ILDC earlier than 1986**

We would also like to inquire from you about the newsletter and the birthday card. Do you still want to receive them? ***We might stop sending both the newsletter and the birthday card if you do not reply to this inquiry.*** Please reply to us (c/o Ms. Yuko Okuma, AHI) by e-mail, phone call, fax or post mail as soon as you receive this inquiry. Hoping to hear from you very soon. Check your ID printed on the address label on the envelope if correct. Example: 86xxxxx (86 is the year participated).

❖ **WANT TO READ THE AHI ALUMNI NEWSLETTER ONLINE?**

Why not become an online reader? We will inform you the publication date of every issue of the English Newsletter by e-mail, instead of sending the paper copy. You can read or download it from our website. It will reduce the time gap and mailing cost, and also eco-friendly! Of course, if you would like to continue receiving the paper copy as before, AHI is pleased to send you by post mail. Those who would like to receive the AHI English Newsletter by e-mail, please inform us.

CALL FOR ARTICLES

Attention all AHI Alumni! It is time to write your precious stories and field experiences so that others would know. Its a way to propagate effective strategies that you have tried and tested. Let's learn from each other. Hurry, grab a pen and start writing.

Please refer to the following themes below:

1. Environment/Biodiversity and Development
2. Peace-Building
3. Gender
4. Community Based Rehabilitation & Community Based Inclusive Development
5. Health Equity Fund, Health Care Financing, Community Based Health Insurance System

DEADLINE: AUGUST 31, 2011.

Reminder Dear Writers!!!

In order to help carry out smooth editing process, we would like you to observe the following technical requirements. For your text, use only **"NEW TIMES ROMAN"** font style, **size 11**. Do not create any special settings, for example, indention or multiple font styles, as it will only complicate and prolong editing. Write plainly, choose New Times Roman, size 11 and type. That's all. For the photographs: save in jpeg format, it is very important to select the best copy, preferably action not pose, write a very brief description of each photo, and whenever possible convert it into grayscale.