ASIAN HEALTH INSTITUTE August 2016

Series No. 99

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

The Path to Universal Health Coverage

From your Editor Ms. Joy A. Bastian

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

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

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

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

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

PAGE	TABLE OF CONTENTS

FOCUS : Universal Health Coverage

DASCOH's Community Clinic Activation

Mr. Md. Akramul Haque, ILDC 2008

Mr. S. M. Fakhrul Basher

Development Association for Self-reliance Communication and Health (DASCOH), Bangladesh

Mr. Haque

Mr. Basher

1. Background

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

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

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

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

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

2. What is a Community Clinic?

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

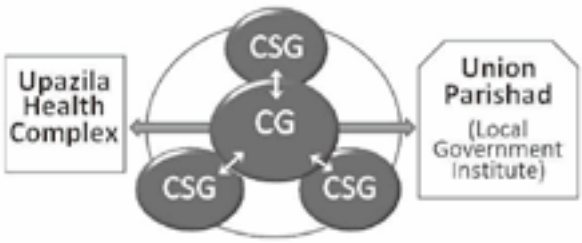
Its services include primary health care services, maternal and neonatal health care services, immunization, acute respiratory infection, diarrheal disease control, health, family planning and nutrition education, treatment of minor ailments and first aid of minor injuries, effective referral linkage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

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

2.1 Human resources

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

2.2 Management of the Community Clinics



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

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

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

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

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

Community Group meeting.

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

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

3.1 Goal, beneficiaries and outcomes of the PHIIR Project

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

Basic health service at the community clinic.

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

3.2 Priorities, approaches and strategies

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

3.3 Strengthening basic health services

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

3.4 MCH case management

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

3.5 Strengthening the management of CCs

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

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

Community map in the CC.

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

The CSG members preparing the community social map.

3.6 Major results achieved in 2013 to 2015

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

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

4. Case story: Sukhandighi Community Clinic

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

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

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

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

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

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

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

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

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

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

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

Ms. Kagumi Hayashi, AHI

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

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

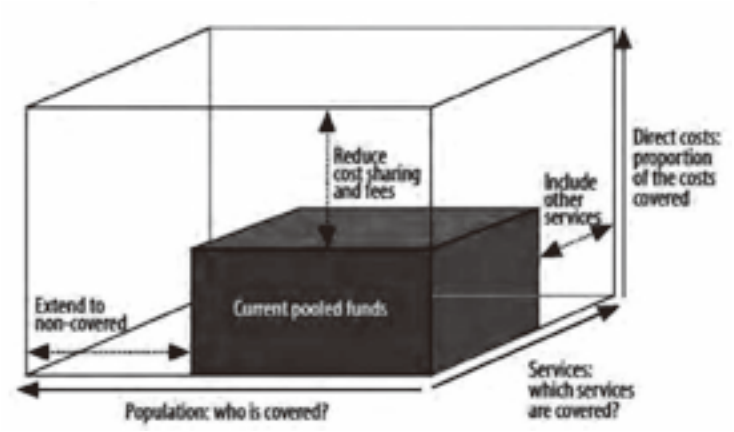
The World Health Report 2010 of WHO whose theme is "Health Systems Financing – The path to universal coverage" says that "There are many ways to promote and sustain health. Some lie outside the confines of the health sector. The "circumstances in which people grow, live, work, and age" strongly influence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

The following three questions emerged:

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

References:

1. Handbook on Universal Health Coverage for NGOs, NGO Study Group 2014, Ministry of Foreign Affairs, Africa Japan Forum ed. 2015.
2. The Global Push for UHC, UHC Coalition

PhilHealth for All Filipinos

Ms. Joy A. Bastian, AHI

1. What is PhilHealth?

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

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

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

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

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

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

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

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

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

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

Puan BHS constructed by the LGU.

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

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

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

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

4. Challenges

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

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

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

FLASH ARTICLE

Participants' Report and Reflection on the Bangladesh Reunion Seminar 2015

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

Mr. Mollah

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

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

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

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

Participants drawing out learning and good practices.

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