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A UICK First 2005 Workshop

With the support of the United Nations Population Fund (UNFPA) and the Kobe City Government, UICK held the "First 2005 Workshop on Adolescent Reproductive Health and HIV/AIDS" in Kobe from 27 June to 7 July 2005. UICK invited 9 participants from 9 Associated Cities. Concurrently, the Seventh International Congress on AIDS in Asia and the Pacific (ICAAP) was being held in Kobe. Taking advantage of this opportunity, the participants attended some of the ICAAP programs.

BACKGROUND

Reproductive health is one of the important components of Programme of Action (POA) which was agreed on in 1994 at the International Conference on Population and Development (ICPD) and defined in chapter VII 7.2-7.3 as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". The chapter further elaborates that "reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go through pregnancy and childbirth safely and provide couples with the best chance of having a healthy infant.

Reproductive health includes a comprehensive approach to reproductive health issues including family planning, maternal and child health, sexually transmitted diseases and HIV/AIDS, which has been dealt separately by vertically divided administrative functions.

Reproductive health eludes many of the world's people because of such factors as; inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behavior; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. 500,000 women or more have died every year by factors that originated in pregnancy and birth. Strikingly, 99 percent of these cases occurred in developing countries.

Reproductive health is not only a fundamental right for all people, but also contributes to micro level problem solving, such as population and poverty issues. Confronting reproductive health issues will contribute to meeting most of the Millennium Development Goals (MDGs) directly or indirectly. It contributes directly to meeting the three health related goals: "Goal 4: Reduce child mortality", "Goal 5: Improve maternal health", "Goal 6: Combat HIV/AIDS, tuberculosis, malaria and other diseases" and synergistically effects the following two "Goal 2: Achieve universal primary education" and "Goal 3: Promote gender equality and empower women". Voluntary family planning relies on a number of experts' recognition of help to meet the "Goal 1: Eradicate extreme poverty and hunger". In addition, it also contributes to meeting "Goal 7: Ensure environmental sustainability" by solving the population issues. (Partly extracted by UNFPA Website)

AIM

The workshop focused on reproductive health and HIV/AIDS prevention especially for the youth who are socially vulnerable. It was designed for invited city officials to increase their basic knowledge on reproductive health and to develop concrete task plans for possible implementation upon return to their respective cities. Accordingly it had not only formal presentations, case studies but discussion on current issues and challenges of UICK Associated Cities (AACs) related to population and development.

PARTICIPANTS

The Workshop targeted the most senior or the second senior officials of public health departments in nine selected Asian Cities: Chittagong (Bangladesh), Weihai (China), Chennai (India), Surabaya (Indonesia), Kuantan (Malaysia), Faisalabad (Pakistan), Olongapo (Philippines), Khon Kaen (Thailand), Danang (Vietnam). (In alphabetical order of country's name)

Dr. Salim Akhter Chowdhury
Health Officer, Chittagong City Corporation, Bangladesh
Mr. Fan Kaimin  
Assistant to the Director General of Health Bureau, Disease Control Section, Weihai Municipality Health Bureau, China

Dr. Kandasamy Manivasan  
Joint Commissioner (Health) & Project Director, Health & District Family Welfare Bureau/Chennai Corporation AIDS Prevention and Control Society, Corporation of Chennai, India

Dr. Esty Martiana Rachmie  
Head, Coordinating Board of Municipal Family Planning, Surabaya City, Indonesia

Mr. Mohamad Zainudin Idris  
Director, Health and Cleanliness Control Department, Kuantan Municipal Council, Malaysia

Dr. Aslam Pervaiz  
Deputy Director, Solid Waste Management, Thesil Municipal Administration, Faisalabad, Pakistan

Dr. Nilda Ticar Montoya  
Rural Health Physician, Social Hygiene Clinic, City Health Department, Olongapo Medical Society, Olongapo City, Philippines

Ms. Wallapa Prangthawat  
Public Health Technical Officer, Technical Supporting Section, Khon Kaen Provincial Health Office, Thailand

Dr. Kim Anh Thi Doan Vo  
Vice Director, Department of Health, Danang People’s Committee, Vietnam

<Interpreter>
Ms. Hong Thi Bui  
Program Assistant, UNFPA Vietnam (Dr. Kim’s interpreter)

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PROGRAM OVERVIEW

Tuesday, 28 June

The workshop was launched by Mr. Kazutoshi Sasayama, Chairman of AUICK after an orientation session by Mr. Nobuyuki Morimoto, Deputy Executive Director. The Chairman welcomed the participants to the City of Kobe and thanked them for making the long journey from their home countries. He said that this workshop would focus on the Adolescent Reproductive Health and HIV/AIDS. He then outlined the goals and work plan of the workshop. He hoped that each city would be able to benefit from this Workshop in order to provide necessary services for promotion of adolescent reproductive health, including protection against HIV/AIDS.

As the first resource person, Dr. Haryono Suyono made a presentation, entitled "Demographic Transition and Empowerment of Human Resources: Strategies for Population Policies and Programs." (See the details on page 8)

In the afternoon session, Dr. Haryono made another presentation on the “Best Practice of Adolescent Reproductive Health and HIV/AIDS in Surabaya.” (See the details on page 12)

This was followed by a presentation by Dr. Chuanchom Sakondhavat, Professor of Khon Kaen University, and Dr. Supat Sinawat, Assistant Professor of Khon Kaen University on the “Best Practice of Adolescent Reproductive Health and HIV/AIDS in Khon Kaen.” (See the details on page 13)
Wednesday, 29 June

In the morning session, Dr. Hirofumi Ando explained how to prepare an effective action plan to improve reproductive health and tackle HIV/AIDS in each participant's city.

Then, each of the participants presented his/her city report. (See the details on page 24)

In the evening, students of the Kobe City College of Nursing presented on their peer counseling activities to the workshop participants as an example of young people's involvement in promoting reproductive health and awareness of sexually transmitted diseases (STDs) and HIV/AIDS issues. (See the details on page 22)

Thursday, 30 June

The morning session was used by the participants to prepare their action plans and for a preliminary meeting for the Open Forum (UNFPA Seminar).

In the afternoon there was a public forum on "Sound Mind and Sound Body: Let us think and learn and have a wonderful adolescence." The Forum was organized jointly by UNFPA and AUICK and opened to public. The

Workshop participants participated as panelists, and engaged in a lively discussion. (See the details on page 36)

Friday, 1 July

In the morning session, two officials of Kobe City in charge of public health services of Kobe City made two presentations. (See the details on page 16)

First, Mr. Hiroshi Terada, Manager of the Health Promotion and Planning Division and "Maternal and Child Health Services of Kobe" presented on the Current Situation and Challenges on the Public Health Services of Kobe.

Second, Ms. Mihoko Higasisaka, Assistant Manager of Maternal and Child Health Section, made a presentation on the Maternal and Child Health Services of Kobe.

Then the participants visited the Health Care Center of Kobe to observe four-month-old babies receiving BCG vaccinations to prevent tuberculosis.
There are about 800 babies in the ward, which has a population of 10,000. The vaccinations are provided three times a month. On this day, about 30 mothers and infants were present.

After registering, there was a group session where information presented by a nutritionist and a dentist. Then the children were measured and examined by a pediatrician. The pediatrician gave advice to parents. The babies in generally good health then receive vaccinations, and those who had health concerns at that time skipped their vaccination on this visit. That was followed by individual sessions with a nutritionist, a public health nurse and a dentist. If any specific concerns were raised, the baby would receive a follow-up exam.

Back in the Center the participants received a presentation by Dr. Hisako Takamura, Professor of School of Nursing at Jichi Medical School, on "Adolescent Health Education in Japan." (See the details on page 20)

After the presentations, the participants proceeded to the Kobe Portopia Hotel to attend the opening ceremony of the International Congress on AIDS in Asia and the Pacific (ICAAP).

After the plenary session, the participants attended the following symposiums and Luncheon Session:
- "New Leadership — Pushing the Boundaries";
- Luncheon Session by UNFPA;
- "Beyond Tokenism: the Challenge of Making Involvement Meaningful for People Living with HIV/AIDS";
- "Decriminalization and Policy Change"

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**Sunday, 3 July**

The morning ICAAP Plenary Session, which was again attended by the participants comprised the following presentations:
- "Drug Use and Harm Reduction in Asia and the Pacific" by Tariq Zafar, Executive Committee Chairman, Asian Harm Reduction Network (Pakistan);
- "Regional Strategies tocope with HIV/AIDS among Mobile Populations" by Sharuna Verghis, Regional Coordinator, Caram-Asia (Malaysia); and
- "The Sex Trade in the 21st Century" by Carol Jenkins, Asia Pacific Network of Sex Workers (Thailand).

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After the plenary session, the participants attended the following symposiums and Luncheon Session:
- ICAAP Symposium on "Prevention of Mother to Child Transmission";
- Luncheon Session by WHO;
- ICAAP Symposium on "Learn From the Success — Bridging Continents"; and
- ICAAP Symposium on "Comprehensive Approach for Care, Self-help and Community Support in the Context of ART Scale-Up".

**Saturday, 2 July**

In the morning, the participants attended the ICAAP Plenary Session, which was composed of the following presentations:
- "Asian-Pacific Overview of the HIV Epidemic and Response" by J.V.R Prasada Rao, UNAIDS (Thailand);
- "Political Leadership" by Nimal Siripala De Silva, Minister of Healthcare, Nutrition and Uva Wellassa Development (Sri Lanka); and
- "Community Leadership in Treatment Advocacy" by Periasamy Kousalyan, D, Coordinator of the Positive Womens Network of South India (India).
Monday, 4 July

The morning ICAAP Plenary Session was composed of the following presentations:
- "3 by 5 Initiative: Its Progress and Challenges" by Jim Yong Kim, Director of HIV/AIDS Dept, WHO (Switzerland);
- "Sexuality Education: A Human Rights Perspective" by Sunil Pant, Blue Diamond Society (Nepal); and
- "The Critical Role for AIDS Vaccine in the comprehensive AIDS agenda; an update" by Seth Barkley, International AIDS Vaccine Initiative (U.S.A.)

After the plenary session, the participants attended the ICAAP Symposium: "Promotion of Sexual Health Amongst Adolescents in and out of School".

In the afternoon, the participants visited the Kobe City Hall to pay a courtesy call on Mr. Tatsuo Yada, Mayor of Kobe. Dr. Sultan Aziz, Director of Asia and the Pacific Division, UNFPA, and Ms. Kyoko Ikegami, Director of UNFPA Tokyo Office, who attended the ICAAP, accompanied the workshop participants.

Tuesday, 5 July

Presentations of the ICAAP Plenary Session in the morning were as follows:
- "Integration of Prevention and Care" by Tim Brown, East-West Center, Hawaii University (U.S.A.);
- "Chemotherapy and AIDS: Past, Present and Future" by Hiroaki Mitsu, Professor, Kumamoto University Graduate School of Medicine (Japan); and
- "Gender Issues" by Nafisah Mboi, Consultant of Indonesian National AIDS Committee (Indonesia).

After the ICAAP session, the participants from Surahaya, Kuantan, Faisalabad, Olongapo, Koh Kaen and Danang each presented their action plan at the AUICK workshop.

Wednesday, 6 July

To sum up this workshop, the participants had an evaluation meeting and the participants exchanged their views frankly about the overall workshop.

At the closing ceremony, Mr. Sasayama complimented the participants for their achievements in and contributions to the workshop and handed certificates to each of them.
After enjoying a farewell luncheon hosted by AUICK Chairman Mr. Sasayama, the participants went on a brief excursion to Osaka.

**REVIEW**

The workshop suggested that the peer group education is one of the most useful and effective methods to promote the awareness of adolescents on protection against HIV/AIDS, although a few participants felt uncomfortable with the peer group counseling where young girls are advised to use contraceptives because it may encourage the early sexual experience among younger people. However, most of the participants found the idea of peer group education useful and they adapted it explicitly in the action plans they prepared.

The ICAAP programs which the participants attended also provided them with the latest information on HIV/AIDS from a global perspective, and all of the participants were pleased with the invaluable experience of attending an international conference.

At the end of the review session, the workshop participants were requested to inform the AUICK Secretariat about the important steps they will take to implement their plans of action. The progress made in the implementation of the action plans will be monitored when the AUICK Secretariat visits each city at a later date to assess the usefulness of the workshop. The results of the monitoring will be published in future issues of AUICK Newsletter.
Demographic Transition and Empowerment of Human Resources
- Strategies for Population Policies and Programs -

Dr. Haryono Suyono
Member of AUICK International Advisory Committee
Former Coordinating Minister for Social Welfare and Poverty Alleviation, Indonesia

Demographic Transition

Dr. Haryono began his presentation with a global overview of demographic transition. He explained that life expectancy of 45 years was not uncommon prior to around 1750. The largely agrarian societies at that time compensated high mortality with high fertility, as larger numbers of people were required to carry out labor-intensive agricultural activities. Then technological advances spurred self-reliance and improved quality of life, and subsequently declining mortality was followed by lower fertility. In short, he noted, an era of high mortality, high fertility (TFR=4.5-6.0) and 45-year life expectancy was succeeded by a period of moderate mortality, moderate fertility (TFR=3.0-4.5) and 45-55-year life expectancy.

From 1750 onward, the world experienced massive population growth. The total world population doubled from 1750 to 1850 and tripled from 1850 to 1950. Hence, from 1750 to 1950, the era of European settlement, world population grew six-fold.

Into the modern age, further technological development, urbanization, medical innovations and health care intervention spurred lower mortality and lower fertility, resulting in relatively slow population growth. Dr. Haryono pointed out that in many countries, the speed of fertility decline closely followed the pace of decreasing mortality, a process that was largely aided by public policy intervention including UNFPA efforts. He mentioned Taiwan, China, Singapore and Korea as prime examples of countries that experienced rapid fertility change, as they managed to successfully reduce fertility within the span of a generation. By contrast, he noted, in the United Kingdom it took around 100 years for fertility to decrease to levels that reflected lower mortality.

Dr. Haryono discussed the so-called demographic bonus that results in rapid fertility declines, whereby a proportionally large working-age population is less burdened by child and old-age dependency and better able to contribute to raising a nation's wealth and prosperity. This increased capital can be used to invest in such areas as health and education for long-term benefits. He explained, however, that effective population policy planning and sound implementation of programs are required to take advantage of the demographic bonus, and concluded that many countries have not yet been successful in this endeavor. He said political talk and discussion are often not followed up by concrete effective actions.

Dr. Haryono stressed that demographic transition does not mean the end to population growth. He pointed out that China and India (the two "giants"), Bangladesh, Indonesia and Pakistan (now having populations over 100 million), as well as the smaller countries of Southeast Asia have doubled their populations over the past half century and continue to see high population growth.

Furthermore, he raised the issue that in addition to population growth, we are witnessing rapid change in population structures. He pointed out that in several countries the 15-64 age group has doubled or tripled in a generation, as has the 65+ age group. He then asked the question if budgets for health, education, poverty reduction and facilities for the aged doubled or tripled at the same time. The simple answer, he said, is no.

New Strategies: Empowerment of the People

Dr. Haryono drew attention to the fact that although improvements have been made in infant mortality, maternal mortality, life expectancy, adult literacy and income per capita, many developing countries remain low on the Human Development Index (HDI). He stressed that for effective progress, future strategies must be based on commitment and focused on people and their communities. Moreover, participation and empowerment of the people, all people including women, youths and the poor, are key elements for success. He was clear on the point that empowering people enables them to contribute to the betterment of their society. He mentioned the following as some specific strategy objectives:

1. Putting people first: People have the right to be free from ethnic and gender discrimination, free to pursue equal opportunities and free from fear.
2. Changing not just attitudes but behavior: Promoting knowledge and awareness must be followed up by ensuring people's involvement and participation.
3. Introducing Millennium Development Goals and HDI. Participation of the people is needed and targets must be met with numbers.
(4) Introducing integrated approaches: Human development, family income and environment must be simultaneously addressed yet each person should be able to participate according to his/her choices. Ensuring health, education and income will help empower the people.

(5) Maintaining local government and NGO commitment: Focus should be placed at the local level to help people help themselves.

**Millennium Development Goals**

Finally, Dr. Haryono outlined the Millennium Development Goals and emphasized some strategies and issues that deserve special attention. They are:

(1) Eradication of extreme poverty: Areas of focus include education (especially for women) and micro-credit or village banking systems to help individuals and groups set up and run small businesses. In contrast, national governments usually just focus on large-scale projects in cities.

(2) Universal education: Primary school education must be universal, but we should also aim for high-quality education and higher education. Improved education helps break the poverty cycle.

(3) Gender equality: Support for female education is needed as well as special training for women so they can realize the objectives of good health and self-reliance.

(4) Reducing child mortality: Efforts should be people-centered and focused at the local level.

(5) Improving maternal health: In Indonesia, maternal mortality has declined but it remains the highest among ASEAN countries (306 per 100,000 births).

(6) Combating HIV/AIDS, malaria and other diseases: HIV/AIDS in particular is an increasing concern in Asia.

(7) Ensuring environmental sustainability: Special attention is particularly needed for the poor to help them live in a decent environment.

(8) Developing global partnerships for development: Partnerships must also be maintained between the government and private sectors and developed through international cooperation and networking, such as through AUICX. Working together we can achieve better results.

**Questions and Answers**

**Q: How can we encourage private sector involvement in family planning?**

A: Government initiatives can focus on involving the private sector, either directly or through NGOs. Private sector incentive is usually in the form of monetary profit, so success in this aspect is needed. But if profit can be generated by private sector involvement, this in turn enables more money to be directed at family planning initiatives.

**Q: Can the Earth support expanding populations?**

A: Yes. The Earth can support growing populations as long as people are educated to know how to carry out sustainable economic and social practices.

Editor's Note: This article is a summary of a presentation delivered by Dr. Haryono Suyono at the First 2005 Workshop. AUICX takes full editorial responsibility for the content.

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**Young People and HIV/AIDS in Asian Cities: Challenges and Actions**

Mr. Sultan A. Aziz

Director, Asia and Pacific Division, UNFPA

HIV/AIDS in Asia is one of the great challenges. Over a million new cases were diagnosed in Asia in 2004. In India, five million people have AIDS. Before, commercial sex workers and injecting drug users usually contracted it, but now it is spreading among the general population. Young people are particularly affected, and 60 percent of the world's young people live in Asia. There is nothing inherent in Asia's customs and traditions that will protect it from an HIV/AIDS epidemic, unless governments, communities and individuals take action.

Asia is also witnessing the feminization of AIDS. Nine out of ten women in India who have AIDS had no other sex except with their husband.

Investing in young people is critically important.

However, the picture is not all bleak. In fact, it's the opposite. A girl born today is more likely to stay in school, and delay childbirth, than she would have been 20 years ago.

Young people need information about HIV/AIDS and how to protect themselves. Condoms — both kinds (male and female). Clean needles. Encouragement to have just a single partner. Abstinence. Monogamy. They need to be able to find services in youth-friendly settings, that are inexpensive and convenient. Young people need to be able to safely and easily access information, without stigma or abuse.

Young people in poverty are underserved. Almost one fourth of the world's young people live in extreme
poverty. The future of young people could define the future of our countries. Fertility differences between the poor and the rich are among the largest of the health indicators.

Education is the key to breaking the cycle of poverty, but poor people are the least likely to finish school. Maternal deaths are also closely associated with poverty. Poverty, underdevelopment, and illiteracy are the principal factors in the spread of HIV/AIDS. In poverty, HIV/AIDS is almost a death sentence.

There is also the factor of gender inequality. Women are more susceptible. There are 7.3 million young women with AIDS, and 4.5 million young men. Poverty drives people to risky behaviors or to being victims of sexual exploitation. Many of the men are very sexually experienced. Biologically, the risk is two to four times higher for women than for men during unprotected sex.

In urban areas, the rates of infection are rising, except in Bangkok. The changes of urbanization bring new challenges. More than half of migrants to urban areas are less than 25 years old, and women are the largest proportion. They are driven to cities from rural poverty, and end up living in a poor urban neighborhood. Reproductive health services are very poor in these areas. The urban adolescent is less likely to use a condom.

What is the way forward? A partnership between city governments and young people is crucial. We need to engage and empower young people.

When we asked young people for their recommendations, they said:
1. Scale up funding
2. Provide more youth-friendly services and information
3. Government should work in partnership with young people — both local and national governments.

Young people have strength and energy. They are vital resources for driving grassroots initiatives. We need to engage young people who live on the streets. City governments often criminalize the urban poor. We need to integrate them into the political and economic life of the city.

Urban governments need to translate the national policies on the eight Millennium Development Goals into local action.

One Millennium Development Goal is to significantly improve the lives of 100 million slum dwellers. A critical component of this is sexual and reproductive health. To make progress in that area, we need to:
1. Improve health information services.
2. Increase access to service delivery points.
3. Encourage community involvement.
4. Take measures to improve conditions for the working poor, especially women.

Questions and Answers

Q. Can we get help from UNFPA for anti-retro viral treatments? Women who can’t get access to this treatment are often abandoned by their families.
A. Governments and people are just coming to grips with the “it can’t happen to us” feeling. The truth is right in our own back yards. Abandonment or the social stigma seen is the most terrible part of this disease. We are dealing with the burden of culture, history and attitudes. If we are concerned about saving lives, there is no place for stigma. These raise profound policy issues. If there is no comprehensive national policy on the issue, then there is no anti-retro viral treatment available. So far, there hasn’t been enough effort on this. The UNFPA focus is on prevention. In Danang, you should contact the WHO about this and bring this to their attention.

Q. We have no anti-retro viral treatments. What do you tell a patient when they ask if they can buy it a pharmacy?
A. There is so little information about what is going on. Philippine’s politicians won’t lift a finger to help. We must choose life over death.

Q. Do you see a remedy for Islamic societies, where we can’t talk about sex lives?
A. If the final word is about saving a life, then we can suspend all other norms. What is the consequence of people not being informed? I don’t think Islam is going to fall apart if we talk about these things.

Q. How can we afford multiple agencies? I don’t even know how many agencies are already at work in my city.
A. Governments need to think critically about health infrastructure. Clarity and simplicity deliver results. Sometimes we add to the confusion. India is the model the rest of Asia is watching. There is a correlation between the economy and poverty. If you have a lot of capital, it raises the problem of resource allocation. Don’t despair. You’re on the right road. But be more demanding of local government.

Q. Why is the UNFPA not funding the program in Chinagong?
A. The funding is coming through the Asian Development Bank.

Q. Why don’t we take families and teach them all about sexual and reproductive health, instead of youth?
A. Families do need to be empowered. Because of cultural attitudes, often whatever the father has to say is the last word. So how do we educate people without disrupting the family? Many religions and societies are very conservative, and believe in family values. We put ourselves on the back for being that way, but we are closing our eyes to a raging torrent. The power of culture transcends borders. You have to look at the information you are coming to them with.
Best Practices

Surabaya Case

Dr. Haryono Suyono
Member of AUICK International Advisory Committee
Former Coordinating Minister for Social Welfare and Poverty Alleviation, Indonesia

Background

Surabaya is Indonesia’s second-largest city and has a population of 2.7 million. It is a port city and the capital of East Java province. It is also a strategically important city given its location as a regional hub. The mayor is elected by the people, while the heads of the city's 31 districts are appointed. Its districts are further divided into 153 villages, 1,350 community organizations and 8,762 neighborhood organizations.

Dr. Haryono pointed out that in addition to the official population of 2.7 million, there are an estimated 300,000 to 500,000 migrant workers who are not counted nor eligible for health care and other services. He stressed that these migrant workers are human resources that should be developed and tapped, and it is important that these migrant workers be treated as city residents and supported accordingly.

Poverty

Dr. Haryono stated frankly that we cannot talk about health in Surabaya without discussing poverty. It is estimated that 15 to 25% of families in the city live below the poverty line. As an example of poverty conditions, he raised the issue of shanty towns or slums located in the city's outskirts, where homes constructed from scrap materials are often shared by families having alternating patterns of sleep and work.

A prime factor behind the poverty is lack of "legal" or "legitimate" jobs. In fact, he said there are higher numbers of people working illegitimately than legitimately. Due to the scarcity of legitimate jobs, people are willing to work for low paying illegitimate jobs, which provide no insurance and no health care. This situation applies especially to the 300,000-500,000 migrant workers.

Many children and youths have to work or try to find work due to familial needs. Moreover, among the impoverished are increasing numbers of unmarried young women.

Health Services

Public health services are provided through hospitals, district clinics and outreach "health clubs" called posyandu. A number of shortcomings in the provision of health services. For instance, although one clinic is allotted per district, the system neglects to take into account actual population numbers and population increases. Furthermore, as he mentioned earlier, non-residents are not eligible for health care. He stressed the need for clinics to encourage themselves to provide "people-centered" services, or in other words services for all people in need. He also drew attention to the relatively high child mortality rate, and suggested that efforts on immunization should be doubled or tripled to address the problem.
Family planning is an ongoing endeavor. On a positive note, contraceptive prevalence is high due to past activities, and special professional services for pregnant women are available in all government clinics. He also cited the posyandu, or health and family planning clubs, which encourage health awareness and safe practices at the community level. Local women's organizations are also working to increase community participation in health.

As regards HIV/AIDS, the total number of confirmed cases has risen from 57 in 2002 to 167 in 2004, a 300% increase in just a few years. However, that the official figures do not tell the real story, as people are reluctant or unable to report they have been infected or unwilling to be tested. Illustrating the lack of official statistical understanding of the problem, he also noted that a large portion of efforts for prevention and support are not documented, as they are done by NGOs and other non-official means.

Dr. Haryono explained that a focus is being placed on educating young people, especially women, on health issues such as HIV/AIDS and family planning. Hospitals are providing HIV/AIDS testing and steps are being taken to get people out into the community, while midwives and other professionals are being encouraged to talk about family planning and be involved with local residents.

Questions and Answers

Q: Is there a relation between HIV/AIDS and migrant workers?
A: Yes there is a relation because the migrant workers are a very vulnerable segment of society. The link is clear; the link is poverty. Some of these people must turn to prostitution as a means to make a living. Intravenous drug users are another highly susceptible group. Poverty and HIV/AIDS are inseparable issues.

Q: How can you overcome conservative elements to promote reproductive health in schools?
A: No single solution is available. Trial and error and continuous actions are required. But one must be careful of making serious mistakes, as they can easily reverse the progress of previous accomplishments.

- If there is opposition to the concept of reproductive health education then perhaps try to make the educational content less direct or obvious. Focus on promoting the goals of the program instead of the program content. Show appreciation for results, such as through newspaper articles or other means.
- Commitment is required in face of opposition, especially in the case of politics. The vision for a policy or program should be one of shared responsibility, one that encourages the participation of all individuals and segments of society.

Khon Kaen Case

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Background

Dr. Chuanchom began her presentation with an overview of the health status at the national level. Thailand has a population of almost 62 million, of which only 31% live in urban areas. The country, however, is experiencing rapid urbanization. As a result of intensive family planning initiatives, annual population growth has reduced from 3.1% in 1960 to 0.8% in 2003. Infant mortality has also drastically improved, decreasing from 103 per 1000 in 1960 to 20 per 1000 in 2003.

Adolescent Reproductive Health in Thailand

Dr. Chuanchom defined adolescent reproductive health as referring to the physical and emotional well-being of adolescents and their ability to remain free from unwanted pregnancy, unsafe abortion and sexually transmitted diseases (STDs) including HIV/AIDS. She noted that a recent national survey found that over 45% of young people (58% for men and 36% for women) had had their first sexual encounter by the age of 18, and 25% had by the age of 16, which indicates that today's young adults are becoming sexually active at younger ages compared to
previous generations. Furthermore, in a survey of students in Khon Kaen, 73% of males had had sexual intercourse with sex workers, which shows there is high risk of HIV/AIDS being spread to students.

Dr. Chuanchom pointed out that despite decreasing numbers of young people, there is a rising problem related to adolescent reproductive health. She noted that young people seldom use condoms or other forms of contraception, especially for a first sexual encounter. Although Thailand generally has been successful with its family planning policies, such programs have been directed mostly to married couples, while adolescents have relied on the media, friends and other potentially unreliable sources for reproductive health information.

Dr. Chuanchom explained that abortion is illegal in Thailand, except for women who have been raped or whose health may be detrimentally affected by pregnancy. There are, however, a significant number of illegal abortions performed, including those done by unqualified persons.

HIV/AIDS

The first case of AIDS in Thailand was reported in 1984. The first outbreak of HIV/AIDS was observed among intravenous drug users in Bangkok in 1987, and the second outbreak occurred among sex workers in Chiang Mai in 1989. Between 1990-91, many cases were reported among pregnant women, followed by increasing numbers of infected babies. Today the incidence of HIV infection in pregnant women remains high at around 1.5%. As for the number of young people infected, she explained that 11.1% of the infected population is between the ages of 10 and 24 years.

As of 2004 there have been an estimated 1.1 million HIV/AIDS cases, and over 500,000 deaths due to the disease. New HIV/AIDS cases in 2004 are estimated to number 20,000. She also highlighted that the male-female proportion of AIDS cases has changed significantly over time, from 4.5:1 in 1995 to 2.1 in 2004.

Dr. Chuanchom outlined Thailand's four major systems for tracking HIV/AIDS: (1) an AIDS reporting system, (2) a sentinel zero-prevalence surveillance system, (3) a STD reporting system, and (4) a behavior surveillance system.

In 1991, the National AIDS Control Committee chaired by the Prime Minister issued a resolution to implement the 100% condom-use program on a national scale. Dr. Chuanchom pointed out that as a result of such initiatives the rate of condom use increased from less than 20% in 1989 to over 95% in the mid 1990s, although it has since dropped back to 90%.

Thailand was the first developing country to launch a national program to prevent mother-to-child HIV transmission. Highlighting the effectiveness of the program, Dr. Chuanchom estimated that assuming a transmission rate of 30% without the program and 8% with the program, approximately 2,225 infections are being prevented each year.

Dr. Chuanchom also outlined Thailand's national AIDS prevention plan, and mentioned the country's programs aimed at youths, such as the National Youth Policy, the Ninth Children and Youth Development Plan and the Long-term Children and Youth Development Plan.

Practices in Khon Kaen

Dr. Supat Sinawat's part of the presentation focused on adolescent reproductive health and HIV/AIDS in Khon Kaen. He noted a series of programs and strategies that are being carried out in Khon Kaen relating to education, community involvement, information dissemination, awareness promotion and various means of support.

Dr. Supat said that sex education in Thailand is still a sensitive issue due to conservative elements of society, even though it has been taught in primary and secondary schools (as "family life planning") for over 20 years. Because people today are becoming sexually active at younger ages, it is important to have sex education implemented in primary schools, as secondary school may be too late for many people.

Khon Kaen University is the only medical university in northeast Thailand. Teams from the Faculty of Medicine provide courses to secondary school students on sexuality, STDs, HIV/AIDS and other reproductive health issues. Furthermore, research and other efforts in HIV/AIDS by faculty members such as Dr. Chuanchom have spurred various programs at the local level that have eventually been adopted as national policy. In 2006, the university established a designated AIDS institute to serve as a center for sharing information, promoting prevention and treatment, encouraging research and building cooperation between government and NGOs.

Dr. Supat stressed that community involvement is a very important and effective approach in promoting reproductive health awareness and programs. He cited as a prime example Khon Kaen's "mobile education teams" that go out into the community to strengthen educational participation and encourage people to trust and follow the proper information. Furthermore, he suggested it was important to involve as many people from as many segments of the community as possible, and cited as an
example his experience that even monks can contribute by allowing use of temple space for health-related activities. As Dr. Haryono mentioned in his presentation as well, involving the religious leaders of the community in some capacity is an important component of the goal to have the participation of multiple agencies and facets of society.

Other educational activities conducted in Khon Kaen include training courses in sexuality and reproductive health counseling for school teachers and various levels of meetings for medical personnel to share and disseminate current information on reproductive health and HIV/AIDS.

Khon Kaen has also set up visits to specific subgroups in order to obtain better information about high-risk groups, such as the military, sex workers, factories, homosexual groups and isolated housewives. Dr. Supat explained that conducting questionnaires during the visits provides data that can be used to supplement the government data, which can be unreliable. He suggested giving participation incentives to factories and other organizations in the form of some kind of accreditation for cooperation. Such visits are also used as opportunities to provide counseling and ensure accessibility to information, and at the same time condoms can be distributed.

In Khon Kaen and nationwide, HIV/AIDS counseling and testing are available at nearly all community hospitals and higher levels. Counseling on reproductive health is available in secondary schools and hospitals and also through a telephone hotline.

### Questions and Answers

**Q**: Has the rate of HIV infection in youths been increasing or decreasing?

A: The rate has been decreasing thanks to reproductive health education and changing attitudes about condom use.

**Q**: Relating to condom use, how do you transform knowledge and awareness into actual behavior change? For example, how can women force men to use condoms? Are condoms distributed free of charge?

A: This is a difficult problem because the women, especially prostitutes, are often vulnerable to the wishes of the men. As an alternative to condoms, we have tried distributing female condoms, but these are relatively expensive. Condoms are no longer available free to everyone, but they are available at subsidized prices for those who are not getting them free.

**Q**: What steps are you taking to prevent HIV/AIDS among university students?

A: 20-25% of students are sexually active, so effective strategies are needed. We have found that lectures are not effective, so we prefer to organize peer counseling. Furthermore, for a decade, sex education has been compulsory from primary school upward.

**Q**: Are the strategies and programs you mentioned being implemented at the national or provincial level?

A: In fact, many strategies were initiated in Khon Kaen and then brought up to national level since they were proven to be effective. Many were pilot projects as part of the research by Dr. Chuanchom, which were then forwarded to the then Prime Minister, who was very open and cooperative on the issues. Successful reduction of cases today is largely a result of this cooperation.

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Editor's Note: This article is a summary of the presentation on best practice in Surabaya delivered by Dr. Haryono Suyono and the presentation on best practice in Khon Kaen delivered by Dr. Chuanchom Sakondhavat and Dr. Supat Sinawat at the First 2005 Workshop. AUICK takes full editorial responsibility for the content.
Current Status and Future Issues on Public Health of Kobe

Administrative Bodies Responsible for Public Health

The national, prefectural and city governments all conduct public health measures. The national government is responsible for gathering information on regional health activities, providing training, technical and financial support to prefectural and municipal governments. The prefectural government is responsible for establishing and improving facilities, for technical support to municipal governments, both to municipal governments and over a wider area. The municipal government is responsible for establishing and improving facilities in each municipality, improving the quality of human resource, and carrying out the public health projects that are close to citizens.

Three Areas of Public Health Projects

Because Kobe is quite large, it has a somewhat unique structure. Public health projects in the city of Kobe are divided among three main areas:

1. Public health center, municipal health centers
2. Kobe Institute of Health
3. Mental Health Center

Kobe has one public health center, on the ninth floor of the Chuo Ward office. The center is responsible for planning and coordinating programs, which are then implemented by the municipal health centers. It plays the role usually performed by the prefectural health center, overseeing the health and risk managements systems of Kobe. It includes five offices for food and health standards.

Kobe has nine wards, with a public health and welfare office in each one. Citizens visit the municipal health centers for direct delivery of services.

The Kobe Institute of Health deals with regional and environmental issues. It also supports the municipal health centers on scientific and technical matters. It is involved with inspections, studies, examinations and analysis of regional and environmental public health issues.

The Mental Health Center offers administrative services concerning mental health, and provides citizens with accurate information and counseling services related to mental disorders.

Current Issues on Public Health

The public health issues in Kobe include merging the public health organization with welfare services. The division between these two fields has become increasingly blurred. Nursing care, for instance, is merging with general public health care. And general health care provides preventive services to help reduce future nursing care. The City has to figure out which organization should be responsible for what. It is important that the administrative activities of the City should be directed to its citizens.

Public health services are mainly preventive. They can run for long periods and sometimes it is difficult to see the immediate outcomes and fruits of the services. Good examples are vaccination and immunization programs. It is difficult to measure the output, and also difficult to convince citizens of the benefit of public health services.

Public health services are getting more public attention recently. This is partly because of diseases like SARS, and also because of new types of food that are becoming available. It has given us a chance to be more visible, and public health risk management is more of an open concern for citizens.

In line with "Healthy Japan 21," a national campaign to promote health, Kobe created its own "Healthy Kobe 21" program in 2002, to help citizens enjoy good health throughout their lives.

Eight Categories of Public Health Services

Public health services promoted by Kobe are roughly divided into the following categories:

1. Maternal and child health
2. Adult and elderly health
3. Management of intractable diseases
4. Infectious disease control
5. Tuberculosis control
6. Mental health
7. Environmental health
8. Medical and pharmaceutical affairs

Maternal and Child Health Project

There are several issues that are addressed in the strategies of Kobe and the larger nation alike. These include a dwindling birthrate and an aging population, women's social advancement (women are getting higher education and jobs outside the house), an increase in child abuse (physical, mental and sexual abuse as well as negligence), and a shift from extended families toward nuclear families.

Childcare is a major concern in families where both parents work. The mother often works long hours and the father even longer hours.
The fertility rate is decreasing, and a population pyramid clearly shows the change in population structure. In 1930 the pyramid was very broad at the bottom and narrowed steadily toward the top. By 1950 it had begun to bulge slightly in the middle. By 1960 and 1970 the bulging in the center continued, almost completely eliminating the pyramid shape. By 1980 and 1990 a pyramid was no longer recognizable, as the bulk of the population moved upward without corresponding replacements at the bottom. Projections for 2020 show the widest part of the graph at the top, instead of the bottom. Viewed in a series, it provides a shocking image, and helps show the serious problem we are facing.

There were sharp changes in both the birth rate and the infant mortality rate from the period 1900 to 2000. The birth rate in 1900 was just over 30 births per 1,000 people. By 2000, it had fallen to about 8.6 per 1,000 people. The infant mortality rate in 1900 was just under 160 per 1,000 births. By 2000 it had fallen to 2.6 per 1,000 births.

There has been a steady development of a maternal and child health care system. Significant dates include:

- 1937 — Health Care Center Law — enforcement of health guidance for pregnant women and their babies
- 1942 — Establishment of the maternity handbook.
- 1958 — Nursing care for premature babies.
- 1961 — Health checkups for three-year-olds.
- 1965 — Maternal and child health law.
- 1974 — Research into treatment for chronic childhood diseases
- 1977 — Health checkups 18-month-old babies
- 2003 — Funding of infertility treatment projects

The Maternal and Child Health Handbook is issued to women who register their pregnancies. It is used for recording health information about the pregnancy, birth, and care after birth.

There is a project in place to expand visiting to all newborn children, by a maternity nurse or hygienist. They will weigh the baby, give childcare advice, respond to concerns the mother might have, and give information on other resources available. There are separate guidelines for visits to babies who were born prematurely.

Health check-ups for babies are scheduled at four months, nine months, 18 months and three years. These will confirm proper growth, provide early detection and treatment of diseases and disabilities, and provide support for parents with childcare anxieties and difficulties.

For the four-month checkup, the compliance rate in 2003 was 96 percent. For the nine-month check-up, it was 91 percent. For the 18-month check-up and the three-year check-up, it was 97 percent. These check-ups are often carried out in one location, on the same day, and help create a community center type of atmosphere. It provides a good opportunity for us to give information to parents, and it is also a good opportunity for them to exchange information with each other.

Classes on childcare are also held. Few young mothers today have enough chances to care for or even hold infants, and to learn about diaper changing, clothing, skin care, etc. The classes also allow parents to share problems such as, multiple pregnancies. They also help prevent parents from caring for children in isolation, without support from other parents, and help promote community support for childcare. The classes include:

1) Bringing up babies:
For parents of babies of five to six months old, information on accident prevention, play, baby food, dental care, sanitation, making friends, and reading picture books, are provided.

2) Continued Care:
For children over 18 months with continuing need for support in regard to areas like speech or social skills. Instruction by hygienists, childcare workers, and psychological counselors will be given, on group play and maternal concerns about raising children. Opportunity for Information exchange among parents facing similar problems will also be created.

3) Child Abuse Prevention:
Group counseling to support families who cannot establish proper parent-child relationships. Other classes include parenting for very low-birth-weight infants, and classes for parenting a handicapped child. There are also classes for expectant mothers and/or their husbands, about pregnancy and fathers’ responsibilities for childcare. These classes are offered on Saturdays or holidays. Other classes focus on health care programs for adolescents. They are
offered, when requested, by professionals. The classes include sex education for seventh-graders, taught by qualified midwives, and a class on sexually transmitted diseases, for ninth-graders, taught by doctors.

The city also operates a hotline for adolescent problems, and an automated answering service for common adolescent concerns.

The city has hospital programs for premature baby care (babies under 2,000 grams), for nurturing treatment, and for research into chronic diseases, such as leukemia, kidney disease, and cancer.

The city also has a program for fertility treatment, including aid for in-vitro fertilization or micro-insemination. These treatments cost a lot, and often have to be repeated multiple times.

Other Services
1) Adult and elderly health:
The city provides the following services to citizens over 40 years old: a) a health handbook, b) health education, c) health counseling, d) health examinations (cancer screening, etc.), e) functional training program and f) home-visit guidance. The city also cooperates with private facilities providing services to prevent people from being bedridden, and to assist those who are bedridden.

2) Management of intractable diseases:
Public financial support for medical expenses, and other support and advice on receiving medical care at home are given to those suffering from certain intractable diseases.

3) Infections disease control:
Provides accurate information about infections, promotes screening and immunization programs, mounts awareness campaigns, and carries out surveillance on infectious diseases. It is especially important to prevent influenza, in particular among the elderly.

4) Tuberculosis control:
The national rate for tuberculosis infection is 24.8 per 100,000 people, while in Kobe it is 35.9 per 100,000. This year the city started a project to reduce the incidence of infection to below 30 per 100,000 people by promoting early detection, appropriate treatment and by improving the patient support system.

5) Mental health:
Programs offered by the city include social and vocational rehabilitation, the provision learning opportunities about mental health issues for affected families, legal and administrative assistance, and awareness campaigns.

6) Environmental health:
The city issues business licenses for eating establishments, inns and hotels, public baths, barbers and beauty salons, and performs inspections of these businesses. It also offers animal protection, including advice on how to raise and train pets, and vaccinations to control rabies and other infections.

7) Medical and pharmaceutical affairs:
The city issues licenses to dentists and other clinics, performs on-site inspections at medical facilities, helps reduce medical accidents and hospital-acquired infections, and provides high-quality medical services giving due consideration to the convenience of its citizens. In 2003, the city started an advisory service to receive inquiries and hear complaints on medical services from citizens. The goal is to build trust between patients and their families and medical staffs and their institutions, and to improve the quality of medical services.

Health Risk Management System

The Public Health Center plays a leading role in preparing manuals and guidelines for risk management. It works with the municipal health centers to implement the guidelines. With SARS in 2003, and avian influenza in 2004, the city prepared an action plan and manuals for dealing with these diseases. The city also set up a contact office to respond to questions. This office is open on holidays and at night, in addition to regular hours.

Future Commitments

The city will continue to promote "Healthy Kobe 21" and will conduct an interim review to assess the program. The city will also start a new prostate cancer screening program. Other existing screening programs will be upgraded: mammography examination will be introduced; the minimum age for uterine cancer will be lowered, and a gastric cancer screening unit will tour the city, usually at the municipal health centers.

The budget for the Public Health and Welfare Bureau in 2005 is 18 percent of the city's general account spending.

Statistics of Public Health

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<th>Population (As of June 2005)</th>
<th>Males</th>
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<tr>
<td>Dental clinics</td>
<td>886</td>
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Questions and Answers

Q. The rate of divorces is very high. What are the causes of that?
A. Yes, there are many divorces. There are no concrete measures to deal with this.

Q. Do you refer children in divorced families to the welfare department? What department cares for them?
A. We do not refer them to the welfare department. The child-home section, in another department, takes care of them. A foster-parent type program is also in place.

Q. How are the activities in the municipal health centers coordinated?
A. By the Public Health Center, which supervises the municipal health centers.

Q. How is cancer screening for a large city promoted?
A. There are many public relations activities, and the screening unit makes tours of the city, to raise awareness of the citizens. But the rates of screening are still quite low. We would like to raise them higher. We follow national guidelines for cancer screenings.

Q. Is the screening free for citizens?
A. It is not free.

Q. Is the screening free for those who can't afford it?
A. The poor can receive screening free of charge.

Q. Are tuberculosis patients treated at home or in a hospital?
A. They are mainly treated at a hospital. We get better compliance with the treatment regimen that way.

Q. What steps did you take in regard to SARS and Asian flu?
A. With these two diseases, we performed some complete sterilizations at some facilities, and also performed health checks of vulnerable populations.

Q. How do the different government levels of health care deal with each other and communicate?
A. We are in very frequent phone contact. The governments are close. We have not felt a communication problem in our case.

**Maternal and Child Health**

Q. What is the maternal mortality rate in Japan?
A. Three years ago, the rate was 7.3 per 100,000 births. Two years ago, the rate was 6.9 per 100,000 births. Factors for this usually include complications during birth, leading to hemorrhage and/or infection. A mother can suffer an amniotic embolism, something that happens in about one per 100,000 births. This can lead to respiratory failure, when water fills the lungs. It is important to watch for fetal heart rate drops, difficulty in breathing and chest pain during delivery.

Q. Are breast-feeding practices an issue here?
A. It is up to the mother to decide which method to use. We encourage breast feeding, because of the good nutrition and the good communication with the baby that it offers.
Adolescent Health Education in Japan

Dr. Hisako Takamura
Professor, Health Education Studies
School of Nursing, Jichi Medical School

Dr. Takamura began her presentation stating that at her school there is no "sex education" among their courses which could trigger heavy criticism, but they focus on sexuality education. This involves defining sexuality, and understanding that everyone is a sexual being.

Teachers and parents have previously thought that sex education is just about intercourse. It is difficult to shift from the old concept to the new concept. Under the old philosophy of "sex is life," major problems are created for young Japanese people. Their self-esteem and gender awareness can be lowered, while their participation in casual sex and the development of sexual networks is on the increase. Dr. Takamura stressed that they sought to give them the capacity for making their own decisions, by focusing on "sexuality is life."

Dr. Takamura explained that this was empowerment education, and required three elements to achieve it. The first element is to define our quality of life. The second one is to attain our defined goals, and the last is peer counseling.

Peer counseling is moving away from learning led by teachers, to sharing values within the same generation. It helps provide the mentality and the capacity to live fully - a goal of empowerment education.

Empowerment is the power to control one's own way of life, and the attainment of goals through cooperation with others. There are three types of empowerment; individual (psychological), organizational, and community, among which the first, individual, is the most important.

The process includes active listening, dialogue, heightening awareness, and progress towards individual and social action. The goal of empowerment education is to change the individual and group structure. The previous system of "sex education" didn't achieve the objectives of improving self-esteem, self-sufficiency, and healthy behaviors. To fill that gap, we use peer counseling.

The Healthy Family Plan 21 is a 10-year project, begun in 2001. It seeks to enhance health care for adolescents, support safe pregnancies and childbirth, provide support for infertile couples, and provide conditions for better children's healthcare.

The cornerstone of a concrete approach is having various groups and organizations cooperate to focus on adolescents. This new approach to adolescent reproductive health tries to provide knowledge and guidance toward leading a better quality of life.

Dr. Takamura explained how peer counseling had been developing throughout Japan. It had a natural and spontaneous birth at the Jichi Medical School, School of Nursing. The first sessions were held at a local community center and students took the initiative. After seeing that, the municipal governments, the municipal and prefectoral health centers, and NGOs got involved, one of which was the Tochigi Society on Adolescent Health. This NGO is made up of people from diverse backgrounds and educational levels. The practical model for this NGO comes from Tochigi Prefecture, where they are working to promote cooperation between local and regional governments, school healthcare programs, and the NGO.

Four years ago Tochigi Prefecture had the worst abortions statistics in the country, and the highest rates of STDs. The prefectural health and welfare department trained peer counselors and set up peer counseling centers. The prefectural board of education conducted a survey on peer counseling and dispatched specialists, doctors and ob-gyns, to assist. Instead of discussions, these groups wanted to take action, and determined that peer counseling was the most effective way. Peer counseling is in effect expanding across the prefecture.

The Tochigi Workshop on Education trains peer counselors, using an approved curriculum. That curriculum includes a 30-hour basic course, 10 hours of training on sexuality, 10 hours on peer counseling, and 10 hours on the practical activities of the class. A follow-up 15-hour course, given after six months, includes five hours on brushing up on peer counseling skills, five hours on review of practical actions, and five hours on empowerment.

In a survey of adolescents, we learned that they 1) did not want to use condoms, and 2) did not think they would get pregnant. There was a need to educate them about contraception. It was necessary to open many channels, work that could not be done by the local government alone.
A female peer counselor said she had joined because she had had difficulty getting sexual advice. She said that her dates did not want to wear a condom. As a peer counselor, she was comfortable giving advice, as they were from the same generation. A male peer counselor said he became involved because he had a friend who had a difficult time with an abortion, and he had failed to give the friend good advice. It opened his mind to peer counseling. Email counseling has proven very popular, and provides the most number of contacts.

Scientific research had led to development of some of the training materials. With phone counseling, you cannot provide enough training. There is a manual for phone counseling, and the counselors are always brushing up on their training. Some have been to other countries to study adolescent reproductive health. Some of the counseling is done in an open area and eighty-seven percent of the people involved are female. They had a representative from Tunisia, who upon return home established a counseling center called "Clover Room".

Some of the issues going forward include:
1. Finding/training coordinators. In many areas public health nurses are coordinators. In other areas, midwives or doctors are coordinators.
2. Training and fostering supervisors. In Japan, about 20 supervisors are being trained.
3. Training the peer counselors.
4. Setting up a system to launch peer counseling with other organizations.
5. Evaluating the effectiveness of peer counseling techniques.

The studies on other models of sexual education has also been conducted. Measurements include reductions in abortions and pregnancies. One study is interviewing those who received peer counseling. It contacts the people three to six months after the counseling session, and asks about what positive changes were made after the counseling.

The following are areas in which improvement was found after counseling among people who took the course.
- a more specific life plan
- improved knowledge of sexual activities
- greater ability to express themselves
- greater acceptance of their own sexuality
- awareness that sex should be with a steady partner
- ability to think about pregnancies and STDs when anticipating sexual activity
- confidence about using a condom properly
- that when going out with a member of the opposite sex, it is important to know the person
- how to resist peer pressure
- to be more confident rejecting a proposal for sex

**Questions and Answers**

**Q. What is the target age group for training?**
A. It depends on the prefecture. In some it is 16 to 20 year olds. In others it is 18 to 20 year olds.

**Q. The Japan Family Planning Association ... how is it involved?**
A. It can train someone from any prefecture.

**Q. What is the family reaction to daughters on television talking about condom use?**
A. Most families are quite favorable. Also, the discussion is not just about condoms, but about life plans, etc.

**Q. Who operates the peer counseling rooms and where are they located?**
A. The room is in a building facing a main street, and in a fashionable location. It is funded from the prefectural budget, but operation is delegated to the NGO.

**Q. What are the most important criteria for selecting counselors?**
A. Last year we developed new criteria. They call for the counselors to be both physically and mentally fit, and be willing to train.

**Q. How do you attract counselors?**
A. You offer them a chance to acquire knowledge and the opportunity to meet people of different backgrounds. A network is created where often the counselors themselves recruit other counselors.

**Q. What is the role of communication skills?**
A. Part of the training is negotiation skills.

**Q. Why are there more girls than boys?**
A. Among both adults and young people, there are always more girls involved. It is a problem. We want both boys and girls.

*Editor's Note: This article is a summary of a presentation delivered by Dr. Hisako Takamura at the First 2005 Workshop. AUICK takes full editorial responsibility for the content.*

AUICK Newsletter No.45 20 December 2005
Peer Counseling Demonstration

Students of the Kobe City College of Nursing presented a demonstration of their peer counseling activities to the participants of the Second 2005 Workshop as an example of young people's involvement in promoting reproductive health and awareness of sexually transmitted diseases (STDs) and HIV/AIDS. The workshop participants not only observed the demonstration, but they also participated, as the students invited them to play the role of the high school students to be counselled.

To begin the event, the college's president, Dr. Kiyoko Ikegawa, welcomed the overseas visitors to Kobe and thanked everyone for the opportunity to speak about the college's activities. She pointed out that Kobe learned a lot about how to help each other through its experience of the Great Hanshin Earthquake in 1995. She cited "care" as an indispensable element for the desirable development of a society. She also mentioned that the peer counseling activities were a good example of how we could help each other through caring, and that such initiatives were particularly important in light of the rising numbers of HIV cases in Japan especially among adolescents.

Ms. Kumiko Adachi, an instructor at the college, then introduced the peer counseling demonstration. She explained that "peer" in this case meant "friend" and that the college students created their own materials to educate and counsel high school students on HIV/AIDS, condom use and other reproductive health issues.

The students explained that they themselves developed the content of the counseling program and that they felt great satisfaction when the high school students enjoyed the exercises and learned something valuable. They also expressed their desire to communicate with peer workers in other countries, as such activities were increasing here and around the world.

Mr. Nobuyuki Morimoto, Deputy Executive Director of AUICK, closed the session by mentioning that in Japan parents are generally too shy to talk to their children about sex education. Furthermore, condom sales to minors are illegal here, as authorities believe easy availability would promote sex and demoralize society. He praised the college students for their efforts and stressed the important role they and their activities play in contemporary society.
A
ction Plan Guidelines

Dr. Hirofumi Ando
President of AUICK

One of the major objectives of the workshop was for participants to develop an action plan for improving reproductive health services and HIV prevention strategies in their respective cities based on measures learned at this workshop and the ICAAP. Dr. Ando presented a proposed set of guidelines for the action plan. He noted, however, that these guidelines were to be used flexibly, as each city had different conditions and varying levels of reproductive health programs in place.

Step 1. Clearly define the target population, which may be a certain age group, in or out of school youths, one or more specific socio-economic groups or a combination of the above. Selection of the target population should take into account population projections and other dynamics based on the City Reports. A five to 10-year span is recommended.

Step 2. Identify the problems and constrains of current programs. These may include financial and personnel resources, administrative procedures and political commitment among other items.

Step 3. Propose a set of measures to be implemented in order to help provide better adolescent reproductive health service. The measures can be classified first in broad terms such as (1) reproductive health services, (2) information, education and communication activities and (3) other support activities. More specific measures may include the following: IEC activities to increase awareness and knowledge, advocacy activities to secure commitment from political and community leaders, mobilization of mass media, increasing coordination of concerned departments or agencies, increasing participation of NGOs and the private sector, involvement of academic and research institutions, and increasing support from external aid organizations.

Step 4. Identify the organizations and individuals who would be implementing the proposed measures. It may also be necessary to describe how to mobilize them.

Step 5. Propose a time frame required for each step of the action plan to be implemented and the results achieved. Use of a flow chart is recommended to make the schedule easy to visualize.

Dr. Ando also reminded the participants to consider the following points raised in the preceding presentations when formulating their action plans: (1) their own political commitment, (2) their visionary input, (3) their courage to bring about change, (4) their willingness to apply something new and (5) the need to carry out sustainable actions. These points are particularly relevant considering the constraints and opposition that participants may face in carrying out their initiatives.

Dr. Ando presented the adoption of peer counseling as a model action plan and suggested the following steps: (1) sending the suggestion to the supervisor for approval and consulting with colleagues for support including budgetary requirements (1st month), (2) recruiting counseling trainers and contacting academic institutions and NGOs (schedule: 2nd month), (3) contacting the concerned agencies/ministries for support and participating in workshop (schedule: 3rd-4th months), (4) developing training materials and program with technical support (schedule: 3rd-4th months), (5) training of youth counselors (schedule: 5th-6th months), (6) provision of peer counseling (schedule: 7th month and beyond) and (7) monitoring of peer counseling (7th month and beyond).

Finally, Dr. Ando urged the participants to make committed efforts to facilitate the provision of quality reproductive health services and information for the young people in their respective cities, respecting their reproductive health and human rights.

Questions and Answers

Q: How can we implement a plan when we do not have the authority or control to do so?

A: Your action plan should be designed to be implemental within your organizational or administrative environment confines. Even with limited authority you should be able to find a way to make improvements where you can, such as by bringing in innovation and partners to improve information and services.

Comment: Dr. Haryono pointed out that one of the objectives of this workshop is for participants to find a new approach or strategy that they were unaware of or had never considered. Furthermore, they should keep in mind that these are long-term programs, and it is very important to meet and talk to people through networking, community work and fieldwork.

Comment: An observer from Pakistan mentioned that it is important to find mechanisms to overcome conservative opposition. In Pakistan, for example, religious leaders have been brought into the programs and are cooperating as participants.

Comment: Dr. Haryono suggested that in face of religious opposition, it may be beneficial to try an indirect approach. For example, first try to include religious leaders in a ceremony or other initial aspect of a program. Aim for gradual involvement. Avoid confrontation. Get their support for the goals of a plan, not the details.
City Report and Action Plan

During the workshop the participants made a presentation on the outline of their cities and action plans which they were expected to implement upon their return. This article is the summary of their city reports and action plans.

Chittagong

Dr. Salim Akhter Chowdhury
Health Officer
Chittagong City Corporation
Bangladesh

CITY REPORT

Chittagong is the second-largest city in Bangladesh and is a major port. The city has a population of approximately 4 million and is divided into seven zones and 41 wards.

Reproductive Health

To provide primary health care services to city residents, Chittagong has been operating 25 primary health care centers, which are funded by the Asian Development Bank and UNFPA under a project by UPHCP. In addition, the city operates 19 health care centers through its own resources. At all of the above centers, medical doctors and support staff provide medical services free-of-charge and also offer counseling on health education and family planning and carry out other information, education and communication (IEC) activities. The city also operates six maternity hospitals, which are focused on reducing infant and maternal mortality.

Chittagong is encouraging traditional medicine and operates five homeopathic clinics and one homeopathic college. The city's other medical education institutions include the Midwifery Institute and the Institute of Health Technology. Health-related activities by the city include health education, mosquito control, sanitation, HIV/AIDS control, and dengue, tuberculosis and leprosy control.

HIV/AIDS

HIV/AIDS rates of infection are still relatively low in Bangladesh, but the country as well as the city of Chittagong recognizes that AIDS is a growing concern which will have devastating consequences if not effectively addressed. Bangladesh is particularly vulnerable to the disease as almost half its population is under 16 years of age, and risky behavior such as unprotected sex and intravenous drug use are widespread. In addition, the country has a thriving sex trade, and unsafe blood transfusion practices are common.

Chittagong is currently implementing a HIV/AIDS prevention project. The specific objectives of the project are to improve the quality and effectiveness of health promotion initiatives, enhance the infrastructure for HIV/AIDS prevention, increase condom use especially among drivers, slum dwellers and other socio-economically deprived groups, increase knowledge of HIV/AIDS among health workers, college students and city employees, and obtain data on HIV/AIDS cases and the most vulnerable groups.

Components of the project involve training of health workers, including doctors, pharmacists, nurses and support staff, various IEC activities, condom promotion and establishment of facilities for HIV/AIDS testing.

The project has the strong commitment of the mayor, and involves various segments of society including universities, local leaders, school communities, and peer groups. The project is headed by an advisory committee comprised of Chittagong's mayor, its CEO, its chief health officer, a UNICEF representative, the project manager and representatives of NGOs. Operating under the advisory committee is the working group, which is headed by the project manager followed by the project coordinator, administrative officer, medical officers, health workers, pharmacists and medical workers.

ACTION PLAN

General objectives
To improve the reproductive health services and HIV/AIDS prevention program of college and university students in Chittagong.

Specific objectives
1. To establish a peer education program at each college and university.
2. To improve the quality and effectiveness of health education and promotion.
3. To increase the level of knowledge about HIV/AIDS.
4. To increase condom use.
5. To conduct research that will help with effective planning.
Target group
2,000 college and university students.

Measures and strategies
1. To produce skilled peer educators (one male and one female) at each school.
2. To explain the program to the management committee.
3. To build partnerships and networks with specific stakeholders and other agencies.
4. To mobilize the mass media for support.
5. To provide clinical services and referrals.
6. To survey the program participants for future planning.

Performance indicators
1. Monthly review meeting.
2. Quarterly review meeting.
3. Monitoring and evaluation.

Budget:
Approximately 2,000 U.S. dollars.

Timeline
Month 1: Meet with mayor and management committee.
Month 2: Peer educator selection and training.
Months 3-6: Activities are implemented.
Month 7: Prepare new model.

Weihai

Mr. Fan Kaimin
Assistant to the Director of Health Bureau
Weihai Municipal Government
China

CITY REPORT

Weihai is a port city and popular tourist destination. It has a population of almost 2.5 million and is an economically strong and modern city that aims for harmonious integration between people and nature. It has twice won the UN’s International Award for Best Practices to Improve the Living Environment, and in 2004 it won the UN Habitat Scroll of Honor Award. Although the city experienced negative natural growth in 2004, the population continued to rise due to migration.

There are five levels of government in China: national, provincial, city, county and town. There is very strong central government control. Only the national and provincial levels of government have legislative jurisdiction, but local government can decide on means of implementing policy such as in social welfare, public health and urban planning. The mayor is appointed by the People’s Congress and serves a five-year term. It is the mayor’s responsibility to propose eight deputy mayors.

Reproductive Health

To promote public health, China has made a series of regulations, master plans, ordinances and action plans, which include initiatives on infectious diseases, HIV/AIDS, maternal and infant health care and family planning. As mentioned, the local government is under the control of the central government, and must abide by central government policies.

To implement the national public health policies, Weihai has developed a number of programs, including plans to improve maternal and infant health and family planning. The plans promote increased antenatal consultation and antenatal examination and dissemination of information on condom use. Family planning is particularly important for China due to the need to control the growth of its already high population. As a result of successful planning, the birth rate in Weihai has continued to decline annually over the past five years.

HIV/AIDS

Weihai is now working to improve its programs for increasing adolescent health education, reducing the incidence of abortion and preventing infectious diseases, especially HIV/AIDS. As of 2004, there have been only nine confirmed cases of HIV/AIDS. Goals for 2010 are to bring infant mortality to under 6 per 1000 (currently 7.1 per 1000), reduce the birth defect rate to 4 per 1000, decrease maternal mortality to 15 per 100,000 and raise the contraceptive prevalence rate to 98%.

The city has been highly successful in its family planning initiatives, particularly in promoting contraception use. Weihai has also done well at reducing mortality. In less than one generation both adult mortality and infant mortality have been significantly reduced.

ACTION PLAN

Target population
14-year-olds to 24-year-olds (current population of this group is 70,000.)

Current program
National:
The Chinese government has taken a number of steps to address complex social and political issues. In 2004 it began promoting condoms and needle exchange programs. It has begun free anti-retro viral drugs for farmers and impoverished people, free care to prevent mother-to-child transmission, free voluntary HIV testing, free schooling for AIDS orphans, and care for AIDS patients and their families.

Local:
We are disseminating information and introducing sex education into secondary schools.

Problems and constraints
Financial constraints, provision of information, increase in
risky sexual behavior, a traditional culture that inhibits education about sexual transmission of disease are some of the problems and challenges involved.

**Action plan**
1. Increase investment in education from one million U.S. dollars in 2006 to three million U.S. dollars in 2010. Increase funds for prevention and control of HIV/AIDS and other STDs from 200,000 U.S. dollars in 2006 to 400,000 U.S. dollars in 2010.
2. Set up a website within three months, to disseminate information about sex and HIV/AIDS prevention and control.
3. Form two or three peer counseling groups, by the end of 2005.
4. Improve the dissemination of information with the assistance of the Education Bureau, promote sex education in secondary schools, and improve communication among youths, teachers, parents and society.
5. Improve cooperation with NGOs such as the Women's League Commission, the Communist Youth League, and the Red Cross.
6. Improve international cooperation, not only with developed countries but also with developing countries, learning from their experience on adolescent reproductive health and HIV/AIDS prevention and control.
7. Strengthen the training of health care workers.
8. Work with hotel and service employees to help achieve 100 percent condom usage.

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**CITY REPORT**

Chennai is India's fourth-largest city and a major port. It is the capital of Tamil Nadu state and its population, which was 4.85 million in 2004, is steadily growing. Major industries of the city include automobile components, leather and textiles, film, petrochemicals and manufacturing. The city is also strong in education and IT. Poverty is widespread with many people living in slums.

The Chennai Municipal Corporation is headed by a mayor, followed by a deputy mayor, standing committees, ward committees and a commissioner. The mayor is directly elected to serve a five-year term.

**Reproductive Health**

At the national level, the immediate policy objectives are to address the unmet needs for contraception, health care infrastructure and health care personnel, and to provide integrated services for basic reproductive and child care health. As part of the policy, the central government has devised the following components with regard to reproductive and child health: (1) Prevention and management of unwanted pregnancy, (2) maternal care that includes antenatal, delivery and postpartum services (3) survival services for infants and (4) management of STIs and RTIs.

In Chennai, the Indian Population Project 5 was implemented in 1989 with the following objectives: (1) universal immunization, (2) universal antenatal care, (3) universal post-natal care, (4) 98% institutional delivery, (5) reduction in third and higher births, (6) 60% couple protection rate and (7) increased examinations for infants. The city achieved these objectives in 1995 and continues to make improvements where possible.

**HIV/AIDS**

Tamil Nadu is considered a high risk state in India. HIV/AIDS here is not confined only to high-risk groups. The infection rate among pregnant women aged 15-24 is 0.5%. In 2004, intravenous drug use accounted for almost 40% of HIV infections, followed by heterosexual transmission at 8% and homosexual transmission at 6.8%.

In 1998, the Chennai Corporation AIDS Prevention and Control Society was established, with the city commissioner serving as the organization's president and the joint commissioner of health as the project director. The mayor, ruling and opposition party leaders, and representatives of NGOs and people living with AIDS comprise the executive committee.

In order to reduce the spread of HIV/AIDS and strengthen capacity to respond to HIV/AIDS on a long-term basis, a multi-pronged approach is being adopted which focuses on the most critical interventions to limit HIV transmission. Services are needed for both prevention (both for high risk and low risk groups) and care (both for those infected and their family members).

Specific measures on HIV/AIDS implemented in Chennai include (1) establishment of counseling and testing centers, (2) family health awareness campaigns, (3) low-cost care including provision of drugs and establishment of community and drop-in centers, (4) training programs for medical staff, (5) telephone counseling, and (6) various IEC activities.

Challenges relating to HIV/AIDS include increasing civil society involvement, securing private sector participation, integrating HIV/AIDS initiatives with existing health programs and services, provision of low cost or free services to the needy, stigma and discrimination of people living with HIV/AIDS and migration.
ACTION PLAN

Vision
The adolescents will be free from malnutrition and disease, that they will acquire knowledge and skills to enable them to have normal physical and mental development, and to make them responsible citizens.

Goal
To ensure that youths have access to healthcare services for adolescents, and to empower them to make decisions about changes in their behavior and lives.

The health and education infrastructure is not youth friendly. We need adolescent reproductive health services, including those targeted toward family planning.

Objectives
To prevent anemia, dental disorders, worm infestations, skin disorders, etc., and to educate youth on all aspects of sexual and reproductive health. (We have in fact reduced anemia by large numbers.) To prevent sexually transmitted infections.

Target group:
Nearly 800,000 people, counting 16 percent of the total population belong to the age group of 15-24 years old. Every year there are 14,000 unwanted births. Sexually transmitted infections are found in 8 to 10 percent of adolescents.

The current school program makes the task difficult. There was no sex education before; it has just recently been introduced. There is increasing sexual activity, lack of awareness of contraception and STIs, and lack of empowerment. There are 13 abortion clinics in the city. There is both child and adolescent abuse.

How did we arrive here?
India's five-year plan calls for the fertility rate to reach net replacement level by 2010. The problem with the family planning approach aimed at reaching a target was that it led to cheating on reporting. Now we are using the cafeteria program approach. Adolescent health was never part of the program, even though the age for marriage in India is one of the lowest in the world. Unabated migration is also a problem. Also, NGOs, CBOs (community-based organizations), and religious leaders were not taken on board in family planning issues.

Misconceptions about solutions for these issues include believing the following options would be sufficient on their own:
1. Increasing the facilities.
2. Increasing the manpower.
3. Providing more money.

There are two options:
1. Targeted interventions:
   Advantages: The focus, effectiveness and short period of implementation of targeted interventions.
   Disadvantages: Interventions are costly, and are difficult to coordinate and sustain.
2. Integrate solutions with existing health delivery system.
   Advantages: cost-effective, sustainable, trained staff.
   Disadvantages: overloading of system, may lack focus.

Recommendation
A peer education program for school/college students, and for the out-of-school population.

Budget
Funds of 102,770 U.S. dollars are available. Funding is not an issue. My supervisor says, “Funds are no problem — produce results.”

Timeline
1. Planning — Months 1-2. I am an advocate of sitting down with stakeholders and planning with them.
3. Hardware — Month 6. Print materials and hold exhibits in selected schools.
4. Advocacy — Publicize using television and radio, street plays, traveling van exhibits, and print media.

Monitoring
Use monthly reviews and peer meetings. Evaluation by an outside agency is very important.

Surabaya

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Surabaya City Government
Indonesia

CITY REPORT

Surabaya is the second-largest city in Indonesia and has a population of around 2.6 million. It is also the country's oldest city, a major port city and the capital of East Java province.

The mayor of Surabaya is elected by the people to serve a five-year term. Below the mayor and deputy mayor are the city's 23 departments (including health), six agencies, four offices and 31 districts, which are further divided into 163 villages. The local authority consists of an executive and legislative board. The legislative board members are directly elected to serve five-year terms and are responsible for legislation, budgeting and monitoring of services and programs. The mayor has the authority to set policy on internal government systems, but for public policy, approval of the legislative board is required.
Reproductive Health

In 2004, Surabaya's budget for public health services was divided into 46% for health promotion, 19% for preventive health and hygiene, and 35% for community health. The Department of Health is currently aiming to (1) improve quality, availability and reach of health services, (2) improve individual, family, community and environmental health and (3) encourage community independence on health. Strategies involve making improvements in the following areas: (1) human resources in health management, (2) health planning, (3) quality of health services, (4) efforts for preventive health and disease control, (5) efforts for family health services and (6) city hygiene and sanitation.

Relating to reproductive health, the city has the following programs and services available: (1) Services and counseling for mothers/child health (2) Reproductive health and family planning services, (3) immunization (4) information, education and communication activities and (5) controlling SDIs including HIV/AIDS.

Challenges facing the above programs include inadequate budgets, shortage of qualified people to execute the programs and inadequate knowledge of reproductive health. Relating specifically to immunization, the program has low coverage of young women and pregnant women. IEC activities, on the other hand, are hampered by a lack of coordination among institutions involved.

HIV/AIDS

The incidence of HIV/AIDS in Surabaya has been increasing annually, going from just one case in 1997 to over 300 cases in 2004. The program to combat the disease is being implemented jointly by the health department, hospitals, community health centers and NGOs. The program is aimed at the general population with specific emphasis on targeting adolescents and high-risk groups such as sex workers, drug users and the poor. In addition to decreasing the rate of HIV/AIDS infection, the program aims to increase knowledge of HIV/AIDS in the community and raise awareness of preventive measures. The budget for HIV/AIDS has been increasing yearly, with a substantial increase occurring in 2005, particularly for testing and supporting people living with HIV/AIDS. At present there is generally low knowledge of HIV/AIDS at the community level, and people suffering from HIV/AIDS are stigmatized and discriminated against.

Current Status of Adolescents

The number of youths 15 to 19 years old is 269,084, about 10 percent of the population. The number of youths 20 to 24 years old is 336,362, about 12.5 percent of the population.

A survey showed that two percent of females and seven percent of males in senior high school, had premarital sex. Among all adolescents, 15 percent had premarital sex. The age of first sexual encounter was as low as 14 among males.

Adolescents and HIV/AIDS:
2000 = 16 HIV cases, 9 AIDS cases.
2001 = 46 HIV, 15 AIDS.
2002 = 41 HIV, 44 AIDS.
2003 = 99 HIV, 49 AIDS.
2004 = 217 HIV, 166 AIDS.

Existing services for adolescent reproductive health and HIV/AIDS are very limited. Online counseling is not available. Adolescents do not come to the health centers for counseling about reproduction. Condom use among the high-risk population is very low.

ACTION PLAN

Objectives
We need a priority program on adolescent reproductive health, to improve young people's knowledge about reproductive health issues and HIV/AIDS.

Target group
Public health center workers, junior high school teachers, senior high school teachers and students, young people out of school.

Program — Timeline
1. Public health centers
   One doctor and two nurse/midwives for each center. Each center to have room for adolescent reproductive health services. (Jan-Mar 2006, 15 centers; Apr-Jun 2006, 30 centers; Jul-Sept 2006, 45 centers; Oct-Dec. 2006, 51 centers)
2. Junior high schools
   One teacher at each school to receive training. (Jan-Mar 2006, 15 schools; Apr-Jun 2006, 30 schools; Jul-Sep 2006, 45 schools; Oct-Dec. 2006, 57 schools)
3. Senior high schools
   One teacher at each school to receive training. Five students from each school to form peer group counseling team. (Jan-Mar 2006, 12 schools; Apr-Jun 2006, 24 schools; Jul-Sep 2006, 36 schools; Oct-Dec. 2006, 42 schools)
4. Out-of-school youths
   Form two peer counseling groups in each subdistrict. (Jan-Mar 2006, 10 subdistricts; Apr-Jun 2006, 20 subdistricts; Jul-Sep 2006, 31 subdistricts)

Action steps — Timeline
1. Meet with mayor to request support for program. Jul 05.
2. Coordinate with related departments (health, education, city management, communication and information). Aug-Sept 05.
3. Contact schools and/or NGOs to look for trainer. Oct.-Nov. 05.
4. Develop training material. (Nov.-Dec. 05).

Budget
Funding to be established by budget committee. Use local government budget for program start-up.
Kuantan

Mr. Mohamad Zainudin Idris
Director, Health and
Cleanliness Control
Department
Kuantan Municipal Council
Malaysia

CITY REPORT

Kuantan is situated on the east coast of peninsular Malaysia and has a population of 409,000. It was upgraded from town to municipal status in 1979. A total of 55% of the area is protected as permanent forest reserve and 35% is reserved for agriculture (mainly oil palms). Scenic beaches near and within the city are popular attractions. Primary incomes of the population are derived from agriculture and various other industries. The city is currently experiencing high population growth (3.8%) from migrants due to its economic opportunities. Approximately 50% of the population is below the age of 20.

The Kuantan Municipal Council, headed by the mayor, is the third level of government in Malaysia below federal and state levels. A maximum of 24 members are appointed to the council's board, and each member may serve no longer than two two-year terms. Full council meetings are held monthly, where major policies, budgets, projects and general matters are discussed and decided.

Reproductive Health

Kuantan is not directly responsible for health, as this is the jurisdiction of the Ministry of Health at the national level. Public health in Kuantan falls under the jurisdiction of the Department of Health and Cleanliness Control, but other departments also have related responsibilities, so collaboration between departments is carried out. The city is responsible for abatement of dengue and some other communicable diseases, as well as more general tasks such as cleanliness of food establishments and preventive measures for activities that may have impact on the quality of the environment.

HIV/AIDS

As of 2004, there have been 297 confirmed cases of HIV and 66 cases of AIDS in Kuantan. This marks a steady rise since 2000, when there were 108 cases of HIV and no cases of AIDS. The 20-49 age group accounts for the largest proportion of those infected, but it should be noted that there were six cases of HIV in infants below age 2.

In Malaysia for the period 1986-2000, the majority of reported HIV/AIDS cases were males within the age groups 20-29 (37.3%) and 30-39 (42.9%). By risk category, most of the infections resulted from intravenous drug use (76.2%) followed by homosexual transmission (17.5%). The country is taking a holistic approach to HIV/AIDS prevention.

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**Objectives**
1. To ensure that the 80,000 adolescents in the Kuantan area are reachable and well informed about sexual and reproductive health within three to six months.
2. To promote healthy lifestyle practices.

**Assumptions:**
1. The agencies are capable of offering reliable resources, information and knowledge about adolescent reproductive health and HIV/AIDS.
2. That with an integrated approach and coordination among the agencies, the number of new HIV infections among adolescents can be reduced.
3. That all adolescents in the area are reachable.

**Target group**
Targeted youths are between ages 7 to 18.

**Strategies**
Coordination of the functions of relevant government agencies and NGOs.

**Timeline**
1. Set up a new district coordinating committee.
   a. Propose new committee members to mayor. Sept. 2005
   b. Obtain state administrator approval and advise ministries and NGOs. Oct. 2005
   d. First committee meeting to detail existing programs. Nov. 2005
   e. Establish youth-friendly health clinic.
   f. Propose future programs.
2. Implementation
   b. Discuss with Education Department and institutions of higher learning the programs in schools.
   c. Kuantan Municipal Council to host monthly meetings of the Coordinating Committee on AIDS.
   d. Treat youths with HIV/AIDS and unwanted pregnancies.

**Evaluation**
By the end of the year, assess reduction in the number of youths involved in drug abuse, reduction in number of youths with HIV/AIDS, unwanted pregnancies or abortions, reduction in all HIV cases, and the number of youths receiving treatment for HIV. (Academic staff from School of Medicine, International Islamic University, to do the evaluation.)

**Role of Kuantan Municipal Council**
The council can also help improve adolescents' lives by offering sports facilities, essay and debate competitions, recreational activities; assist other agencies in providing these facilities; and help provide media access to promote programs.
Faisalabad

Dr. Aslam Pervaiz
Deputy Director, Solid Waste Management
Tehsil Municipal Administration Faisalabad
Pakistan

CITY REPORT

Faisalabad is situated approximately 100 km west of Lahore and has a population of 2.14 million. It is an industrial city, and being the nucleus of the textile industry in the area, it is actually known as the Manchester of Pakistan. Population density is 12,740 persons/km2 and the average number of persons per home is high at 7.3.

Pakistan is divided into provinces which are further separated into districts and Tehsil (or counties) which contain villages and municipalities. In 2001, TMA Tehsil Faisalabad succeeded the municipal corporation of Faisalabad. The Tehsil council of Faisalabad is the city's elected body and consists of union councils, women, workers and minorities. The council is headed by a nazim, which is the equivalent of mayor.

Reproductive Health

Pakistan has a high total fertility rate of 4.8. Infant mortality is also high at 77.5 deaths per thousand births. Approximately 88% of children under age 1 are immunized against measles. Maternal mortality rate is 4.25, and approximately 85% of births are attended by a qualified health worker.

Public Health is administered by the district and provincial governments. The master plan for public health promotion set out various objectives to be achieved by the end of 2005 as follows: (1) eradication of polio through special campaigns in the district, (2) establishment of a national program on family planning and primary health care to be largely executed by female health workers, (3) improvement of preventive health care in the community through extension of immunization programs, control of communicable diseases, improvement in sanitary conditions and better health education, (4) provision of health care to outdoor/indoor patients, (5) provision of free emergency treatment, (6) capability to perform major and minor surgeries at district hospitals and rural health centers and (7) provision of diagnostic facilities like lab tests and x-rays and ambulance services, especially in rural areas.

Reproductive health services are provided through the following sources: (1) district government health facilities, including four Tehsil hospitals, 11 rural health centers, 169 basic health units, 67 zila council dispensaries, five government rural dispensaries, 34 city dispensaries and six mother/child health care centers, (2) the national Population Welfare Department, (3) the Prime Minister's program for family planning and family health, and (4) NGOs including the Family Planning Association of Pakistan, Marry Stopes and the Red Crescent.

HIV/AIDS

There is no official data on HIV/AIDS at the national or local level. However, UN estimates indicate that there could be approximately 70,000 cases of HIV/AIDS in the country. In Faisalabad, only four cases of HIV/AIDS have been confirmed, one of which is female. There is only one diagnostic facility in the city. In general, there is very little awareness of HIV/AIDS. There are no counseling services on HIV/AIDS and no test centers.

ACTION PLAN

Objectives
(As formulated by the government of Pakistan in the Ten Year Perspective Plan 2001-2011.)
1. To reduce population growth from 2.16 percent to 1.6 percent.
2. To increase contraceptive use from 27.8 percent to 53 percent.
3. To strengthen the ability of NGOs for service delivery, especially in slums and labor colonies.
4. To use a micro-credit program for the poor to help start new businesses.
5. To strengthen the program of lady health workers, as they deliver peer counseling and reproductive health services.
6. To improve the literacy rate from 64.7 percent.

Target group
A group of 1.1 million people of reproductive age.

Proposed measures and timeline
1. Encourage condom use through special campaigns.
2. Educate adults on proper use of condoms.
3. Work together with the Population Welfare Department.
4. Work with the Executive District Officer of Health to improve the service delivery of the lady health workers, and their training in reproductive health. (It is very difficult for female patients to move about for counseling.) Time frame: three months. Train lady health workers on peer counseling. Time frame: six months.
5. Ask the mayor to propose to NGO's working in our city that they create a peer counseling service using male volunteer youths. Time frame: eight months.
6. Enlist the support of religious leaders.
7. Establish a pilot voluntary testing and counseling center, with an initial budget allocation of 8,400 U.S. dollars. This would be set up in one of the city's dispensaries. The target population would be injecting drug users. Time frame: three months. Display posters to publicize center. Time frame: one month.

The organizations working in the fields of adolescent reproductive health and HIV/AIDS include: 1) health department, 2) Population Welfare Department, 3) Prime Minister's Program of Reproductive Health and Primary
Olongapo

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City Health Department
Olongapo City
Government of the Philippines

CITY REPORT

Olongapo is situated on the west coast of central Luzon and has a population of approximately 250,000. Until 1992, the city existed in the shadow of the largest U.S. military base outside the United States. Having an absence of agricultural and manufacturing industries, the city is promoting itself as a center for services and trade. It is aiming to become a free port zone, and is developing its potential for tourism and cultural attraction. The population structure is as follows: 35% are below age 16, 62% are age 16-74, and 3% are age 65 and over.

Being a highly urbanized city, Olongapo is independent of the province. The mayor, vice mayor and city council members are elected. The vice mayor and the council function as the legislative body while the mayor is the local chief executive. Under the mayor there are various departments that carry out the execution and enforcement of national and local laws.

Reproductive Health

Essentially, programs on health are guided by policy and programs mandated by the Department of Health at the national level. Local governments are permitted to enhance and improve on these initiatives. Some ordinances and executive orders formulated in Olongapo over the past eight years include (1) recognition of the HIV/AIDS Core Team at James L. Gordon Memorial Hospital and provision of necessary funds, (2) upgrading of certain health examination fees at the city social hygiene clinic, (3) required quarantine for suspected SARS-infected persons and sanction for violation, (4) establishment of a task force to review and monitor current activities and projects relating to adolescent reproductive health, (5) establishment of a task force to monitor and assess current programs and projects on reproductive health and (6) establishment of an AIDS council to evaluate current programs and activities for prevention and control against STDs and HIV/AIDS.

The city has expanded its immunization program and currently 98% of infants are covered. However, some mothers lack knowledge about immunization and accessibility can be considered a constraint.

Relating to family planning, means of contraception are being provided and promoted. Campaigns are conducted in schools and counseling is available to young couples. However, there remain misconceptions of the effect of contraceptives and religious beliefs tend to serve as a deterrent.

HIV/AIDS

There have been no cases of HIV/AIDS in Olongapo. The city does not handle testing for HIV/AIDS. At present, the city’s social hygiene clinic is conducting serology examinations by RPR, TPHA and HBs AG, and under the STD control program, smear examinations by culture and gram staining are being carried out. Patients diagnosed as positive in an RPR test are requested to be tested for HIV/AIDS. However, due to the high cost of the test, most patients decline. For examination and treatment of HIV/AIDS, cases are referred to San Lazaro Hospital in Manila, which charges fees for these services.

ACTION PLAN

Goal

Preventing the further spread of HIV/AIDS.

Objectives

General objectives:
1. Provide adolescents with knowledge and understanding about reproductive health and HIV/AIDS.
2. To increase the percentage of adolescents practicing risk-free behaviors.
3. For a person infected with HIV, to improve their access to quality information, treatment and support.
4. To improve the attitude toward people infected with HIV.
5. To improve the efficiency and quality of programs and services for adolescent reproductive health and HIV/AIDS.

Specific objectives:
To instill in adolescents the importance of life.

Target group

41,545 adolescents (15-24 years old).

Activities/strategies

Preparation phase:
3. Establish an adolescent reproductive health and HIV/AIDS counselor at the city and village level.
4. Expand and improve programs targeted to vulnerable groups.
5. Strengthen preventive programs.

Implementation phase:
1. Strengthen management support system.
2. Integrate stigma reduction measures.
3. Obtain HIV testing kits.
4. Conduct training on HIV/AIDS.
5. Conduct lectures on behavior changes, fertility awareness and moral values.
6. Promote delayed marriage to youths both in and out of school.
7. Create peer counseling programs for youths both in and out of school.
8. Use mass media to communicate information about adolescent reproductive health.
9. Conduct school program regarding adolescent fertility and empowering Filipino youth.
10. Monitor and evaluate program.

Responsible persons:
1. City mayor and city officials.
2. City health personnel.
3. School officials.
4. NGOs.
5. Department of Social Welfare.
6. Youths at community level.
7. Community officials.
8. Health counselors.

**Budget**
1,000 U.S. dollars

**Output indicators**

**Preparation phase:**
1. Understanding the roles of adolescent reproductive health and HIV/AIDS task force.
2. Increasing the knowledge of school and out-of-school youth on adolescent reproductive health and HIV/AIDS.

**Implementation phase:**
1. Number of trainers trained.
2. Number of NGOs, community officials, youth and counselors involved.
3. Understanding of physical and behavioral changes by youth.
4. Understanding of benefits of delayed marriage by youth.
5. Establishment of peer counselors.
6. Increased adolescent awareness of HIV/AIDS and STDs.
7. Youth well-informed about fertility and empowerment.
8. Sustain programs on adolescent reproductive health and HIV/AIDS.

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Khon Kaen

Ms. Wallapa Prangthawat
Public Health Technical Officer
Khon Kaen Provincial Health Office
Thailand

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**CITY REPORT**

Khon Kaen is situated 450 km from Bangkok in Thailand's northeast region and is the capital of the province that bears the same name. The city has a population of 125,000 and serves as the regional center for education, business and government. Khon Kaen province has a population of 1.77 million and agriculture is the main source of income. Continual growth in various industrial sectors is playing a significant role in the development of the province.

The municipality of Khon Kaen has a directly elected municipal council and an executive board. The 24-member council serves as the legislative body the duties of which include approval of budgets and passing of municipal ordinances. The executive comprises a president, a mayor and three deputy mayors, who are elected by the council. It functions to administer municipal functions.

**Reproductive Health**

Public Health in Khon Kaen falls under the jurisdiction of the Bureau of Public Health and Environment. Programs and services for reproductive health in the city include (1) family planning counseling and related information, education, communication services, (2) mother/child education and services for pre- and post-natal care and safe delivery, (3) prevention of unsafe abortions (4) information, education and treatment for reproductive tract infection, (5) counseling and services for adolescents, (6) education on sex, sexuality and responsible parenting, and (7) prevention of HIV/AIDS and STDs.

**HIV/AIDS**

As of May 2005, there have been 5,599 confirmed cases of HIV/AIDS in Khon Kaen province. There were 410 cases in 2002, 505 in 2003 and 529 in 2004. The 20-39 age group accounted for the largest proportion of those infected at 70%, and the 25-34 age group alone accounted for as much as 57% of all cases. At for means of transmission, 84.1% was heterosexual, 2.4% was intravenous needles, 5.2% was from mother to child and 8.4% was unidentified. HIV prevalence has been significantly reduced among some high-risk groups, such as commercial sex workers (from 27% in 1996 to 7% in 2004) and military conscripts (from 28% in 1996 to less than 5% in 2004).

Khon Kaen province is actively fighting HIV/AIDS through condom promotion, an antiretroviral drug program for people living with AIDS, and collaboration among government, NGOs and people living with AIDS. Promotion of condoms has been quite successful, particularly among sex workers and their clients. There are now 447 condom vending machines in Khon Kaen, which help provide easy access to condoms. Efforts to raise awareness about HIV/AIDS have been carried simultaneously with condom promotion.
The antiretroviral drug program has 24 participating hospitals and has provided care for 1,864 cases of HIV/AIDS. The program emphasizes the psychological needs of people living with AIDS together with their requirements for physical care.

Partnership among government, NGOs and people living with AIDS has fostered and strengthened HIV/AIDS programs and activities. Various NGOs focused on HIV/AIDS are active in Khon Kaen, and national budgets are provided to support NGOs and people living with AIDS. HIV/AIDS committees comprising the above groups help manage response and formulate action plans for public agencies. Furthermore, an AIDS center is located in each of the province's 25 districts.

**ACTION PLAN**

In Thailand, the love for king, country and religion are paramount forces. If an idea is proposed as doing something for the king, everyone will want to join the campaign. Most of the population is Buddhist. Even among counselors there are Buddhist monks.

**No. 1 Goal**: To decrease the rate of HIV infection among adolescents.

Factors leading to this rise in the infection rate are premature sexual behavior, sex without condoms (especially among close friends), lack of skill to use a condom properly when they are used, and lack of good access to condoms. We are striving to have 100 percent use of condoms, and to supply adolescents with the knowledge of how to properly use the condoms.

This requires a great deal of training, organizing, coordinating and enrollment of support from many parts of the community, including schools, businesses, NGO's, and individuals.

Activities for the first two years of the program include forming an AIDS committee, recruiting members and volunteers from different parts of the community, training the trainers who in turn train other volunteers who will serve as counselors, production of brochures, leaflets, etc., to publicize the programs, and supply condoms.

Activities in the subsequent years include continuing the training, expanding the program throughout the community, and measuring and evaluating the success of the programs. The target population for these programs can be found in schools, workplaces, and throughout the community.

**No. 2 Goal**: To decrease unwanted pregnancies among adolescents.

Significant factors in this problem include lack of contraceptive skills, an inability to safely resolve unwanted pregnancies, and illegal abortions. Activities to improve the situation include establishing a "Friends Corner Club" where resources are available to adolescents, establishing counseling clinics to provide advice and knowledge, and to make information available via a web site for easy and anonymous access. Target populations to recruit resources for these positions include health personnel, school teachers, NGOs, and workplaces.

**No. 3 Goal**: To decrease both maternal and infant mortality rates.

Factors involved in these problems include substandard levels of service from Public Health staff, complications in pregnancy that are not identified and treated in a timely manner, and the lack of a prenatal care system. Activities to address these problems include increasing the training of Public Health staff, especially in the areas of prenatal care, pregnancy care, and both delivery and emergency delivery care; and producing a manual in those areas of care for healthcare to staff to use. The targeted place for this activity is the 24 hospitals in the area.

**No. 4 Goal**: To decrease health problems in vulnerable groups.

In particular, this refers to prison inmates, where there is a high rate of HIV infection. Overcrowding in prisons, and lack of means to control sexual behavior in prisons, are contributing factors of this. Activities to work to control this problem include assessing the risk behaviors and environment that inmates are subject to, seeking means to change those behaviors and the environment, and developing adequate medical equipment and health personnel for prisons.

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**Danang, Vietnam**

Dr. Kim Anh Thi Doan Vo
Vice Director, Department of Health
Danang People's Committee
Vietnam

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**CITY REPORT**

Danang is located in central Vietnam and has a population of 800,000. The city serves as a social and economic center of the region and is home to an international airport and seaport. Its economy is roughly divided into 55% tourism and trade, 35% agriculture and 10% fisheries. The 0-15 age group accounts for over 30% of the population, while those over 60 years are just around 8%. School enrolment among adolescents is 87%, and over 30% of the population has graduated from high school. Average per capita annual income is estimated at US$500.

**Reproductive Health**

The city health network is under the jurisdiction of the city party secretariat and the city people's committee. It is also directly managed by the provincial department of health, which advises the city party committee on carrying out state
health policy and provides leadership on expertise, professional skills, human resource management and budgeting. Hospitals in the city fall under various jurisdictions: national (7.4%), city (41.4%), district (21%), commune (10.7%), ministries and military (12.1%) and private (7.3%).

Measures to promote reproductive health encompass family planning, safe motherhood, safe abortion and prevention and treatment of STDs including HIV/AIDS. Current objectives include increasing community-wide participation, increasing health staff and their capacity, procurement of new equipment and more funding, formulation of policies to encourage small families, and ongoing research and training.

Specifically relating to adolescent reproductive health, the city is promoting the following activities: (1) extracurricular activities in schools, (2) incorporation of reproductive health issues in school curriculums, i.e., in biology, geography and civil education, (3) training of health providers and related people and (4) development and distribution of information, education and communication materials.

Challenges to increase awareness and understanding of reproductive health among adolescents are (1) establishment of an environment that enables effective policy implementation, (2) mobilization of community participation, (3) empowerment of youths, (4) coordination and cooperation between health and non-health sectors and (5) human and financial resources.

The UNFPA-funded project “Improvement of the Quality and Utilization of Reproductive Health Services in Danang City” is paying special attention to improving the capacity of reproductive health service providers through training on safe motherhood, diagnoses and treatment of STDs and HIV/AIDS and counseling. The project also aims to improve accessibility of reproductive health information and services.

The Save the Children-funded Reproductive Health Care Project focuses on training for the provision of reproductive health counseling to youths.

**HIV/AIDS**

The first case of HIV/AIDS was confirmed in 1993 and there have been 636 cases of HIV and 250 cases of AIDS (including 214 deaths) as of mid-2005. Approximately 100 new cases are now occurring annually. Although over 98% of youths claim they have heard about HIV/AIDS, many do not know the modes of transmission nor how to prevent it. The above-mentioned programs, in addition to raising awareness of HIV/AIDS and the capacity of health workers, are also helping to reduce the stigma attached to the disease and people living with it.

**Short-term objectives:**
1. To improve the access to adolescent reproductive health services and HIV/AIDS prevention projects.
2. To change behaviors and attitudes of the service providers.
3. To improve the quality of service tools and equipment.

**Target group**
Youth aged 10 to 19, a population of 16,000. Also, health workers and health collaborators, a population of 330.

**Constraints**
Limited budgets, limited accessibility to adolescent reproductive health services, cultural and religious aspects.

**Executing agency**
City People's Committee.

**Implementing agency**
Department of Health.

**Activities — Timeline**
1. Present information from this workshop to city leaders. July 2005.

**ACTION PLAN**

**Objectives**

**Long-term objectives:**
To improve the quality of reproductive health and HIV/AIDS services to adolescents.
UNFPA Seminar

AUICK held the UNFPA Seminar jointly with the Tokyo Office of the United Nations Population Fund (UNFPA) at Kobe International House from 1:30pm to 4:30pm, Thursday, 30 June 2005. The seminar, subtitled "Sound Mind and Sound Body: Let us think and learn and have a wonderful adolescence," was organized as a forum of AUICK's First 2005 Workshop open to the public, and attended by 150 people.

Opening

The seminar was opened with a welcome address by Mr. Yoshikane Fujimoto, Executive Director of AUICK. He explained that the seminar was conducted with the objectives of raising awareness and understanding of issues relating to reproductive health and HIV/AIDS and informing the general public of other countries' experiences, challenges they face, and the initiatives they are taking with these concerns. Then, he introduced Ms. Kiyoko Ikekami, Director of UNFPA Tokyo Office, as a facilitator of the Seminar.

UNFPA Activity Reports

Ms. Kiyoko Ikekami invited three guests from UNFPA to provide general information on UNFPA's viewpoints and peer education activities against HIV/AIDS in Asia.

First, Dr. Farah Usmani, HIV/AIDS Advisor of UNFPA, presented a general overview of HIV/AIDS in Asia. She pointed out that Asia is home to 60% of the world's population and 20% of the cases of HIV/AIDS. She said HIV prevalence in Asia is high as a whole, but ranges from 0-5%. Due to the region's high population, however, even low prevalence translates into a high number of cases, and these number are quickly growing. There are several interlinked issues that underline Asia's vulnerability to HIV/AIDS, such as low knowledge about the disease, high migration and mobility within the region, high numbers of intravenous drug users, and proportionally high populations of young people. She explained that most countries in the region have a national plan and a national organization in place. There have been some successes, but overall there is generally insufficient coverage of programs and lack of impact. Priority areas have been set, which include the prevention of HIV among young people and women. She also stressed the combined need for global, regional and local initiatives together with multifaceted collaboration and cooperation.

Second, Ms. Katia Lukicheva, a young peer activist for Kyrgyzstan, introduced her peer education activities on reproductive health and HIV/AIDS in her country. She explained that their peer education activities involve communication with young people to raise their awareness of the issues and understanding of how to protect themselves. She stressed that peer education was a friendly and highly effective means to get the message out.

Mr. Chen Zuo, leader of the peer educators of Renmin University in China, explained that in China until a few years ago people were very reluctant to discuss HIV/AIDS and other reproductive health issues, but now there are many NGOs there working in the field and also government support for related initiatives. Aiming to attract more people to participate in discussion of the issues, he has established a national youth network. He stressed that although young people need the support of adults and governments, youths must help themselves by themselves, as they are the future.

Reports from Ten Cities

The ten senior officials from ten Asian cities in charge of adolescent reproductive health and HIV/AIDS made brief reports on the history, current status, countermeasures, and challenges of HIV/AIDS in their respective cities and countries.
Dr. Salim Akhter Chowdhury from Chittagong, Bangladesh, reported: "The spread of HIV infection is rapidly increasing. Some highly positive HIV prevalence areas were considered as having great potential to make Bangladesh a HIV/AIDS prone country in the very near future. Almost half of the population is under 15 years of age, and risky behaviors, including high rates of unsafe injecting drug use, a thriving sex trade, and unsafe blood transfusion practices, are widespread."

Mr. Fan Kaimin from Weihai, China, reported: "In 1993 the first HIV/AIDS was found in Weihai. At present Weihai had nine HIV/AIDS patients. All of them were under control. Adolescents often do not know how serious the problem of HIV/AIDS is, how it is caused or what they can do to protect themselves. The other challenges are the floating population, which is increasing very fast, and the increase of risky sexual action."

Dr. Kandasamy Manivasan from Chennai, India, reported: "In 1986 the first case of HIV was identified in India. Chennai Corporation AIDS Prevention And Control Society (CAPACS) was established in 1998 to combat the spread of HIV/AIDS among the general population within Chennai City besides providing care and support facilities to the HIV/AIDS patients. The challenges for them are: (i) Bringing about behavioral changes in the high risk group and the general community, (ii) Empowerment and rehabilitation of marginalized groups such as commercial sex workers, homosexuals, and injecting drug users, (iii) Dealing with the continuing migration trends, which lead to high-risk behavior and street children, (iv) Dealing with the high percentage of slum dwellers, (v) Provision of free anti-retroviral treatment to all those who have become infected, and (vi) Overcoming stigma and social discrimination."

Dr. Esty Martiana Rachmie from Surabaya, Indonesia, reported: "In 1996 five HIV positive cases were firstly found in Surabaya. Each year the number of cases found increased remarkably. By 2004 there were 323 HIV/AIDS cases found in total. The challenges are (i) To reduce stigma and discrimination of HIV/AIDS among government officials, religious leaders and PLWH, (ii) To promote safe sex and condom usage, (iii) To provide support and care for HIV/AIDS patients, and (iv) To conduct operation research for improving intervention against the spread of HIV/AIDS."

Mr. Mohamad Zainudin Idris of Kuantan, Malaysia, reported: "National efforts to combat the epidemic of HIV/AIDS have been initiated since 1985. The first case of HIV was detected in 1986, and in 1997 systematic HIV/AIDS surveillance system has started, and up to now there are about 65,000 HIV careers and 7,000 AIDS careers. While in Kuantan, 297 cases of HIV and 66 cases of AIDS were detected in 2004. For the purpose of improving adolescent sexual and reproductive health, certain measures are formulated and implemented by Kuantan Municipal Government, with cooperation of other agencies or NGOs. For example, special program including exhibition on such issues as sexual abuse, idea of contraception are conducted in every school under National Population and Family Planning Development Board."

Dr. Aslam Pervaiz from Faisalabad, Pakistan, reported: "According to the Government of Pakistan, there were 1,998 cases of HIV/AIDS reported in 2002. Based on the WHO estimate of people living with HIV/AIDS, deaths related to HIV/AIDS would have been approximately 3,500 in 2002. No authentic data is available at national and city levels, except at one diagnostic facility at Allied Hospital Faisalabad. So far, four cases of HIV/AIDS positive have been identified by the private sector of the Faisalabad District. Pakistan is currently classified by WHO/UNAIDS definitions as a low prevalence but high-risk country for the spread of HIV infection due to a number of varied factors, including low literacy rate, high prevalence of sexually transmitted infections, limited safety in blood transfusions, increasing numbers of injecting drug users, use of contaminated needles, high injection use rate, and its highly mobile refugee population."

Dr. Nilda Ticar Montoya from Olongapo, Philippines, reported: "Out of 74,341 HIV tests done from 1985 to 1990, 44 were identified positive. There was a total of 49 HIV cases in 1992. Seven years after the pull out of the US armed forces, twelve additional cases were identified bringing the total cases to 61. Several organizations such as the I CARE Fellowship, Youth with a Mission, Precious Jewels Foundation and the Reach-Up Project of the City Government, provide material and spiritual as well as educational support to the children of PHIVs."

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Ms. Wallapa Prangthawat from Khon Kaen, Thailand, reported: "In Khon Kaen HIV/AIDS was first identified in 1988. The number of AIDS cases and deaths due to AIDS reported from 1988 to May 2005 are 5,599 and 1,036 respectively. A behavioral surveillance conducted annually in June-July, shows that the percentage of the 11th grade students who had sexual intercourse was 24.5% of males and 6.4% of females. During their first sex, only 29.5% of male students and 48.6% of female students used the condom. The result of Mother to Child HIV Transmission Prevention Program in 2005 showed that out of the coverage of 97.8% of the ANC attendees (18,605 cases), the prevalence rate of infected mothers was 0.8% (148 cases), and the percentage of ARV received was 88.8% of HIV infected mothers (131 cases) and 99.3% of their infants (149 cases). The cumulative number of children under 15 years old living with HIV/AIDS in 2005 was 420 cases. It is a serious health threat which has spread from the earlier known high risk groups to other vulnerable population such as married women, their infants and youth."

Dr. Kim Anh Thi Doan Ve from Danang, Vietnam, reported: "In April 1993 the first HIV case was found in Danang. Up to 31 May 2005 there have been 253 AIDS patients. The 6/6 districts and 43/47 communes have people living with HIV. City’s central area has a higher rate than other areas. The number of young affected people under 29 years old increased year after year in 2001, 60% in 2002, 72% in 2003, and 73% in 2004. Migration is a big problem in Danang. The rate of migrants with HIV is relatively high accounting for nearly 40% of the found cases. The management of the affected people is very difficult, and the risk of AIDS spreading over the community is relatively high. To prevent the spread of this epidemic, the City People’s Committee issued the Decision No. 161/2004/QD-UB dated 28 September 2004 on the issuance of the Action Plan on HIV/AIDS Prevention for the period 2005-2010. More than 30 branches and mass organizations involved in the activities such as behavior change, counseling, capacity development in management and monitoring, and mobilization of the community."

Dr. Chika Shirai from Kobe, Japan, reported: "On 17 January 1987, Japan’s first female AIDS patient was reported in Kobe. This news encouraged 6,000 people to be tested for HIV antibodies and more than 10,000 people to use the HIV infection consultation service annually. In 1993 and 1994, a range of AIDS-related programs were conducted by public health centers throughout Kobe City, including seminars, production of educational videos, lectures by HIV-positive people, photo exhibitions and symposia. Because of some financial difficulties due to the great earthquake, the AIDS prevention efforts by the Kobe City Government are currently focused only on HIV antibody testing and counseling services. Annually about 1,400 people are tested for HIV. Since 1989, over 80 HIV-positive cases have been reported in Kobe, where only a limited number of hospitals are capable of providing AIDS treatment."

Discussion

The discussion open to the floor was facilitated by Ms. Ikehani.

Q: What is the relation between policies on sexually transmitted diseases (STDs) including HIV/AIDS and poverty reduction?

A: Data shows that approximately 80% of HIV/AIDS cases are spread through sexual interaction. The poor are a particularly vulnerable group due to lack of knowledge about the disease and how to protect themselves. We at the UNFPA are making efforts to take a multi-faceted approach in the formulation of our programs to appropriately address the interconnected nature of the problems. (Ms. Kiyoko Ikehani)

- There is indeed a close link between poverty and susceptibility. People who live in shools are particularly vulnerable. A multi-dimensional approach is required, one that not only increases awareness and knowledge, but one that actually leads to behavioral change. (Dr. Kandasamy Manivasan)

- We should keep in mind that in 2000, leaders of 180 countries agreed on the Millennium Development Goals, under which the eradication of poverty and combating HIV/AIDS are top priorities. The poor usually have low access to knowledge and facilities, so they easily become victims. Commitment is one of the prime requirements needed to realize these goals. (Dr. Haryono Sujono)
Q: Why did you choose to become involved in peer education and what kind of training is needed?
A: I studied cultural communication at university and this is a practical way to use what I have learned. I also like to serve as a resource base to others and provide them with the knowledge they need. Most importantly, I believe that peer education, especially young people teaching young people, is a very effective approach. As for training, I studied reproductive health, and as a UNFPA representative, I have taken a certified program and receive ongoing training. (Ms. Katia Lukicheva)

Q: I feel there is lack of knowledge among young people in Japan about global issues such as child labor, war and HIV/AIDS. How can we convey the message to young people?
A: It is important to talk about HIV/AIDS because it is a social problem not a personal problem. You could encourage discussions in schools, for example, by organizing events or organizing competitions between schools for the most successful event. (Ms. Katia Lukicheva)
  • Peer education is a good approach. You can also use the arts as a medium, for example, by holding photo contests or video contests. (Mr. Chen Zuo)
  • In Vietnam, HIV/AIDS issues are taught in secondary schools. For children not in school, meetings and competitions are organized. The mass media also allocate time to inform people on these issues. (Dr. Kim Anh Thi Doan Vo)
  • In addition to individual efforts, you could try tapping into resources and funding available through development agencies to pursue an issue that you feel strongly about.

Q: I hear about Japanese men who go to Southeast Asia to have sex with prostitutes and then come back to Japan infected with HIV/AIDS. I am angry that Southeast Asian countries allow this to happen. What are they doing about this problem?
A: I think most people would agree that the "sex tourists" are the ones to blame for this, not the prostitutes. However, this question raises the issue of misconceptions about the disease and the inappropriate placement of blame on its vulnerable victims such as sex workers. We have to address the behavior, not just criticize. (Dr. Farah Usmani)
  • We have many so-called sex tourists in Vietnam. We carry out campaigns among the sex workers to promote condom use and we give advice and warning to the Japanese men and other tourists regarding the risks. (Dr. Kim Anh Thi Doan Vo)

Q: What are the best means to promote use of condoms? Does promoting condoms mean we support pre-marital sex and promiscuity?
A: Unfortunately many people believe that promoting condoms is promoting promiscuity. We use evidence-based advocacy in such cases, because evidence shows that use of condoms prevents the spread HIV/AIDS. Promoting condoms is difficult in the face of conservative and religious elements, but we are working with religious leaders and making progress. A multi-layered comprehensive program is required for effective results, and we also have to adapt the practices to the local context. (Dr. Farah Usmani)
  • We should keep in mind that the sex workers do not always have the choice to use a condom, as clients may refuse, and they are the ones in control. (Dr. Haryono Suyono)

Closing Remarks

Dr. Hirofumi Ando
Dr. Hirofumi Ando, President of AUICK, summarized some of the main points raised in the presentations and discussions as follows:

1. HIV/AIDS is a global issue that has no boundaries, especially in light of increased migration and mobilization worldwide. Its center is shifting from Africa to Asia, and no country is isolated from the problem or immune to its effects.

2. Groups particularly vulnerable to the disease are the poor, especially the young, commercial sex workers and intravenous drug users.

3. We need political commitment for effective policies and programs, but each of us must also be "politically committed."

4. The stigma and discrimination associated with HIV/AIDS is a problem that we can all play a role in improving. We have to help ourselves to help others, which of course applies to all aspects of HIV/AIDS and many other issues. Peer counseling is a prime example of such initiatives, and of the passionate dedication of young people that is sure to achieve timely results.

Dr. Ando closed the seminar by thanking the organizers of the forum, UNFPA Tokyo Office and AUICK, as well as Ms. Ikekami for her excellent chairpersonship and all the panelists and participants for making this event a success.

Participants

1. UNFPA Personnel
   Dr. Farah Usmani
   Advisor, HIV/AIDS & Reproductive Health, UNFPA / UNFPA CST for South and West Asian Kathmandu
   Ms. Kiyoko Ikekami
   Director, UNFPA Tokyo Office

2. Peer Education Activists
   Ms. Katia Lukicheva
   Y-PEER Focal Point for Kyrgyzstan
   Mr. Chen Zuo
   Leader of Peer Educators of Renmin University, China

3. City Officials
   Dr. Salim Akhter Chowdhury
   Health Officer, Chittagong City Corporation, Bangladesh

Mr. Fan Kaimin
Assistant to the Director General of Health Bureau, Disease Control Section, Weihai Municipality Health Bureau, China

Dr. Kandasamy Manivasan
Joint Commissioner (Health) & Project Director, Health & District Family Welfare Bureau/Chennai Corporation Aids Prevention and Control Society, Corporation of Chennai, India

Dr. Esty Martiana Rachmie
Head, Coordinating Board of Municipal Family Planning, Surabaya City, Indonesia

Mr. Mohamad Zainudin Idris
Director, Health and Cleanliness Control Department, Kuantan Municipal Council, Malaysia

Dr. Aslam Pervaiz
Deputy Director, Solid Waste Management, Tehsil Municipal Administration, Faisalabad, Pakistan

Dr. Nidae Ticear Montoya
Rural Health Physician, Social Hygiene Clinic, City Heath Department, Olongapo Medical Society, Olongapo City, Philippines

Ms. Wallapa Prangthawat
Public Health Technical Officer, Technical Supporting Section, Khon Kaen Provincial Health Office, Thailand

Dr. Kim Anh Thi Doan Vo
Vice Director, Department of Health, Danang People's Committee, Vietnam

Ms. Hong Thi Bui
Program Assistant, UNFPA Vietnam (Dr. Kim's interpreter)

Dr. Chika Shirai
Manager, Public Health and Welfare Department, Hyogo Ward, Kobe City Government, Japan

4. AUICK
   Dr. Haryono Suyono
   Member of AUICK International Advisory Committee / Former Coordinating Minister for Social Welfare and Poverty Alleviation

Dr. Hirofumi Ando
President of AUICK

Mr. Yoshikane Fujimoto
Executive Director of AUICK

Mr. Nobuyuki Morimoto
Deputy Executive Director of AUICK

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In 1996 AUICK started the First Study Course on Specific Fields of Urban Policy, and invited senior officials in charge of the relevant department from nine medium-sized cities selected from nine Asian countries, including Faisalabad City. From 1996 onwards every year one participant from Faisalabad City has attended the seminar in Kobe on different subjects based on that year's theme. Thus, the relationship between AUICK and Faisalabad City has been continuously developed.

**RELATIONSHIP WITH AUICK SINCE 1996**

At the beginning of the relationship, the Faisalabad City government was run by the mayor elected by the council of the Faisalabad Municipal Corporation (FMC) consisting of 90 councilors. Basically FMC was responsible for the construction of roads, sewerage, sanitation and food etc., while the departments of education, labor and health were administered by the provincial government.

Under the local government plan of the present regime, the Faisalabad District came into existence on 14 August 2001, consisting of six sub-divisions: Faisalabad City, Faisalabad Sadar, Chak Jhumra, Jaranwala, Samundri, and Tandlianwala. Since by virtue of a clause of Section-180 of the Punjab Local Government Ordinance 2001 the Tehsil Municipal Administration (TMA) Faisalabad was a successor body of FMC, AUICK continued its relationship with Faisalabad City through TMA Faisalabad. It was headed by Mr. Mumtaz Ali Cheema who was the first Tehsil Nazim (Mayor) of Faisalabad City elected by the people.

Faisalabad District Government (FDG), and entrusted Dr. M.A.Kareem Iqbal to negotiate the continuation of our relationship with Mr. Tauseef.

The administrative structure of FDG is as follows:

City District Nazim
- District Coordination Officer
  - Agriculture
  - Community Development
  - Education
  - Finance and Planning
  - Health
  - Information Technology
  - Law
  - Literacy
  - Revenue
  - Works and Services

City District Nazim (Mayor) acts as a head of FDG, and perform functions and exercise powers assigned under the Local Government Ordinance 2001.

**MONITORING MEETING ON 25 MAY 2004**

On 25 May 2004, Dr. M. A. Kareem Iqbal visited Faisalabad City with Ms. Shaheda Fazil, UNFPA Assistant Representative in Pakistan.

They met with Mr. A. M. Mumtaz Ali Cheema, Tehsil Nazim of TMA Faisalabad, and then with two academics of University of Agriculture Faisalabad: Dr. Asghar Cheema, Dean & Head of Department of Sociology.

All four parties — UNFPA Pakistan Office, AUICK, TMA Faisalabad and University of Agriculture Faisalabad — reached an agreement to work together in collaboration and in accordance with UNFPA-AUICK guidelines.

In August 2005 Faisalabad City and Sader were converted into four towns — Lyallpur, Andina, Jinnah and Iqbal — while the remaining four tehsils were given the status of towns. At the subsequent local election, Mr. Rana Zahid Tauseef was elected as Mayor and District Nazim of Faisalabad. After due consideration, AUICK decided to continue its relationship with Faisalabad City through the
MONITORING MEETING
ON 1 FEB 2005

From 31 January to 3 February 2005, AUICK dispatched a
delegation to Faisalabad, composing of Dr. M. A. Kareem
Iqbal, Mr. Toshinkhi Baba, Deputy Executive Director of
AUICK, and Mr. Kyoji Ueda, Director of International
Division, Kobe City Government. The delegation had a
monitoring meeting with the city officials who
participated in the past training courses in the afternoon of
1 February at the Council Hall of Tehsil Municipal
Administration Faisalabad. This was the first official visit
of AUICK Secretariat to Faisalabad City. Dr. Iqbal
facilitated the meeting.

Dr. M. A. Kareem Iqbal

Dr. Iqbal stressed that AAC’s role and responsibility is to
utilize knowledge and experience obtained through the
workshop to solve urban problems, and to aim to become a
model city among other middle-sized cities in their
country. He pointed out that AUICK was established to
collect and disseminate information on urban conditions and
urban planning, and to help develop a network of
urban administrators in Asian cities, to provide
financial support. Mr. Ueda noted that Kobe City is
prepared to offer practical support in different way to
that of AUICK, by arranging tie-up with JICA, JBIC, and
other institutions.

Comments from Past Participants

Mr. Rai Mohammad Amin Khan, Tehsil Municipal
Officer, Services and General
Administration, attended the
Second 2004 Workshop on
AUICK Associate Cities
Research: STELLA Modelling.
He indicated that the main
problems in Faisalabad City
are pollution, transportation,
and waste management and so on. "To produce positive results
after participating in the AUICK training course, financial
support is most necessary. For example, we have launched the
WASA project, with the financial aid of 3 billion
Pakistan Rupee from JICA."

Mr. Safdar Hasan Raja,
Director General of Faisalabad
Development Authority,
attended the 1998 Study
Course on Specific Fields of
Urban Policy. He raised the
issue that AUICK training
courses should provide
information on financial aids.
He also proposed to have
discussions each day after the course, since just listening
to the lecture would not be enough to fully understand
them.

Mr. Shajjar Hussain, Chief
Medical officer of Health,
attended the 1997 Study
Course on Specific Fields of
Urban Policy. He said that he
is now in charge of family
planning. "An ultimate goal of
medical education is to be
physically, mentally and
socially fit. As education
takes root among people, it will bring about changes in
awareness, and population growth will become moderate.
The problem is, who will be responsible for giving health
education about HIV/AIDS and other subjects? We need
this kind of training program, which provides technical
knowledge for health care. Human resources, in particular,
technical experts should be fostered."

Mr. Syed Ghias Ud Din,
Managing Director of Water
Supply & Sanitation Agency
for the Citizens of Faisalabad,
Housing and Urban
Development and Public
Health Engineering Department,
attended the 2003 Seminar on
Population and Sustainable
Water Management in Urban
Planning. He suggested that theoretical discussion be
followed by practical training, and it be arranged by
AUICK for AACs.

Mr. Rai Qamar-Uz Zaman,
Deputy Director of the
Department of Solid Waste
Management, attended three
past training courses: the 1996
Study Course on Specific
Fields of Urban Policy, the
1998 Study Course on ICPD
and Health Care, and the 2004
Workshop on UNFPA Goals
and Urban Policies. He underlined the necessity of
capacity building for trainers in specific fields. "One
element is that the teaching program at Allied Hospital is
not so satisfactory. Training for trainers is most in need."

Dr. Iqbal responded that specific fields will be taken up
one by one in the coming workshops, including case study
on rainwater harvesting in Chennai, and reproductive
health program in Thailand and so on. Computer analysis
on administrative indicators with Stella model will be
another possibility.

Mr. Mumtaz Ali Cheema,
Tehsil Nazim (Mayor) of
Faisalabad, attended the 2002
Workshop on Population
Ageing and Administrative
Countermeasures for the
Aged. He also attended the
AUICK Associate Cities
Conference held in Kobe from
31 July to 1 August 2004, and
signed the affiliation of AUICK Associate Cities Network.
He concluded the meeting as stating "I expect that
Faisalabad City will continue to collaborate with AUICK
and Kobe City for the future, through our friendly
relations."

REVIEW MEETING ON FAISALABAD
POPULATION ENVIRONMENTAL
DYNAMICS PROJECT
ON 2 FEB 2004

The Kobe delegation also held a meeting on 2 February
2005 in the University of Agriculture Faisalabad to
review the progress of the baseline study of the
Faisalabad Population Environmental Dynamics Project
2004-2007. It was attended by Prof. Dr. Basheer Ahmed,
Vice Chancellor, and Prof. Dr. Asghar Ali Cheema, Dean
& Head of the Department of Rural Sociology,
representing University of Agriculture Faisalabad, Mr.
Mumtaz Ali Cheema, Tehsil Nazim (Mayor) of
Faisalabad City, and Rai Mohammad Amin, Tehsil
Municipal Officer, representing Tehsil Administration
Faisalabad.

Dr. Asghar Ali Cheema, as an AUICK’s academic
collaborator for Faisalabad, made a presentation on the
Baseline Study 2004-2007. While highlighting the
progress made in the collection of data, he mentioned
the inadequacies of data and the need for their
validation.

The population of Faisalabad is 2.2 million. It is Pakistan’s
third biggest city and an important industrial center. The
Mayor of Faisalabad gives topmost priority to the provision
of basic facilities to all citizens. The city is confronted
with major problems of solid waste management,
defective sewerage and drainage systems, water supply and
pollution. High infant and maternal mortality also are
areas of concern.

The academic collaborator mentioned that the university
can play a significant role to support the City Government
in addressing major problems being faced by the City. In
addition to research, the University faculty can help design
plans and execute various training programs, as well as
assist the trainees in implementation and monitoring. It
can also develop training modules and organize training
courses for city planners and administrators.

It may be recalled that the UNFPA Headquarters has
recommended that the Regional Projects funded by
UNFPA must be closely linked to UNFPA Country
Programs in the 9 countries participating in the Project.
Even though Faisalabad is not one of the ten selected
districts under UNFPA’s Seventh Country Program (CP),
it supports activities through AUICK, which can promote
not only the goals of 7th CP, but also establish vital
linkages for the integration of population, Representative
Health and Gender Issues within the district level
activities in Faisalabad. UNFPA Pakistan Office
nominated Ms. Shaheda Fazil, Assistant Representative as
the Liaison Officer for the purpose.

The City Government, in consultation with the academic
collaborator, would be shortly submitting a project
proposal for financing by JICA.

AUICK’s initiatives and efforts in the development of the
Faisalabad Population Dynamics Project were greatly
appreciated by all concerned.

Memorandum of Understanding

Another important event participated by the Kobe
delegation on 2 February 2005 was the signing of the
Memorandum of Understanding between the Faculty of
Agriculture Economics and Rural Sociology, University of
Agriculture Faisalabad and the TMA Faisalabad. They
inter alia formalized the close working relationship
between the academic collaborator and the City
Government and UNFPA, when the three parties mutually
agreed to:

a) Establish an organization capacity with Faisalabad
City to monitor population, socio-economic and
environmental issues and to formulate and implement
appropriate policies and programs accordingly;
b) Concentrate our efforts, particularly on issues such as
Solid Waste Management, Effluent Disposal,
Reproductive Health, HIV/AIDS, Poverty Alleviation
Education Policies, especially for women and girls;
c) Strive to collect and provide information pertinent to
population, socio-economic and environmental issues
and related good practices by supporting and
expansion of AUICK Web-based data;
d) Strive to establish close collaborative relationship with
UNFPA, National and Provincial Governments, Non-
Governmental Organizations (NGOs) and non-profit
organizations so as to further strengthen the capacity
of Faisalabad City.
e) Strive through the activities mentioned above, to serve
as a model of a developed medium sized city so as to
spread projects yielding positive results for other cities
in Pakistan.
MONITORING/REVIEW MEETING ON 10 NOV 2005

Dr. M. A. Kareem Iqbal organized a monitoring/review meeting on the Faisalabad Population Environmental Dynamics Project on 10 November 2005 at the Committee Room of the Faisalabad District Government.

The following persons attended from Faisalabad:

Mr. Athar Hussain Khan Sial
District Coordination Officer,
City District Government representing Mayor of Faisalabad
(Chair of the meeting)

Prof. Dr. Asghar Cheema
Dean, Faculty of Agriculture Economics, University of Agriculture Faisalabad
(Academic Collaborator)

Dr. Aslam Pervaiz
Deputy Director,
Solid Waste Management,
City District Government

Mr. Rai Qamar-Uz Zaman
Deputy Director,
Solid Waste Management,
City District Government

Unfortunately, the newly elected City District Nazim and Mayor of Faisalabad City, Mr. Rana Zahid Tauseef could not attend due to a last minute pre-occupation with the Supreme Court of Pakistan. Mrs. Shaheda Fazil, Deputy Representative of UNFPA (Liaison Officer) also could not attend due to her prior commitment with the earthquake relief work.

Dr. Kareem Iqbal recalled the Memorandum of Understanding signed on 2 February 2005 between the Faculty of Agriculture Economics and Rural Sociology of the Faisalabad Agriculture University and the City Government. He also recalled that the UNFPA Headquarters has recommended that the Regional Projects funded by UNFPA must be closely linked to UNFPA Country Programs in the 9 countries participating in the Project.

As the Academic Collaborator, Dr. Asghar Cheema presented his report on "Baseline Socio-Economics Survey on the Faisalabad Population Environmental Dynamics Project 2004-2007". (The details will be published together with the reports from the other Associate Cities in a book later.)

On behalf of the City Government, Dr. Rai Qamar Uz Zaman made a presentation reviewing the progress so far made in the attainment of UNFPA's, M.D.Gs (Millennium Development Goals) as follows:

1. Solid Waste Management System
   a) Establishment of a Solid Waste Management Department (SWM) in the Faisalabad City
   b) Replacement of old method of sweeping by sanitary workers on main roads with mechanical road sweepers.
   c) Placement of containers at the temporary Transfer station where previously the waste was lying openly.
   d) Development of proper landfill site in process.
   e) Shifting of cattle from the main city.
   f) 1,500 tons of waste produce daily.
   g) Only 70% is transferred to the dumping site with existing machinery.
   h) Inadequate number of vehicles for transportation of waste.
   i) Non-availability of facility of segregation and recycling of inorganic waste.
   j) No proper workshops for vehicles maintenance and repair.

2. Roads
   a) Remodeling of main squares of the city.
   b) Widening of main roads of the city by removing encroachments.
   c) Reconstruction of the main roads of the city.

3. Street Lights
   a) Network of streetlights has been revamped.
   b) 13,000 old street light points have been repaired/replaced.
   c) 4,000 new street light points have been added.

4. Parks and the Green Belts
   a) Developed 140 kilometers Green Belts.
   b) Developed 150 parks; the main ones being Canal Park, Ghausia Park and Rafiqat Ali Park etc.
   c) Re-modeling of Bagh-e-Jinnah.

5. Medical and Health Services
   a) Establishment of a general hospital located at Ghulam Muhammad Abad.
   b) Establishment of Cardiology and Liver Centre at District Headquarters Hospital, Faisalabad.
   c) Installation of incinerator for hospitals based at Allied Hospital.

6. Water Supply System
   a) Water Resources: 60MGD.
   i) Chenab Well Field
   ii) Tube – well along R.B. Canal
   iii) Canal Water Treatment Plant Jhal Khanna – Millat Town
   b) 60% of population now has access to piped water.
c) 40% of Faisalabad households still get drinking water from hand pumps and motor pumps.

d) The underground water of Faisalabad city is saline with the TDS ranging between 2,500 to 1,000 P.P.M.

7. Sewerage and Drainage

a) Existing sewerage situation in Faisalabad is far below acceptable standard.
b) This insufficient sewerage system affects the living condition and health of the entire city's population.
c) 60% of all household connected to street sewerage.
d) 30% of household sewerage discharges into open.
e) 10% of households are with no controlled discharge.

8. Environmental Hazards

a) The textile and grain mills are a major source of air, water and land pollution.
b) Dying process in the textile industry is a major source of pollution that goes unchecked.
c) Untreated industrial waste is also a source of pollution.
d) There is currently no monitoring of air quality in Faisalabad.
e) Vehicles' exhaust pollution containing nitrogen oxides and lead is high.
f) Growing number of smoky and noisy vehicles (Rickshaws, vans etc.).
g) Unsafe disposal of hazardous waste of hospitals. Only 2 hospitals (Allies and District Headquarter Hospitals) have the facility of incineration.
h) Animal driven vehicles also contribute to pollution of the environment.

9. Education

a) Upgrading of Govt. College to Govt. College University.
b) Upgrading of Govt. College of Education to University College of Education.
c) Establishment of New Universities namely (University of Faisalabad, and Hamdard University).

d) The actual number of schools has nearly doubled from 1970 to 1997 and enrollment has increased substantially for both girls and boys, while a majority of schools and colleges are overcrowded.

e) The physical facilities of the schools are of low quality.

9. Education

f) Teachers are often untrained and there is general shortage of funds.

g) Buildings are old and insufficient.

10. Population

Faisalabad City population has exploded growing from 43,000, its first recorded population in 1931 to 2.5 million in year 2002-2003. Faisalabad City is unable to control its rapidly growing population, resulting in low quality of life and poor living condition of people. 40% of people are living in Katchi Abadies (squatter settlements).

11. Other

a) Shifting of oil depots from the city.
b) Shifting of industries from the residential areas.
c) Removal of encroachments from different roads and bazaars.

d) Shifting of truck stands from the city.
e) Shortage of fire fighting equipment, trained staff and fire brigade vehicles.
f) Shifting of cattle from the city area.

g) Shifting of vegetable markets from the heart of the city.
h) Re-modeling of the general bus stand is in process.

12. Involvement of AUICK

How is AUICK involved in these changes from 1996 to 2005? The participants who participated in these workshops played a major and definite role in all the above-mentioned activities by improvement in the following areas:

a) Maximum utilization of available resources.
b) Definite role of NGOs.
c) Chain of command in administration.
d) Optimum utilization of time.
e) Health education.
f) Sharing of experiences.
g) Definite role of women's participation.
h) Development of a pool of professionals through research and trainings.
i) Use of website for effective and timely dissemination of information/knowledge.
j) Better planning and policies for sustainable urban development.
k) Improving knowledge, awareness and understanding of major issues of population, environment, education, etc.

13. Commitments of Faisalabad City

To achieve these goals, the City Government of Faisalabad is highly committed, but at the same time the major concerns/requirements of the Faisalabad City have to be reviewed.

After a thorough discussion between the participants, the following recommendations were made for consideration by AUICK:

1. Training courses

i) The duration is very short. They should preferably be at least of 3 months in duration.

ii) The subject should be specific to such themes as Solid Waste Management and HIV/AIDS.

iii) Scholarships may be arranged for officials of the City Government Faisalabad, especially relating to Solid Waste Management, HIV/AIDS, HIV/AIDS, HIV/AIDS preventive health, etc.

2. Projects prepared

In the year 2005 three projects will be prepared by the City Government and Department of rural Sociology Agriculture University Faisalabad. These projects will be concerned with:

i) Solid Waste Management

ii) HIV/AIDS

iii) Baseline data

These projects will be sent by the end of December 2005. AUICK may make special efforts for approval and funding of these projects.

Editor's Note: This article is a summary of two reports presented by Dr. Kareem Iqbal. AUICK takes full editorial responsibility for the content.
Meetings of AUICK Committees

EXECUTIVE COMMITTEE

Regular Meeting on 24 June 2005

The AUICK Executive Committee held the first regular meeting of FY2005 at the meeting room of the AUICK Office from 11:20 am to noon on Thursday, 24 June 2005.

In the opening remark, Mr. Kazutoshi Sasayama, Chairman of AUICK, underlined how the year 2004 was important as a kick-off of the new strategy. He also emphasized that capacity building is essential to strengthen partnership between the associated cities.

Following the opening remark, the Secretariat presented a report on achievements for FY2004. The Secretariat gave a brief description on the Mayor's Conference held on 31 July and 1 August, which was one of the main achievements in 2004.

The Secretariat continued to present a financial report for FY2004. The Secretariat added that UNFPA had introduced a new financial system to consolidate its result-based policy since 2004, and every partner NGO of UNFPA, including AUICK, was required to shift to the new system from January 2005. Mr. Inoue informed that the auditors checked the financial report and confirmed that there was no problem.

The achievements and the final accounts for FY2004 were anonymously approved by the committee members. Then, some valuable suggestions were raised by the members.

One member suggested that AUICK's activities be more publicized to attract more supports and collaborations from the citizens through maneuvers such as giving a more appealing title to each event. The Secretariat responded that AUICK would open one of the programs of the First 2005 Workshop to the public, especially designed for adolescents, as the UNFPA Seminar jointly organized with UNFPA Tokyo Office. The title would be "Sound Mind and Sound Body: Let us think and learn and have a wonderful adolescence" which would be more attractive to the targeted young people than the original title of the workshop: "Adolescent Reproductive Health and HIV/AIDS."

Another member suggested that it would be more meaningful to facilitate the use of human resources such as university professors or retired ambassadors who would be suitable candidates for AUICK to approach for cooperation in future activities.

Members Attended:
Kojiro Nilo (Chair)
President, Kobe Institute of Urban Research
Takashi Iga
Professor Emeritus, Kobe University
Shozo Takayose
Professor, Himeji Dokkyo University
Kiyoko Ikogawa
President, Kobe City College of Nursing
Chen Raxing
Professor, University of Ilyogo

Takafumi Inoue
Director, representing Executive Director, Civic Affairs, Culture and Tourism Bureau, Kobe City Government, and Auditor of AUICK
Kazutoshi Sasayama
Chairman, AUICK
Yoshikane Fujimoto
Executive Director, AUICK

AUICK welcomes your contribution

Sharing information is a crucial part of AUICK’s activities. This newsletter is intended to be a venue for the exchange of information on urban and population problems in Asian cities. Your contribution to the newsletter is very important. Based on our regulations, payment will be made for published works. Please send your opinions, articles, information, papers, and pictures to:

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