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FEATURE: Population Ageing and Appropriate Measures for the Aged

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AUICK Second 2006 Workshop

AUICK held the Second 2006 Workshop under the theme of "Population Ageing and Appropriate Measures for the Aged" in Kobe, Japan, from 30 October to 10 November 2006, with the support of the United Nations Population Fund (UNFPA) and the Kobe City Government. AUICK invited nine participants from nine AUICK Associated Cities and two interpreters.

BACKGROUND

World Population is growing rapidly, but it is ageing even more rapidly. In the last half century the world population more than doubled, from 2.5 to 6.1 billion. The population of people aged 65 and over, however, more than tripled, from 131 million to 417 million. Over the next half century, the world population may grow by about 60% to 10 billion, but the population of people aged 65 and over will almost triple again, from 417 to 1.5 Billion.

This accelerated ageing process is even more dramatic in Asia. In the last half century, Asia's total population almost tripled, rising from 1.4 to 3.7 billion. Those 65 and over, however, grew by almost four times, from 57 to 217 million. The future will see even greater ageing. While the total Asian population may grow from 3.7 to 6.4 billion, or 57 percent from 2000 to 2050; those 65 and over may grow from 217 to 907 million, or an increase of more than 4 times. Moreover, the number of very old people in Asia -those 80 and over- has grown from about 4 million in 1950 to 29 million in 2000. This number will grow to over 225 million by 2050.

Population ageing has a great impact on both society and economy. It brings a shrinking of the workforce, an increasing social-security burden, and a major change in family structure and medical problems. As women represent the larger number and proportion of older people in almost all societies, the issue also has important gender implications. On the other hand, the positive aspect of ageing is that the elders have more time to contribute to the society with their rich experience of life and work.

The UNFPA has been actively involved in ageing issues for many years. It has worked with many countries to formulate appropriate public policies and promote policy dialogues to respond to the challenges posed by the social, health and economic consequences of population ageing. It has also assisted many countries to meet the needs of older persons, with particular emphasis on the poor and especially women.

AIM

This workshop is designed for senior officials of AUICK Associate Cities (AACs) who are in charge of policies and programs directed at the aged. In view of the UNFPA Policy Guidelines on Ageing, the Workshop is designed to help the participants improve their knowledge of the urban policy implications of the population ageing processes and the social and economic impacts. It is also designed to increase the participants' understanding and know-how of administrative measures for the aged through presentations of city reports, case studies, discussions and field observations. Each participant is also expected to develop a concrete action plan for appropriate administrative measures for the aged, which is to be implemented upon their return to their cities.

PARTICIPANTS

The workshop was designed for the senior-most officials of the appropriate department, from the nine AUICK Associate Cities: Chittagong (Bangladesh), Weihai (China), Chennai (India), Surabaya (Indonesia), Kuantan (Malaysia), Faisalabad (Pakistan), Olongapo (Philippines), Khon Kaen (Thailand), and Danang (Vietnam). Countries are listed in alphabetical order. The participants included the following:

Mr. Mohammed Nasim Bhuinya
Project Manager, Partnership Agreement-3, Second Urban Primary Health Care Project, Health Department, Chittagong City Corporation, Bangladesh

Mr. Xing Jie Cai
Vice Director, Civil Administration Bureau, Weihai City, China

Ms. Shantha Kamari Paranthaman
District Family Welfare Medical Officer, District Family Welfare Bureau, Corporation of Chennai, India

Ms. Wiwiek Widayati
Head of Cooperation Division, Surabaya City, Indonesia

Mr. Anuar Bin Che Mahmud
Deputy Director, Pahang Social Welfare Department, Kuantan Municipal Council, Malaysia

Dr. Naseem Ahmad
Executive District Officer (Municipal Services), Engineering, Local Council Services, City District Government, Faisalabad, Pakistan

Mr. Fernando Moselina Magrata
Acting City Administrator and Hospital Administrator, Office of the City Administrator, Olongapo City, Philippines

Ms. Nudnapa Juntavaree
The workshop began with opening remarks by Dr. Hirofumi Ando, President of AUICK. He noted that for Japan, ageing is currently a pressing issue; and it is also an important issue for all countries in the future. He also noted that the elderly should be considered a resource for a city. Thus it behoves city governments to find ways to mobilize this resource and use it to improve the quality of life for all.

He reminded the participants that AUICK workshops are an attempt to develop what has come to be called "South to South" development assistance. Developing countries learn not only from the more wealthy "North" countries, but also from one another.

Finally, he explained that the action plan to be developed by each participant is a specific tactic of AUICK, to help the participants turn their experience in Kobe into a plan that can be implemented at home to promote better urban planning and to advance the quality of life of their citizens. In a subsequent presentation, Dr. Ando provided some specific guidelines for the development of action plans.

Dr. Gayl D. Ness, Professor Emeritus, University of Michigan, made a presentation on "Aging in Asia." Professor Ness provided an overview of the basic demographic dynamics of ageing in Asia. This begins with the Demographic Transition, or the movement of a society from high to low birth and death rates. This transition is closely associated with the change from traditional rural-agrarian to modern urban industrial society. First, the death rate declines while fertility remains high. This gives us a period of rapid population growth and an increase in the proportion of the young population, those under 15 years of age. At this point, a society faces high costs in providing education for the new young.

The second part of the transition is when fertility falls to come into line with the lower mortality, closing the demographic transition. The proportion of young people declines, reducing the burden on the society and creating a window of opportunity where there are many working age people for a smaller group of young and old-age dependent people.

A few decades after fertility has fallen, the proportion of aged people begins to rise. For example, in traditional societies the proportion of people over 65 years of age is rarely above 5 percent. Within two or three decades after fertility has fallen to modern levels, the proportion over 65s may be up to 10 percent and rising. Japan illustrates a very advanced stage of a modern urban-industrial society with very low fertility. Its population of people over 65 years of age is now 20 percent and is projected to rise to 35 percent by 2050. The "very old" population - over 80 years - is now 5 percent and is projected to rise to 15 percent by 2050. This is illustrative of what the future may hold for most if not all countries.

Along with this ageing comes a significant change in the sex ratio - the number of males per 100 females. At birth this is typically 105-106. But the higher age specific death rates for males gradually reduces this ratio. By ages 20-50 there are usually roughly equal numbers of males and females. Beyond that age, there is an increasing surplus of females, or a decline in the sex ratio. Again using Japan as an advanced example, at age 80 today there are only about 50 males for every 100 females. Thus an additional "problem" of ageing is the substantial increase in the proportion of women among the aged. This will pose special problems to policy makers and program directors.

Beyond these basic population dynamics, Professor Ness provided graphs for each of the nine countries of the AUICK Associate Cities, showing where they are along the lines of the development. Some, such as China, Thailand and Malaysia, have had a rapid fertility decline and will soon begin to see substantial rises in the number of aged. Others, such as Bangladesh, India and Pakistan, may have a half century or more before the proportion of their aged begins to put pressure on their societies.

Dr. Jun Matsunami, professor, Graduate School of International Cooperation, National University of Kobe, delivered a presentation on "Local Government and Population Ageing in Japan." He provided an overview of the structure and functioning of local government in Japan and how this affects programs for the aged.

Dr. Matsunami began his presentation by describing the structure of Japanese central and local governments and their functions. The great majority of social services in Japan are delivered by local governments. This is because local governments collect local taxes from various sources, and there is a huge financial transfer from central
government. This equalizes the differences between local governments, while most of them become less independent.

One of the advantages of local government control is that it is closest to the people and best understands both needs and resources at the local level. But local governments may also be weak in establishing and protecting a national level of welfare.

The population of people over 65 now represents more than 20 percent of Japan's population, and is projected to rise to 35 percent by 2050. The rising tide of the elderly raises questions about roles of central government and local governments, in terms of how medical care insurance system and public pension system should be managed.

Morning Session of 1 November

Dr. Haryono Suyono, IAC member, presented the best practice in Surabaya.

In Surabaya, mortality fell rapidly after World War II while fertility remained high, producing a period of rapid population growth. In the 1970s the country began a modern family planning program, which turned out to be one of the more successful ones in the world.

There is also now a large influx of elderly women into the cities. This pattern shows two important conditions. Recently the elderly population is growing more rapidly than the total population, and rural poverty is pushing older people out of the villages to live with their children who have made some progress in the city. In Southeast Asia women typically have longer life expectancy than men, and in Surabaya, there is a large influx of elderly women to live with their newly urbanized children.

This growth of the aged has gone almost unnoticed in Indonesia, where for the past three decades we have been more concerned with reducing fertility than caring for the aged. But now the Mayor of Surabaya has recognized the problem and the city's Department of Social Welfare has begun to organize support for the aged.

They have developed some organizations, including the Gerontologi Abiyoso, which opens and operates homes for the elderly, and Karang Wardha, community level organizations, which promote activities for the aged.

The city is now turning to mobilizing community groups and Non Government Organizations to assist in addressing the problem of the aged.

Afternoon Session of 1 November

Mr. Takeshi Yamamoto, Manager, Senior Citizens' Welfare Division, Senior Citizens' Welfare Department, Public Health and Welfare Bureau, Kobe City Government, made a presentation on "Care for the Elderly in Kobe: Problems, Progress and the Future." He provided a rich and detailed account of the city's attempts to address the problem of the aged.

Japan's aged population (65 years and over) constituted only 10 percent of the population in 1950; today it is 20 percent and by 2050 it is projected to reach more than 35 percent. Kobe has followed the national trend closely. In 1950, recovering from extensive war damage, Kobe's roughly 5 percent, or 25,000 elderly lived and died at home with family members, usually in three generation families. Today with 1.5 million people, Kobe's aged population is 308,000, or 20 percent. Most live in a one generation family, one third live alone and the great majority die in hospital or at a home for the aged. The trend will continue - by 2014 fully one in four of the population will be 65 years old and over.

Over the past half century of ageing, Kobe has experienced a near miraculous economic development. Rising from the ashes of the war, it has become a city of wealth and charm, with a standard of living and a quality of life that is enviable throughout the world.

The services for the elderly were once limited and largely decided by government, they are now extensive, varied and "user" oriented. They should be universal, comprehensive, locally oriented, and affordable.

One of the varieties of the service is the Silver College with three-year courses for people over 57. Its 4,000 graduates are now active in a great variety of community organizations. There are senior clubs in all the neighborhoods. A basic health service is available for all.

A city bus pass permits free travel to encourage the elderly to get out of their homes on non-stop busses. There are ward social workers and civil affairs committees who can identify the elderly in need and help connect them to a wide range of effective services.

This system of services has evolved over many years, and for much of that time, Kobe was growing wealthier year by year. Today Kobe faces a shrinking economy and reduced revenues. And this comes at a time when the number and proportion of the aged will only increase dramatically. Kobe now faces the question of who will pay and how will the services be paid for. The national elderly care insurance system now pays the bills. Users pay some 10% of their costs and insurance pays 90 percent. That 90% is paid for by the citizens of 40-64 years of age (31%), the national government (25%), the Prefectural government (12.5%) and the municipality (12.5%). At the moment this is adequate, but the growth
trends are frightening. Over the past six years the number of people designated to receive assistance in Kobe grew from 32,000 to 60,000 and the total costs doubled from 40 to 80 billion yen. That trend is expected to continue. The number of elderly is growing and the proportion of those designated to receive health care is also growing.

At this moment the city is deeply involved in a review of the services. When Mayor Yada met with the workshop participants, he spoke of the problems of deciding how such a system can be supported; how these services will be paid for.

Kobe's experience is not unique; it is only more advanced than that of most developed countries, and it offers an important view of the longer term future for most Asian developing countries as well. All societies are ageing. Kobe has been immensely successful in providing good support for the aged. But the future poses problems that are daunting to say the least.

**Morning Session of 2 November**

Ms. Akemi Fujiyama, Manager, Community Health Promotion, Public Health Department, Public Health and Welfare Bureau, Kobe City Government, made a presentation on "Measures on Maintaining Physical and Mental Health of Elderly People in Kobe."

She began her presentation by explaining that the Kobe City Government has articulated a number of visions for a Healthy City. The Kobe 2010 Vision sees progress through minimizing death in early life, prolongation of a healthy life expectancy, and lifting up the quality of life of the citizens.

Against this vision, the City sees three major challenges: the low birth rate; an increase of "lifestyle-related diseases" and an increase of bed-ridden and demented older people. Though Kobe is not immediately concerned with the low fertility, it is important to note that Kobe's total fertility rate of 1.23 children per woman is less than the national average of 1.36. Neither will sustain the population size and after about 2010, Japan's population will begin to decline.

To deal with the life-style related diseases and the problems of the aged, the Community Public Health Division engages in a wide range of activities. It promotes a periodic health check up of all people 40 and over. They have also developed a series of guidelines for work among the aged, which promotes a balanced diet, constant exercise, participation in social activities, and so on.

The numbers of those needing medical care, and the demented elderly are both growing substantially. Health costs are increasing faster than the national economy. Kobe's per capita medical spending in 2004 amounted to 400,000 Yen for the total, but 800,000 Yen for the aged.

On the ground at the ward level the city works to promote health and care for the needy. Costs are borne in part by insurance and in part by the city. But the sustained increase in costs presents a major challenge for the city government as well as for the national government. This is a period of high change.

**Afternoon Session of 2 November**

Participants took a field trip to facilities for the aged.

**Sun Life Uozaki** is a neighborhood elder care facility in Higashinada ward, not far from city center. It has four levels of care for a total of almost 100 people. About 40 people come for day care. They arrive by public transportation or special vans for those in wheel chairs. They can shower and bathe, have meals, undertake exercise regimes and engage in social and craft activities with one another, and they go home in the evening. This is especially helpful for families that take care of an aged family member at home. There is also a short stay facility where up to 20 people can come for a few days to accommodate a special need of the family with which they normally live.
Then there are two facilities for people needing greater care. A **Group Home** provides comfortable quarters for older people who cannot live alone, especially for the demented elderly. Two units accommodate 8 persons each. All 8 share a common living room, large kitchen and dining room; and each person has a closet and bedroom, with balcony. Staff are there to help with cooking, cleaning and daily living. Finally, an **Elderly Nursing Home** is for as many as 30 persons who need extensive nursing care; some are terminal patients.

All these facilities are light, clean and well appointed and they are staffed by kind young men and women. The facility is supported by the City of Kobe, by insurance payments and by additional fees that some users pay.

**Silver College** is at the other end of the spectrum. It is a real three year college with four curricula, enrolling as many as 1,200 students (420 in each year). The minimum age for enrollment is 57 years, and the majority of the students are in their 60s and 70s. They can study Welfare, International Exchange and Cooperation, The Environment, and Arts and Music. The college’s motto is **Study Again and Serve Others**. Operating since 1993 the college now has an active alumni association of some 4,000 who engage in a variety of community services. Faculty members are drawn from surrounding universities and students attend classes twice a week. This is for those elderly who are active, fully functioning and want to keep their minds and bodies productive in these later years.

**Shiawase-no-mura (Happy Village)** is a comprehensive welfare complex, which is geared mainly toward the physically and mentally handicapped. Its aim is to keep them as involved as possible with the normal life of the city. The facility is located on a 205 hectare mountainous area about half an hour from city center, over the Rokko Mountains.

There is extensive occupational training for the handicapped. There are also advanced medical facilities in a hospital dedicated to the most extremely disabled. Its various facilities can accommodate about 1,200 patients at different levels of disability. It also has overnight camp sites and day picnic areas, a swimming pool, and other facilities. This is a great assist to families with disabled members, enabling them to sustain their home care while helping them through the more difficult aspects of managing their disabled members. And for those who need more extensive nursing and terminal care, this is also available in a beautiful mountain setting.

The facility was planned and built in the 1970s-80s, when Kobe’s finances were growing. Three quarters of the costs of the 1,000 staff and extensive grounds and facilities are borne by the city, only one-quarter by the users, through insurance and fees. Today there are pressures from the economic stagnation, and the issues of raising fees and reducing costs have been discussed but are yet to be solved.

The workshop participants remarked on the range of services and the high quality of both settings and staff in this set of facilities. Kobe provides a model to be emulated in care for the elderly; but it also shows clearly how the ageing of our societies places immense strains on our resources. The future is filled with challenges and not many clear answers.

**Morning & Afternoon Session of 3 November**

9 participants presented city reports of respective cities. (Please see pp. 9-27 for details)
Morning Session of 6 November

Participants took a field trip to 2 facilities for the aged.

**Kobe Lifelong Learning Center, Comista Kobe** was founded to encourage senior citizens to participate in voluntary activities, classes, workshops, lectures and other events so that they can deepen their learning in diverse fields and enjoy opportunities that would make their lives even more meaningful and worthwhile. Since its foundation on August 2000, more than 80,000 people used the center each year. The activities range from education and sports to hobbies, and the center also provides a wide variety of information, consultation services on learning and education. This facility is located near the city center, using the building of a former elementary school.

Then they visited **Kobe Comprehensive Care Center for the Aged**. The center contains various facilities; ranging from rehabilitation, a long- or short-stay, day care center to consultation on care. The center was established in November 1998 by Kobe City Government.

**Special Nursing Home “Shin-ai Home”** is located on the 3rd and 4th floors of the building. The home accommodates the elderly in need of steady care who have difficulty in receiving nursing care at home, and provides them with necessary care services. It has a capacity of 50 people; with 6 single rooms, 10 twin rooms, and 6 quad rooms. Shin-ai Home also operates the **Senior Citizens’ House Higure** on the 5th and 6th floors, with 20 rooms. The House is equipped with a Life Support Advisor in the on-site care support center for the aged, staff members who visit residents periodically to check on their well-being, a consultation service for living related matters and an emergency response system. This facility is operated by a social welfare corporation called Jesus Corps.

The **Geriatric Health Service Facility “Kobe”** is located on the 2nd floor. This facility provides in-patient care, including nursing care and rehabilitation to people whose symptoms have stabilized and no longer need treatment, in preparation for returning home. And on the 1st floor, there is a **Local Rehabilitation Center**, which provides training and care guidance as necessary by physical, occupational or speech-language-hearing therapists, either at home or in the center in addition to consultation on welfare equipment and housing renovation to the elderly who have difficulties in daily life. The center is fully equipped with rehabilitation instruments and the staff, and the elderly people worked to rehabilitate themselves from the disease’s aftereffects.

After the visits to 2 facilities, the participants enjoyed a one-hour cruise of Kobe Port.

Afternoon Session of 6 November

**AUICK** held a discussion forum on "What Elderly People can contribute to Society," inviting 8 elderly activists, who are leaders in a variety of community organizations. AUICK IAC members also participated in the forum.

Representatives from each group presented different types of activities, including a college for the aged, a networking system for dispatching lecturers and teachers, mountain hiking, and a work placement center.

The participants had many questions and engaged in a lively exchange with those active seniors. There was a great interest in details of how the senior labor exchange works, and what drove these Kobe elders to remain active and lead local organizations.

This exchange reinforced a growing perception of a common problem throughout the region. Everywhere governments, communities and people are searching for new and more effective ways to care for the aged. Kobe’s active elderly have shown one important set of activities to address this problem.
**Morning & Afternoon Session of 7 November**  
**Morning & Afternoon Session of 8 November**

These sessions were devoted to drafting and final presentation of action plans. (Please see pp. 9-27 for details)

**Morning Session of 9 November**

To sum up this workshop, the participants had a meeting for review and evaluation of the overall workshop. The participants exchanged their views and opinions frankly about the workshop. Then the closing ceremony was held. Mr. Kazutoshi Sasayama, Special Advisor of AUICK and Former Mayor of Kobe, honored their achievements during the workshop and handed a certificate to each of them.

After the official closure of the workshop program, Mr. Sasayama hosted luncheon for the participants.

**REVIEW**

In their written evaluations, the participants gave high marks to the presentations, which they felt helped increase their knowledge of the problems of ageing. They also appreciated the field visits, the general organization of the workshop, and the opportunity to meet Japanese elder community leaders. Overall, the workshop provided the three major elements that all AUICK workshops have been designed to provide: 1. Technical information and the high quality of services a city like Kobe can provide; 2. An opportunity to learn from one another in "south to south assistance"; and 3. The opportunity and assistance to develop a plan of action to activate in their cities upon their return home. We can elaborate on each.

1. Technical knowledge and standards. The participants learned about the basic demographic dynamics that produce an ageing population. They also saw where their own cities fit into those dynamics; some already feel the pressure of the ageing population while for others these pressures are still a generation in the future. In Kobe they also found two very important lessons. One set the standards for high quality of care for the aged. These are standards all cities should attempt to meet. But they also learned that even a wealthy city like Kobe faces severe challenges in continuing to provide high quality services to the aged. All cities will face these challenges in the future.

2. South to South assistance. The participants learned much from one another. This, in fact, brought the most innovative output from the workshop. Cities like Weihai, Khon Kaen, Surabaya, Kuantan, Danang, and even Chennai in India, have come through the demographic transition in which their national family planning programs helped to reduce fertility quickly and safely. In many cases those well developed programs are no longer needed to the same extent. Thus participants developed the idea to transform their family planning programs into family welfare programs that include care for the aged. These programs have developed strong organizational networks for delivering services and information throughout the country. It will be far better to continue to use those organizations through simple adjustments rather than to abolish them with all of the strengths they have. The participants also came to recognize that although deep Asian traditions enjoin families to care for the aged, urbanization and modernization are undermining those traditions everywhere and new patterns of aged assistance must be developed by governments everywhere.

3. All participants developed specific action plans that will take what they have learned back to their own cities. In this way, they translate what they have learned into specific and practical work plans that will help their cities better meet the challenges of an ageing population. Where the challenges lie far in the future, the first steps will include obtaining better information on the number of aged, their growth and their conditions. Where the aged now pose challenges, participants were able to develop specific and practical steps they can take at home to meet those challenges.
City Reports and Action Plans

Chittagong, Bangladesh

Mr. Mohammed Nasim Bhuiya
Project Manager, Partnership Agreement-3, Second Urban Primary Health Care Project, Health Department, Chittagong City Corporation, Bangladesh

City Report

Chittagong's total population in 2005 was 3.79 million. It has grown very rapidly in the past half century, from only 430,000 in 1950. Both natural increase and increase in migration have contributed to this growth. The result was a growth of the young population; in 1970 the 0-14 age group was 44 percent of the population and the aged (65 and over) were a mere 3 percent. Since 1970 the Total Fertility Rate has declined remarkably from 6.1 to 1.60, well below the replacement level. This implies a decline of the young population to 31 percent and a rise of the aged to 6 percent. The current age structure gives Chittagong a window of opportunity as the dependent age populations are at a low point. The aged will increase, but are expected to be still only 11 percent of the population in 2050.

Currently the aged do not constitute a major problem. They are small in proportion and for the most part can be cared for by the family, where strong family ties imply high value on caring for parents in their old age. Nonetheless, the city government expresses a rising concern for the problem of ageing, recognizing that institutions must be put in place now for the eventual increase of the aged. Both health and welfare schemes are being developed. The 41 ward health centers and city hospitals are turning attention to the aged. A night school has been established for the aged, a pension system for the poor aged in 41 wards was put into place this year and there are plans for building old people's homes. Non-governmental Organizations (such as the Problin Hitoshi Sanga) are emerging and drawing attention to the future problems.

Action Plan

Identification of Problems or Issues;

1. Communities' attitude and behaviour towards aged people.
2. Lack of awareness about the ageing issue among the people and policy makers.
3. Family and community support.
4. Absence of laws and ordinances for the welfare of older people.
5. Absence of adequate plans and implementation strategies for the aged.
6. Lack of social awareness regarding rehabilitation of the aged.

Objectives to be achieved

1. There is a serious lack of information on the situation of ageing population. Thus efforts will be directed toward data collection, analysis, and dissemination among the policy makers and the community to increase awareness regarding aged people and to ultimately establish an ageing unit.
2. The major focus is on the policy considerations and to identify the issues for policies and programs.
3. The main purpose of our city executives is to investigate both the existing policies in operation and what are feasible policy interventions to be considered for the welfare of the elderly population.

Proposed actions to achieve objectives

The main objective is to use media to create awareness about the problems of the aged among the public and policy makers.

1. Report and present action plan to offices, January to February 2007.
2. Consult with colleagues regarding action plan for ageing people, February to March 2007.
5. Reviewing the data analysis, August to October 2007.
7. Policy recommendation to Honorable Mayor and General body of the Chittagong City Corporation, November to December 2007.

Monitoring

1. A monitoring cell will be established to monitor the activities.
2. Monitoring cell comprising local leaders especially ward commissioners, local elites, university professors, teachers, retired officials, social workers and religious leaders.
3. Monitoring cell will monitor the activities regularly.
Weihai, China

Mr. Xin Jie Cai
Vice Director, Civil Administration Bureau, Weihai City, China

City Report

Weihai is a new and rapidly growing port city of 2.5 million at the tip of the Shandung peninsula. It was only half a million in 1950. Both natural increase and immigration have contributed to its growth. China's rapid fertility decline after 1970 is reflected in Weihai's age structure. The young (0-14) now constitute just 18 percent of the population and those 65 and over are 13 percent, growing from just 3 percent in 1970. The aged are growing rapidly, and are now a substantially higher proportion of Weihai's population than of China's overall. Weihai has been a leader among China's cities in rapid economic growth and environmental protection; it is also a leader in the country's emerging problem of the aged.

It is recognized that services and institutions for the aged are limited and insufficient. Thus there is now a major thrust to increase both. Health and pension insurance are limited especially in rural areas, but are being extended. New welfare organizations and old people's homes are being rapidly developed. A service system for the aged is being developed based on home care, community care and institutional care. And a special effort is being made to develop a market for the aged with companies encouraged to build apartments and services for the aged.

Action Plan

In the city, we will build a high-level centre for the elderly. There are about 1,000 elderly in the city who are without children, handicapped and demented. It is necessary for us to build a service home for them, after this workshop, we will put it into practice.

(1) To report to the mayor, mobilize the support from mayor. (11 Nov., 2006)
(2) To choose the place. We now have the idea to build it in Wenquan town Huangni District, covering an area of 100 hectares. (Dec., 2006)
(3) To consult with other city officials, i.e., Health Bureau, Planning Bureau and City Construction Bureau. (Dec., 2006-Jan., 2007)
(4) To mobilize financial resources. The total amount will be 40 million yuan, we have two ways to raise money. One is from the lottery (about 20 million yuan), another is from the government (about 20 million yuan). (Feb., 2007)
(5) To plan and to design. The initial construction area will be 5,000 – 6,000 square meters with 400 beds. (Dec., 2006-March, 2007)
(6) To invite bids for the construction. (March, 2007)
(7) To go into operation. (April, 2007-Jan., 2008)
(8) To train doctors and nurses for the centre. (Feb., 2008)
(9) To decorate. (Feb., 2008-April, 2008)
(10) The elderly move into the centre. (May, 2008)

There will be 40 doctors and nurses in the centre, their salary will be paid by the government. If there are vacant beds, the center can provide them to those who have
family or children. They must pay the fee for the meals and accommodations, the cost is about 600 yuan.

In rural areas, Weihai put emphasis on the construction of old people homes and service centers for the elderly. Weihai has the jurisdiction of Rongcheng, Wendeng and Rushan county. There are nearly 10,000 elderly people without family and children in Weihai, among whom there are 9,000 elderly people in the rural areas. Before 2005, there were only 64 homes for the elderly with beds for 4,000. That can not meet the needs of the elderly. Weihai municipal government paid much attention to this problem, and prepared 25 million yuan for the construction of the homes. By the end of 2006, there will be an additional 100 homes with 7,000 beds. It is estimated that all constructions will be completed by the end of 2007, at that time there will be 120 homes with 9,000 beds, and about 7,000 senior people will move into the homes for the elderly. All costs will be paid by the city government. After this workshop, I will monitor the program to be completed on time.

Otherwise, in order to provide high quality service to the elderly in rural areas, we will build social welfare service centers in three counties and Huancui District, each center covers an area of 20,000-30,000 square meters with 15-20 doctors and nurses. The center in Huancui District has already been completed, both Wendeng county and Rushan county have already begun construction in 2006, Rongcheng county will begin in 2007.

### Social welfare service centers

<table>
<thead>
<tr>
<th>Name of county</th>
<th>Opening time</th>
<th>Areas (SqM)</th>
<th>The amount of beds</th>
<th>Doctors and nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huancui District</td>
<td>Aug., 2003</td>
<td>20,000</td>
<td>500</td>
<td>20</td>
</tr>
<tr>
<td>Wendeng</td>
<td>May, 2006</td>
<td>20,000</td>
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<td>15-20</td>
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<td>Rushan</td>
<td>Oct., 2006</td>
<td>30,000</td>
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<td>Rongcheng</td>
<td>Jun., 2007</td>
<td>20,000</td>
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### Action Plan Flow Chart

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<tr>
<th>Items</th>
<th>2006</th>
<th>2007</th>
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<tr>
<td></td>
<td>Nov</td>
<td>Dec</td>
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<tr>
<td>1. To report to the Mayor (1st month)</td>
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<td>2. To choose the site (2nd month)</td>
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<td>3. To consult with the city officials (3rd - 3rd month)</td>
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<td>4. To mobilize financial resources (4th month)</td>
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<td>5. To plan and design (5th month)</td>
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<td>6. To invite bids for the construction (5th month)</td>
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<td>7. To go into Operation (6th - 14th month)</td>
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<td>8. To train doctors and nurses (15th month)</td>
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<td>9. To decorate (15th - 17th month)</td>
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<td>10. The elderly moving into the center (18th month)</td>
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</table>
Chennai is a city of some 4.9 million, which has grown rapidly from 1.4 million in 1950. Like all of India, the rapid mortality decline after 1950 ushered in a period of high population growth from natural increase. Migration also swelled the city, which was experiencing rapid economic development. As usual, this produced a young population with very few aged people. The under 15s in 1960 were 36 percent of the population and the 65s and over were a mere 2 percent. Fertility has fallen particularly in the past two decades and the Total Fertility Rate in 2005, 1.72, is below replacement level. Life expectancy has risen to 77 for males and 78 for females, and there are now 7.7 percent of the population 65 years and over. This is projected to rise to 16 percent by 2020. Chennai's ageing pressures are beginning to assert themselves.

With strong traditional family values, and an explicit statement in Public Law 125 that "all with means are...obligated to support parents in their old age," the care of the aged in Chennai has not been a major problem in the past. The rising numbers will place increasing pressures on families, however, and the government will play a greater role in assisting in care of the aged. A specialty in geriatric medicine began in government hospitals as early as 1978. At present the government does not maintain homes for the aged as those run by Non Governmental Organizations appear adequate. Old age pensions and support for the aged poor provide support to about half of the aged population.

**Action Plan**

The problem of ageing is not very serious for Chennai, so very few specific plans/programmes have been developed.

Enumeration of more details about senior citizens by the family welfare bureau/census department will have to be undertaken, so that city planners can develop more Elderly Care Homes, Elderly Nursery Care Homes.

The enumeration details will be;

1. Number of solitary elderly people
2. Elderly couple households
3. Elderly who require Nursing Care
4. Number of applicants for Homes of the aged
5. Number of people with dementia/Alzheimer's disease/Parkinson's disease (who require physiotherapy/ rehabilitation therapy)

Major services that can be implemented are;

- **Health education** on prevention of life style related diseases like obesity, smoking, diabetes and hypertension for young and middle aged people.
- **Comprehensive health care services to the aged and follow up of people after medical checkup** (Blood pressure, Blood test for diabetes, Oral exam, and Urine exam), cancer screening programs for women and men. To be conducted in the form of a camp once a year on special days like elders' day, Independence Day, Women's day.
- To develop **Geriatric clinic days** in every ward/zone once a week.
- **Day Care Centers for senior citizens** with provision of one meal can be developed replacing the maternity wards which are not functioning in the maternity homes.
- Establishment of more **Senior citizen clubs**.

**Action Plans**

- **City Level**

  1) Enumeration of more details of the elderly group along with other population particulars of the family. Enumeration work takes place every year starting from the month of February. There are family registers where all the names of family members are written.

  2) Formulation of action plan based on the information obtained from the enumeration and discussion with different level about starting (a) Geriatric Clinic days in the health post/center which is familiar to the family members once a week, (b) outreach health services to the aged at their doorsteps, (c) Day Care centers for the elderly people in maternity homes where the maternity wards are no longer needed, (d) to start a geriatric ward with 20 beds if possible, replacing one of the maternal ward. Except (d), all the above work can be done without much financial commitment to the local and state government.

  3) Establishment of senior citizens clubs with the help of NGOs, like president of Lions Clubs, Rotary Club, Sathyam Foundation.
Level of discussion will be with:
- Honorale Mayor, Commissioner corporation of Chennai and Joint Commissioner (Health) corporation of Chennai
- Chairman, Health Committee, and Counselors (Political People).
- District family welfare Medical officers

- State Level
  4) Proposal to provide geriatric wards in all the hospitals (1% of beds)

Responsible persons are: Director of Public Health, Health Secretary to Government, and Health Minister.

### Action Plan Flow Chart

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<tr>
<th>Items</th>
<th>2006</th>
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<td>Nov</td>
<td>Dec</td>
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<tr>
<td>Report to commissioner about issues of the aged</td>
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<td>2</td>
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<tr>
<td>Enumeration of details about the elderly</td>
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<tr>
<td>a. living in the family alone</td>
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<td>b. sick elderly</td>
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<td>3</td>
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<tr>
<td>Discussion with different levels, Honorale Mayor, commissioner, Addl. Commissioner, Health officers, geriatrics, professors of Govt. Hospitals</td>
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<td>4</td>
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<tr>
<td>Training on Geriatric Care to the doctors</td>
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<td>5</td>
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<tr>
<td>Starting Geriatric Clinic days as our patient departure</td>
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<td>6</td>
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<td>Out reach services for sick elderly</td>
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<td>7</td>
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<tr>
<td>Day care center for elderly in one of the maternity homes</td>
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</table>

To be decided by the Mayor

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**Surabaya, Indonesia**

Ms. Wiwick Widayati  
Head of Cooperation Division, Surabaya City, Indonesia

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**City Report**

Surabaya is Indonesia’s second largest city and the major sea port of Eastern Java. It has grown rapidly to its current population of roughly 2.7 million. The city follows Indonesia in its basic pattern of growth. Rapid mortality decline after 1950 produced high rates of population growth and a young population. In the 1970-80’s a major successful national family planning program brought down fertility, beginning in East Java. In 1970 the 0-14 age group in Indonesia constituted 44 percent of the population and the aged were a mere 3 percent; by 2000 the young had dropped to 31, the aged were 4 percent; by 2025 it is projected that the young will constitute only 23 percent while the aged will be 8 percent. East Java was more advanced in that by 2000 the young constituted only 25 percent of the population and the aged were 12 percent. Surabaya has an even smaller young population, but its aged is less than all of East Java, where a greater number of aged remain in the villages. Still, there is an increasing migration of the aged, especially older women, migrating to the city. In 2005 roughly 8 percent of the population was 65 or over, and the sex ratio in this age group was only 89 males for every 100 females.

In the city government the Health and Social Departments are the two units directly concerned with the aged. The health department has clinics in each of the city’s 53 wards. While they provide comprehensive medical care, they are also beginning to have a special interest in the aged. The Social Department oversees a number of community associations (Kerang Werda and Gerontologi Abiyose) that provide a variety of services, including homes for the aged population. It is now recognized that the elderly population is growing and will require more services. The city government will begin with expanding the role of the community organizations.

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**Action Plan**

1. Identification of Problem or Issue
   - Number of elderly people increase.
     - 2003: 190,989
     - 2004: 203,587
     - 2005: 204,357
     - 2006: ?

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March 2007  
AUICK Newsletter No.48
A large number of aged organization in every district (about 33 organizations) - members of this organization is elderly people.

• One of them is successfully to develop, based on the community. (Ngagel Rejo Community Base)

Existing Condition:
• Lack of the number workers handling the elderly.
• Lack of the access to get more information (such as healthy, social economy, etc) - so that way they don't have more knowledge about it.
• Lack of appreciation for the aged organizations. Actually, this organization can contribute to the social strength of the community.
• Lack of support by City Government to create some activity needed by the aged. At present, activities for the aged people include health services and social services.

Problem:
What can we do to establish community support for greater social strength in community?

2. Objective(s) to be achieved
Strengthen the community base with more effective programs for the aged people.

3. Proposed Actions to Achieve Objectives
• Name of Program "Strengthen of community base existence : implemented "Ngagel Rejo" Model "
• Location : Surabaya (East Java, Indonesia)
• Target : 2 district (to develop 2 of 33 district)
• Department in charge : Welfare Department Surabaya City Government
• Counterpart : Non Government organization, University (Airlanga University), Company who take care of the aged people, Health Department, BKKBN (at present this board is called Bappenas), Community Leader, Community base, etc
• Year Enforcement : Dec. 2006 - 2007
• Budgeting : Surabaya City Government, another counterpart
• Goal : - Strengthen the community base existence in 2 districts.

Component activity :
• Inventorying information /data
  • Informal meeting with 33 districts to obtain information (Dec. 2006)

• Meeting with the NGOs, leaders (Jan. 2007)
• Meeting with the University (Jan. 2007)
• Meeting with the company (who take care of the aged people) (Feb. 2007)
• Meeting with the some departments (Health, Social, Bappenas) (Dec. 2006)
• Making analysis from the meeting report (March 2007)
• To hold the FGD (Focus Group Discussion) between agencies to decide "Ngagel Rejo" Model implementation in 2 districts (promote some increase of services variety which the aged need) (April 2007)
• Meeting with the Mayor of Surabaya to propose this program (why we should put the program for the ageing people in Surabaya) (April 2007)
• Implemented program
  • Dissemination of the models in 2 districts to be implemented (May 2007)
  • Invite the key persons in 2 districts who can take part in this program (May 2007)
  • Organize social workers to conduct services for the aged people (June 2007)
  • Organize some companies who take care of the aged people (July 2007)
  • Allocate Surabaya City Government budgeting for the aged people (make coordination with Health, Social, Bappenas) (Dec. 2006)
  • "Ngagel Rejo" Model implementation is running in 2 districts (July to Dec. 2007)
  • Review of activity implementation (Dec. 2007)
• Monitoring
  • Conduct the monitoring at Dec. 2006 to 2007

3. Monitoring System :
Reviewing Data Collection
• Data of number of the aged in each district.
• Obtain information collected by City Government or aged organizations.
• Obtain information about the kind of support by City Government.
• Data of aged health report.
• Data of implementation activity report.
• Obtain information of family members living with the aged people.

Making progress report
• How much have activities which have been conducted done to encourage the strengthening of the aged organization?
• Do the aged people have access for getting more information, health, etc. easily?
• Is there any counterpart who takes care of the aged people?
• Is there any increase in the number of workers to handle aged people?
### Action Plan Flow Chart

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<td>Step 1: Inventorying information/data</td>
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<td>1 Meeting with 33 aged organizations</td>
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<td>2 Meeting with the NGOs, community leaders</td>
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<td>3 Meeting with the university</td>
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<td>4 Meeting with the company (who take care for aged people)</td>
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<td>5 Meeting with the relevant departments (Health, Social, BBKBN)</td>
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<td>6 Making analysis from the meeting report</td>
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<td>7 To hold the FGD (Focus Group Discussion)</td>
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<td>8 Presentation to the Mayor of Surabaya</td>
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<td>Step 2: Implementation program at 2 districts</td>
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<td>1 Dissemination of the model</td>
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<td>2 Inviting the key person</td>
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<td>3 Organizing social workers to conduct services for the aged people</td>
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<td>4 Organizing relevant companies to take care of the aged people</td>
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<td>5 Allocating Surabaya City Govt. budgeting for the aged people</td>
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<td>6 &quot;Ngangt Rejo&quot; Model implementation</td>
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<td>7 Review of activity implementation</td>
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### Kuantan, Malaysia

**Mr. Anuar Bin Che Mahmud**  
Deputy Director, Pahang Social Welfare Department, Kuantan Municipal Council, Malaysia

**City Report**

Kuantan is a medium sized city on the East Coast of Malaysia in the State of Pahang. In 2005 its total population was roughly 403,000. Past mortality declines produced a period of rapid population growth. Economic development brought in many migrants. Fertility began to fall in the 1980s, reducing the proportion of the young population, but not yet increasing the proportion of the aged. In 2005 the young (0-14) constituted 32 percent of the population, down from over 40 percent earlier, but the aged still constituted only 4 percent. This will change in the near future as the proportion of young will decline and the aged proportion will rise.

At present the city has no special organizational unit or office concerned with the aged. This is still a state or district level responsibility. The District level government has been given responsibility for the young and the aged together. The elderly who need special housing are sent to other states (Johore). There is an old age pension scheme at the state level that provides RM 200 per month to the aged poor. The city recognizes that serious problems lie in the near future of caring for the growing number of aged, but as yet the city has not been given responsibility for the problem.

**Action Plan**

The problem of ageing is not very serious for Kuantan, Malaysia. There is no special plan to be implemented by the Department of Social Welfare or City Council. But the development process in Kuantan is growing fast, so an action plan must be set up for elderly people.

There are several issues to be considered before we develop an action plan. The major issues are;

1. Our perception towards ageing issues.
2. Lack of community and family support.
3. Lack of knowledge about centers for the aged: why these centres will be an important issue in future.
4. Absence of laws and ordinance specialized for the aged.

**ACTION PLAN**

Related to this issue, I have specified 5 action plans for the sake of elderly people;

1. Housing Problem.
2. Health Services
3. Insurance Scheme
4. Poverty among the Aged
5. Family Problem
<table>
<thead>
<tr>
<th>Activities</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>1. Housing Problem</td>
<td>3 years</td>
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<tr>
<td>2. Health Services</td>
<td>2 years</td>
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<tr>
<td>3. Insurance Scheme</td>
<td>1 year</td>
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<tr>
<td>4. Poverty Among Elderly</td>
<td>1 to 5 years</td>
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</tbody>
</table>

(I will request my colleagues and university experts to work together for data/observation in all action plans at the same time)

1. Housing Problem

Upon returning to the office, present this suggestion/problem to my Department to explore the housing problem in City within the first month.

Then discuss this matter with my colleagues (2nd to 3rd month). Also discuss with City Officials and university experts for assistance.

When getting endorsement from my office and committee, go to the field for conducting data collection and observations. Request my colleagues and university experts to assist me in conducting the analysis. (from 4th to 8th month).

Then start to review data analysis with key City Officials and relevant agencies in the 9th to 10th month.

Public dissemination of the result of data analysis through daily papers, Department Report and Bulletin, City Bulletin, and Mass Communication (11th to 14th).

The policy will be recommended to Mayor and Key Political Leaders in the 15th to 17th month for revision and consideration and information will be got from them if needed.

Establish a unit and sub-committee to deal with ageing issues in the housing problem (18th to 20th month).

Lastly, the units start to work with the plan. (from 21st month on).

2. Insurance Scheme

Submit the report immediately upon returning to the office and discuss the rationale, impact, and justification with the the City Department Head. Consultation meeting with the officers and political leaders, NGOs and private agencies for the establishment of Insurance Scheme and get their support.

Health Service Plan will be issued to the City Official and City Legislative Body for The Enactment of City Ordinance. A campaign will be conducted to the elderly and middle age and other interested members. See flow chart for details.

3. Health Services (1 to 3 years)

Report to the Head Department upon arrival as soon as possible and present my plan to explore the matter. (within the first month)

Form a committee within our department and city officials.

When all the data is ready, discuss with the Head Department and Key City officials (9th to 10th month).

Publish and announce the data analysis and relevant ageing issues in the Department and City Bulletin and Media for information and comment (10th to 12th month).

The policy recommendation will be provided to the Head Department, Mayor and key political leaders for support and consideration (13th to 14th month).

Establish a unit to deal with population ageing especially on health services. (15th to 16th month).

Lastly, the unit starts to work with the action plan (17th month on).

4. Poverty among the Aged (1 to 5 years)

A report and action plan will be submitted to the Director, Department Of Social Welfare in December to January 2007.

Consult with colleagues and city officials and relevant government agencies regarding an action plan on February and April 2007.

Consult with experts in city and universities about aged poverty by arranging workshops and seminars.

Data analysis and review within May to September 2007.

Public dissemination of data analysis: City Bulletin, Department Report, Daily Paper and arranging workshop/seminar. (October to December 2007)

The policy recommendation by City Mayor/Head Department (January to February 2008).

Form a unit for this plan (February to May 2008) and the unit will start to formulate programs and policies for the aged.
### Action Plan Flow Chart for Housing Problem

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<th>Items</th>
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<td>1 Report and present plan to the Office</td>
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### Action Plan Flow Chart for Insurance Scheme

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### Action Plan Flow Chart for Health Service

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### Action Plan Flow Chart for Poverty among the Aged

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### Action Plan

**IDENTIFICATION OF PROBLEMS OR ISSUES**

- **Urban unemployment and poverty**
- **Insufficient health services**
- **Clean drinking water**
- **Urban needs and infrastructure**

There was recently a celebration of the International Day of Older People. Older people have free access to libraries, have special strips on their identity cards, have proper representation on government bodies, special facilities in government hospitals, and a variety of special benefit packages. A ten year plan, for 2001-11, has been developed with attention to such things as senior citizen clubs, special geriatric wards in the hospitals and other economic benefits. Most of this, however, lies in the future.

### Faisalabad, Pakistan

**City Report**

Like all Pakistan, Faisalabad is still in the very early stages of the demographic transition. Mortality has fallen, but the total fertility rate is still high. It was 6.3 in 1950 and today is still as high as 5.1. Thus the proportion young (0-14) is over 40 percent and the aged are a mere 5 percent of the population. Fertility is declining slowly, so that by 2025 the young will be down to 34 percent of the population, but the aged will not yet begin to rise and will still be at about 5 percent of the population. In effect, Faisalabad’s as Pakistan’s problems of ageing lie very much in the future.

Nonetheless, Faisalabad has begun to pay attention to the problem of the aged and provides some special services.

---

**Dr. Naseem Ahmad**

Executive District Officer (Municipal Services), Engineering, Local Council Services, City District Government, Faisalabad, Pakistan
OBJECTIVES
1) Independence (Cater to older persons’ needs and access to basic services and care)
2) Participation
3) Care (Promotion of family and community care, access to health, social and legal services)
4) Dignity (Prevention of exploitation, physical or mental abuse, promote fair treatment, being valued independently of economic contribution)

The translation of the objectives into reality will require initiative on the part of older persons and the establishment of an enabling environment by the rest of the society.

PROPOSED ACTIONS TO ACHIEVE THE OBJECTIVES/KEY IMPLEMENTATIONS
The following programmes can be undertaken to address the problems in the city.
1. Public awareness (use of media to create awareness).
2. Meetings with the professors of the colleges, universities, NGOs, and colleagues regarding the welfare of the aged people.
3. Data collection for aged people.
4. Consultation with religious leaders for awareness of aged people.

MONITORING
Monitoring will be made monthly and quarterly.
1) Review progress public awareness.
2) Data collection of the aged in the city/district.
3) Getting information about kinds of activities which are created by city district government or NGOs for aged people.
4) Getting information of family members who are living with aged people.
5) How activities until now have encouraged the aged organization.

VISION AND GOALS
To ensure that people will be enabled to age with security, dignity and continue to participate in their societies as citizens with full rights.

At the same time the rights of older persons should not be incompatible with those of other age groups. The reciprocal relationships between the generations must be nurtured and encouraged.

Olongapo, The Philippines

Mr. Fernando Moselina Magrata
Acting City Administrator and Hospital Administrator, Office of the City Administrator, Olongapo City, Philippines

City Report
Olongapo has a distinctive history. Until recently it was "Subic Bay," the home of the U.S. 7th fleet. Along with Clark Air Force Base, it is now a Philippines city and part of an effort to develop a sea port and air terminal hub for all Asia. The city now has roughly 211,000 people. It reflects the Philippines general position in the demographic transition. Mortality has fallen and fertility is
declining. The crude death rate is only 5 per 1000 of the population and the crude birth rate is at the moderate level of about 24. This implies a young population (0-14) of about 35 percent of the population and an aged population of only 3 percent.

Although the aged are not yet a large proportion of the city's population, the government is aware of the pending rise. Thus the government aims to establish: policies and programs to assist the elderly to be active members of the community, services for the elderly and grass roots organizations concerned with care of the elderly. The key units of government will be the Social Welfare Development Office and the office for Senior Citizen Affairs. The city recently opened a Center for Women, to include the elderly as well as younger women. The Senior Citizen's Resource Center was opened and now provides services to almost 6,000 senior citizens. Other government offices will be concerned with the indigent, and with promoting Non Governmental Organizations caring for the aged.

**Action Plan**

**A) INTRODUCTION**

Programs and State policies highlighting the welfare and benefits of senior citizens are mandated under Republic Act No. 7432 otherwise known as "The Senior Citizens Act" which was enacted on 23 April 1992. It is the enabling law to carry-out the Constitutional provisions which state that:

a) "Section 10- Declaration of Principles and State Policies — The State shall provide social justice in all phases of national development"; and

b) "Article XIII, Section 11- The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable costs. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women and children."

The Senior Citizens Act defined "senior citizen" as "any resident citizens of the Philippines who are at least sixty (60) years old, including those who have retired from both government offices and private enterprises". Since the enactment of the enabling law prescribing the procedures and guidelines for the establishment of programs that empower and provide benefits for the elderly, the City Government of Olongapo has instituted various initiatives for its implementation. First among these programs is the setting up of an administrative infrastructure that shall formulate, implement, monitor and evaluate holistic approaches and plans of actions for the elderly. While the administrative structure involves various government agencies and non-government organizations, the City Social Welfare and Development Office, a component Department of the City Government, serves as the lead agency in the development and implementation of programs on social services for the senior citizens.

The City Government of Olongapo, from the inception of the senior citizen empowerment program, has been at the forefront of implementing plans and initiatives for the welfare and well-being of the elderly. These had been manifested when in 2004 and 2005, the City was recognized by the Department of Social Welfare and Development as having the most outstanding (Region-wide) Senior Citizens Program in Central Luzon. Lest it be said that there is a bias against the younger population, the City was, likewise, awarded consecutively as the "Most Child-Friendly City", both Region-Wide and Nation-Wide in 2003, 2004 and 2005.

The program for the senior citizens was further given impetus under the current leadership of Olongapo City Mayor James Gordon, Jr. Under the present dispensation, not only were the current programs sustained or enhanced, but other development programs were introduced such as the construction and operation of the Olongapo City Center for Women, the on-going construction for a new Olongapo Center for Assistance, Rehabilitation and Empowerment (OCARE) which shall be co-occupied by male senior citizens, financial support for the Office for Senior Citizens Affairs (OSCA) and the creation of the Council for the Welfare and Empowerment of the Elderly which is basically composed of private stakeholders to promote further community participation. There are other new initiatives in the offering which may, perhaps, include doable initiatives and specific measures learned from the AUICK experience.

However, reality shows that despite the best efforts of all concerned, development efforts benefiting the senior citizens have unmet needs creating challenges and problems. There were several challenges affecting programs designed for the senior citizens and all these were mentioned in the City Report. This Action Plan, however, shall focus on highlighting the most universal and compelling problem which is the non-inclusive and insufficient health insurance for most of the senior citizens.

**B) PROBLEM STATEMENT ON THE NON-INCLUSION OF SENIOR CITIZENS AS DIRECT MEMBERS OF THE NATIONAL HEALTH INSURANCE PROGRAM (NHIP)**

The rise of the ageing population brings with it the concomitant increase in the demand for health services by the elderly. A study done by the consulting firm Recelis et al (2003), on the share of health expenditure of Filipino elderly on the National Health Account, shows that the elderly are relatively heavy consumers of personal health care (22%) and relatively light consumer of public health care (5%). This means that the aged are heavy users of care provided by the hospital, non-hospital health facilities and traditional care facilities from out-of-pockets costs. A substantial number, if not the majority of the senior citizens are not covered by public health care insurance.

Of the various problems and challenges facing the development thrusts for senior citizens, it is the non-inclusion of the elderly, or those who are 60 years old and over, in the National Health Insurance Program (NHIP) which is the most compelling that requires immediate attention. Undoubtedly, senior citizens are often afflicted
with sickness categorized as intensive cases which require extended confinement at the hospital. Ironically, this sector which should have been the priority target of public health insurance was excluded from the coverage of the (NHP) which is administered by the Philippine Health Insurance Corporation (Philhealth).

Records at the City Planning and Development Office (CPDO) show that, as of the year 2003, there were ten thousand seven hundred seventy-nine (10,779) citizens who were 60 years old or over. These elderly comprised a substantial 5% of the total population. On the other hand, records from the Office for Senior Citizens Affairs (OSCA) show that of the total elderly citizens, barely 4,145 (38.5%) are covered by the NHP either as retirees or as dependents of their children who are Philhealth members. This shows that a huge 6,634 or 61.5% of the elderly citizens are left out and with no health insurance.

The City of Olongapo ran and managed the James L. Gordon Memorial Hospital, a tertiary-training hospital with a 305-bed capacity. JLGMH is the primary source of diagnostic, curative and therapeutic resource is the City. While the hospital normally attains 100% occupancy rate in its private rooms, including Triage patients, it is still highly subsidized by the City Government because of its public nature and the classification of its patients which is 70% service/charity and 30% private. One of the reasons for the hospital's inability to attain financial sustainability is the confinement of senior citizens who are without health insurance coverage.

Based on the data from the Census of the Philippine Hospital Association (PHA), a 4-day confinement for an ordinary case shall entail an average of P 7,500.00 per patient. Supposing that in a year, 25% or 1,660 of the 6,634 uninsured elderly were confined for ordinary cases at the hospital, JLGMH stands to lose or subsidize the amount of P 12,450,000.00 in terms of costs and services as most of them are indigents or can ill afford the costs of hospitalization. The amount will be more staggering if these senior citizens are admitted for intensive cases which would entail an average of P20,000.00 per confinement.

The NHP automatically covers retirees and employees, regardless of the status of their appointments, in the public or private sectors. Payments of the corresponding insurance premiums, equivalent to 8.5% of their salaries, are automatically deducted from their monthly payrolls. The government or the private employers, on the other hand contribute 11.5% of the employees' monthly salary as government's or employer’s share. Self-employed citizens, not beyond the age of 60, can likewise apply for NHIP coverage as self-paying members. Their spouses, children below the age of 21 and parents, who are at least 60 years of age, are covered by the health insurance as dependents. The NHIP has a special program termed as "Indigent Component Program" for citizens who are not gainfully or have no regular source of income and those who are considered indigents.

Under the Philhealth Indigent Program, an annual insurance premium of P1,200.00 is required of which P 600.00 shall be paid directly by the local government unit (LGU) and the rest will be paid to the Philhealth by the LGU. The remaining P 600.00 shall be paid either, wholly by the local government unit (LGU) or under costs-sharing scheme whereby P 300.00 shall be contributed by the LGU and the other P 300.00 shall be shared by the prospective member. But then again, beautiful as it may seem, the Philhealth Indigent Component has left out the elderly who are beyond the reglementary age of sixty.

The Constitution mandates to adopt an integrated and comprehensive approach to health development and other social services to the elderly. However, it is sad to note that the enabling law which is supposed to provide this comprehensive health development has effectively excluded the very segment of the society which it is mandated to serve. Under these circumstances, it is now up, therefore, to the local government units to devise their own strategies and measures to alleviate the non-inclusion of the elderly in the national health insurance program.

C) GOALS AND OBJECTIVES

The primary goal of this Action Plan is to establish a Senior Citizen Health Care Plan which would extend and/or expand health insurance coverage to senior citizens who are not dependents of their children's Philhealth insurance and are not qualified for direct membership due to old age. During its initial stage, the Health Care Plan aspires to cover 3,500 of the uninsured elderly citizens the number of which will be increased progressively until all senior citizens are covered.

The attainment of these primary goals will bring about the achievement of peripheral, albeit, significant objectives which include the following:

a) Universal health coverage for the elderly citizens not relying on the services and facilities provided by the national health insurance program which effectively excluded the senior citizens from membership coverage;

b) The Health Care Plan will effectively reduce the cost of subsidies being provided by the City Government, through James L. Gordon Memorial Hospital (JLGMH), to the 3,500 elderly citizens/patients from P 6,562,500.00 to P 3,265,500.00 or by roughly 64%;
c) The Plan stands to generate P 2,100,000.00 from out-of-pocket contributions from the 3,500 senior citizen members and another P 2,100,000.00 as health premiums from the City Government. These new monies would somehow cushion the financial impact of taking care of the sick elderly and will help the fiscal sustainability of JLGMH;
d) The Health Care Plan will help achieve the policies and strategies of the City in providing comprehensive health care and rehabilitation for the sick elderly and foster their capacity to attain more meaningful and productive ageing.

D) PROPOSED COURSE OF ACTIONS

The Health Care Plan calls for the establishment of a scheme patterned after that of the Health Maintenance Organization (HMO) focusing exclusively on the elderly citizens who are 60-years old and above. The City of
Olongapo, as a Corporate Body, and using the facilities and resources of its various health facilities, including but not limited to the City-run James L. Gordon Memorial Hospital and barangay health centers, shall sell and market this health care plan for the elderly.

The Health Care Plan expects to provide benefits and services that will proximate those that are being provided by the NHIP to its members. The only difference is on the matter of financing. While the health premium will be similar as those of the NHIP which is P 1,200.00/annum, participation on the other hand will be between the City and the elderly member with a 50%-50% sharing on the annual costs. With both stakeholders sharing equally the costs of the annual premiums, the Health Care Plan stands to generate an initial capitalization of P 4,200,000.00 which will be deposited as a Trust Fund under the City Treasury.

A Board of Directors shall be organized for the purpose and who shall be responsible for the administration and operation of the Health Care Plan. The Board shall be composed of representatives from the city government, the City senior citizens’ federation, and private organizations/non-government organizations (NGOs) to further private sector participation and transparency. It is, however, imperative that the President of the Federation of Senior Citizens Association of the Philippines (FSCAP), Olongapo Chapter shall be a signatory to any fund withdrawal from the Health Care Plan. The Health Care Plan, through the various stakeholders, shall devise its own By-Laws and if at all necessary, the Senior Citizens Health Care Plan shall be registered with the Securities and Exchange Commission.

The specific activities and actions leading to the establishment of the Senior Citizens Health Care Plan are as follows:

1) Official submission and presentation of the Action Plan to for the establishment of the Senior Citizen Health Care Plan the City Mayor and discussion of its rationale, impact and ramifications with the various City department heads, most especially with the Chief of Hospital, the City Health Officer and members of the City Finance Committee;
2) Consultation meetings with the officers of the FSCAP and group meetings with different senior citizens association in the seventeen (17) barangays of the City to gain its support and approval for the establishment of the SC Health Care Plan;
3) Drafting and approval of a Resolution from the FSCAP signifying their commitment of support for the establishment of the SC Health Care Plan and requesting the City Mayor and the Sangguniang Panlungsod (City Legislative Body) for the enactment of a City Ordinance for the establishment of the same and allocating funds thereof;
4) Conduct of membership campaign among the senior citizens in various barangays and distribution of application forms among the interested members to build-up the data base of potential and/or committed future Health Care Plan members/beneficiaries;
5) Creation of an Executive Committee, through an Executive Order, to draft the proposed By-Laws of the SC Health Care Plan for proper presentation to the Interim Board of Director for consideration and adoption;
6) Presentation of the SC Health Care Plan and the Resolution of support from FSCAP to the Sangguniang Panlunsod and enactment of a City Ordinance creating the same and allocation of initial funds for its maintenance and operation;
7) Approval of the Ordinance creating the Senior Citizens Health Care Plan by the City Mayor and issuance of an Executive Order for the Creation of the Board of Directors and appointing its Interim Members;
8) Presentation of the Draft By-Laws by the Executive Committee to the Board of Directors for discussion, amendments, finalization and adoption. Presentation of the approved By-Laws to the officers and members of the FSCAP, in a general meeting called for the purpose, for ratification;
9) Collection of corresponding premiums from the members, which could be paid in two (2) equal payments and issuance of SC Health Care Cards to paid-up members. All monies collected from the members personal share shall be with official receipts and be deposited at the Office of the City Treasurer.
10) Actual operation and implementation of the Senior Citizen Health Care Plan.

The City Government may tap various non-traditional sources to finance the Health Care Plan which may include, but not be limited to:

1) Share from the annual "Alay-Lakad" (Walk-for-a-Cause) which is sponsored by the City of Olongapo through the CSWDO;
2) A special "Pintakasi" (Cockfighting) whereby gate receipts collected shall be allocated to finance the SC Health Plan;
3) Direct grants and/or donations from the Philippine Gaming Corporation (PAGCOR), Philippine Charity Sweepstakes Office (PCSO) and other private/business organizations and individuals.

E) PROGRAM MONITORING

The monitoring works for the various activities heretofore stated shall be the responsibility of the following City Government agencies with the Office of the City Administrator as the Lead Agency:

1) Office of the City Administrator (OCA)
2) City Social Welfare Development Office (CSWDO)
3) City Planning and Development Office (CPDO)
4) James L. Gordon Memorial Hospital (JLGMH)
5) City Public Affairs Office (PAO)
6) Office for the Senior Citizens Affairs (OSCA)
7) Federation of Senior Citizens Association of the Philippines, Olongapo City Chapter (FSCAP)
8) City Legal Office (CLO)
9) City Treasurer's Office (CTO)

The specific monitoring role of these agencies in relation with the aforesaid activities are as follows:
SPECIFIC ACTIVITY
AGENCY/IES CONCERNED

1) Activity No. 1 - OCA, PAO
2) Activity No. 2 - OCA, CSWDO, JLGMH, PAO, CPDO
3) Activity No. 3 - OCA, CSWDO, PAO, CPDO
4) Activity No. 4 - OCA, CSWDO, JLGMH, OSCA, PAO
5) Activity No. 5 - OCA, CPDO, CLO, JLGMH
6) Activity No. 6 - OCA, CSWDO, CLO, JLGMH, FSCAP
7) Activity No. 7 - OCA, CLO
8) Activity No. 8 - OCA, CLO, CSWDO, FSCAP
9) Activity No. 9 - OCA, CSWDO, FSCAP, CTO
10) Activity No.10 - OCA, JLGMH, FSCAP, CSWDO, CTO

Upon its operation, the City Accounting Department shall prepare and provide the City Mayor and the Board of Directors a monthly and quarterly reports of fund disbursements and financial transactions for monitoring on the status of the Health Care Funds.

### Timelines

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<tr>
<td>1) Official submission and presentation of the Action Plan to the City Mayor for the establishment of the Senior Citizen Health Care Plan and discussion of its rationale, impact and ramifications with the various City department heads, most especially with the Chief of Hospital, the City Health Officer and Members of the City Finance Committee.</td>
<td>20 - 24 November 2006</td>
</tr>
<tr>
<td>2) Consultation meetings with the officers of the FSCAP and group meetings with different senior citizens association in the seventeen (17) barangays of the City and other stakeholders to gain its support and approval for the establishment of the SC Health Care Plan.</td>
<td>27 November 2006- 15 December 2006</td>
</tr>
<tr>
<td>3) Drafting and approval of a Resolution from the FSCAP signifying their commitment of support for the establishment of the SC Health Care Plan and requesting the City Mayor and the Sangguniang Panlungsod (City Legislative Body) for the enactment of a City Ordinance for the establishment of the same and allocating funds thereof;</td>
<td>18-22 December 2006</td>
</tr>
<tr>
<td>4) Conduct of membership campaign among the senior citizens in various barangays and distribution of application forms among the interested members to build-up the data base of potential and/or committed future Health Care Plan members/beneficiaries;</td>
<td>27 November 2006- 30 March 2007</td>
</tr>
<tr>
<td>5) Creation of an Executive Committee, through an Executive Order, to draft the proposed By-Laws of the SC Health Care Plan for proper presentation to the Interim Board of Directors for consideration and adoption;</td>
<td>26 December 2006 - 12 February 2007</td>
</tr>
<tr>
<td>6) Presentation of the SC Health Care Plan and the Resolution of support from FSCAP to the Sangguniang Panglunsod and enactment of the City Ordinance creating the same and allocation of initial funds for its maintenance and operation.</td>
<td>08 January 2007 - 09 February 2007</td>
</tr>
<tr>
<td>7) Approval of the Ordinance creating the Senior Citizens Health Care Plan by the City Mayor and issuance of an Executive Order for the creation of the Board of Directors and appointing its Interim Members.</td>
<td>12 February 2007 - 26 February 2007</td>
</tr>
<tr>
<td>8) Presentation of the draft By-Laws by the Executive Committee to the Board of Directors for discussion, amendments, finalization and adoption. Presentation of the approved By-Laws to the officers and members of the FSCAP, in a general meeting called for the purpose, for ratification.</td>
<td>13 February 2007 - 09 March 2007</td>
</tr>
<tr>
<td>9) Collection of corresponding premiums from the members, which could be paid in two (2) equal payments and issuance of SC Health Care Cards to paid up members. All monies collected from the members' personal share shall be with official receipts and to be deposited at the Office of the City Treasurer.</td>
<td>12 March 2007 - 30 March 2007</td>
</tr>
<tr>
<td>10) Actual operation and implementation</td>
<td>02 April 2007</td>
</tr>
</tbody>
</table>
Khon Kaen, Thailand

Ms. Nudnapa Juntavaree
Chief, Department for Promotion of Participation and Decentralization, Khon Kaen Municipality, Thailand

City Report

Khon Kaen is the heart of the Northeast. Lying some 250 miles northeast of Bangkok it is the center of a large region bordered on the north and east by the Mekong River, separating Thailand from Laos and Cambodia. The city has grown rapidly from central government policies aimed at creating growth poles throughout the country to balance the dominance of Bangkok. Khon Kaen is a small city, of less that 150,000 population. With the rest of the country it has come through the demographic transition with especially rapid decline in fertility since about 1975. The city’s Total Fertility Rate is now below replacement level. The young are now a declining portion of the population, now less than 22 percent, and the aged are beginning to rise; today they are 8 percent and are projected to grow to over 20 percent by 2050.

Thailand is unique for its low level of official urbanization. Only 30 percent of the population lives in urban areas. At present many of the elderly prefer to remain in the village and rural areas and do not swell the urban population. Nonetheless, Khon Kaen City has begun to develop programs for the elderly. They focus on health and welfare issues, with the Health and Welfare agencies of government given major responsibility. Welfare subsides of 300 baht per person per month are available. There are some 25 city staff directly concerned with the aged and the budget for the aged has grown from 1.8 million baht in 2005 to 2.88 million in 2006; it is projected to rise to 7.56 million in 2070.

During the past years, the ageing population has begun to manifest itself and the demographic transition has changed the structure of its population. This change in the population structure has a great impact on the...
community’s economy and shrinks social-security services and has become burdensome to the future Khon Kaen Municipality.

At present, KKM has an existing program which promotes self-help projects, including the creation of healthy-lifestyles awareness as a strategy to promote healthy ageing.

The KKM also provides welfare assistance to the senior citizens by giving a subsidy of 300 baht per person/month to senior citizens. It has adopted a mechanism to visit people in 80 communities on Thursdays. These services are made available to one to three communities, including the nearest area, a time.

The Bureau of Public Health and Environment Services is in charge of providing general health care assistance and a disease prevention program. The Centers are open on Mondays to Fridays. KKM has four Public Health Service Centers.

In the past, the program of KKM towards the ageing population is to provide welfare assistance by way of health care and monthly subsidy. It shall be noted, however, that the City does not have an institutionalized activity aimed at enhancing the personal capabilities and empowering the elderly citizens based on the following social principles:

- That the elderly are human resources that are worth contributing in community development;
- That elderly citizens, given the proper training and orientation, still have the capacity to help not only themselves, but their families and others;
- That the elderly citizens can be tapped in various social endeavors of the society and the community.

OBJECTIVES TO BE ATTAINED

1. The Action Plan aims to enhance personal capacity building for the senior citizens.
2. The Plan shall help organize a support system between and among the elderly citizens by organizing social groups.
3. The Plan shall help organize community services which would involve various elderly social groups.

PROPOSED ACTIVITIES TO ACHIEVE OBJECTIVES

Name of Project: "Healthy life care in the Future"
Location: Khon Kaen Municipality Area
Target group: Elderly Citizens aged between 55 - 65 years. The rationale for this aged limitation is the general belief that senior citizens within this age-bracket have the physical and mental capacity to learn new skills and have the capacity to help one another.

Key Implementation:
- Prepare Action Plan stating its goals, objectives, strategies, activities and measures necessary for its administration.
- Presentation of the Action Plan and its general overview to the City Mayor for his support and commitment.
- Coordinate and discuss the Plan with the various department and agency heads of the city government, faculty of Khon Kaen University, the College of Asian Scholars and other non-government organizations (NGOs) and other stakeholders for support and, perhaps, revision of the Plan to make it more effective and conducive to all concerned.
- Through the tri-media, conduct information, education and communication (IEC) drive to inform the city residents, especially the senior citizens on the concept of the Plan.
- Implementation of the Plan.
- Monitoring Activity.

IMPLEMENTATION AGENCY/AGENCIES

While the project implementation will entail the involvement and participation of various government agencies and offices, the Social Welfare Division and Department for Promotion of Participation and Decentralization of Khon Kaen Municipality shall be the lead agency/agencies.

Year Enforcement: 2007-2008

Healthy life care in the future of Khon Kaen municipality Model

1. Activity; Capacity Building
   - Primary health care leadership development
   - Vocational training, such as cooking, photography etc.
   - <to enhance teacher training>
   - Other <for new ideas from the Coordinate function>

2. Activity: Social Grouping

3. Activity: Organize service to communities

Note: All three activities are supported by Khon Kaen Municipality

MONITORING SYSTEM

A Program Secretariat will be created for the purpose of overseeing the over-all performance and activities of the Project. A regular monitoring process shall be put in place, including but not limited, to the following:

- Monthly review and program evaluation and quarterly meetings with the various stakeholders, including the members of the academy who are involved in the program implementation;
- Site visitations of communities where elderly support groups were organized to check and evaluate their activities, performance and problems. Results of these site visitations must be documented for discussion during the meetings.
- Preparation of progress reports to the City Mayor and continuous communication with other department heads as often as necessary, to keep them informed on the status of the Program.
### Action Plan Flow Chart

<table>
<thead>
<tr>
<th>Items</th>
<th>2006 Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<tbody>
<tr>
<td>1. Making action plan for implementing activities</td>
<td>X</td>
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<tr>
<td>2. Present project to the city Mayor</td>
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<tr>
<td>3. Coordinate and discuss Project with City Department Heads, members of the academies</td>
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<tr>
<td>4. Information, education and communication campaign using the tri-media</td>
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<td>5. Activity implementation</td>
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<td>6. Monitoring</td>
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<td>X</td>
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### Danang, Vietnam

**Mr. An Van Nguyen**  
Vice Director, Danang Labor, Invalids and Social Affairs  
Department, Danang People’s Committee, Vietnam

### City Report

Danang is a rapidly growing Vietnamese seaport, roughly half way between Hanoi and Ho Che Minh City. Growing at more than 10 percent per year, it now has a population of just over 780,000 people. Vietnam has recently come through the demographic transition with fertility falling rapidly. Its population under 15 has been declining and now is just one quarter of the population. The aged have been rising and now constitute about 6 percent of the population. They are expected to rise to over 11 percent by 2025. Still blessed with a large and growing working age population, the city is beginning to experience the ageing problem that presents challenges to the more economically advanced countries of Asia.

Recognizing the rising ageing population, Vietnam has promulgated new laws to support the elderly, including a salary adjustment and social insurance scheme. Most elderly are still active and are now recruited for work by hospitals and other social service organizations. The city’s Department for Labor, Invalids and Social Affairs has responsibility to develop projects to care for the elderly. There are voluntary senior citizen groups and special centers to care for the elderly. Health insurance covers all people 85 and over, with income allowances of 100,000 and 200,000 VND per month for those over 90 and 95 respectively. Another plan provides VND 150,000 per month for the elderly poor. Although the family is expected to provide basic care for the elderly, there is a growing number of government and Non Governmental Organizations providing recreation and care centers throughout the city.

### Action Plan

#### Identification of Critical Problems
- Health care: more sickness ⇒ health care insurance is covered.
- Material life care: healthy elderly still have a need to work ⇒ generating income.
- Lack of budget: committed for the aged’s activities, income.
- Spiritual life care: the aged are stressed.

#### Proposed Actions
Establishment of the City Fund for Protection of the Aged (hereafter called Fund) with the financial support from the City Government, NGOs and the Community.

#### Immediate Objectives of the Fund:
- Provide soft loans to the individual aged.
- Integrate with the Poverty Reduction Programme and collaborate with the Social Policy Bank and credit groups to provide soft loans to the aged for their small scale production and business.
- Provide monthly allowance to the care givers of the lonely and isolated aged in the community.
- Provide financial support to the associations of the aged and volunteer groups.

**Funding mobilization:**
- City Government: annual allocation of 50,000,000 VND  
- NGOs, companies, enterprises,  
- Local community on occasion of the International Elderly People’s Day (1 Oct) and National Elderly People’s Day (6 June)
- Establishment of the Fund Management Committee  
- Formulation of Fund Management Regulation  
- Recruitment of Personnel (part time, full time staff)  
- Distribution of Fund

**Proposed Action — Other related activities:**
- Organize "Silver volunteer" group and groups of "Collaborators" to guide, provide counseling and monitor activities of the Govt. administration agencies.
on the Implementation of the Ordinance.
• Organize groups of "Voluntary students" to provide health check-ups and counseling for the aged.
• Organize art performance: music, folk song performance for the aged.

Monitoring
• Regular meetings/discussion
• Reporting system
• Auditing
• Review

Focal point personnel on Population Issues

City Leaders:
- City Chairman: Mr. Tran Van Minh
- Vice Chairperson: Mme. Nong Thi Ngoc Minh

City DLISA:
- Mme. Nguyen Thi Thanh Hung: Director
- Mr. Nguyen Van An: Vice Director
- Mme. Tran Thi Hong Van, Head of the Social Protection Division
- Mme. Nguyen Thi Minh, Deputy Head of the Social Protection Division

Collaborating agencies:
- Mr. Nguyen Huu Cung Chairman, City CPFC
- Mr. Nguyen Van Kien Vice President, FFC responsible for the aged
- Mme. Doan Vo Kim Anh, Deputy Director, City DoH

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time Line</th>
<th>Responsible person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Formulate Plan of Action for the Aged for approval of the City Chairman</td>
<td>Nov/2006 - Feb/2007</td>
<td>City DLISA</td>
</tr>
<tr>
<td>2. Draft Regulation on Establishment and Management of the Fund and submit to the City Chairman for approval</td>
<td>Nov/2006 - Feb/2007</td>
<td>City DLISA &amp; City Association of the Aged</td>
</tr>
<tr>
<td>3. Collaborate with Thai Phien Club for the Retired People on organization of &quot;Silver groups&quot; and &quot;collaborator groups&quot;</td>
<td>Feb 2007</td>
<td>City DLISA &amp; City Association of the Aged</td>
</tr>
<tr>
<td>4. Call for financial support from NGOs, enterprises, companies, set up some pilot projects for fund</td>
<td>From Feb 2007 onwards</td>
<td>City DLISA &amp; City CPFC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time Line</th>
<th>Responsible person</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Propose a meeting to discuss about the aged issues</td>
<td>May - June 2007</td>
<td>City PC and Representative from AUICK (if available)</td>
</tr>
<tr>
<td>6. Organize &quot;Voluntary student group&quot; to take care of the aged</td>
<td>Summer time (June-July)</td>
<td>City YU and Universities</td>
</tr>
<tr>
<td>7. Organize &quot;Medical student&quot; group to provide health check-ups for the aged</td>
<td>Regularly</td>
<td>City DoH, Medical University and Local Authorities</td>
</tr>
<tr>
<td>8. Regular meeting / discussion to draw lesson learnt and experience and revise the activities if necessary</td>
<td>Every 6 months, starting from June 2006</td>
<td>City PC and relevant agencies</td>
</tr>
</tbody>
</table>
Rabat Conference

Conference on Youth in the Middle East and North Africa

In Rabat, Morocco, 4-6 Dec. 2006

On behalf of AUICK, Kobe, Japan, and the Asian member countries of AUICK, Dr. Haryono Suyono attended the International Conference on Youth in the Middle East and North Africa, held on December 4-6, 2006 at Rabat, Morocco. The conference was jointly organized by Arab Urban Development Institute and other institutes such as Rabat Municipality Government, the National School of Architecture, Morocco and the World Bank.

Dr. Haryono Suyono was given the honor as the first speaker at the general plenary session, presenting his paper entitled "Demographic chances in urban areas and their socio-economic implications in Asia", followed by a report of Dr. Alexandre Kolev from Sorbonne University, Paris on "Youth Opportunities and Second Chances in Eastern Europe: Lesson for MENA", and Dr. Sarah Shono & Ms. Susan Smith from the American University of Sharjah on "MENA Women's Transition from School to Work". The session was chaired by Dr. Emanual Jeminen, Director of WDR of the World Bank.

Dr. Haryono Suyono elaborated that The Asian Urban Information Center of Kobe (AUICK) was officially established in 1989 in a cooperative agreement between the City of Kobe and the United Nations Population Fund (UNFPA). The aim of AUICK is:

- to contribute to the suitable development of cities through the collection and collation of information, and to study and research problems commonly shared by various cities in Asia, while extending cooperation in a relationship of mutual trust.

One of the enduring characteristics of AUICK is its focus on urban administrators as what have often been called the front-line managers of the urban panoramas. AUICK has been concerned with listening to what the urban administrators have to say about their problems, the strategies and tactics they develop to address those problems, and the kinds of assistance they would need to better discharge their jobs in addressing those problems. It has also been concerned with developing effective training programs for urban administrators throughout Asia to understand their problems and to learn or to share ways to solve those problems.

The demographic transition in developed countries required a longer process, such that the governments had sufficient time to take strategic actions to prepare appropriate services for the various segments in need, such as for the under-fives, the adolescents, the adults and even for the elders. The long transition process gave them time to meticulously plan, and not be intimidated by time pressures, and hence the process of adjustment took place in smooth progression.

Further end-phenomena was that demographic transition which took 100 years in many European countries, required less than one generation to occur in many Asian countries. The apparent consequence was the rapid decline in population growth, characterized by significant changes in the age structure, i.e. producing a larger segment of the younger population, and more strikingly is the significant magnitude of the surviving elders. The younger segment exploded two, three, or even four times compared to the conditions before the drastic and concurrent declines in fertility and mortality rates.

The rapid declines in mortality rates also gave rise to the increased life expectancy, such that persons who would have been deceased at their younger years are still surviving at an advanced age. These old-age survivors are not vacating their employment position, further resulting in compelling the younger cohorts, who are better educated, to wait longer until they can occupy positions of their dreams.

The changing structure of the youth and adolescents which is happening at the moment in Asia will have far ranging and concern-raising impact into the future as it is rapid, far beyond what the developed nations have experienced, and virtually uncharted by empirical studies. Furthermore, policy decision-makers are faced with a new political environment heavily laden with new democratic values, the rise of human rights issues, sustainable development; all demanding transparency, higher participatory management, and particularly higher accountability and stringent use of the ever-decreasing public resources.

All of these would demand comprehensive reforms, and in turn requiring the innovativeness of researchers to look into
strategic issues, also demanding candid and open international cooperation. All will be done to formulate policies and programs with high flexibility, ever placing population at the central of empowerment in facing future challenges never before envisioned. For that reason AUICK in cooperation with other organizations and local governments in Asia develops approaches to help solve these problems through research, training and programs benefited all parties, especially people in the villages.

The presentation was highly appreciated and the conference expressed its hope that further and more in depth cooperation be developed such that fruitful lessons learnt could be shared, and that the Mid-Eastern and African countries could benefit more.

Editor's Note:
The Arab Urban development Institute (AUDI) founded in 1980 with permanent headquarters in Riyadh, Kingdom of Saudi Arabia is a regional, non-governmental, non-profit urban research, technical and consulting organization. The Institute is affiliated with the Arab Towns Organization (ATO), with headquarters in Kuwait. The Institute serves as the technical and scientific arm of ATO. The institute has active membership of more than 400 Arab cities and towns representing 22 Arab states. A major goal of the Institute is the enhancement of the quality of municipal services in Arab towns and cities. This is achieved through professional and technical support to municipalities and municipal officials and administrators. The Institute is also dedicated to the improvement and preservation of the Islamic and Arab character and heritage of Arab Towns.

Because of the similarity of objectives and activities between AUICK and AUDI, Ms. Thoraya Obaid, Executive Director, UNFPA, has repeatedly suggested that AUICK should establish a collaborative relationship with AUDI. Upon her suggestion, AUICK invited a representative of AUDI to the First 2006 Workshop, and Dr. Ali Mahmoud Mousa Madibo Urban Planning Expert of AUDI, attended the workshop. (See the details on page 8 of the AUICK Newsletter No.47) In turn, AUDI invited a representative of AUICK to the Conference on Youth in the Middle East and North Africa: Expanding Economic Prospects in Urban Areas to be held in Rabat, Morocco, from 4 to 6 December 2006, and Dr. Haryono Suyono, Member of IAC, attended the conference to present a paper on "Young Population in Asia and Its Socio-Economic Implications in comparison with Middle East and North Africa".

Committee Meetings

International Advisory Committee

Annual Meeting, 5-6 Nov. 2006

From 5 to 6 November 2006, the AUICK International Advisory Committee (IAC) held an annual meeting in Kobe.

The meeting opened with welcoming remarks by Dr. Hirofumi Ando, President of AUICK, that the Secretariat would like to receive from IAC useful suggestions and advice in implementing the AUICK program as efficiently and effectively as possible. It was followed by remarks by Dr. G. Giridhar, Director of CST in Bangkok and UNFPA Representative in Thailand, who attended the meeting representing Mr. Kunio Waki, Deputy Executive Director of UNFPA.

Under the chair of Dr. Gayl D. Ness, the morning session was mainly devoted to the discussion on the review of the activities undertaken in 2006, and the afternoon session was focused on the annual work plan for 2007 and the direction of the project for 2008-2011.

The IAC members made the following suggestions and recommendations:

1. The qualifications for workshop participants should be specified further and IAC members should be utilized to a greater extent in the selection process including the consultation with the concerned Mayors. The IAC members should meet them to discuss the suitability of workshop participant nominations as well as the performance of the former workshop participants. The IAC members also recognized the difficulties in selecting appropriate workshop participants, and congratulated the Secretariat for the excellent job it has done;
2. Qualifications include the capacity of the nominee to share information and experience with their colleagues;
3. To supplement the monitoring work of the AUICK Secretariat, the local UNFPA offices and the local university or research institutions should be mobilized;
4. The Action Plan Strategy has been an excellent innovation and should be continued. It should also be more pragmatic and implementable for the participants. The participants should be adequately notified that
Action Plans will be expected, without being given rigid frameworks before the workshop. They should also be encouraged to consult with the previous workshop participants from the same city. For this purpose, the establishment of an "Alumni Association" of workshop participants was proposed;

5. There was a specific suggestion from Dr. Giridhar that the Action Plans should not be forgotten as a useful monitoring tool in themselves and that the concerned Mayors should approach more proactively the local UNFPA Offices for support to implement the Action Plans. Formal request letters from the Mayors to local UNFPA Offices would be very helpful. He also proposed that he would follow up with the UNFPA regional planning meeting in Bangkok the following week of the uniqueness and achievements of the AUICK project;

6. It was also suggested that AUICK organize briefing sessions on its unique work for UNFPA representatives at regional meetings. There could also be support from the UNFPA Country Support Team (CST) for the preparation of case studies.

7. While the information activities are viewed very positively, the IAC suggested that AUICK should go "beyond the web-based database" to disseminate information more widely through such means as the preparation of articles based on case studies by IAC members for publication in the local newspaper and the dissemination of more copies of the Newsletter to workshop participants so that they will share it with many colleagues. IAC also suggested that a separate small publication on best case practices be prepared. Review of the data in line with MDGs and ICPD Program of Action was also suggested;

8. The MIS projects (or the City University Partnership, CUP), as part of the mainstreaming exercise, should first be extended to other cities within the same country and then to neighboring countries; and

9. Concerning the workshop topic, in view of the recent tsunami crisis in Asian countries, a suggestion was made to organize a workshop on emergency medical service or link reproductive health service to the efforts of "crisis management."

In the morning of 6 November the IAC members approved the minutes of the meeting and the draft of the concept of the project for the years 2008-2011.

At the closure of the meeting, IAC paid special tribute to Dr. Toshio Kuroda and Mr. Kareem Iqbal who were not able to attend the meeting for their continued commitment and support to the AUICK program.

After the meeting the IAC members attended a luncheon hosted by Mr. Kazutoshi Sasayama, who has been working for AUICK as a special advisor since he retired from the chairmanship of AUICK.

Participants

JAC Members
Prem P. Talwar
Adjunct Professor, University of North Carolina (India)
Haryono Suwono
Former Minister Coordinator for People Welfare and Poverty Alleviation (Indonesia)
Krasae Chana Wongse
Former Minister of Foreign Affairs (Thailand)
Gayi D. Ness
Professor Emeritus, University of Michigan (USA)
Garimera Giridhar
Representative, UNFPA Thailand and Director of UNFPA CST in Bangkok (Representing Mr. Kunio Waki, Deputy Executive Director of UNFPA)

AUICK Secretariat
Hiroyumi Ando, President
Yoshikane Fujimoto, Executive Director
Nobuyuki Morimoto, Deputy Executive Director
Yuko Yama, Staff
Midori Suntiyoshi, Staff

Joint Meeting

On 6 November 2006, AUICK held a Joint Meeting of its three committees: Executive Committee (EC), International Advisory Committee (IAC), and Domestic Advisory Committee (DAC). This was the first attempt to create an opportunity for all the committee members to gather and have discussion on the direction of AUICK's new project.

The Joint Meeting was officially opened with a remark by Mr. Tatsuo Yada, Chairman of AUICK. He stated that 2007 would be critical for AUICK, as it is the final year of the present project, and the main theme of the meeting would be the development of the new concept for the coming 4 year term.
First, Mr. Fujimoto, Executive Director of AUICK, briefed the achievements attained from 2004 to 2006 under the current project for the years 2004-2007, and then explained the concept paper on the direction of the AUICK project for the years 2008-2011, which was adopted by the annual meeting of IAC. The concept paper features the further development of mainstreaming of the AUICK program into UNFPA country programs, through the idea of City-University Partnership (CUP), which is the most effective way to tackle the emerging urban population issues. The mainstreaming exercise is in progress in Thailand, Vietnam and Indonesia, and will be further extended to other AACs.

Dr. Kojiro Niino, Chairman of the EC, expressed great pleasure in having an opportunity to exchange ideas and opinions on AUICK activities among the members of the different committees. He also expressed great respect to IAC members for having made much effort to realize project goals. Then, Dr. Hirofumi Ando, President of AUICK, facilitated the discussion.

Main points of the discussion are:

• To facilitate local universities will be important for local governments to set up model cases to analyze the relationship between population and urban issues, as universities have all the necessary skills for data collecting and analyzing. This is why the concept "CUP" came up.

• In association with the City-University Partnership, there should be a framework in which Japanese lecturers/researchers can be involved in the AUICK projects.

• A more concrete explanation of the effectiveness of the AUICK project should be given to the public who can understand it through written reports only.

• It is necessary to make every effort to publicize AUICK’s activities to the public so that people will be able to understand the importance of AUICK projects and we will be able to attract their strong support.

• In terms of publication, the Secretariat has made an excellent website, which is accessed around the world every day. It is already well-made but still has room for improvement, especially to attract more Japanese viewers who cannot read English.

• AUICK holds an open forum on various themes as part of the workshop program every year. More than 100 people including high school students attend the forum, and exchange ideas and opinions with workshop participants. This is one of the best opportunities for AUICK to promote its works. The secretariat is expected to make publicity statements easier to understand so as to attract more people to the open forum.

• In terms of substantial contribution to the promotion of public welfare, it is necessary to foster experts who will go between administrative officials and citizens.

Members Attended:

Executive Committee
Kojiro Niino  President, Kobe Institute of Urban Research
Kiyoko Ikegawa  President, Kobe City College of Nursing
Chen LaiXing  Professor, University of Hyogo
Tatsuo Yada  Chairman, AUICK
Hirofumi Ando  President, AUICK
Yoshikane Fujimoto  Executive Director, AUICK

International Advisory Committee
Gayl D. Ness  Professor Emeritus, University of Michigan (USA)
Prem P. Talwar  Adjunct Professor, University of North Carolina (India)
Haryono Suyono  Former Minister Coordinator for People Welfare and Poverty Alleviation (Indonesia)
Krasae Chanawongse  Former Minister of Foreign Affairs (Thailand)
Garimera Giridhar  Representative, UNFPA Thailand and Director of UNFPA CST in Bangkok (Representing Mr. Kunio Waki, Deputy Executive Director of UNFPA)

Auditor
Kyoji Ueda  Executive Director, International Affairs Office, International Affairs, Culture and Tourism Bureau, Kobe City Government, and of AUICK.

Secretariat
Nobuyuki Morimoto  Deputy Executive Director, AUICK

Note: No member of DAC attended the joint meeting.
On 20 November 2006, the AUICK Domestic Advisory Committee held an annual meeting at the Office of the Institute of Prosocial Research (IPR), Tokyo.

The Secretariat reported the achievements of the current strategic project for 2004-2006, the Annual Project Work Plan (2007) which the Secretariat is scheduled to submit to UNFPA shortly, and the concept of the next project for 2008-2011 to be reviewed by the UNFPA officials involved in 2007.

Mr. Shinya Hoshino remarked that since AUICK's approach to help solve the urban problems through information and personnel networks among Asian medium-sized cities is quite unique and effective, AUICK should develop a successful model of urban management in AUICK Associate Cities, and disseminate it to the other cities in the Asian countries.

Member Attended:
Shinya Hoshino
President, Institute of Prosocial Research

After the meeting of the AUICK Domestic Advisory Committee, the Secretariat members visited the Office of the Global Issues Cooperation Division, International Cooperation Bureau, Ministry of Foreign Affairs, and met with Director Takeshi Osuga and Ms. Cheiko Tatsumi.

The Secretariat briefed the MOFA officials on AUICK activities and the concept of the next AUICK project for the years 2008-2011, and asked the MOFA officials for their continued support.

The MOFA officials commended the work of AUICK as a unique strategic effort to help medium-sized cities in Asia and agreed to support it as much as possible. They shared the concern of the AUICK about the "counterurbanization" of regional projects in 2008 that the implementation of inter-country activities may be delayed unless its procedures are clearly defined and communicated to the concerned parties.