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AUICK First 2010 Workshop

AUICK held its First 2010 Workshop in Kobe, Japan, from 6 to 12 June, with the support of Kobe City Government and the United Nations Population Fund (UNFPA). As a follow-up to the Second 2007 Workshop on the same theme, its title was "Maternal and Child Health Care (including Family Planning) in Natural Disasters - Stage II". Participants were senior city government officials and academic experts from each of five AUICK Associate Cities (AACs).

"There is now international acknowledgement that efforts to reduce disaster risks must be systematically integrated into policies, plans and programmes for sustainable development and poverty reduction, and supported through bilateral, regional and international cooperation, including partnerships."

(Final report of the 2005 UN World Conference on Disaster Reduction, Kobe, Japan)

Background

At the beginning of 2010, a huge earthquake devastated Haiti, taking the lives of an estimated 230,000 people. Prior to this, Asian countries were hit by disasters such as the 2008 Sichuan Earthquake, the 2005 Kashmir Earthquake and the 2004 Sumatra Earthquake Tsunami. Kobe and its surrounding areas were struck in 1995 by the Great Hanshin-Awaji Earthquake, which claimed the lives of 6,434 people. Between January and November 2009, there were 245 disasters in the world, which affected 58 million people, killing 8,919, and causing US$19 billion in economic damages. Asia is the most vulnerable continent to storms and floods, which affected 48 million people there in 2009.*

The United Nations Population Fund (UNFPA) believes that the concept of disaster-risk reduction is based on the recognition that disasters will occur, but that informed and committed societies can anticipate them and their effects, thereby minimizing loss of life and property, and accelerating recovery efforts. It is critical to consider the kinds of gender differences that make women disproportionately vulnerable in disasters, and that sometimes lead to discrimination against them in the recovery process. Women and their children must be visible to responders, to ensure the success of post-disaster recovery, and they must have a say in the formulation of disaster risk-reduction plans. Immediately after disasters occur, it is necessary to ensure safe childbirth and reestablish maternal health services where they have been devastated, and to provide basic services including water, sanitation, food, health and protection, and also psychosocial support to survivors. It is also important that appropriate family planning services are continuously provided in such conditions.

Aim

AUICK Workshops aim to increase the capacities of city planners and administrators in Asian medium-sized cities to address population and development issues. Second-stage Workshops are conducted for senior officials of AUICK Associate Cities (AACs) who have attended previous Workshops, to return to Kobe together with local academic experts. There, they share information and best practices, and receive on-site training related to their AUICK Workshop formulated Action Plans, at the facilities of Kobe City Government.

At the Second 2007 Workshop, senior city officials of AACs in charge of maternal and child health care or crisis management each developed concrete Action Plans for improved MCH services and disaster preparedness, which they implemented in their cities in cooperation with colleagues and academic experts from local universities. The First 2010 Workshop provided training toward the re-formulation of the Plans by five participants of the Second 2007 Workshop, with academic experts.

The Workshop incorporated not only North-South (Kobe-AAC) training at Kobe City programmes facilitated through cooperation among private, public and academic sectors, but also South-South (AAC-AAC) sharing of information and knowledge among participants, toward the revision of their Workshop Action Plans. Ultimately, it aimed to foster lasting collaboration between city administrations and the academic community, to solve population-related issues in the urban setting.

*United Nations International Strategy for Disaster Reduction (UNISDR) Secretariat
Participants

Participants of the First 2010 Workshop were senior officials and academic experts of five AUICK Associate Cities (AACs), including Chittagong (Bangladesh), Weihai (China), Chennai (India), Olongapo (Philippines) and Danang (Vietnam).

The participants included the following (in alphabetical order by country):

**AUICK Associate City (AAC) Government Participants**

**Mr. Mominur Rashid Amin**  
Private Secretary to the Mayor, Chittagong City Corporation, Bangladesh

**Mr. Sun Lin**  
Chief Engineer, Weihai Construction Committee, China

**Ms. B. Jothi Nirmalasamy**  
Deputy Commissioner, Health and Family Welfare Bureau, Corporation of Chennai, India

**Dr. Arnildo Castro Tamayo**  
City Health Officer, City Health Department, Olongapo City Government, Philippines

**Mr. Nguyen Van Phat**  
Chief, Social and Cultural Affairs Division, Danang People's Committee, Vietnam

**Academic Expert Participants**

**Dr. Subash Chandra Roy**  
Principal, Laboratory Medicine, Institute of Health Technology, Chittagong, Bangladesh

**Dr. Li Chunrong**  
Chairman, Obstetrics and Gynecology, Weihai City Hospital, China

**Dr. Charumathy Baskaran**  
Deputy Project Coordinator, District Family Welfare Bureau, Corporation of Chennai, India

**Dr. Victor dela Cruz Quimen, Jr.**  
Dean, College of Nursing, Gordon College, Olongapo, Philippines

**Dr. Tran Dinh Vinh**  
Head, Obstetrics and Gynecology Department, Danang Hospital, Vietnam

**Resource Persons**

**Dr. Gayl D. Ness**  
Professor Emeritus, University of Michigan, USA; Chairman, AUICK International Advisory Committee (IAC)

**Ms. Yuki Suehiro**  
Deputy Representative, UNFPA Bangladesh Office

**Opening Remarks**

The President of AUICK, **Dr. Hirofumi Ando**, welcomed the participants of the First 2010 Workshop to Kobe on behalf of his colleagues, **Mr. Tatsuo Yada** (Chairman and Mayor of Kobe), **Mr. Toshihiko Ono** (Executive Director), **Mr. Shoji Temba** (Deputy Executive Director) and **Mr. Toru Fujiwara** (Manager). Dr. Ando explained that the Workshop would focus on the provision of maternal and child / reproductive health care in disaster situations, and that the participants would re-formulate Action Plans made at the Second 2007 Workshop (on the same theme) with academic expert partners. These Plans would be improved based on the experience of their implementation since 2007 (such as problems encountered and solutions found), as well as knowledge obtained through the First 2010 Workshop, advice from academic partners and best practices shared among Workshop participants themselves.

The AUICK Workshop format is designed to promote North-to-South (Kobe to AAC) and South-to-South (AAC to AAC) collaboration, which increases the sharing of information on issues related to each theme covered. As it is seminar based, the success and results of the Workshop depend on the active involvement of its participants. The theme of the First 2010 Workshop was chosen because of the need to prepare for unpredictable natural disasters to which urban areas are vulnerable, and the importance of providing reproductive health services to women, who are often neglected in disaster planning and management.

Dr. Ando finished by underlining his hope that effective Action Plans would be taken back to each city, and expressing the appreciation of AUICK to both UNFPA and the City of Kobe, for their active support to its Program over two decades.

The following pages contain articles on each presentation, discussion and site visit of the First 2010 Workshop. The articles can be found on AUICK’ s website, at www.auick.org
Providing Population Services under Rapid Urban Growth and Natural Disasters

Dr. Gayl D. Ness outlined the rapid urbanization occurring in Asian countries, and the innovations of AUICK Associate Cities (AACs) to provide services to increasing populations. Contingency plans have to be put in place so that these services can be maintained, assistance received and recovery possible in the occurrence of natural or manmade disasters.

Asian countries began to provide reproductive health services to their populations when they were mostly rural. The last 40-50 years though, have seen the most rapid and large-scale movement towards urbanized populations in Asian history. This change, as well as the challenges it brings to the provision of services, is characterized by the AUICK Associate Cities (AACs).

In 1950, 17 per cent of the population of Asia lived in urban areas. As of 2010, this figure has risen to 42 per cent, a seven-fold increase from 234 million to 1.8 billion, and it is predicted to reach 2.6 billion by 2030. The differing characteristics between rural and urban populations mean different issues facing the provision of services to each. Rural populations are highly dispersed, so distribution networks have to be built to conquer physical distance and isolation. In villages though, residents know one another, and social networks are both highly organized and personal, which creates relatively healthy communities. Thus once a village was reached with family planning services, virtually the whole village was effectively served. Although modern urban populations are densely settled and therefore potentially easy to reach, they pose the problem of weak social networks and communities. These populations are characterized by highly impersonal, weak social networks, with "floating" migrant young populations (a major source of urban growth), which are often not organized into communities, registered or connected to social networks. The challenge in urban areas then, is to find ways to reach these more socially isolated populations, and to improve basic health levels. In addition, human concentration itself produces a relatively unhealthy environment, thus one of the first demands for health promotion in growing cities is the management of human waste and the provision of clean water.

AUICK Associate Cities (AACs) illustrate these issues. They also demonstrate the importance of local administrators, who have developed unique locally specific projects that have been so successful in enhancing reproductive health, especially for the more vulnerable populations.

Providing good services requires political will and good administrative systems, so that local innovations, by people who know the way their society and government work, can be developed, tried locally and then expanded to a wider arena. Such innovations are characterized by the AUICK Workshop Action Plans, implemented by the administrations of AACs in nine Asian countries.

Since 1970, the urban population of Bangladesh has increased from five to 42 million people. For its floating population, Chittagong City Corporation has worked with international NGOs to provide peer educator training on HIV/AIDS, and developed extensive urban greening and waste collection services for the poor.

In China, which has seen massive urban growth from 161 to 609 million people since 1975, Weihai Municipal Government innovations have provided care systems and shelter homes for 10,000 abandoned elderly in the city.

India was the first country to announce government policies to reduce population growth by reducing fertility in marriage in 1952. Its urban population has increased from 69 million to 356 million since 1955. The Corporation of Chennai has established a network of trainers to provide maternal and child health care to local communities, and maternity clinics for safe births have reduced maternal and infant mortality rates. Rainwater harvesting is also conducted by urban households in the city to increase ground water levels.

Indonesia's successful national family planning program, BKKBN, greatly reduced fertility and infant and maternal mortality rates. As its urban population of 127 million is now higher than its rural population, new innovations are needed to provide adequate services to citizens. Surabaya City Government has well organized community groups through its "Posdaya" (family and community empowerment posts), and mobilizes citizens to improve their urban environment through greening and waste recycling programs. It also promotes initiatives such as Management Information Systems (MIS) to provide population data for improved policies, with local academic support.

When Malaysia began its family planning program in 1970, the country was predominantly rural. Now, its urban population of 20 million is far greater. Kuantan Municipal Council has successfully prevented urban poor primary school dropouts by providing financial assistance to poor families for their children's education.

Pakistan's population is still mostly rural, but its urban population has increased since 1960 from 10 to 65 million. The City District Government Faisalabad has recently increased primary school enrolment, waste recycling programs and training for community midwives and female doctors.

In the Philippines, 60 million urban residents double the rural population. Olongapo City Government has recently increased urban health insurance and environment cleaning programs.
Ms. Yoko Saito, Researcher, United Nations Centre for Regional Development (UNCRD) Hyogo Office, Japan

Community Based Disaster Management (CBDM)

Ms. Yoko Saito explained Community Based Disaster Management (CBDM) projects of the United Nations Centre for Regional Development (UNCRD), and the importance of incorporating gender perspectives into disaster preparedness, as well as their links with sustainable development.

The United Nations Centre for Regional Development (UNCRD) conducts research and training in local and regional development. Its Hyogo office was established in April 1999, and has ongoing projects as the School Earthquake Safety Initiative and the Institutionalization of Gendered Community Based Disaster Management (CBDM) in the Context of Regional Development.

The latter of these is based on the experiences and lessons of the Great Hanshin-Awaji Earthquake in 1995, which devastated Kobe, but from which the city has made a strong recovery. The earthquake occurred at 5:46 in the morning of 17 January, 1995, with a magnitude of 7.3, and a seismic intensity of seven. It caused the deaths of 6,434 people and injured over 40,000. One of the key lessons of the earthquake was the importance of community response in the immediate aftermath of such a disaster. In any disaster-prone area, the local population are the potential victims, but also the local resources and stakeholders, the first to respond and last to remain after outside assistance is gone, and the holders of local knowledge on vulnerabilities and traditional coping mechanisms suited to their own environment.

In the case of the Kobe earthquake, most of the 35,000 people rescued were saved by themselves and the people who lived around them. In this context, Community Based Disaster Management (CBDM) is a bottom-up approach of citizens taking control of both pre-disaster planning and post-disaster recovery processes, developed in balance with the top-down approach of command and control by a higher governmental decision making authority. This balance is achieved through communication for information sharing, consensus building, collective decision making, risk-sharing accountability, equal partnerships and self-management to empower the community.

All AACs are susceptible to such manmade disasters as chemical or oil spills and explosions, especially the port cities, where containers of potentially hazardous materials are shipped. Storms, floods and tsunamis are predictable now with vital access to international weather data, which provide good information on the movement of storms and enable national governments to mobilize strong response teams, incorporating the army, police and other agencies. Unpredictable earthquakes and manmade disasters must be prepared for through the development of protection systems. Organizations have to be built for effective response by multi-agency task forces, which should include police, health, utility, road-building and irrigation systems, connected effectively and organized under the mayor or highest political office in each city. Kobe's recent experience has been conveyed to Workshop participants of the AACs, who have designed their own locally appropriate plans for protecting primary and reproductive health care during disasters, under AUICK's Action Plan strategy.

Disaster Management (CBDM) is a bottom-up approach of citizens taking control of both pre-disaster planning and post-disaster recovery processes, developed in balance with the top-down approach of command and control by a higher governmental decision making authority. This balance is achieved through communication for information sharing, consensus building, collective decision making, risk-sharing accountability, equal partnerships and self-management to empower the community. "Community" itself is a not single entity. As in other areas, priority in disaster management should be given to the most vulnerable groups, such as children, women and the disabled. An example of this in practice was the UNCRD Workshop on Gender
In Community Based Disaster Management in Nepal, conducted in 2007-8. The project selected five target communities within the Kathmandu Valley (an area prone to earthquakes) in which to increase awareness on existing earthquake risks, establish community vulnerabilities and capacities in times of disaster, and involve citizens in risk assessment and making hazard maps to show potentially safe or dangerous local buildings. It promoted disaster insurance, safe placement of furniture in homes, and appropriate land use, construction quality and building maintenance. Most participants implemented the lessons they learned and many expressed a desire to train others and pass on information for disaster preparedness to friends and relatives. (This proved important, as women in the communities covered by the project counted friends and neighbors as their main source of disaster-related information).

In many cases, women tend to be excluded from disaster preparedness training, but data from recent cyclones in Bangladesh and the 2004 Sumatra Earthquake Tsunami reveal much higher female than male death rates, because many women were unable to swim or climb trees, wore inhibitive clothing, or lacked independence from their husbands to take themselves to appropriate shelters. In the aftermath of such disasters too, women are often at a disadvantage in accessing livelihood and other recovery programmes (of the formal or informal sector) and psychosocial care. Relatively little attention is paid to re-establishing trade and markets pertaining to women's livelihoods, and those with small businesses often have no official registration, and cannot qualify for financial assistance. The lack of disaggregated data, notably on gender, impairs effective targeting of vulnerable groups and reinforces discriminatory practices. For these reasons, it is especially important to incorporate women into disaster preparedness programs.

According to Resolution 1582 (L) of the United Nations Economic and Social Commission (ECOSOC) of 21 May 1971, regional development includes "popular participation in setting development goals and in development decision-making and organizational processes". Following this principle, UNCRD Community Based Disaster Management (CBDM) projects aim to:

- promote and strengthen a "culture of coping with crisis";
- enhance public perception of vulnerability;
- recognize the motivation of community initiatives;
- increase community participation and empowerment through institutionalization;
- focus on needs-based training approaches;
- involve diverse stakeholders based on needs and objectives in formal and/or informal ways;
- promote tangible/intangible accumulation of physical, technological, and economic assets as project outputs; and
- promote the integration of community initiatives into usual development planning and budgets to ensure sustainability.

In addition to Nepal, UNCRD conducts projects to promote community involvement in disaster preparedness in Sri Lanka, China, and also Bangladesh, a country which is regularly hit by floods, landslides and cyclones. These claimed the lives of over 300,000 people in 1970, and over 130,000 people in 1991, and more recent cyclones SIDR and AILA have also hit in 2007 and 2009. There is a great need for shelters in Bangladesh to protect citizens from such disasters, and a UNCRD project promoted the involvement of citizens (especially female) in shelter construction planning. Committees are often formed for community participation in shelter planning, but they lack interaction with local government bodies in charge of actual construction. The UNCRD project addressed this by inviting government representatives to attend the community meetings. It also trained citizen groups on issues such as global warming and disaster preparedness, which in turn gave them the confidence to voice their needs as a community, and to enhance the management of government projects with their participation. As a result, proper consultation and discussions among citizens, NGOs and government officials (specifically on disaster shelter construction), have led to additional access routes, segregated rooms for females, adequate care for pregnant women, and guidelines for citizens on shelter use.

UNCRD has learned that a number of factors are necessary to achieve the successful implementation of these projects: the root causes of disaster vulnerabilities have to be properly assessed; education should be a mutual, not one-sided process; Disaster Risk Reduction (DRR) should be embedded in all relevant policy, planning practices, attitudes and behavior to promote a culture of safety; community participation, empowerment, ownership, and decision making are vital to make sustainable communities; gender perspectives (both male and female) in CBDM are crucial to make disaster resilient communities for sustainable development; and giving an equal opportunity for education to both men and women leads to their confidence and ownership of projects. Disaster management project sustainability lies in empowering communities to address their own needs, rather than addressing their needs for them.
Best Practice: Case Study of Maternal and Child Health Care in Natural Disasters - Bangladesh

Ms. Yuki Suehiro explained the activities of UNFPA in the context of emergency preparedness and response, and specific assistance in Bangladesh, a country which is regularly hit by cyclones and floods, and whose government has improved disaster preparedness accordingly.

Under its principles of action, UNFPA states that "the right to reproductive health is universal and applies to women, men, and adolescents everywhere, at all times, including during humanitarian crises and natural disasters"; that "accurate demographic and health data is the cornerstone of effective humanitarian response and national reconstruction"; and that "gender analysis must be a critical component of design and implementation of humanitarian response and national reconstruction".

The gender perspective in disaster emergencies implies much more than the survival rate of females. In the aftermath of disasters, women and girls are often victims of increased violence, including sexual violence. Women are caregivers in a disaster, and in many areas, responsible for collecting water, which also exposes them to the possibility of sexual violence. In non-disaster situations, 15 per cent of pregnant women can develop complications, requiring emergency obstetric care. The absence of this care is often overlooked in emergency situations, despite it being a lifesaving intervention. Emergency disasters can even force women into sex for food or shelter services, increasing their vulnerability to HIV/AIDS in such situations. So it is vital that gender concerns are incorporated into planning for emergency conditions.

In addition to preparation and response before and during acute emergency situations, UNFPA aims to provide assistance in chronic refugee and Internally Displaced Person (IDP) settings, and in phases of transition and recovery after disasters strike. In acute emergency or conflict situations, it provides equipment, supplies and technical expertise to promote safe motherhood (including safe delivery, prenatal care, emergency obstetric care and family planning), treatment for sexual violence and Sexually Transmitted Infections (STIs), HIV prevention, and sexual / gender-based violence prevention and care. It collects and analyses demographic and health data on affected populations, in order to determine service needs and improve humanitarian programmes. Gender analysis and advocacy are applied in all of these areas.

Many of UNFPA's publications and guidelines define intervention and immediate response to emergency situations, in terms of what needs to be done before, during and after disasters occur. The Minimum Initial Service Package (MISP) outlines and provides materials to meet minimum reproductive health needs during emergencies, to utilize in an emergency situation without site-specific needs assessment.

In the initial stage of emergency, the first needs of the population include shelter, food, nutrition and basic public primary health services, but the MISP aims to prevent excess maternal and neonatal mortality and morbidity, by promoting the incorporation of reproductive health care into initial health services. This enables clean and safe births at health facilities and homes, reduction of HIV transmission, and provision of guidelines on issues such as prevention and assistance to the victims of sexual violence. Over the course of the recovery period after a disaster, normal medical services can then gradually take over the role of the MISP.

Bangladesh is a country extremely prone to natural disasters, with around 75 per cent of its land base less than 10 meters above sea level, and around 20 per cent flooded annually. Cyclone SIDR in 2007 affected approximately 10 million people, of which around 60,000 were pregnant women in their third trimester. Mortality among females over the age of ten was three times higher than that of males, and reproductive and sexual health care were largely unaddressed. The majority of shelter residents were women, and there was a high incidence of reported sexual violence. UNFPA Bangladesh intervened to conduct field assessments on the needs of the affected population, and provide relevant reproductive health kits, materials to maintain the hygiene / dignity of girls and women, boats for use as ambulances or mobile clinics in flooded areas, and emergency medicines, megaphones and torches. It arranged partnerships among the national Directorate of General Health Services, the Disaster Management Bureau, the United Nations Development Programme (UNDP) and local level NGOs, for increased and effective health care provision.

In the Bangladesh cyclone of 1970, the lives of over 300,000 people were lost, and 130-150,000 people perished in the cyclone of 1991. Cyclone SIDR in 2007, though, claimed 3,406 lives, despite its similar severity. This shows...
the effectiveness of the Bangladeshi Government’s various measures to increase disaster preparedness. Since the 1970s, around 2,500 shelters (each accommodating 800 people) have been built across the country, giving shelter to 1.5 million people during Cyclone SIDR. High-rise schools, hospitals and homes now protect many from the effects of flooding, and a network of 124 polders (artificial areas of low-lying land with flood-prevention embankments) extends up to 100km inland along Bangladesh’s coastal belt. Improved technology means that early warning systems can provide up to five-day warnings of cyclones - in the case of SIDR, the highest level warning signal was activated 27 hours before the cyclone hit land. There is now a clear chain of communication from the national to district governments, to organizations like the Bangladesh Red Crescent, which rapidly mobilized around 40,000 community bicycle-bound volunteers to facilitate mass evacuations to cyclone shelters during SIDR. (These volunteers also educate school students and women’s / community groups on disaster preparedness in normal time.) The increasing provision of life jackets, wireless communication systems, transportation during emergencies, locally procured and distributed hygiene kits, and mobile sanitary latrines and safe water supplies also prevent loss of life in disaster situations.

Challenges remain though during the immediate disaster response phase, when health facilities become flooded with water and dysfunctional, when there are requirements for emergency drugs, family planning commodities, functional medical equipment, and materials for safe/clean deliveries and emergency obstetric care. Skilled birth attendants and disaster management training are lacking in the coastal areas, and the surveillance system to ascertain disease and maternal and neonatal mortality levels is weak.

One year after Cyclone AILA hit Bangladesh in 2009, broken embankments are yet to be repaired, where over 100,000 residents are dependent on food aid, and poor hygiene conditions mean that saline tidal water is still entering localities and flooding homes. The quick recovery in 2007 after Cyclone SIDA was helped by fast receding water levels and massive international relief efforts. After Cyclone AILA though, rather than request immediate assistance, the Government sought long term financial assistance to address the increasing challenges of climate change, through a USD1.5 billion appeal to construct more shelters for 1.6 million people in cyclone high risk areas. As a single shelter building accommodates 800 people though, 20,000 shelters are required; and existing shelters also face poor maintenance and management issues.

In 2010, UNFPA has conducted a field assessment on the aftermath of Cyclone AILA (with other UN agencies) which has revealed that 70 per cent of births take place in homes, and 60 per cent with untrained birth attendants. As an immediate response, UNFPA is assisting the provision of two-week refresher training courses for skilled birth attendants, reproductive health kits for family planning and clean community or home deliveries, hygiene / dignity kits for girls, and awareness programs on good hygiene practices and the importance of ante and pre-natal care and skilled attendance at births. It is also conducting a health facility assessment to establish a referral system and address lacking manpower, equipment and commodities.

In the future, UNFPA Bangladesh will continue to promote disaster early warning and the pre-positioning of emergency healthcare kits, and strengthen field level presence and capacity building for reproductive health care and prevention of gender-based violence. By working with NGOs and other partners, it will contribute to multi-sector humanitarian response coordination, and increase advocacy for gender disaggregated data, to further increase the incorporation of women’s needs into disaster emergency assistance.

Lessons Learned from the Great Hanshin-Awaji Earthquake (1):
Aid and Assistance

Mr. Takaaki Matsuda described Kobe City Government’s response in the aftermath of the 1995 Great Hanshin-Awaji Earthquake, its management of aid and assistance, and the efforts to pass on the lessons learned from the disaster.

At 5:46am on 17 January, 1995, a massive earthquake measuring 7.3 on the Richter scale hit the city of Kobe, whose downtown area was just 16km from its epicenter on nearby Awaji Island. Over 100,000 houses were damaged or destroyed, and 4,571 people in the city lost their lives (6,434 overall), mostly from the collapse of buildings where they slept. Many houses were pre-World War II wooden structures, not built to more recent earthquake-resistant specifications. As downtown Kobe is situated on a narrow stretch of land between the Inland Sea and the Rokko Mountain range, destruction to road and rail networks left residents largely cut off from assistance, and affected national networks. Water, electricity, gas, telephone and sewage lines were disrupted, and many hospitals and health clinics were badly damaged. There was little water for fighting the 175 fires which broke out across the city, and health care service provision was severely disrupted. Damage to public and private properties totaled around 10 trillion yen, and that to port and expressway facilities was valued at 5.5 trillion yen. Many people could not stay in their homes, and moved to shelters set up in school halls and other municipal buildings. At peak, 237,000 people were staying in 600 different shelters around the city, for which the Government set up a relief supply network of food, medicines and blankets, and arranged free medical counseling and telephone services.
Long-term use of the shelters was unfeasible, so temporary housing units were constructed within a month of the earthquake. These were allocated through a lottery system, and so communities of largely elderly citizens became divided, which caused their further distress. The City Government arranged volunteer visitors to provide companionship and monitor their wellbeing, while a more permanent plan was drawn up to provide 82,000 units of re-constructed housing for those in the temporary homes. This time, residents would be re-housed in groups, so as not to disrupt newly forming and delicate community networks.

In the immediate aftermath of the earthquake, images of the fires and destruction in Kobe were shown throughout Japan and around the world, so the city was immediately inundated with offers of aid and assistance. Relief supplies were sent from twenty-four countries to Kobe City Government, and additionally to Hyogo Prefecture and neighboring cities, and organizations like the Japanese Red Cross. Many Japanese citizens also wanted to help in the relief efforts, starting a culture of volunteerism in Japan which grew in the years after the earthquake.

In the immediate aftermath of a disaster, it is vital to secure a route for the distribution of aid, and then arrange a system to send the aid efficiently and directly to those who need it. As the city was severely cut off by the earthquake except from access by sea, ships transported international aid to the few undamaged port facilities on Kobe's Rokko Island from nearby Kansai Airport. Four distribution centers were set up around the city for aid to reach the shelters, which transmitted requirements to the Government. City officials sorted the goods with volunteers, and all of the shipping companies, international airlines and transportation networks operated free-of-charge, with complicated customs and immigration procedures waived. This established a steady supply line to those most afflicted by the disaster, of blankets, medicines, dried foods, tea and water, wood and tents for shelter, soft toys and clothes, as well as international rescue teams of medics and search-and-rescue dogs. Clothes could be easily donated from around Japan through its network of convenience stores, but different sizes and types were difficult to distribute effectively, and many ended up in warehouses. Other unused donated items included a type of medicine for influenza which was unapproved for use in Japan. Such supplies were later re-distributed internationally, upon request.

For financial donations from around the world, a special bank account was set up. This proved an effective form of donation for relief items to be bought when they were needed. (There is a time lapse between requesting and receiving aid from an outside source.) Money donations also meant that goods could be procured locally, which helped to stimulate the economy. And funds redistributed to the Japanese Red Cross established a mechanism for the provision of emergency medicine, food and water supplies, and emergency rescue items like jacks, saws, buckets, pumps, fire extinguishers, emergency food and water supplies, and makeshift toilet facilities, with stockroom keys kept to the Red Cross board members. Fifteen years after the earthquake, residents are increasingly aware and assisted by the Bokomi board members. Fifteen years after the earthquake, residents are increasingly aware and assisted by the Bokomi board members. Fifteen years after the earthquake, residents are increasingly aware and assisted by the Bokomi board members. Fifteen years after the earthquake, residents are increasingly aware and assisted by the Bokomi board members.

Government had envisaged language or local knowledge problems, but the rescue and medical teams' efforts were effective and highly appreciated by the public, who saw that their plight was recognized and supported internationally.

Around 44,000 foreign residents were in Kobe when the earthquake struck. Initially, their situation was not known by the City Government, as they tended to gather in undesignated shelters. Mosques, community churches and local parks were all used by groups according to their religion and nationalities, and so these places were soon added to the relief distribution networks. An earthquake newsletter of information on shelter and assistance was published in various languages, and also distributed to the international community by volunteers, and the Government assisted the re-opening of consulates and international schools.

It is vital that the lessons of the earthquake in Kobe are not forgotten, in order to promote preparedness for future disasters. Kobe City Government learned that collaboration with the local community, NGOs and volunteers is essential in all areas of assistance and recovery, as each plays a huge role in providing support that is beyond the capacity of a single administrative body. The Government itself has facilitated the reinforcing of buildings to be earthquake resistant, and has established Disaster Prevention Welfare Communities for each of 191 (elementary school defined) districts of Kobe. Called "Bokomi", these are resident-managed activity groups which routinely practice emergency drills, disseminate information, and organize awareness raising community events, with the participation of school children, local businesses and one representative of the city fire department to educate each group. Members also provide regular assistance to the elderly and handicapped, forming bonds among citizens and the local emergency service for mutual assistance in the event of a disaster situation. The involvement of children in these groups is most important, because they did not experience the earthquake that hit the city, but they will become the next generation of Bokomi leaders. Around the city, neighborhood parks also stock emergency rescue items like jacks, saws, buckets, pumps, fire extinguishers, emergency food and water supplies, and makeshift toilet facilities, with stockroom keys kept to the Bokomi board members.

Fifteen years after the earthquake, residents are increasingly aware and assisted to be prepared for disasters, while the lessons of the city's experience are disseminated throughout Japan and internationally, by organizations such as AUICK.
Lessons Learned from the Great Hanshin-Awaji Earthquake (2): Maternal and Child Health Care

Ms. Akemi Ozaki showed how maternal and child care needs to be incorporated into disaster prevention planning, and outlined Kobe City Government’s measures to increase the healthy upbringing and appreciation of children.

The Great Hanshin-Awaji Earthquake on 17 January, 1995 took the city of Kobe by surprise, as nobody had expected such a disaster strike. In addition to taking the lives of 6,434 people in Kobe and the surrounding area, the earthquake left over 320,000 evacuees, many of whom went to shelters across the city, unable to live in their houses which were either damaged or cut off from water and electricity. Despite these conditions, 30 per cent of pregnant women stayed at home. Of those who evacuated, most went to extended family homes rather than stay in shelters which were unsuitable for pregnant women and new mothers, lacking in privacy, baby-changing and washing facilities, running water and appropriate meals. Within three days of the earthquake, baby care relief supplies reached the shelters, but many mothers there felt unable to stay, some even preferring to sleep in their cars.

After the disaster, the City Government drew up regional disaster prevention strategies and manuals, which stipulated the importance of providing shelter facilities for children and pregnant women (as well as the handicapped), and of stock-piling baby care items, to be annually checked and renewed. Important lessons had been learned on maternal and child health care in the context of a disaster situation:

- The physical and mental conditions of pregnant women, infants and babies both differ and fluctuate daily.
- It is necessary to secure nutrition, water and hygienic conditions for the safe delivery of babies and their healthy growth, and to prevent infectious diseases.
- Special attention should be given to individual children, such as to those with pediatric chronic diseases or allergies.
- Children need mental health counseling services, as they are easily affected by disasters.
- It is necessary to continue regular check-up services for pregnant women, babies and infants in disaster situations.

Disaster shelter support services can be effectively arranged through cooperation among administrative workers and community leaders, and should incorporate the provision of powdered milk, bottles, disinfectant, baby food, water, paper diapers and clothing, and medical services (including personnel) to deal with emergencies such as deliveries and acute symptoms of children. Shelters should have secure places where mothers can nurse children, children can play, and babies can cry at night. Mothers with children must not be isolated, but rather should be given information on caring for themselves and their children.

Normal maternal and child health services need to be resumed quickly after a disaster, and check-ups should be arranged to assess conditions and requirements, to encourage mothers to go back to normal life as soon as possible. Individual situations should be monitored, and one-to-one, friendly consultation services assess the mental condition and anxieties of mothers, who are often stoical so as not to worry their children. They may need to be assured that it is common for children to regress, to be unable to sleep, or to develop communication difficulties as a result of a disaster situation.

Medical assistance is given to a child at a shelter in the days after the Great Hanshin-Awaji Earthquake hit Kobe

In normal time, Kobe City Government takes steps to assess the needs of pregnant women, mothers and children in each local community, as part of preparations to enable emergency care provision. Handbooks distributed to all pregnant women include health care advice and information on what to do in a disaster situation, and strong collaborative/communicative networks are created among health workers, volunteers, child rearing groups and citizens, which can continue to function well in a disaster situation. (After the Kobe earthquake, shelters in communities with weak social networks were those where trouble most frequently occurred, among residents who became increasingly selfish to their own needs.)

Japan has around 1.1 million births per year. Its Crude Birth Rate (CBR) of 8.7 /1000 and Infant Mortality Rate (IMR) of 2.6 are extremely low, due to high institutional delivery and available facilities. (The highest causes of infant mortality are congenital deformation and chromosome abnormality.) High life expectancy (79 years for men and 86 years for women) and a low Total Fertility Rate (TFR) of 1.37 mean the population is naturally
declining, as couples are marrying and having children later, or declining to do so for economic or employment reasons, with the improved social advancement of women.

The population of Kobe declined considerably after the earthquake, but has now reached its pre-earthquake figure of over 1.5 million people. In order to promote increased childbirth, the 2010 five-year Kobe Children’s Health Plan places the value of children in high regard, supporting child-rearing and promoting their healthy upbringing. The lessons of the Kobe earthquake, specifically the need for increased personal interaction in child-rearing, are also incorporated into the Plan, whose key points are:

- maintenance and improvement of mother and child health;
- thorough local support to child-rearing;
- support to working mothers;
- promotion of child-rearing education;
- child safety and security, and improvement of living environments; and
- child care assistance.

(Financial assistance is also provided for fertility treatment to couples who are categorized as infertile; unable to have children over a two-year period.)

Upon discovering their pregnancy, all women are given free consultation services with public nurses at their local ward office, when they are issued with a mother and child handbook and a maternity badge to wear in public so that others know they are pregnant. Consultation gives the opportunity for the local government to identify high risk pregnant women, such as the young, unintentionally pregnant, those with economic burdens, the unmarried, or pregnant with multiple babies. The ward offices assess the needs of all expecting mothers, and reassure them that they will receive all necessary support throughout their pregnancy and child-rearing, including further regular consultations, financial support (e.g. coupons for medical check-ups) and home visits. Sixty per cent of pregnant women go to their ward office by the 11th week of their pregnancy. They undergo a recommended total of fourteen regular check-ups at medical clinics, once every four weeks up to the 23rd week of pregnancy, every two weeks until the 36th week, and then once a week prior to giving birth. Fathers-to-be are encouraged to attend prenatal group classes at weekends, to appreciate the burden of pregnancy. In the classes, they wear baby-sized and weighted vests, and practice bathing life-size dolls. These initiatives, as well as advice given on issues like baby weight and Sudden Infant Death Syndrome (SIDS), serve to ease the anxiety of mothers, who are visited again after giving birth by a public nurse, to have their concerns assessed and be screened for postpartum depression (using the Edinburgh Scale questionnaire). If they are suffering anxiety, mothers are encouraged to arrange child care or get medical help. This kind of support and monitoring also helps prevent the abuse of children.

Group baby examinations are conducted at ward offices for four, nine, eighteen-month and three year-old children, to check their health condition (ear, nose, eyes etc.), and to administer the BCG vaccine and dental treatment. These give mothers the chance to meet each other and form child-rearing circles, in which volunteers assist and lectures are given on themes like nutrition and promotion of picture book reading. Special group classes are arranged for children with disabilities, low birth weight (under 1.5 kg), or for multiple birth children.

To foster the next generation of parents, classes are held at primary schools for children to meet, interact with and experience holding babies, which parents and local volunteer groups also attend. For adolescents, sex education is given to middle school students by visiting public nurses, and to address the rising incidence of diseases such as HIV/AIDS and around 250,000 annual abortions in Japan, adolescent peer counseling is arranged for university students to educate high school children, frankly discussing issues like the risk of Sexually Transmitted Diseases (STDs).

Kobe City Government continues its work to increase the appreciation of the value of children, and provide comprehensive support to encourage healthy child-rearing, in agreement with the national government on the importance of increasing the fertility rate.

On 10 June, the participants of the AUICK First 2010 Workshop made a courtesy call on the Mayor of Kobe and Chairman of AUICK, Mr. Tatsuo Yada (seated front, center left).
Kobe Minatonomori Park

As part of the First 2010 Workshop program, participants visited Kobe Minatonomori Park, a 5.6 hectare disaster prevention and recreation area, planned and built as a symbol of the city's post-Great Hanshin-Awaji Earthquake recovery. The park characterizes Kobe citizens' involvement in city planning and project implementation, in keeping with the culture of volunteerism which took root in the aftermath of the earthquake and is strongly promoted by the city. From an early stage, local residents were invited to take part in workshops and discussion sessions for the park's planning, which was finalized in March, 2007. They then participated in the cultivation of its wooded area and multipurpose playing field. A first gathering for tree planting in March, 2008 attracted 190 volunteers, who planted over 1,000 trees. The second meeting a year later was attended by 188 participants, who planted a further 500 trees. Turf was potted in May 2009, and then planted a month later by 442 citizens, to make a field of 12,000m². Residents also assisted in the planning and construction of the park's facilities for public events (such as those for sharing experiences and lessons of the earthquake), a nursery garden to cultivate young trees and flowers, basketball and skating areas and a running track.

For the park to be used as a disaster shelter, Kobe City Government has also installed temporary toilets and a warehouse, stockpiled with one day's disaster relief supplies for up to 2,000 people. These include 2,000 blankets, 2,000 Survival sheets, 2,016 bottles of drinking water, 1,000 portions of dried rice rations, 1,050 crackers, 2,016 cans of food and 40 canisters of dried milk. The Government's Industrial Development Bureau annually reviews and renews these items.

Since the park's opening in April, 2010, ongoing participation by citizens in its management and operation is promoted and overseen by the Minatonomori Operation Committee.

Disaster Reduction and Human Renovation Institution

Participants of the First 2010 Workshop also visited the Disaster Reduction and Human Renovation Institution, in the HAT Kobe area, which was redeveloped to provide housing following the Great Hanshin-Awaji Earthquake. The Institution is both a memorial to the victims, and a research and exhibition center to disseminate the lessons of the earthquake to future generations, and visitors from around the world.

The West Building houses two film theaters, a reconstruction area and extensive exhibitions, which vividly depict the destruction caused by the earthquake in Kobe, and document citizens' efforts to rebuild their city. An exhibition of videos, personal accounts and possessions, as well as a "Storytellers' Corner" provide first-hand accounts of those who experienced the disaster, and show their determination to recover, and the culture of volunteerism and community spirit which resolves the city to be prepared for future disasters.

The Institution also conducts research on disaster prevention methods and technology, whose results are displayed as short films, exhibits, games and demonstrations. These show effective earthquake-proof building techniques, emergency equipment and safety measures, for visitors of all ages to learn about disaster preparedness. A gallery, library and seminar facilities provide further information.
Kobe City Medical Center General Hospital

Also as part of the First 2010 Workshop, participants visited the construction site of the new Kobe City General Hospital on Kobe’s reclaimed Port Island, due for completion in March, 2011.

After the thirty-year lifespan of the city’s previous general hospital, the new building is designed to be disaster-resistant and environmentally sound, and to incorporate recent advances in medical technologies. With 700 beds (including two class-one infectious disease and eight class-two infectious disease beds), four-bedded disaster emergency rooms and rapid transportation of patients by helicopter (via a roof-heliport), it will become the city’s main hospital, designated as an emergency medical treatment center; class-one infectious disease and disaster relief hospital; AIDS care core hospital; regional perinatal medical center; and regional cancer medical care hospital. It is situated ten minutes by road from the center of Kobe City, with direct access to a monorail station, for an expected 2,000 patients per day. The three-building construction will cover 21,000m² of a total lot area of 46,000m², which gives room for its expansion, and also an open space for disaster emergency activities. Total floor space of 82,000m² will be on nine floors above ground and one subfloor. False floors and external walls are fitted to equipment shafts, wards, and examination and consultation rooms, so that they can be easily repaired or modified to respond to medical and technological advances.

The hospital has as its philosophy to provide care to pregnant women, and children from birth to adulthood. Its universal design is developed from the viewpoint of patients’ and families’ privacy and accessibility, in consideration of seniors, physically challenged, and women and children. Facilities include rooftop and maternity gardens, multi-purpose toilets for baby changing, a 24-hour nursery center, private rest areas for patients and staff, shops and resident health libraries, and non-step / level change floors. Outpatient medical examination rooms, physiological testing and general photography are installed on the same floor to reduce patient movement, and the spread of infectious diseases within the hospital will be prevented by inhibiting the generation and accumulation of dust and germs, such as through attaching water faucets to the walls, rather than the floors.

The previous city hospital was badly affected by the Great Hanshin-Awaji Earthquake of 1995, which caused sub-floor liquefaction, and damage to medical equipment, furniture, water tanks, and cleaning and sanitary facilities, as well as loss of power and water supplies, which prevented operations from being conducted for a full week. The new hospital has a partial steel frame, reinforced concrete seismic isolation structure, to absorb around half of the shock of an earthquake of the same magnitude. It is built to withstand a major tsunami or cyclone, with a ground floor raised seven meters above sea level. Power sources are electric, gas and oil, with combination and emergency back-up generators in case one or more systems fail, and all equipment has double power lines in case one line is damaged. Three water sources (piped, reused and rain water) provide emergency reserve supplies.

The various disaster-emergency resistant measures add approximately 10 per cent to the building construction cost and 5 per cent to the cost of equipment, but the hospital is built relatively cheaply (around JPY290,000 per m²), through the Private Finance Initiative (PFI). This system creates public-private partnerships (PPPs) of private capital funding public infrastructure projects.

The hospital’s design incorporates the use of heat load control (through a rooftop garden), double-glazed glass and natural resources (solar energy, wind power, rainwater and natural light). Energy use and carbon dioxide CO² are reduced through the utilization of gas and electricity complex to optimize heating sources, and Building Energy Management Systems (BEMS) for comprehensive and continuous energy management through consumption monitoring in each department. These measures have won the hospital the highest ranking of Japan’s CASBEE (Comprehensive Assessment System for Building Environmental Efficiency), showing the city’s commitment to environmentally designed, as well as disaster-resistant infrastructure.

The East Building of the Institution focuses on water resources and water related natural disasters. It houses film theaters and a gallery on the Great Hanshin Flood, which devastated Kobe in 1938, as well as other international disasters and disaster reduction organizations, with a discussion lounge and computer-based educational equipment for interactive learning.

The Institution is run by volunteer citizens, many of whom are retired, but keen to continue playing an active role in sharing their experiences and the lessons of the earthquake, to help prevent such tragedies before they occur.
UNFPA Seminar

UNFPA Seminar: Asian Cities and Disaster Preparedness - Increasing Capacities for Maternal and Child Health Care

On 11 June 2010, AUICK held a UNFPA Seminar on the activities of UNFPA and AUICK. Panels included the First 2010 Workshop participants and representatives of Kobe City Government and UNFPA Asia and the Pacific Regional Office. Around 200 citizens of Kobe attended.

In his opening address to the Seminar Mr. Toshihiko Ono, Executive Director of AUICK, welcomed the citizens of Kobe, and outlined the role of AUICK to disseminate population data, information and best practices in service provision to urban areas in Asia, with the support of Kobe City Government and the United Nations Population Fund (UNFPA). He introduced the Facilitator of the Seminar, Ms. Kiyoko Ikegami, Director, UNFPA Tokyo Office, and Mr. Najib Assifi, Deputy Regional Director, UNFPA Asia and the Pacific Regional Office, and Representative, UNFPA Thailand Office, who spoke on the guiding principles of UNFPA and its activities in disaster prevention and management.

The United Nations Population Fund operates through its headquarters in New York, five Regional and over 110 Country Offices, to support population, development and reproductive health programmes. Its guiding principles are the Programme of Action of the International Conference on Population and Development (ICPD) and the eight Millennium Development Goals (MDGs) formulated at the ICPD Programme of Action of the International Conference on Population and Development (ICPD) and the eight Millennium Development Goals (MDGs) formulated at the Millennium Summit in 2000. These shape UNFPA's vision as an international development agency to promote the right of every woman, man and child to enjoy a life of health and equal opportunity. It supports countries to use population data for policies and programmes to reduce poverty, and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

The ICPD Programme of Action, adopted by 179 countries in 1994, links population issues with development, as a twenty-year programme to be achieved by 2015, which emphasizes that without equal opportunities and rights, women cannot contribute to the development of a society. Its goals include:

- universal access to reproductive health services by 2015, requiring UNFPA's work with governments to make reproductive health services including information, clinics and counseling, reach everyone;
- universal primary education and closing the gender gap in education by 2015, as in some areas boys have more access to education than girls;
- reducing maternal mortality by 75 per cent by 2015, as thousands of preventable deaths are caused annually by complications in pregnancy;
- reducing infant mortality - many newborn babies die in developing countries;
- increasing life expectancy, which is still low in many developing countries; and
- reducing HIV infection rates, which are high in many Asia-Pacific countries.

The 189 member states at the Millennium Summit in 2000 agreed to significantly help the world's poorest countries through eight interlinked Millennium Development Goals (MDGs), the results of a series of international conferences on children, population and development, human rights, women, social development, HIV and AIDS and financing for development. As guiding principles for UNFPA, their achievement will increase development in all countries.

The UNFPA Asia and the Pacific Regional Office (APRO) addresses the technical needs of countries in the region to improve maternal health, family planning, gender rights and young people's sexual and reproductive health, and to reduce teenage pregnancies and the spread of HIV/AIDS and sexually transmitted infections (STI). It works with hundreds of universities and institutions to collect and analyze population data, and to advocate for its incorporation into development planning. For disaster situations, it procures and distributes commodities for reproductive health, including medicines, contraceptives and equipment, working with other UN agencies, national governments and NGOs.

Following comments by Mr. Assifi, the city government and academic representatives of five AUICK Associate Cities (AACs) spoke on the issues their cities faced related to maternal and child health care in disaster settings, and the challenges of Kobe City were presented by Ms. Yukiko Tanaka, Manager, Community Health Promotion Division, Public Health Department, Public Health and Welfare Bureau, Kobe City Government. The Seminar audience then posed questions to the panel.

Comments, Questions and Answers

1. How is Japan supporting the achievement of the Millennium Development Goals (MDGs)?

UNFPA is most appreciative that Japan is among its top five donor countries, enabling its effective work in many countries. The fifth MDG, universal access to reproductive health and a reduction by three quarters in the maternal...
mortality ratio, is more difficult than others to achieve, in part due the inaccessibility to pregnant mothers of clinics in remote areas which lack adequate roads or transportation, and the social issue of families preferring home deliveries where there is no medical assistance in the case of complications. Preventing maternal deaths caused by complications during delivery is not only the duty of health ministries, but also other sectors such as those in charge of transportation and road networks. Countries have plans to improve maternal health care, based on evidence and data, but resources must be directed to where they are needed. All countries and agencies in development work must address such pertinent issues together, through a more coordinated approach of donors and intergovernmental sector support.

Japan has made significant progress to achieve the fourth and fifth MDGs; to reduce child mortality and improve maternal health care. The Japan International Cooperation Agency (JICA) is involved in international support to maternal and child health care, and Kobe can share its experience with other countries. Such organizations as SAARC (South Asian Association for Regional Cooperation) also strengthen political commitment to achieve development goals. Much is achieved, but much more needs to be achieved, through the promotion of bilateral and intergovernmental support.

Does the promotion of equal rights for women and children include opportunities for their participation in policy making?

UNFPA promotes involvement of women and youth in the formulation of programmes and policies to address maternal and child health. The most effective policies start with assessment and feedback, and effective programme design requires the views of target beneficiaries, such as those of young persons for strategies to improve adolescent sexual and reproductive health.

Is there any duplication among United Nations agencies in their provision of maternal and child health care support?

Three main agencies provide health care assistance: the World Health Organization (WHO) helps governments in setting national and global standards for health care and conducts activities for global pandemic prevention (such as in the cases of SARS and Bird 'Flu), the United Nations Children's Fund (UNICEF) primarily works in child health and survival, and UNFPA focuses on reproductive health and related areas targeting women and girls. Here, UNFPA and UNICEF work is close but not duplicated, as they plan and work together in country teams. Disaster contingency planning is developed to involve all agencies and define their roles through the "cluster" approach, minimizing duplication.

What is the status of post-disaster psychological care to women in the AUICK Associate Cities (AACs)?

This varies among cities. Psychological support provision to disaster victims by medical workers, volunteers and NGOs was increased in Chittagong (Bangladesh) and Chennai (India), following the 1991 cyclone and the 2004 Sumatra Earthquake Tsunami, respectively, and in Danang (Vietnam), many local organizations provide support. Less psychological support is provided in Olongapo (Philippines), and Weihai (China), where local welfare volunteer communities will receive training on psychological support as a result of this Seminar.

Have the lessons learned from Chittagong’s natural disasters increased local capacities for disaster management?

In 1991, there was no information or advance warning of a cyclone which killed over 130,000 people. Flood waters rose by 10-15 feet and submerged homes, where many women were trapped, unable to climb or swim, wearing heavy saris and lacking shelter protection. Since then, the development of extensive community training on disaster preparedness (especially to mothers and children on health care measures), and advance storm warning systems through the media and local volunteers (enabling people to seek shelter while their properties are protected), mean that a cyclone of a similar intensity in 2007 caused the significantly lower loss of life of 4,000 people.

In conclusion to the Seminar, Dr. Hirofumi Ando, President of AUICK, summarized the key points it had raised.

There is strong recognition that natural disasters will continue to occur when they are unexpected, and their frequency will increase with the effects of global warming. In Japan alone, typhoons in 2009 were more numerous and occurred later in the year than usual. Natural disasters cannot be predicted, so we need to be prepared for all types, from typhoons and floods, to earthquakes and fires. The aftermath of the Kobe earthquake showed that the local community is the first source of assistance after a disaster occurs, before local or national government help arrives. So, to be effective, disaster preparedness should be based on networks of community participation.

Since the AUICK Second 2007 Workshop on Maternal and Child Health Care in Natural Disasters, there has been significant development in the preparedness of the six cities represented at the Seminar, both physically (through shelter provision), organizationally (through disaster information and training provision), and in the supply of commodities, supported by UNFPA. Post-disaster management is also critically important, especially health care for mothers and children, on which we need to learn and disseminate more in the future, so that effective programs can be developed.
After its inauguration in 1969, UNFPA focused on population data, population growth and family planning. The landmark 1994 International Conference on Population and Development (ICPD) and its Programme of Action (POA) changed its mandate to one that "promotes the right of every woman, man and child to enjoy a life of health and equal opportunity". It "supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect."

In the Asia-Pacific region, UNFPA works through its Regional Office in Bangkok, two Sub-Regional and 23 Country Offices, to advocate for national ownership, leadership and capacity building to implement the ICPD agenda, with other UN agencies, as well as national governments and civil society.

The ICPD POA was built on three pillars. In population and development, UNFPA promotes data collection and analysis to improve government policies and planning, especially necessary at the city level. In reproductive health, UNFPA works to increase adolescent health care and awareness, HIV/AIDS prevention, antenatal care and safe deliveries, and health care service provision equality for all minority groups. It promotes the incorporation of HIV/AIDS information and counseling services into regular check-ups and community-based information and education services, so that it is addressed at the prenatal stages, and in cultures where the issue is sensitive. Gender and equality are addressed as cross-cutting, applicable to all areas of service provision.

The Asia-Pacific region is particularly prone to often unpredictable natural disaster emergencies and human conflict. In chronic refugee and Internally Displaced Person (IDP) settings and post-disaster and conflict recovery (which can present security issues for emergency workers), UNFPA provides temporary health facilities and equipment, and builds reproductive health service capacities for rapid and widespread assistance to the most vulnerable populations - particularly women and young girls. Such humanitarian work requires effective leadership and coordination, adequate, timely and flexible financing, and the "cluster approach" of multi-sector service provision. In disaster situations, it is especially difficult for services to reach affected populations, so UNFPA also works with governments, NGOs, Faith Based Organizations (FBOs) and civil society, which can be more flexible, understanding of cultural barriers, and effective in accessing local communities.

Accurate data and gender analysis improve both disaster response planning and post-disaster reconstruction. And contingency plans should list the medical resources available in each area, and outline how they can be mobilized in a disaster situation within 24-48 hours. Each country's needs, emergency preparations and also development assistance planning are incorporated into UN Common Country Assessments (CCAs), reflected in the Development Assistance Framework (UNDAF). To be effective, these complement national government planning, and follow Inter-Agency Standing Committee (IASC) guidelines for the UN in emergencies. Once formed, plans are pre-tested, exercised and drilled at national and local levels. If population related data is unavailable in a disaster situation, UNFPA rapid assessment teams establish the number, gender and age of an affected population, using such technology as Global Positioning Systems (GPS) so that assistance can be effective. (A national government can also influence delivery speed by relaxing policies to let aid cross its borders.)

UNFPA stockpiles 14 kinds of emergency health care kit to support contingency planning, available immediately by contacting any of its Country Offices. These range from safe delivery materials for birth attendants, to mobile hospital emergency ward units to serve up to 30,000 people. An immediate disaster situation procedure is the Minimum Initial Service Package (MISP), a set of priority activities for trained staff to implement, incorporating instructions and commodities to identify coordination mechanisms; prevent gender-based violence and excess neonatal and maternal mortality (through reproductive health kits and a referral system); reduce HIV transmission (through contraceptive provision); and plan for comprehensive reproductive health services, as each situation permits.

These measures recently supported disaster relief efforts in Myanmar, Pakistan and Sri Lanka, where UNFPA provided rapid needs assessments, strengthened referral mechanisms, gender based violence prevention support, hygiene and maternity kits, MISP training, mobile and static reproductive health clinics, maternity waiting homes for women at high risk, sexual reproductive health / HIV protection services, and livelihood and psychosocial support, in conjunction with community health volunteers.
City Reports and Revised Action Plans

Action Plan Guidelines

During AUICK Workshops, the participants of AUICK Associate Cities (AACs) formulate Action Plans to implement the lessons they have learned as policies to improve their cities' service provision. The First 2010 Workshop participants were given guidelines to revise Plans made at the Second 2007 Workshop, based on each city's requirements in disaster management planning and maternal and child health care provision.

Firstly, each Plan should specify the problem or issue it aims to address. Then, the government department(s) and personnel to oversee the Plan's implementation and its stakeholders are specified. The Plans should detail each type of support to be achieved for their implementation, in terms of political, financial, community, academic, NGO or faith based organization assistance. The local media also often plays a role in mobilizing citizen participation, an important component for projects to be successful.

In many cases, a Plan's first step is its advocacy to senior political officials, including the city mayor and relevant government department heads. Many Plans begin as pilot community projects, achievable within the capacities and resources available to each Workshop participant. These are then expanded city-wide, or further, and can also be duplicated upon their successful completion.

Monitoring and implementation progress reporting then assist the Plans' implementation, as well as AUICK's assessment of its Program. A timeframe lists each Action Plan's actual steps, and the period of the steps' sequential or simultaneous / overlapping implementation, which usually amounts to around 18 months to two years.

Chittagong, Bangladesh

Chittagong, along the shore of the Bay of Bengal, is often affected by cyclones and flooding. The Action Plan for the city aims to improve its disaster preparedness, as well as overall maternal and child health care programs.

Dr. Subash Chandra Roy
Principal, Laboratory Medicine, Institute of Health Technology, Chittagong

Mr. Mominur Rashid Amin
Private Secretary to the Mayor, Chittagong City Corporation

The City

Chittagong is the second largest city, major port, and also referred to as the commercial capital of Bangladesh. It is situated on the bank of the Karnaphuli River and the Bay of Bengal, surrounded by hilly terrain, covers an area of 158 km², and has a population of about five million people. It began to grow as a tiny municipality in 1863 and was renamed Chittagong City Corporation in 1990, which is now divided into 41 wards.

Due to its geographical location, Chittagong suffers from natural disasters. The funnel-shaped northern portion of the Bay of Bengal causes tidal bores, and cyclones cause landfalls. Other types of natural disaster like floods, fires, landslides and earthquakes have also occurred. The most devastating recorded natural disasters to have hit Chittagong are the tidal bore and cyclone disasters in 1970 and 1991, which claimed the lives of over 300,000 and 130,000 people, respectively.

Cyclone shelters have been constructed in the coastal region, which has also been heavily protected with concrete levees and forestation on its embankment. Chittagong City Corporation is improving awareness and warning systems in the community, and has formed the Disaster Management and Relief Committee, maintaining an alert volunteer force, Red Crescent Society and conservancy team. It also provides emergency healthcare facilities and services in all 41 wards, which include food and medicine, transportation, ambulances, fire brigade services, drinking water provision, doctors, nurses, and rescue boats.

Chittagong City Corporation's arranging of maternal and child health care prioritizes newborns and children, to include special care for pregnant women and lactating mothers, neonatal and postnatal care, and intrapartum and immediate postpartum care. The Corporation oversees urban primary healthcare, dispensaries, a midwifery institute, the city's pharmaceutical industry and two hospitals, and organizes medicinal supplies for slum residents, immunization programmes, population growth monitoring, disposal of medical waste, proper surveillance and food safety programs.

Action Plan Progress

The Action Plan formulated at the Second 2007 Workshop established 41 ward level Disaster Management Committees under the guidance of the Central Disaster Management Committee...
Committee, headed by Mayor of Chittagong City Corporation. These conduct disaster management activities with the extensive participation of ward councilors, government officials, the district administration, Chittagong Development Authority, the fire service, NGOs, the Red Crescent Society, community leaders, teachers, health workers, students, volunteers and other city development agencies.

With the allocation of funds from the central government, donor agencies, NGOs and local elites, the City Corporation has also initiated its own fund for disaster management, and is operating a control room to disseminate signals / warnings and receive information from different parts of the city. This enables it to provide logistical support and immunizations, and organize the disaster management team, arranging evacuation, rescue, relief aid and rehabilitation activities for citizens at short notice.

**Proposed Action Plan Revision**

Revisions to the Action Plan made at the First 2010 Workshop aim to increase disaster preparedness and maternal and child health care services. Disaster planning and management programs will be improved through multi-sector coordination among concerned officials, local representatives, community leaders, NGOs, donor agencies and the district administration. The proper implementation of funding will improve warning systems, cyclone shelter construction, blood transfusion programs, family planning and counseling services, emergency transportation (including boat clinics), communication systems, a quick referral system, regular mother and child health care check-ups, and emergency disaster plan demonstrations and drills.

The Plan also aims to reduce maternal mortality and morbidity rates, by increasing antenatal, postnatal and neonatal obstetric care, birth and child rearing assistance, safe and clean deliveries, and availability of midwives, nurses, doctors, birth attendants and essential medicines. School and college students, girls guides, scouts and the Bangladesh National Cadet Core (BNCC) will also participate in the Plan. Based on knowledge from the AUICK Workshop, measures will be taken to prevent sexual violence, HIV transmission and water borne diseases, and improve vaccination and nutrition programs.

Detailed planning and meetings will be arranged for city officials, councilors, and health workers of the city clinics, hospitals, urban primary health care and HIV/AIDS centers. Then, a detailed proposal will be made, with the consultation of academic experts, to ascertain priority and resource availability. These resources will be arranged from Chittagong City Corporation itself, the central government, and domestic and international donor agencies. To create awareness among the community and concerned officials, advocacy meetings, workshops and training on MCH and rescue operations will be held. The Plan will cover the entire city, supported by the local electronic and print media, schools and local mosques / temples.

**Chittagong Action Plan Time Frame: June 2010 - March 2012**

| 1. Report to Mayor                    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 2. Discussion with colleagues         |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| and concerned officials               |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 3. Consultation with academic experts |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 4. Budget creation and allocation     |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 5. Motivation and advocacy            |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 6. Training and workshops             |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 7. Briefing to media and community    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 8. Procurement of equipment and       |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| materials                              |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 9. Repair and construction of         |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| shelter centers                        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 10. Supervision and monitoring        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 11. Coordination                       |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 12. Implementation and continuation    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

**Weihai, China**

An AUICK Action Plan for Weihai has established local welfare communities to improve citizens' disaster preparedness. These will be expanded and promoted by the Municipal Government in the revised Plan.

**Mr. Sun Lin**  
Chief Engineer, Weihai Construction Committee

**Dr. Li Chunrong**  
Chairman, Obstetrics and Gynecology, Weihai City Hospital

**The City**

Weihai is a medium-sized city with a total population of 2.5 million, situated 641 kilometers from Beijing in Shandong Province. The city suffers from such natural disasters as droughts, typhoons, snow and hail
storms, earthquakes, floods and storm surges, such as on 4 March, 2007, when winds reached force 13, and an astronomical tide with a maximum seawater level of 321cm resulted in three deaths, seven missing and thousands of evacuees from 300 collapsed and 6,000 damaged homes. Direct economic loss was more than one billion yuan.

Weihai’s MCH system started in 1966. With the development of the economy and the increasing urban population, the system has been enhanced from medical treatment to include precaution, recovery, birth control and health education measures. The birth, death, infant, child and maternal mortality rates have gradually declined, as has the total fertility rate, since 1975.

In response to various natural disasters, the City Emergency Command System went into operation in 2009, using modern information technology to provide comprehensive disaster relief, and multi-angle, cross-platform decision support capabilities. The city has issued the Natural Disaster Contingency Plan for Weihai City, as an administrative guide to natural disasters and disaster relief work. The private sector is involved in contingency plans for severe weather, ice storm surge and earthquake emergencies, and Weihai Municipal Government is currently drawing up the Annual Training Plan, which will serve as a further guide. Lessons from drills and training are incorporated into the emergency plans, through their highlighting of practical problems, and the plans are constantly revised.

With the assistance of experts, the Ministry of Education educates school students on earthquakes, and various organizations assist in arranging disaster reduction knowledge contests, and widely publicizing earthquake-related information to teachers, students and parents in the Public Safety Knowledge Handbook. In 2010, Weihai Municipal Government has set up primary and secondary emergency evacuation drill groups to further strengthen its disaster prevention organization and leadership.

### Action Plan Progress

The Action Plan of the AUICK Second 2007 Workshop set up a Disaster Prevention Welfare Community Committee in the Government, including representatives of the Health Bureau, Weather Bureau, Construction Commission, the Bureau of Civil Affairs and the State Seismology Bureau. Then, local community welfare schools were set up in 10 of 268 communities of the city. These provide training to citizens on health, safety, disaster prevention and disaster relief, and are operated by 210 volunteers, including doctors, teachers, nurses and other health workers. The next step is to summarize the experience of the 10 pilot programs, and study other programs, in order to popularize the experience to the rest of the 258 welfare communities in the city.

### Proposed Action Plan Revision

The revised Action Plan will promote the welfare communities already established in Weihai, specifically towards the establishment of 10-20 new local community welfare schools. A new committee will also be set up to deal with the issue of mothers, children and older persons during disasters, and old buildings in the city will be renovated to improve their disaster resistance.

Overall, the Plan will improve capacities of the Government and citizens to prepare for and respond to natural disasters, as well as drawing attention to the needs of mothers and children. The Bureaus of Health, Welfare, Education and Civil affairs, the Women’s Federation and the Construction Commission will implement the Plan, in collaboration with doctors, nurses and volunteers of the local welfare communities. Funding will be from the Government and social funds, and the local media and schools / universities will provide further support.

### Weihai Action Plan Time Frame: June 2010 - December 2011

<table>
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<tr>
<th>Steps / Actions</th>
<th>June</th>
<th>July</th>
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<th>September</th>
<th>October</th>
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<tr>
<td>1. Present report to Weihai City Government</td>
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<td>2. Formulate a general plan to elect 10-20 welfare communities to set up community schools</td>
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<td>3. Set up 10-20 community schools</td>
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<td>4. Set up a committee for women and children during disasters</td>
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<td>5. Reconstruction of old houses and other buildings</td>
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<td>6. Give guidance and examine the work of new welfare community schools</td>
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<td>7. Give guidance and examine the work of the committee for women and children</td>
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Chennai has developed good infrastructure for maternal and child health care. Improvements will be made to the provision of this care during flooding and other disasters, through a revised Action Plan.

Dr. Charumathy Baskaran
Deputy Project Coordinator, District Family Welfare Bureau, Corporation of Chennai

Ms. B. Jothi Nirmalasamy
Deputy Commissioner, Health and Family Welfare Bureau, Corporation of Chennai

The City
Chennai is the capital city of the state of Tamil Nadu. It has a metropolitan population of 5.7 million people, of which 25 per cent are classified as living in slum conditions. The low lying areas of the city are prone to floods during the annual southwest monsoons from November to January. The civic authority, along with Government and NGOs, carry out relief works, providing food, shelter and medical emergency services. Storm water drains have been built all over the city, and many existing drains have recently been reconstructed.

The major unexpected natural disaster to hit the city was the Sumatra Earthquake Tsunami of 26 December, 2004. Chennai is only four feet above sea level, and the disaster caused huge loss of life and damage to property. The Tsunami was a trigger for the city to revive disaster management strategies. Housing schemes for coastal residents have been taken up as an emergency measure, and the Government, with the help of private organizations, has constructed permanent, non-vulnerable houses for the Tsunami affected people, which has improved the living conditions of those below the poverty line.

Chennai has good infrastructure with regard to maternal and child health. A standard health system is implemented, and the Government and Corporation of Chennai cater to the health needs of middle and lower income groups. The private hospitals of the city attract patients from all over the world, especially in the fields of cardiology, ortho, renal and neurology.

Infant and maternal mortality rates are lower in the city compared to state and national levels. The well-equipped hospitals handle all cases of maternal and child emergencies, and training of medical and paramedical workers on new technologies, as and when required, has paved the way for improvement in this field.

Disaster preparedness planning for MCH care has already been included in policy decisions, and training programs at all levels are being undertaken. Problems faced are related to (1) conservative practices in families; (2) low awareness regarding hygienic practices; (3) everything happening seen as "fate" or left to "God"; (4) non-cooperation in times of mock-drills; and (5) family decisions being taken only by men and older women.

Action Plan Progress
During the Second 2007 Workshop an Action Plan was developed to create a structure to plan for maternal and child health care during the predictable annual flooding, focusing on the preparedness for the first 48 hours, before outside help arrives. It successfully conducted the following steps:

- evaluation of the risk of cyclone or tsunami flooding for all areas of Chennai;
- mapping of high risk and safe areas using Airborne Laser Terrain Mapper (ALTM) technology, which will lead to flood mitigation works in vulnerable areas;
- identification of 43 schools in elevated areas for use as safe shelters;
- planning for mobilization of relevant officials through District Coordination Committee meetings with various organizations, mock drills by emergency services, readying of cyclone shelters, media participation and inter-departmental coordination planning;
- stock piling of medicines and water, machinery and equipment at designated shelter areas;
- provision of sanitary facilities at shelters for women and children who have special needs;
- development of individual disaster plans by relevant agencies, integrated with the citywide plan; and
- appointment of local disaster coordinators responsible for linking Government and NGO services at the local level.

Some issues have inhibited the Action Plan's comprehensive implementation. There was difficulty in locating evenly distributed safe shelter areas in all of the flood prone areas, and some shelters were distant or inaccessible to slum residents. Sanitary facilities are still not sufficient for women and children with special needs, and are prone to cause diarrheal diseases during flooding. Some agencies have developed disaster prevention plans without proper documentation, and the integrity of some local NGOs involved is also sometimes questionable.

Proposed Action Plan Revision
Revisions to the Action Plan focus on redressing these issues by locating evenly distributed safe shelters, increasing sanitary shelter facilities for women and children, providing MCH in disaster training to relevant agencies and women's self-help groups, and obtaining community support for transporting, relocating and rehabilitating mothers and children in disaster situations.
Further to the original Plan, steps will also be taken to improve flood water management, by distributing flood maps to stakeholders, and constructing storm drains and flood-resistant concrete housing for slum dwellers. The effects of flooding will be mitigated by ensuring the free flow of water from the city through the improved drainage system of storm water drains and de-silted waterways.

The Plan will be implemented by the Health and Family Welfare Department of Chennai Corporation, with zonal administrators, the Revenue, Police and Public Works Departments, Metro Water, the Slum Clearance Board and the Electricity Board. The Commissioner of Chennai Corporation will be the official coordinator and NGOs / community organizations will participate.

Funding for the Plan will be allotted by the city, state and central governments, and after its implementation in Chennai City, the Plan’s expansion to the Greater Chennai area of 6,200,000 people will be proposed. Local media and religious groups will promote the Plan to increase public support, colleges will partake in disaster training and mock drills, and medical students will enroll as volunteers to offer help during times of disasters. Lists will also be drawn up of possible blood donors and their blood groups. The Plan will be monitored by local councilors, heads of each relevant department at the city and state level, and the Mayor and Commissioner of Chennai Corporation.

### Chennai Action Plan Time Frame: June 2010 - December 2011

| Steps / Actions                                                                 | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D |
| 1. Submission of the Action Plan to the Worshipful Mayor and the Commissioner of Chennai Corporation and obtaining of their approval |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 2. Distribution of City Disaster Management Plan and city flood map to all stakeholders |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 3. Appraisal of the Action Plan to the media thus ensuring their support for implementation and for creation of awareness among the public |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 4. Holding of all-department meeting to explain the Action Plan and to sensitize about the roles of each department |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 5. Obtaining / sanctioning of funds for maintenance and construction of storm water drains and de-silting of water ways to prevent flooding, and for construction of concrete houses and improved shelters with necessary sanitary facilities / related issues |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 6. Maintenance and construction of storm water drains and de-silting work |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 7. Construction of flood resistant concrete houses for the slum population |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 8. Laying and repairing of water supply lines by Metro Water for ensuring protected water supply during disasters |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 9. Locating evenly distributed safe shelters |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 10. Improving sanitary facilities to meet the special needs of women and children |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 11. Ensuring support from students and teachers by addressing them separately |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 12. Training of all women’s self help groups in maternal and child health care during disasters |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 13. Training of relevant agencies and the community in transporting, relocating and rehabilitating the affected, especially mothers and children, during times of floods |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 14. Conducting of mock drills involving students, self-help groups, NGOs and the community |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 15. Informing of the public through the media by the Worshipful Mayor about the preparedness of the Administration for facing future disasters |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

### Olongapo, Philippines

Typhoons and flooding are increasingly affecting Olongapo. AUICK Workshop Action Plans have created a Disaster Volunteer Brigade (DVB), for community members to augment the activities of the Government's Disaster Management Office.

**Olongapo City, with a population of 227,270 is located in the southernmost portion of Zambales Province, Philippines. Spanning a total land area of 18,500 hectares, and topographically characterized by mountainous terrains...**

**Dr. Arnildo Castro Tamayo**  
City Health Officer, City Health Department, Olongapo  
*City Government*

**Dr. Victor dela Cruz Quimen, Jr.**  
Dean, College of Nursing, Gordon College, Olongapo  
*The City*

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**December 2010**  
AUICK Newsletter No.55
located along the Manila Trench and perimeter of Mount Pinatubo, the city remains geographically vulnerable to natural disasters. In June 1990, with an epicenter situated along the northern cities of Luzon, a 3.6 magnitude quake reverberated through Olongapo, causing structural damage. In June 1991, the climactic eruption of Mount Pinatubo caused major disruption to the city's socio-economic infrastructure, and sent destructive volcanic debris across international borders. Typhoon Ruiz in 2006 caused a landslide in the mountainous area of Cabalan village, with consequential loss of lives and property.

While the extensive damage wrought by natural disasters may have been a painful learning experience, it nonetheless prompted the city's governing body to take action. Since creating the Disaster Management Office (DMO), the city has been able to responsively manage emergency situations and categorically prepare for natural calamities. A Disaster Volunteer Brigade (DVB) is likewise in the pipeline to complement the DMO's structure, especially with the recent effects of climate change causing unconventional "super-typhoons" and flash floods. Armed with a solid contingency plan, functionally equipped manpower and effective local leadership, Olongapo City's Disaster Preparedness Program has in recent years been aptly recognized as having one of the best local disaster response teams in the country.

The city's health care status is at a comparatively high level against national or regional standards. Operating on a dichotomized health care delivery system, preventive health care is being managed under the City Health Office, and curative health care through modern tertiary level hospitals. While population health remains optimally sound, issues still abound with regards to traditional health practices, universal access to social health insurance, and the high risk social environment for sexually transmitted diseases. In order to increase facility based deliveries to improve the Maternal Mortality Rate (MMR), UNFPA supports equipment provision to Olongapo's health centers.

Although local disaster response is effective, the city still needs to work on functionally incorporating maternal and child health concerns into disaster planning. Capacity building on the UNFPA Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations (see page 16) has been initiated, and is pending city-wide implementation. With effective local leadership, manpower, and strong commitment from key stakeholders, the city is now embarking on further mobilizing resources to fully implement a comprehensive Disaster Management Program, so that disasters can be fully mitigated, and that unnecessary loss of life will no longer ensue.

**Action Plan Progress**

The Second 2007 Workshop Action Plan established a Disaster Volunteer Brigade (DVB), for community members to augment the activities of the Government's Disaster Management Office. An executive order was passed for the creation of the Brigade, outlining its organizational composition, role and functions. Then, members were recruited and trained on basic life support, disaster preparedness, the emergency response information system and referral, and the MISP. Awareness campaigns were conducted through the local media, and leaflets and fliers distributed to citizens.

The DVB was mobilized during Typhoon Labuyo and Typhoon Maring in September, 2009, when a state of emergency was declared, with 90 per cent of city roads flooded and 15 of 17 local communities severely affected. The Brigade has been successful in its work with the Government's City Disaster Coordinating Council (CDCC), due to the commitment and support from local leaders, a functionally equipped Disaster Management Office, the infrastructure available, a well established Socio-Economic Information System (supported by AUICK and UNFPA), and support from civil society. Some hindering factors, however, include competing priorities, natural hazard areas, and limited resources and technical capacities.

In the future, reproductive health care will be incorporated into the city's Disaster Management Program, a localized climate change adaptation ordinance will be formulated, resources will be mobilized to upgrade technical capacities and logistics, and successful practices will be replicated for improvement and expansion.

Climate change is expected to result in more frequent and severe hazards, which are likely to increase people's vulnerability, resulting in even more disasters. Ultimately, the success of the Action Plan will be limited unless concerted efforts from all stakeholders and other sectors are coordinated to achieve better health outcomes and effectively mitigate the effects of these natural disasters.

**Proposed Action Plan Revision**

The revised Action Plan of the First 2010 Workshop aims to sustain and expand the activities and membership of the Disaster Volunteer Brigade, by conducting disaster prevention training to the local community, increasing private sector and NGO participation, and raising funds to cover its running costs.

Firstly, the Mayor will be informed on the vulnerability of the city to natural disasters. Members of the DVB will again be recruited from the community, and their roles to augment the activities of the Disaster Management Office will be decided. Training will improve the Brigade's capacity to deal with the increasing threat of climate change related extreme weather conditions, and the private sector and local media will be enlisted for financial and promotional support. To coordinate its work with other organizations, the Brigade will increase collaboration with the Philippine Red Cross and local NGOs, the Soroptomist Group, Lion's Club and Rotary Club.

The Plan will incorporate schools, universities and local religious groups into its collaborative management, and further funding will come from bingo and raffle events, as well as the Philippine Charity Sweepstakes Office (PCS0).
Danang, Vietnam

Through the AUICK Action Plan of 2007, authorities in Danang have supported the incorporation of maternal and child health care into disaster management plans. The revised Plan will further promote disaster preparedness at the community level.

Mr. Nguyen Van Phat
Chief, Social and Cultural Affairs Division, Danang People’s Committee

Dr. Tran Dinh Vinh
Head, Obstetrics and Gynecology Department, Danang Hospital

The City
Danang City is located in central Vietnam, between Hanoi and Ho Chi Minh City, separated from Laos by the western Truong Son Mountains. It covers an area of 1,256 km² and has a population of 887,069 inhabitants, as of 2009, estimated to reach one million by 2014.

Danang is one of the natural disaster-prone cities in Vietnam, a country where disasters annually cause great loss of life, and economic and environmental damage. Due to its location in the tropical monsoon zone with heavy annual rainfall, diverse geological conditions, and fast economic and demographic growth during the last two decades, Vietnam, especially in coastal cities in the central regions like Danang, has suffered all kinds of natural disasters caused by climatic extremes. The most frequent and destructive of these are floods and flash floods, landslides and debris flows, river bank and coastal erosion, and sand storms/flows. In the ten years from 1999 to 2009, Danang suffered the highest number of severe storms in Vietnam’s central region (34 storms). These killed 210 people and destroyed over 15,000 houses, damaging and flooding many more. Total estimated damages to infrastructure were valued at nearly 6,000 billion VND. These disasters also severely affect living conditions, the quality of life of the local people and the socio-economic development rate of the city.

Action Plan Progress
The AUICK Second 2007 Workshop Action Plan for Danang increased the capacity of its Health Department to provide maternal and child health care during natural disasters, with the cooperation of local authorities. It set up the Special City Committee for MCH in Natural Disasters in 2007, which was immediately operational. The Committee is led by the heads of the Health Department and several other departments, supported by the city authorities. The Committee members work in close cooperation with other agencies and health centers, and bi-monthly meetings decide lists of essential disaster contingency measures, which are then submitted to city leaders. These measures were implemented during heavy storms from 2007 to 2009. Authorities realized the urgent need for MCH action and strongly supported and funded all necessary activities. Severe flooding in the city over the period, though, showed that much needs to be done to minimize damages and loss of life caused by...
the storms. Some people, especially women and children, had to stay in temporary shelters with poor conditions while being evacuated. (In all there were 33,920 evacuees over the period.) Others were living in areas which were isolated, completely inaccessible for a long period of time, and lacking food, drinking water and basic health care services. Many families who had been moved to new areas, according to city planning policies, lived in the main path of the flood currents, and had to suffer greatly.

Proposed Action Plan Revision
The revised Action Plan will address the needs for more accurate weather forecasting and adequate communication systems, especially during natural disasters, and identification of vulnerable areas through research and surveys. This will enable relevant departments and agencies to give early warnings to local communities, and conduct evacuations when necessary. Multi-function houses serving as local shelters in natural disasters will be improved, as well as care services for mothers and children, especially after natural disasters occur.

To implement the Plan, the Health Department will work with the Natural Disaster Management and Prevention Centre/Department, the Weather Forecast Station, Police Department, military authorities and the City Council. Funding will be sought from charity organizations and NGOs, in addition to the city's budget. The Plan will focus on the districts in the city's suburbs at high risk of flooding and severely hit by storms, where a strong sense of natural disaster resistant community will be promoted. All individuals and local businesses need to be aware of what to do and how to cooperate before, during and after natural disasters happen. The media will educate on the need and ways to stay prepared, and volunteer students can attend various courses and offer help when required. Charity groups' activities and services from churches and pagodas have always been important in natural disasters, and these will also be promoted. Then, the Action Plan's implementation will be monitored bi-monthly by the Committee for Maternal and Child Health Care, and annually or semi-annually by the City Government.

Danang Action Plan Time Frame: June 2010 - December 2011

| Steps / Actions | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D |
|----------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Conduct committee meetings to prepare lists of action items | | | | | | | | | | | | | | | | | | |
| 2. Conduct a coordination meeting with city leaders and persons concerned | | | | | | | | | | | | | | | | | | |
| 3. Have each action implemented by relevant departments and agencies | | | | | | | | | | | | | | | | | | |
| 4. Track implementation status | | | | | | | | | | | | | | | | | | |
| 5. Review action items and carry out necessary modifications | | | | | | | | | | | | | | | | | | |

First 2010 Workshop Closing Remarks
Throughout the First 2010 Workshop, participants provided feedback as an assessment and guide to AUICK on its Program. They commented that the Workshop presentations "opened new attitudes to disaster management" and were "useful in understanding health issues". In sharing experiences in disaster management and maternal and child health care (MCH), lectures gave "guidelines to face disasters", and were deemed "excellent", "well assessed" and "very informative". The site visits to Kobe's facilities for MCH and disaster preparedness were noted for their citizen participation, and were "very useful" in providing lessons to the AUICK Associate Cities (AACs) to duplicate. Presentations by representatives of the United Nations Population Fund (UNFPA) both "shed light on MCH care in natural disasters" and provided stimulus to increase education and training on MCH in the AACs. The UNFPA Seminar's sharing of knowledge was described as both "active" and "well organized".

Overall, participants commented that the sharing of Kobe's "noteworthy experiences in MCH" and the "chance to get experience of other countries" gave "fruitful lessons to implant in the AACs". They assured that lessons learned would be shared with government colleagues and put into practice as policies through the Action Plans formulated at the Workshop, which will also lead to increased collaboration between the AAC Academic institutions and governments represented. They also proposed that information sharing workshops be held in the AACs themselves.

The AUICK Secretariat highlighted the importance of participants keeping UNFPA Country Offices informed on the progress of their project implementation, and the role of the Action Plan system as a concrete way for the lessons of the Workshop to be implemented by the participants, as the persons who know best how to effectively apply the Plans in their cities.
In the 1980s, the United Nations Population Fund (UNFPA) supported a series of studies and conferences focusing on urbanization, population dynamics and development. Among these, the 1987 International Conference on Population and Development, held in Kobe, highlighted medium-sized cities' role in the development of their countries, their lack of financial and administrative capacities to solve population and growth related issues, and their neglect in overall development planning. The Conference Declaration recommended that UNFPA support the development of a network to link officials of Asian medium-sized cities, to take action on its findings. This led to the establishment of the Asian Urban Information Center of Kobe (AUICK) in April 1989, as a cooperative agreement between the City of Kobe and UNFPA.

AUICK's first activities were a series of urban inquiries to the mayors and administrations of over 200 Asian cities, to find out the problems and issues affecting each city's populations and development. The inquiries revealed urban administrators' concerns on expanding urbanization and population related issues such as migration, health care, family planning, urban air and water pollution, and found that many sought capacity building technical information. AUICK took on the role to facilitate the exchange of this information, conducting in-depth studies and disseminating lessons learned on cities' changing characteristics and successful service provision practices.

AUICK began to arrange Workshop training seminars in 1996, for participation by Asian local government officials, to put a capacity-building approach to development into practice. Between 1996 and 2003, it trained 242 city administrators and planners from 69 cities in 13 countries, and arranged eight seminars on primary care, health, population ageing, and water and environment issues in urban settings. It also published a Newsletter to reach a wider audience of developmental planners and related institutions throughout Asia, and its website at auick@auick.org contains a database of information and reports. AUICK's activities are guided by UNFPA and its Asia and the Pacific Regional Office, and Domestic and International Advisory Committees, made up of scholars and political figures of prominence in Asia.

Since 2004, AUICK has worked with a core group of nine principal stakeholder AUICK Associate Cities (AACs), to build the capacities of 'critical masses' of trained personnel to improve service provision in each of the cities. The relevance of these cities to the AUICK Program is in the developmental challenges and characteristics that they share, and what they can learn from Kobe and each other. Their nine mayors participated in the 2004 AUICK Associate Cities Conference on ICPD Tenth Anniversary Review: The Current Status and Future Challenges of Asian Medium-sized Cities, to commit to sending senior officials to AUICK Workshops and incorporate lessons learned into their administrations' policies. A further twelve Workshops, on themes of primary and reproductive health care, environment, medical care and welfare, public utilities, waste management, HIV/AIDS, ageing issues and urban policy, have trained 113 senior AAC government officials and academic experts. The meetings incorporate best practice study dissemination, discussion and city report presentations by each AAC representative, to maintain the South-South (AAC-AAC), as well as the North-South (Kobe-AAC) element to AUICK's Program.

Since 2005, participants have formulated 89 Action Plans, of which over 50 per cent have become city government policies to improve welfare provision. The Plans are a quantifiable, results-based outcome to the AUICK Program, and with recent City-University Partnership, Technical Support and Research Projects, they show AUICK's commitment to building Asian cities' capacities to manage their own solutions to emerging and persistent development challenges.
Chittagong - As an AUICK Workshop Action Plan of 2009, a Management Information System (MIS) implemented by the city's Premier University is linking service statistic data from health centers with Chittagong City Corporation, for improved policy formulation. The city is also developing a Geographic Information System (GIS) to further strengthen maternal and child health care provision.

A 2010-13 Canada International Development Agency (CIDA) project in Chittagong aims to improve maternal and infant health by establishing two community health centers and outreach facilities, training traditional birth attendants and peer educators, and mobilizing community groups to increase HIV/AIDS awareness. (acdi-cida.gc.ca)

The Government of Bangladesh and the International Development Association (IDA) are supporting the Chittagong Water Supply Improvement and Sanitation Project to improve water supply and sanitation for around 250,000 slum dwellers. (waterworld.com)

Weihai - Weihai has achieved the highest environment appraisal level of Shandong Province in 2010, based on environmental quality and management, increased power plant desulfurization and sewage treatment. (weihai.gov.cn)

Chennai - Construction has begun on a desalination plant to supply 100 million liters per day of potable water in Chennai, from an Rs six-billion plant. (chennaionline.com)

Surabaya - The Global Partnership on Output-Based Aid (GPOBA) is supporting a scheme in Surabaya to extend piped water connections to 15,000 low-income households of around 77,500 people. (gpoba.org)

Kuantan - Kuantan Municipal Council is to launch an initiative in 2010 for members of the public to highlight problems affecting the community. Cell phone users will be able to report problems so that proper and fast remedial action can be taken. (thestar.com.my)

Faisalabad - Marking Mother and Child Health Week (1-6 November), the Department of Health, City District Government Faisalabad, has increased awareness programs, training of female health workers, registering of all pregnant women and lactating mothers, and ante and post natal care, reproductive health education and nutrition programs. For children of 0-5 years of age, emphasis is on immunization, vitamin supplements, respiratory infection treatment and de-worming. Immunization Day was also marked with increased oral polio vaccinations, and vaccinations for every pregnant woman and medical worker against H1N1 (swine 'flu). (Dr. Masooma Sardar, AUICK Liaison Officer for Faisalabad).

Olongapo - A Management Information System (MIS) in Olongapo, supported by AUICK and UNFPA, has been named as a Project Best Practice by UNFPA Philippines Office. Implemented by the City Planning and Development Office as the Socio-Economic Information System, the MIS generates updated population data to improve service provision by Olongapo City Government. (philippines.unfpa.org)

Olongapo City Government has created the City Energy Management Committee (CEMC), to intensify energy conservation and efficient utilization of power by Olongapo residents through seminars, surveys and conservation measures for the public and private sectors. Energy Conservation Officers (ECO) designated in each local community and Government department will monitor the program. (olongapocity.gov.ph)

Khon Kaen - The International Conference on Local Government (ICLG) was held by Khon Kaen University's College of Local Administration on 18-19 November, as the first global forum in Thailand on public administration and policy, local development and good governance. A case study on Kobe City was presented by Dr. Hirofumi Ando, President of AUICK, and Dr. Gayl D. Ness, Chairman, AUICK International Advisory Committee, presented on the challenges and dilemmas of local government in a global age. (home.kku.ac.th)

Danang - The fourth ASEAN Socio-Cultural Community (ASCC 4) meeting was held in Danang on 16 August, focusing on dealing with global challenges, developing human resources for economic recovery, creating social welfare for women and children, and building cultural identity. (vovnews.vn)

AUICK welcomes contributions from its Associate Cities to auick@auick.org
shows what has been accomplished in places affected by ongoing conflicts or by military occupation, and the special challenges of countries that have endured both political instability and natural disaster. (unfpa.org)

**World Health Day, 7 April 2011** - Antimicrobial resistance is the theme of World Health Day 2011. Its global spread threatens the continued effectiveness of many medicines and risks jeopardizing important advances being made against major infectious killers. The World Health Organization (WHO) public awareness campaign will call on governments and stakeholders to implement the policies and practices necessary to prevent and counter the emergence of highly resistant superbugs, and to also provide appropriate care to those seriously affected by these microbes. (who.int)

**The Path to Achieving the Millennium Development Goals** - The United Nations Development Programme (UNDP) has released the publication *The path to achieving the Millennium Development Goals: A synthesis of evidence from around the world*. The publication examines the experience of 34 countries to show trends in progress, successes, failures and the impact of the recent global crises. It identifies constraints and states that with national commitment, innovative policies and pro-poor economic growth, the MDGs are within reach. (undp.org)

**Global Strategy for Women’s and Children’s Health** - UN Secretary-General Ban Ki-moon and Heads of State and Government, along with the private sector, foundations, international organizations, civil society and research organizations, have begun the *Global Strategy for Women’s and Children’s Health*, a major concerted worldwide effort to accelerate progress on women’s and children’s health, with pledges of more than $40 billion over the next five years. Launched in New York on 22 September, 2010, the strategy aims to save the lives of more than 16 million women and children, prevent 33 million unwanted pregnancies, protect 120 million children from pneumonia and 88 million children from stunting, advance the control of deadly diseases such as malaria and HIV/AIDS, and ensure access for women and children to quality facilities and skilled health workers. Child mortality (MDG 4) has been reduced, but not quickly enough to reach the target. Maternal mortality (MDG 5) remains high in much of the developing world. (un.org)

**Asia-Pacific Disaster Report / Making Cities Resilient** - The UN ESCAP / UNISDR Asia Pacific Disaster Report, 2010 outlines ways to reduce vulnerability to disasters in the region which generates one quarter of the world’s GDP, and accounted for 85 per cent of deaths and 38 per cent of global economic losses due to natural disasters over the last three decades. UNISDR has also released the disaster preparedness guide, *Making Cities Resilient*. (unescap.org) (unisdr.org)

**Billion Tree Campaign** - As of November 2010, 10.6 billion trees have been planted under the *Plant for the Planet: Billion Tree Campaign*, organized by the United Nations Environment Programme (UNEP) since 2006, which encourages people, communities, businesses, industry, civil society organizations and governments to plant indigenous or appropriate trees. The Campaign has also raised awareness on the United Nations International Year of Biodiversity in 2010. (unep.org/billiontreecampaign) (cbd.int)

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**AUICK Monitoring Activities**

**Visits to AUICK Associate Cities**

**Visit to Danang People's Committee, Vietnam**

From 26-28 September 2010, Dr. Hirofumi Ando, President of AUICK, visited the Danang People’s Committee, to review the progress of AUICK supported developments in the city and discuss future projects. AUICK has trained senior officials from Danang departments of education, health care, environment and urban planning at fourteen Workshops in Kobe since 2004. Dr. Ando met with Dr. Phung Tan Viet, Vice Chairman of the Danang People's Committee, who explained that the data generated by the AUICK supported Management Information System (MIS) with Danang University had been effectively utilized by Danang authorities and enterprises, especially in annual socio-economic development planning. He also met Mr. Luong Minh Sam, Director of the Danang Foreign Affairs Department, and Ms. Nguyen Thuy Anh, Head of the International Cooperation Division and AUICK Liaison Officer, 

**A visit to Danang City Hospital**
to discuss proposed technical support to the city for improved maternal and child health care services. **Dr. Tran Dinh Vinh**, Head, Obstetric Ward, Danang Hospital, explained the status of the current AUICK Research Project on Maternal and Child Health Care / Family Planning (MCH/FP), and visits were organized to Danang City Hospital, as well as a newly constructed 600-bed hospital, with a large maternal and child health department to deal with 70,000-90,000 deliveries per year, averaging around 25 babies per day. **Professor Bui Quang Binh**, Dean, Economics Department, Danang University of Economics and Business Administration, also informed on the progress of the AUICK supported Management Information System (MIS) Project, which provides the Danang People's Committee with population-based data to improve policy and service planning.

**Visit to Chittagong City Corporation, Bangladesh**

From 28-30 September, **Dr. Hirofumi Ando**, President of AUICK, visited the offices of Chittagong City Corporation. He met with the Mayor, **Mr. Manjur Alam**, as well as **Mr. Mominur Rashid Amin**, Private Secretary to the Mayor, **Dr. Nasim Bhuiya**, Project Manager PA-3, Second Urban Primary Health Care Project, and **Dr. Salim Akhter Chowdhury**, Chief Health Officer, to discuss collaborative projects with Chittagong. **Prof. Dr. Anupam Sen**, Vice-Chancellor, and **Mr. Taufique Sayeed**, IT Institute Project Director, Premier University, gave an account of the current progress of the Management Information System (MIS) set up in Chittagong, as an AUICK Workshop Action Plan to provide population related data to assist with policy formulation. **Dr. Mohammad Ali**, Medical Officer, Health Department, Chittagong City Corporation, and **Dr. Subash Roy**, Principal, Laboratory Medicine, Institute of Health Technology, updated on the progress of the MCH/FP Research Project. This is being conducted in all nine AUICK Associate Cities (AACs) to facilitate dissemination of data and information on conditions and services, for policies and strategies to improve the health of mothers and children.

**Visit to UNFPA Bangladesh, Dhaka**

On 1 October, Dr. Ando met with **Dr. Noor Mohammad**, Assistant Representative, **Mr. S.M. Jakaria**, Programme Officer (RH), and **Ms. Yuki Suehiro**, Deputy Representative, UNFPA Bangladesh, who explained the activities conducted with the city of Chittagong, including support to the AUICK MCH/FP Research Project.

**Visit to UNFPA Asia and the Pacific Regional Office, Bangkok, Thailand**

On 4 October, a meeting at the Asia and the Pacific Regional Office (APRO) of UNFPA was held with **Ms. Nobuko Horibe**, Regional Director, **Mr. Najib Assifi**, Deputy Regional Director and UNFPA Representative in Thailand, and **Ms. Eriko Hibi**, Regional Program Coordinator, UNFPA APRO, to discuss AUICK's ongoing work with UNFPA.

**AUICK welcomes your contribution**

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

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