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FEATURE: Providing Primary / Reproductive Health Services in Asian Urban Areas with Attention to Vulnerable Populations, Especially Women and Girls

2-16 AUICK Research Dissemination Meeting

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ARCHIVE
AUICK held the 2011 Research Dissemination Meeting in Bangkok from 12-14 June, with the support of Kobe City Government and the United Nations Population Fund (UNFPA). The Meeting was arranged to disseminate the findings of the 2010 Research Project, "Providing Primary/Reproductive Health Services in Asian Urban Areas with Attention to Vulnerable Populations, Especially Women and Girls". Participants were senior officials and academics from the nine AUICK Associate Cities (AACs), and the Meeting was attended by UNFPA Asia and the Pacific Regional Office Officials, as well as members of AUICK’s International Advisory Committee (IAC).

"Reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide."

(UNFPA Annual Report 2010)

"If we can reach the poorest and most vulnerable populations with reproductive health information and services, we can save many lives and improve countless others."

(Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights; UNFPA Publication)

Aim

The AUICK Research Project, Providing Primary/Reproductive Health Services in Asian Urban Areas with Attention to Vulnerable Populations, Especially Women and Girls, collected information and data on maternal and child health care, in order to determine problems and the priorities assigned to them, and to identify successful practices in the AUICK Associate Cities (AACs).

Based on the findings of the study and other information accumulated by AUICK, senior health department officials and academic experts of the nine AACs assessed information and exchanged views and experiences at the 2011 Research Dissemination Meeting. The Meeting was held in Bangkok, Thailand, in part to facilitate participation by UNFPA Asia and the Pacific Regional Office (APRO). Participants aimed to apply lessons learned toward effective policy formulation to improve services in their cities.

Opening Remarks

On behalf of AUICK, Dr. Hirofumi Ando, President, welcomed the 2011 Research Dissemination Meeting participants to Bangkok, "The City of NGOs". He outlined the activities that AUICK has undertaken since 2004 with the financial support of UNFPA and the City of Kobe. These have included fourteen workshop training programs, Action Plans to improve services in the AUICK Associate Cities (AACs), such as maternal and child health programs during emergency situations, and technical support to set up Management Information Systems (MIS) in five cities, which improve population data for policy formulation.

AUICK was established in 1989, in response to the call by the first Executive Director of UNFPA, Dr. Rafael Salas, to promote the balanced development of small and medium-sized cities in Asia. Their populations are increasing more rapidly than those of larger cities, but there is limited information available on the issues affecting their sustainable development. As these cities have an important role to play in the overall development process, knowledge and understanding on their populations and current conditions is vital toward improving the quality of life for their citizens. Through the review of the 2010 Research Project and exchange of information and experience, participants of the Research Dissemination Meeting could assess future needs, in order to strengthen health service provision to vulnerable populations in their respective cities.

Dr. Ando expressed his appreciation to the representatives of the AACs, the members of AUICK's International Advisory Committee, and Mr. Caspar Peek (Regional Programme Advisor) and Mr. Christophe Lefranc (Technical Advisor) of the UNFPA Asia and the Pacific Regional Office, for their participation in the Meeting.
Participants of the 2011 Research Dissemination Meeting, 12-14 June, Bangkok, Thailand

AUICK Associate Cities (AACs)

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AUICK International Advisory Committee (IAC)

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UNFPA Asia and the Pacific Regional Office

Mr. Caspar Peek  
Regional Programme Advisor

Mr. Christophe Lefranc  
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UNFPA Asia and the Pacific Regional Office

Mr. Caspar Peek explained the importance of local health service programs, and the partnerships needed for effective service delivery.

Through the 2010 Research Project, AUICK Associate Cities (AACs) addressed vulnerabilities in health service provision, including the issue of equity, which is at the core of human development.

The Global Strategy for Women and Children's Health, recently launched by UN Secretary General Ban Ki-moon, also has a strong focus on sexual and reproductive health, and sustainable development in locally owned health plans. Urban environments, increasingly in Asia, call for more integrated, universally available health services, prevention, treatment and care administered through strong systems with sufficient skilled health workers at the core, and innovative approaches to their financing and delivery.

Local health systems play an ever more important role in the delivery of services, especially in the light of the decentralization occurring in many Asian countries. In a rapidly urbanizing world, the crucial role of urban health departments in delivering health services to populations, particularly women and girls, is increasingly evident.

The 2010 Research Project by AUICK was timely, as there is an urgent need to strengthen health systems to improve the capacity of health workforces, so that the most vulnerable urban poor, particularly women and girls, have access to the best possible integrated essential services, including family planning information services, antenatal, newborn and postnatal care, emergency obstetric skilled care during childbirth and related facilities, prevention of HIV and other sexually transmitted infections.

We know what works to address these issues, and we know how health systems could be better. One problem is money; Asia has high expenditures on health services, but relatively low per capita government expenditure.

With decentralization comes the expectation that local governments will have more access to funds, and must provide efficient and effective delivery of more cost-effective health care. This calls for leadership and partnership. Leadership is crucial, with much importance on the personal commitment of appointed local leaders.

The most progress in improving the quality of health services happens where national and local leaders are personally committed and involved: “be the change you want to see in the world”, to quote Mahatma Gandhi.

Partnerships are crucial, as governments alone cannot provide the best possible health for citizens. They are primarily responsible for the wellbeing of populations, but require the meaningful involvement of community leaders and other exponents of civil society, not least women and girls, the private sector, academia and opinion leaders - engaging in partnerships to find new modalities to develop better health services for more people.
Asian Urbanization: New Challenges for Reproductive Health Services

Dr. Gayl Ness outlined changes in reproductive health indicators and services, in the context of massive urbanization in Asia.

It is remarkable to note that Asian urbanization is the greatest population movement the world has ever seen, the fastest and the largest. In the past sixty years Asia’s urban population grew from 234 million to 1.8 billion; by 2050 it will be 3.2 billion: a 14-fold increase in one century! By contrast European urbanization took 250 years and involved growth from 120 million to 527 million: a 4.5 fold increase. This massive transformation in Asia is first of all a tribute to the tremendous improvement in the quality of life. The speed and magnitude of Asian urbanization represents a massive improvement in human welfare. But urbanization also poses massive new challenges to all forms of services, sustaining and extending human welfare, not least in the area of reproductive health services. Indicators show tremendous improvements in reproductive health services following 1950.

The Infant Mortality Rate (IMR) is the single best indicator of the welfare of a society. In 1950 throughout Asia this was close to 200, or 20% of babies dying before their first birthday. By 1980 the rate had halved and by 2010 had further decreased. Total Fertility Rates show a similar pattern. With uncontrolled fertility in 1950, 6-7 children were born per woman. By 1980 this figure had halved, and it is still decreasing. The most rapid progress was made in the first three decades. Large scale health programs began about 1950. Family planning efforts began slowly in 1965, and moved rapidly from 1970-90. Asia was predominantly rural at that time, so health care provision challenges were in rural areas. Asia led the world in developing modern population and health services especially for the rural areas.

Until 1952, most countries were pro-natalist; more people meant more power for work or war. India changed that in 1952, by introducing the world’s first policy to reduce population growth by reducing fertility. This decision was based on very advanced demographic and macro economic analysis. In order to achieve economic development, output per capita had to be increased, so by definition population growth was seen as an obstacle to economic development. Through United Nations regional programmes such as ECAFE/ESCAP, India and Pakistan pulled Asia into the 20th century as such policies spread in the 1960s. India had begun its national census in 1861, so had nearly 100 years experience of demographic analysis which went through global UN programs, with Latin American and African countries following in the 1970s and 1980s. The lesson here to be learned is that Regional Programmes promote development. Although country programmes are more powerful, with more resources, regional programs are very important in moving development processes along.

When Asia began its very effective work in promoting family planning and fertility population planning, the rural problems were different from the urban challenges faced today. Asia’s great success in improving reproductive health services was in meeting the rural challenges, overcoming physical distance and separation to bring services to remote populations living in small villages. Successes were seen as differences in urban–rural health indicators were reduced, through the initiatives of local administrators, such as in having villages work as well as organized, close community networks to promote reproductive health care.

The challenge of the new urban setting is to provide services to increasing populations of young reproductive aged workers, both male and female, who are often rootless and not embedded in any close knit community. Urban administrators have to work out different ways to reach these “floating” populations, and the AUICK Associate Cities (AACs) provide many examples of successes in meeting this challenge, in the form of Action Plans from AUICK Workshops; the many projects which participants have developed and taken back to implement in their cities.

Information on the implementation of AUICK Action Plans in the nine AUICK Associate Cities (AACs) can be found on pages 17-22.
Chittagong, Bangladesh

Dr. Shahana Perveen
Health Officer, Health Department, Chittagong City Corporation

The City

Chittagong is located in the Southeast of Bangladesh, on the coastline of the Bay of Bengal. It is the second largest city and main sea port of the country, known as "Port City". First established as a Municipality in 1863, upgraded to Municipal Corporation status in 1982, and City Corporation status in 1990, Chittagong is now divided into 41 wards, and covers an area of 158 km². Chittagong City Corporation Health Sector facilities include six MCH hospitals, 20 charitable dispensaries, 41 Urban Primary Health Care Centers (ADB), a Midwifery Institute, a Health Technology Institute and a Homeopathic College. The city also has its own pharmaceutical industry, and the government works extensively with NGOs to provide immunization, family planning and emergency medical services.

In the early 1970s, the majority of Chittagong’s population faced serious health problems such as diarrhoea, Acute Respiratory Infection (ARI), malnutrition, inadequate sanitation facilities, as well as overcrowding and poor housing. Reproductive health services, population control, family planning, use of contraceptives, data on exact age, births and marriages, the Expanded Programme of Immunization (EPI) and other health related services have suffered due to the illiteracy of the people and lack of proper knowledge on reproductive health.

Reproductive Health Services

RH services now include maternal and child health care; neonatal child health care and paediatric surgery; gynaecology and obstetrics departments; treatment of HIV/AIDS and Sexually Transmitted Diseases (STDs); epidemiology; family planning services; health education services; free contraceptives; mother and child health cards and red cards, and free services to slum dwellers.

Challenges and Recommendations

Over-population is now a problem in Chittagong, and the industrial sector is declining, meaning fewer jobs and decreasing per capita income. Health facilities are largely inadequate for the city’s population and unequally distributed, and there is a lack of awareness on health issues among illiterate citizens.

Successful Practices of Chittagong include its child and reproductive age immunization and Directly Observed Treatment Short Course (DOTS) programs, and the reduction of Maternal Mortality and Total Fertility rates to below the nationwide levels. Birth registration has also increased.

In the future, unplanned urbanization needs to be addressed, with the issue of large migration from surrounding areas. As cyclones and flooding regularly occur, natural disaster management also needs to be improved accordingly.
Weihai, China

Dr. Xu Minlan
Associate Professor, Department of Social Work, Shandong University at Weihai

The City

Weihai is a coastal city in Shandong Province, in the Northeast of China. The city has experienced rapid development over the thirty years since economic reforms in 1978. Family planning policy began at the end of the 1970s, primarily for economic development, but also to improve the health of women and children. Since then, a strict national one-child policy has been enforced. Meanwhile, later marriage and child delivery were promoted. As a result, the infant, child and maternal mortality rates have since decreased. The population of Weihai was 2.54 million in 2010. Both the birth and death rates have decreased over recent years, and with a low total fertility rate, there is now negative population growth.

Reproductive Health Services

The 2010 AUICK Research Project found that the important reproductive health issues in the eyes of administrators are firstly family planning services, with special emphasis on the issue of provision to the immigrant population of the city. The second issue is HIV/AIDS prevention and treatment. Here too, the sexual activity of young immigrants is addressed. According to the administrators, the overall level of Weihai’s reproductive health conditions is good, but they can be improved.

With recent increased investment in reproductive health services, numbers of doctors and nurses are increasing faster than the population, but services need to be improved in comparison with those of developed countries. High priority is given to maternal and child health because of the one-child policy, and resource availability is high too.

Weihai has 90 hospitals, with 78 community health centers and 124 rural village health clinics. In 2008, 98 percent of women had delivery assistance without any cost, and 98 percent of children under three received health care services, including free check ups and vaccinations. In terms of specific reproductive health needs, funds are still lacking, as are new equipment and facilities. The city has no slum areas, but people under the poverty level are living scattered around the urban and rural areas, numbering 1,808 (0.15%) of the urban, and 32,300 (2.5%) of the rural populations. They are provided with government subsidies to help them achieve basic living standards, for which the government provided CNY 25,352 million in 2008.

There are no specific health programs for the poor, but they have access to all regular reproductive health services. The immigrant population size was estimated at 0.45 million (14.48%) in 2000, and 0.29 million were registered in 2009. This reduced number, however, was recorded because those living in Weihai for more than six months cease to be officially categorized as immigrants. Now, 2.53 million of Weihai’s total population of 2.82 million are categorized as permanent residents, so 290,000 are migrants. Future improvements in transportation and investment in infrastructure are expected to bring increased immigration to the city.

There is no special budget designated for reproductive health, but the overall health sector budget in 2008 was CNY 474.84 million, 3.9 percent of the total city budget of CNY12,222 million. Services include programs for family planning, health insurance, HIV/AIDS prevention, vaccinations and pre-marriage examinations. For migrants, there are special family planning services free of charge, help centers for unexpected pregnancy in teenagers, and management of female migrants at reproductive age. Health insurance comes under a national program with universal coverage, but reimbursement of health care costs is low.

For the prevention of HIV/AIDS, Weihai has 18 laboratories, 12 counseling centers and a program for surveillance of those with high risk behavior. There are 85 free vaccination clinics, and the government pre-marriage examination program in 2008 was available to every couple, providing 90 CNY to prevent congenital disease. Ninety percent of couples took up the service.

Challenges and Recommendations

In spite of the overall good service level in Weihai, there remain many challenges in reproductive health, including a lack of coverage to educate the younger generation, which means their lack of knowledge on the issues involved. Although services are universally available, the quality of health care for immigrants needs to be improved, and there should be more cooperation between government and RH service agencies, in order to meet the demands and requirements to improve service provision.
Chennai is one of the oldest Government Corporations in India, established in 1688. The city covers 174 km², and has a population of 5.03 million. Urbanization is an impending crisis in Chennai's state, Tamil Nadu, as in India as a whole. In Tamil Nadu, nearly 44 percent of the population is urban, whereas in India 30 percent (300 million people) live in towns and cities, and this is estimated to reach 534 million by 2026 (USAID). Around one third of this urban population dwells in slums, out of which 80.8 million live below the poverty line (National Family health Survey - III).

India's private health sector is one of the largest in the world, with private health expenditure ranging from 75 - 85 percent of total expenditure. In 2008, 5.2 percent of the GDP was spent on health, out of which only 13 percent of the total health expenditure was spent by the government.

Reproductive Health Services

In Tamil Nadu There are 11 teaching hospitals, 26 district headquarter hospitals and 227 other hospitals, with 8,000 doctors and 28,000 paramedical personnel. The Infant Mortality Rate (IMR) has declined over recent years, from 80 per 1,000 in 1980 to 58 in 1992 in Tamil Nadu and 17.4 in Chennai, considerably lower than the national rate of 79. The Total Fertility Rate (TFR) in Chennai has also declined manifestly from 3.9 in 1971 to 2.02 in 1990, and further to 1.6 in 2009-10, i.e. below the replacement level. The Child Birth Rate (CBR) in Chennai fell from 31.0 in 1971 to 17.3 in 1992 and 16.43 in 2008. The death and maternal mortality rates in Chennai were 3.00 and 0.20 respectively in 1992, but increased to 3.69 and 0.3 in 2008.

Chennai has achieved near 100 percent rates of institutional delivery, immunization, vaccination, and antenatal / prenatal care. HIV prevalence was 0.3 in 2009, and a total of 2,227 HIV positive cases, which have increased in the recent years as there is a better reporting system, and the number of people counseled for HIV has also increased over the years. Total STI cases found in 2009 were 35,987, of which 32,878 were managed. Total cases of cancer screening conducted in 2009 numbered 99,461. There is though, a lack of public awareness on facilities and services available.

Each of ten city zones in Chennai has an Emergency Obstetric Center with an operating theatre providing normal and assisted deliveries, antenatal, intranatal and postnatal care, baby care clinics, immunization and growth monitoring, health education and vaccination programs. Over one hundred Health Posts also provide outreach services to local communities, through government and volunteer health workers. Services include contraceptive provision, management of Reproductive Tract Infections (RTIs)/ Sexually Transmitted Infections (STIs), detection and follow up of cancer of the cervix/ breast, field supervision, Implementation Intensified Pulse Polio Immunization, screening for HIV, an Integrated Counseling and Testing Centre (ICTC), and for adolescents, health education, correction of anaemia and information on healthy lifestyle practices. These are promoted through posters and personal / group interaction.

There are also special programs for slum populations, who number around 1.8 million people (37 percent of the population). Two mobile health vehicles visit two of ten zones per day, providing health awareness through Information and Education Campaigns (IEC), and treatment of minor and preventable illnesses and referral of major illnesses, serving around 2,500 patients per week, or 120,000 per year. Major government benefit schemes for the urban poor give Rs. 6,000 to mothers for their first two pregnancies, Rs. 25,000 to girls who marry above 18 years of age, Rs. 600 to mothers who deliver in institutions, and financial compensation in the case of failed sterilization operations. A gift pack worth Rs.180 and a bed with protective net worth Rs.325 is given to all new born babies. Free four-meal diets for three days are organized for all new mothers, with follow up by SMS on vaccinations and 24-hour emergency services. Migrants, numbering around 100,000, have access to all the above services and programs.

Chennai was the first city in India to record 100 percent institutional delivery, and the first to administer de-worming tablets albendazole twice a year for 600,000 school age children, enhancing Hb percentage in the prevention of anemia. It was the first city to provide all pregnant mothers with a government incentive of Rs. 6,000 for care during the antenatal and postnatal period, and the city to take up screening of the largest number of women aged 35–50 for cervical lesions to prevent early cancer of the cervix.

Challenges and Recommendations

The major challenges faced by Chennai include the inequitable spatial distribution of facilities with multiple service providers; overload on tertiary institutions, and primary care institutions which are under-utilized, mainly due to a weak referral system; the non-integration of service delivery with focus mostly on RCH activities; limited capacity and de-motivation of health care professionals; limited community linkages and outreach; a lack of awareness among the slum/poor population; the limited role of NGOs; unhealthy, poorly sanitized conditions in slums; and disproportionate budget allocation. The total
city budget has increased, but there was a decline in the proportion of RH budget from 3.96% in 2000 to 2.75% in 2009. Political commitment is the key for the successful implementation of RH programs. In order to improve them, areas need to be prioritized by size of population and magnitude of health problems, especially the slums.

Improving the referral system will reduce the burden on tertiary institutions. There is a need for increased funds, infrastructure, equipment, provision of vehicles and manpower. There are also plans to improve the RH conditions of adolescent girls and promote the postponed age of marriage, to increase literacy among adolescent girls/women and educate them regarding HIV/AIDS, RTI and STI, and to fix the Institute of Public Health (IPH) standards for the urban and rural populations. Periodic capacity building and refresher courses will also increase health worker skills and motivation.

Recommendations toward improving service provision include a National Urban Health Mission to be based on the model of the National Rural Health Mission; regular outreach health services for the slum population and other urban vulnerable groups; decentralized city-specific planning, with a project for formulation and implementation; effective integration among the Health Department and all health related departments; proposals for institutional mechanisms and management systems for ensuring effective integration and clear accountability; and optimal utilization of Public-Private Partnerships (PPP).
from 29,000 in 2004 to 50,000 in 2008. Net immigration is about half of this figure.

Challenges and Recommendations

Recommendations include increasing funding, physical infrastructure, human resources and equipment to augment reproductive health and family planning services. Posyandus, the public health centers, should be opened on weekends as well as weekdays, so as to accommodate working mothers. Health promotion and education need to be enhanced to make parents aware that immunization is essential, and premarital counseling is required as part of efforts to reduce maternal mortality.

Kuantan, Malaysia

Dato’ Dr. Marlia Binti Mohammed Salleh
Director, Hospital Tengku Ampuan Afzan, Kuantan

The City

Kuantan is a medium sized port city with a population of just under half a million, in Malaysia’s East Coast state of Pahang. Since Independence in 1957, the city has grown rapidly. This was first stimulated by new road construction linking Kuantan to all the rest of the country, which subsequently attracted many new industries and immigrants to the city.

Reproductive Health Services

Reproductive health in Kuantan Municipality falls under the jurisdiction of the Department of Health Kuantan at the district level, and the Ministry of Health Malaysia at the national level. Reproductive health services were initially operational with maternal and child health as their main component, with services delivered through a system of rural health facilities in the form of midwife clinics and health centres. This was a three-tier system of the Rural Health Unit, comprising of one main health centre for health subcentres and 20 midwife clinics, to cater for a population of 50,000 people.

A review undertaken in 1972 recommended a conversion to a two-tier system by upgrading the existing health subcentres to health centres, and the midwife clinics to community clinics. In recent years, the coverage of these services has increased to include the urban areas, delivered through polyclinics and MCH Clinics. The Department of Obstetrics and Gynaecology of Kuantan Hospital provides diagnoses and treatment for referred cases. The Federation of Reproductive Health Associations, Malaysia (FRHAM) in Kuantan, an NGO, provides limited reproductive health services, and the city’s branch of the National Population and Family Development Board (NPFDB) also provides reproductive health services and complements the Health Department. Reproductive health services are additionally provided through one Government General Hospital, one maternal and child health clinic, seven health centres, 20 community clinics, four private hospitals and 66 private general practitioner’s clinics, one National Population and Family Development Board (NPFDB) facility, and the Fertility Centre Clinic at the International Islamic University Malaysia (IIUM).

Programs and services for reproductive health include maternal and child health education, family planning, antenatal, safe delivery and postnatal services, adolescent, women’s and men’s health programs, infertility clinics, HIV/AIDS and STI prevention the programs, and education and counseling on sexuality. Family planning services are provided by the Health Department, FRHAM and NPFD. Even though there has been an increasing trend of new acceptors over the years, the practice of effective family planning among high risk groups does not show much improvement.

A population survey done by NPFD in 2004 revealed that the unmet need for family planning in Malaysia was 24.5%, compared to 9.3% for other Asian countries. Unmet need is high among women who are residing in rural areas, illiterate or above 40 years of age. Among the reasons are their being afraid of complications, and non co-operation or approval from husbands for them to practice family planning.

Looking at the Millennium Development Goals set for the country, Malaysia has achieved all targets, except for Goal 5, on the Maternal Mortality Rate (MMR). Malaysia and Kuantan aim to achieve the target of 11 deaths per 100,000 population by the year 2015. In the year 2008 though, there were five maternal deaths in Kuantan. If we convert this to the Maternal Mortality Rate, it will be 74 per 100,000. In the year 2010, there had already been four deaths by June, giving the MMR as 83 per 100,000, so the city has to improve greatly its strategies for reduction of maternal mortality. One of these strategies is to identify high risk women who are pregnant as well as those potentially high risk women who can become pregnant.

Other strategies include ensuring that doctors and paramedics handling obstetric cases are adequately experienced, trained and privileged. There should be some of staff taking care of mothers, and there is a need for pre-conception clinics to identify high risk women and provide them with counseling. Antenatal care should be strengthened and more focused on high risk mothers, and training in emergency obstetric care needs to be integrated into the training of all personnel handling maternity cases.

Changing attitudes to sexuality and availability of effective family planning among high risk groups does not show much improvement.

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of contraception promote promiscuity among adolescents in the age group of 10-19 years. Furthermore, changes in lifestyle, family structure and moral and ethical values have contributed to social problems like abandoned babies, illegal abortions or unwanted pregnancies in the city.

HIV and AIDS cases seem to be increasing in number among the pregnant mothers in the city. This can be seen in the screening program for HIV among all pregnant mothers, as the number of those who are HIV positive is increasing. From January to March, 2011, of a total of 2,068 mothers screened, five turned out to be HIV positive.

Challenges and Recommendations

In terms of human resources, the issue of shortage of manpower and expertise has always been given high priority. The expansion in scope for primary health care and reproductive health services has been compromised by inadequate numbers and mixes of personnel. The vacancy rate for medical and health officers is high, and for community nurses it is also high. The existing norms for manpower in the Ministry of Health at the national level have not been in keeping with new challenges in health care. To address the human resource issues, it is recommended to work with the State Health Department, the Ministry of Health at the national level and central agencies (Public Service Department) to implement the proposed manpower projection and norms, including needs in tandem with the expanded scope of services. It is also proposed to continue to upgrade existing skills to meet special demands. Every health clinic should be manned by a family physician, as well as paramedics trained in specialized functions. Recommendations also include the developing of relevant standard operating procedures, procedure manuals, clinical practice guidelines and a consensus statement. Continuous education in reproductive health needs to be strengthened, and criteria are required for credentialing of staff and accreditation of facilities and relevant training institutions. The use of information technology for career enhancement should also be promoted.

Faisalabad, Pakistan

Dr. Masooma Sardar
Deputy District Officer, Health Headquarters Faisalabad

The City

Faisalabad, in Northeastern Pakistan, was founded in 1892 by Sir James Lyall, British Lieutenant Governor of the Punjab Province. With a population of 7.3 million, 2.9 million of whom live in the urban area, Faisalabad is the third largest city in Pakistan. Also known as the Manchester of Pakistan due to its textile and cottage industries, the city has experienced rapid urbanization and massive population movement, and is now facing issues regarding reproductive health services, sanitation, hygiene conditions, safe drinking water, housing, employment socioeconomic / crime burden and environmental pollution, among others.

Reproductive Health Services

The population of Faisalabad per doctor is 1,183, per midwife, 6,203, and per lady health visitor, 16,845. The city has two teaching hospitals, 30 private hospitals, five Tehsil headquarter hospitals and 12 rural health centers. Basic health units number 168, and are mostly in the rural areas. Mother and child health centers number five, and government dispensaries, 33.

There is no specific budget allocation in the health sector for RH Services, except for the $0.22 expenditure on health per capita PPP$, less than one percent of the whole city budget designated for health care. Health indicators show better conditions in Faisalabad than those of the Punjab Province as a whole. The Infant Mortality Rate (IMR) is 33, while it is 77 in Punjab. The Child Mortality Rate is 95, reduced from around 120, and the Maternal Mortality Rate (MMR) is 97 in Faisalabad, 250 for Punjab. The Contraceptive Prevalence Rate in Faisalabad is 49.3%, while it is 32% in Punjab. There is no data available for Menstrual Regulation (MR), very little data on Sexually Transmitted Infections (STIs) / HIV/ AIDS, and there are no human resources or private clinics/ hospitals or beds specifically for RH services, except for one Red Crescent Hospital.

Some successful practices include the establishment of a District Health Information System (DHIS), for the collection and utilization of data. A private- public-NGO partnership model is developing with the increased involvement of NGOs, and recruitment of Health staff is increasing to overcome shortages. Upgrading/up-scaling of
existing health facilities include the increase from 40 to 250 beds at the Government General Hospital G.M. Abad.

More allocation of funds in the district budget for health, especially for the urban slum areas, has come about under a new administration. Closer liaison between the new administration, the political set-up and City District Government Health Department has yielded improved services, and the procurement of more medicines and equipment, especially for maternal and child health (MCH) services.

To increase public awareness, campaigns focus on immunization, preventive care, family planning, primary health and reproductive / MCH care services, and labour rooms are being made functional 24 hours per day, seven days per week. Health camps, seminars and electronic media (radio, cable and local television talk shows and messages) also inform on health care issues.

The District Health Management Team and the District Health Technical Team are being revitalized, and micro-planning is being revised on all aspects of primary and reproductive health services, with logistical resources, and data availability is also low.

City of Olongapo, two of which are located inside the Subic Bay Freeport Zone. Aside from the existing public and private hospitals, there are 17 government quality-certified Barangay Health Centers (BHCs) that provide regular health services, including consultation with provision of medicines and immunizations. Nine of these BHCs are accredited as BEMONC (Basic Emergency Maternal Obstetric and New-Born Care) facilities, strategically located in the various barangays.

Using the standard ratio on government health workers to population, set by the Bureau of Local Government Supervision (BLGS) of the Department of the Interior and Local Government (DILG), Olongapo City fares relatively well in public health standards. With a combined number of 140 doctors/physicians from the City Health Department (CHD) and the City-owned tertiary training James L. Gordon Memorial Hospital (JLGMH), the doctor to population ratio is at 1:1,659. The CHD and JLGMH have a combined total of 205 nurses, thus Reproductive Health Services Olongapo’s reproductive health conditions are better than those of the country as a whole. Its Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Child Mortality Rate (CHMR), at 7, 19 and 8.6 respectively, are substantially below the national levels, which are 19, 94 and 33. All births are now attended by professionals, and most are conducted in the nine BEMONC facilities or at JLGMH. There is a 100% vaccination rate for children a ratio of 1:1,133, not including volunteer nurses at the hospital and various health centers.

Pregnant women are required to have at least four prenatal check-ups, with at least one visit each during the first two trimesters and two visits in the third trimester. BCG is given as early as a child is born, and doses of DPT, OPV, Hepa-B and measles

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Olongapo, Philippines

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The City

Olongapo City lies 127 kilometers north of Manila, at the southernmost part of Zambales Province on the western coast of Central Luzon. It has a total land area of 103.3 km², around half of which is urban built-up, and the remainder is classified as forest and watershed areas. The population was 242,531 in 2010, and is growing at an annual rate of 2.19% (2000-2007), substantially higher than that of the intercensal period of 1995-2000, when the rate was 1.68%.

The City has an average of 11.38% migration incidence. Overwhelmingly, 75% of the migrants are of working age, from 15 to 64 years. Persons considered migrants are those living in the city for less than five years. In 2008, households of informal settlers or squatters comprised 3.11%.

Reproductive Health Services

The City Government of Olongapo extends its medical and health programs and services through the City Health Office, James L. Gordon Memorial Hospital and a network of health centers located in the 17 barangays (local communities) of the city. Augmenting the public medical and health care needs are 11 private hospitals operating in the

Challenges and Recommendations

The trend of the rural population of Faisalabad District shifting to the urban area, in addition to massive in-migration from other districts, poses serious challenges for the City Administration. It has a low percentage of total budget for health service provision, and no specific allocation for reproductive health services. The 2010 Research Project found a number of issues which need to be addressed. There is a lack of awareness in administrators and politicians, who even questioned the definition of reproductive health itself when surveyed. The public also have little awareness on the related issues. So, there is a lack of commitment on behalf of politicians, and shortages in human, financial, infrastructure and logistical resources, and data availability is also low.
are given before the child reaches nine months old, to consider her/him fully immunized.

The level of STD infections in Olongapo has been reduced substantially, from near 200 a decade ago (and much higher a generation ago) to just 64 today. The City leaders still view the problem of sexually-transmitted diseases as a major reproductive health care issue though, which could be attributed to migration, unregistered sex workers at the Subic Bay Freeport Zone, or an influx of foreign tourists and investors.

The City of Olongapo is one of the very few cities in the Philippines to have enacted and approved a Reproductive Health Code (City Ordinance No. 23, Series of 2007), which adopted and integrated a comprehensive policy on reproductive health care, in line with its pursuit of sustainable human development that values human dignity and offers full protection to women, children, youth and families. As defined in the Code, Reproductive Health Care (RHC) mandates access to a full range of methods, techniques and services that contribute to reproductive health and well-being, by preventing or solving reproductive health-related problems.

Ongoing programs and projects of the city to promote and enhance maternal and child care and family planning services include MCH initiatives for the establishment, operation and maintenance of nine Basic Emergency Obstetric and Newborn Care (BEmONC) facilities, and nutrition and related Information, Education and Communication (IEC) programs. For the prevention and control of Sexually Transmitted Infections (STI) and HIV/AIDS, the City has established the multi-sectoral Olongapo City AIDS Council; the Olongapo City Community Theater Group (OCCTG), composed of MSM (Men who have Sex with Men) for increased awareness and advocacy; a confidential AIDS Hotline to encourage medical and counseling services; an STI/AIDS surveillance system for increased management, in coordination with the HIV/AIDS Core Team (HACT); for all registered Sex Workers to be issued with health cards; treatment and for all positive cases; mandatory information programs for health card applicants; and adolescent reproductive health fora for in-school and out-of-school youth, in coordination with the Department of Education and the City Social Welfare and Development Office (CSWDO). In addition, family planning programs arrange regular/weekly pre-marriage counseling for those applying for marriage licenses; regular/monthly seminars on responsible parenthood and mothers’ classes on family planning; regular/quarterly conduct of pap smear and breast examination in coordination with JLGMH; quarterly conduct of tubal ligation through the Marie Stoppe Foundation and JLGMH; promotion of gender sensitivity initiatives through micro-capital grant assistance to various women’s organizations, in coordination with and under the auspices of the United Nations Population Fund (UNFPA), and the conduct of symposia on adolescent fertility awareness in both public and private high schools.

**Challenges and Recommendations**

The population to health manpower ratio needs to be further improved, and facilities upgraded. Funds will continually be needed to meet the demands of Olongapo’s growing population, and to subsidize for the social service needs of the urban poor. Medicine provision for migrant populations needs to be ensured, and social health insurance with family memberships effectively sustained.

The city could not afford higher fertility rates, especially with persistent issues on low contraceptive use. Moreover, amidst an environment of at-risk sexual behavior, the city needs to strengthen its STI, HIV and AIDS prevention program, as the country is now on the brink of a major HIV epidemic, following a rise in cases by over 200 - 300%.

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**Khon Kaen, Thailand**

**The City**

Khon Kaen Municipality, in the centre of the Northeast region of Thailand, is the largest city in Khon Kaen Province. Situated 450 kilometers from Bangkok, the Municipality covers an area of 46 km², and has a population of 382,156, with a hidden population of over 50,000 in 84 communities.

Khon Kaen is the economic, as well as educational, cultural and historical center of the Northeast. Thus a lot of people move to the province for business opportunities, resulting in a non-registered population of over 300,000.

As at the national level, Khon Kaen has experienced sustained economic development with increased living standards. Health and family planning services have increased substantially, bringing rapid declines in both mortality and fertility, and a general rise in the wellbeing of the population.

The Maternal Mortality Rate (MMR) was reduced in

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Khon Kaen Municipality from 20.83 per 100,000 live births in 2007, to 15.53 in 2009. The government set target calls for an MMR of no more than 18 per 100,000 live births. Although this target was reached, the MMR has since increased to 22.53 in 2010.

Reproductive Health Services

Over 97% of births in Thailand take place in hospitals or institutions, and are assisted by professionally trained health personnel (doctors/nurses/midwives). In Khon Kaen Province, only five of 19,320 births from 2009-10 are recorded as occurring without professional assistance. When births are assisted by such persons as village health volunteers, traditional birth attendant or family members, a doctor or nurse makes a follow up visit to check on the health of both mother and the baby.

The prevalence rate of HIV infections in pregnant women in KKM has decreased from 1.28% in 1999 to 0.48% in 2009. However, the ratio of infection between adult male and female has increased from 3.9:1 in 2002 to 2.4:1 in 2009. HIV transmission from mother to child has decreased, though. The Contraceptive Prevalence Rate (CPR) of married women at the reproductive age (between 15 and 44 years) continues to rise, having reached 79.2% in 2006.

Despite the accessibility of family planning services and although Thai culture does not support abortion, studies suggest that around 60% of women with unplanned pregnancies seek services from non-medical professionals to induce abortion through various techniques. The latest hospital-based survey in 1999, conducted by the Department of Health (Ministry of Public Health), found that a total of 45,990 women were admitted for treatment of abortion complications; 71.5% from spontaneous and 28.5% from induced abortion. Of the admissions, 41.2% were aged 15-24 years.

The overall indicators show that perinatal and child health is improving in Khon Kaen. In 2007, the Perinatal Mortality Rate had decreased to 6.55 per 1,000 total births, lower than the national target set in the 9th National Health Development Plan (NHDP) at nine deaths per 1,000 births by the end of 2007. Infant Mortality Rate (IMR) statistics in Khon Kaen are shown on a survey of population change by the Provincial Health Office, which is carried out every five years. In 2007, the Infant Mortality Rate was 12.65 per 1,000 live-births, lower than the national target of the 9th NHDP of 19 per 1,000 live births by the end of 2007. Thai national data showed that the mortality rate of children under-five for 2003, from the same report, was 27.39 per 1,000 live-births.

Malnutrition in Thai children appears to be decreasing, although the increasing rate of overweight children is a cause for concern. From routine health reports, the malnutrition rate in children was 8.71%. The national target of the 9th NHDP was set at lower than 7%.

Currently 92.2% of pregnant women receive at least four antenatal care visits. Cases of the first care visit being before 12 weeks of gestational age increased from 46.18% in 2008, to 65.36% in 2009 and 67.56% in 2010. Most antenatal care is provided in hospitals and/or health centers by medical and health personnel (doctors/nurses/midwives). Khon Kaen has organized several projects for slum dwellers, including health promotion and prevention projects, with the provision of a total budget of five million baht per year. (A policy has been set to transfer decision making and budget from the city municipality to local municipalities, for local health needs to be properly served.) A health awareness project is implemented in slum areas to encourage people to increase self-care and set the priorities of their community health problems. Health promotion projects for disabled people and for HIV/AIDS cases in slum areas provide a monthly allowance of 500 baht to all cases, and several work training schemes. Educational scholarships are also given to children with HIV.

If the city’s migrants transfer their medical service registration to Khon Kaen City prior to their migration, they can access most forms of health care, but the majority of migrants do not do this, and so find difficulty accessing some medical services.

In terms of the budget for health, THB 1,291,280 of the cost is covered by the city government, while THB 112,171,068 is covered by the national government and THB 1,750,000 is covered by other sources (eg. donors etc.).

Challenges and Recommendations

Views of health care / urban administrators are that overall reproductive health conditions are very good, but can still be improved. High priority is put on reproductive health care, but with competing demands, the health care sector has a very limited budget. More is needed in terms of funding, political support, personnel and cooperation among the organizations involved in service provision. The main reproductive health issues addressed are Sexually Transmitted Diseases (STDs), HIV/AIDS (especially in people under 20 years of age), family planning for the health of mothers, unplanned pregnancy, and the specific needs of the City to improve its primary/reproductive health care services.
The City

Danang, is the largest city in central Vietnam, after Ho Chi Minh and Ha Noi. It covers an area of 1,283 km², and has a population of 887,000, which is estimated to reach one million by 2014. Danang is on the end of the East-West Economic Corridor (EWEC), which stretches over Vietnam, Laos, Thailand and Myanmar. It was separated from the previous Quang Nam-Danang Province in 2007, and it is now directly responsible to the central government. Its economic output includes seafood exports, furniture, household goods, clothing and tourism, and some 4,900 factories and production facilities are located in the city.

Reproductive Health Services

Danang's Maternal and Child Health (MCH) system consists of the Obstetrics-Gynecology Department of Danang Hospital, a Reproductive Health Center, and 10 other Obstetrics-Gynaecology Departments (of six district hospitals: two private, one police and one military hospital), 56 health stations and a new Obstetrics-Gynaecology hospital.

A total staff of 450 persons administer maternal and child health services, including 80 doctors, 100 nurses, 120 midwives, 30 medical and 40 radiation technologists. The figure is expected to increase to 850 under current programs. Of 700 deliveries per month, around 25% are C-section (caesarean operations) due to abnormal delivery. There are an average of 10 cases of Vacuum Extraction (VE), 3-4 stillbirths and 75% normal deliveries.

Obstetrics-Gynaecology departments of major hospitals have modern equipment, and Danang has achieved the rate of 100% of visits to hospitals, medical centers or private clinics by pregnant improved, through more infrastructure, human resources and public awareness, especially RH information and education for women. The priority level for RH is medium, and more specific programs are needed, with the involvement of more specialized agencies. Privatizing health care is considered as an option for improving the situation of inadequate resources available for reproductive health care. The RH issue seen as most important by administrators is birth control methods to improve mothers’ health. In order to improve preliminary RH services, more women, an average of once a month before delivery. The City has also developed many new medical centers or private clinics by pregnant women, an average of once a month before delivery. The City has also developed many new and modern facilities both at the city and district levels, has improved medical staff qualifications, and has made significant improvements to the care and survival of critically ill neonates. Incredibly, Danang achieved a zero rate of maternal mortality in 2009, and its infant and child mortality rates were 6.64 and 9.29, respectively. There were no cases of newborn tetanus in the city from 2003 to 2010.

Eighty five percent of the reproductive health care budget is covered by the city government from its budget, patients’ fees and health insurance. Ten percent is covered by the central government, and five percent by other sources, such as charities or NGOs.

Lessons learned by the City in reproductive health care implementation include the positive changes brought about by increased involvement of city leaders, the diversification and “equitization” of RHC services, the promotion of training for both intensive medical staff and general staff, and getting the involvement of the community by raising awareness through the mass media.

For child health care, malnourishment has been eliminated by getting the involvement of teachers at nurseries in children's feeding, as 60% of children under the age of five have been sent to nurseries. The best ways to raise awareness on children's nourishment have been found to be through the media and direct examination when children are taken to doctors. Group consultations are not effective, as many mothers are busy everyday with their work.

Maintaining a database on the number of children under five years of age will be very good for undertaking activities like weighing children, checking they receive sufficient Vitamin A, and ensuring malnourished children are well-treated.

Challenges and Recommendations

Challenges include the provision of services to increasing numbers of immigrants, a lack of resources (funds, equipment and staff), figures of neonatal cases remaining high, providing reasonable salaries for medical staff, and finding effective ways for information dissemination, especially among men.

In the views of urban administrators, the City's reproductive health conditions need to be financial resources are necessary, as is increasing numbers of skilled staff, modern equipment, facilities such as consultation rooms, and establishments for care.
provision. In terms of institutional assistance, it is deemed necessary to push ahead with socialization or privatization. Increased education and communication on RH is also required for persons of all ages and sexes.

The slums in Danang have been completely cleared and replaced with houses for persons with low income. There are still 19,356 poor households though, among which 825 are considered very poor.

Immigrants number 110,000 people (11,000 per year from 2000 to 2010), and this is projected to continue over the coming years. The City does not have health care or social welfare programs for its immigrant population, due to their unfixed location.

To improve the health of newborns, Danang has the following objectives:
- develop the Neonatal Intensive Care Unit (NICU) at the new Obstetrics-Gynaecology department to be comparable to the best NICUs in Vietnam, and to work toward international standards;
- enhance regional staff capacity in women and newborn care;
- minimize community-acquired newborn infections and hospital-acquired newborn infections;
- improve neonatal resuscitation at delivery rooms and theatres, as well as safe neonatal transport in Danang and surrounding areas; and
- encourage all governmental organizations, non-governmental organizations, individuals and the community to support neonatal health missions.

Important issues have emerged from the AUICK Research Project and Research Dissemination Meeting, which cities must address toward improved primary/reproductive health services.

Local governments need to work with communities to increase awareness on available services. Population data is vital for policy makers to plan effective programs with medical leaders.

The current culture of decentralization in Asian countries needs the commitment of mayors and skilled, motivated health workers at the local level. A strong central political system to make decisions needs an equally strong local administrative system to apply decisions as programs by people who know what is required at the local level.

Reproductive health concerns a number of issues, of which maternal and child health care is one of the most important. High fertility means that women bare children early, frequently and late, all of which can kill mothers and children.

Best practices should be shared among cities to improve health, such as by reducing fertility. Danang and Weihai have achieved near zero antenatal mortality by giving high priority to productive health services. Khon Kaen Municipality arranged free monthly hospital examinations and immediate treatment for pregnant mothers, and reduced perinatal transmission of HIV to almost zero. (The Thai government has also massively reduced HIV infections through open acknowledgment, contraceptive promotion in the sex trade, provision of free anti-retroviral drugs and mobilization of communities to increase awareness.)

All pregnant mothers should have access to clinics, and mayors must work to achieve at least a 90% visit rate, to reduce the risks involved in childbirth and to detect and prevent against the incidence of HIV.

As local administrators, many AUICK Research Project participants are on the front line of service provision, and know how to make programs work at the local level. The AUICK Action Plan system (see pages 17-22) encourages the formulation of policies based on shared knowledge, but their implementation requires the support of each city’s mayor and administration. With political commitment, or a mayor’s statement to support a plan, a city official can approach a development assistance funding agency for financial support, which will lead to increased political commitment to future plans.
In 2008, AUICK established a Technical Support Programme which registers retired Kobe City Government officials, professionals and NGO staff, to be dispatched on a volunteer basis to AUICK Associate Cities (AACs). There, they assist with projects and programs to improve the welfare of citizens.

In 2011, AUICK is dispatching expert nurses and midwives to provide technical support at a newly constructed 600-bed maternal and child health care hospital in Danang, Vietnam, where they will help arrange a program to improve nursing skills.

This is the second delegation after AUICK arranged for a team of firefighters to be sent to Surabaya, Indonesia, to improve emergency rescue service coordination and response in 2009.

AUICK incorporated the Action Plan system into its Workshop project in 2005, as a way for the nine AUICK Associate Cities (AACs) to utilize the lessons learned from training programs in Kobe. The Action Plans, formulated by all Workshop participants and based on the issues covered by the Workshops, improve service provision, to address the specific problems faced by each city. The plans’ implementation progress is assessed through monitoring visits, interviews and surveys, and they also provide AUICK with a means to measure the effectiveness of its programme as a whole.

During each Workshop, the participants (usually the heads of city government departments relevant to the issues covered) are given guidelines on effective Action Plan formulation. When making the plans, they decide the problem(s) to be addressed, and the resources and support (administrative, educational, public, NGO, media etc.) necessary for effective implementation.

A timeline for each Action Plan shows when each step is to be taken, and the steps usually amount to about 18 months’ implementation, although they are often sustainable or expandable beyond that period. The plans are formulated to get the approval of AAC mayors, and to be realistically achievable with each city’s available resources. In many cases, small pilot projects are started, with a view to their future expansion from the momentum achieved by the initial implementation period.

Here, we look at the Plans successfully incorporated into the administrations of AUICK Associate Cities (AACs) as policies for welfare improvement.

Chittagong, Bangladesh
AUICK Workshop Action Plan Implementation

The first project for Chittagong was to address the growing problem of HIV/AIDS. A plan was devised to create a counseling center with clinical services, and to launch an education program. A management committee was created, NGOs were mobilized, a media campaign was launched, male and female educators were trained for all colleges and universities, clinical services were developed, and a survey was taken to plan for the future.

Next, two Action Plans addressed Chittagong’s many environmental problems. An improved solid waste management system was devised with tricycle rickshaws to collect trash from slum areas, and a greening program planted large numbers of trees in the urban area. Both programs made extensive use of the many NGOs that work in the city.

Another project was planned to begin to deal with the aging issue. This is not yet a major problem for Bangladesh, since the aged are still small in number and the family system appears sufficient to provide the needed care for them. The problem will rise in the future, however, and the city needs to be prepared. It has now begun a series of discussions and data
gathering activities with appropriate city officials and university scientists to plan for the future. Chittagong is frequently affected by natural disasters such as cyclones, mudslides and flooding.

An Action Plan formed a Disaster Management Core Committee, headed by the Mayor, for crisis management and maternal and child health care provision in disaster situations. It also established disaster management committees at the community level. The plan has additionally mobilized funds and resources for disaster preparedness, adaptable to the needs of the city as they arise.

Finally, based on lessons learned on AUICK Management Information Systems (MIS) in other cities, a Workshop Action Plan established an MIS at Chittagong’s Premier University’s IT Institute, to link service statistic data from health centers with Chittagong City Corporation authorities. The data will be utilized to further strengthen policies for maternal and child health care.

Weihai, China
AUICK Workshop Action Plan Implementation

The first Action Plan for Weihai was a project to increase and prevention services. It set up a website for HIV and STD information, developed educational courses for schools and a peer counseling service. It also linked to local and international NGOs, especially those focusing on women and youth.

A second project worked to ensure 100% primary school enrollment and completion. The city built more primary schools, extended the school bus service, and developed further teacher training to ensure that students would stay on to completion.

Another social program focused on the aged. China today has one of the most rapid rates of growth in the aged population, and the problem will increase dramatically in the next few decades. Weihai estimated it had some 10,000 elderly who have been abandoned or have no children to care for them. With its considerable wealth, the city planned for a series of new elderly homes to care for this population. Construction began in 2008, and the facilities are now operational.

Other projects focus on organizational and physical infrastructure issues. One has institutionalized city-wide contingency planning to link all government departments and emergency services for increased capacity to prevent potential environmental disasters.

This is considered especially important for the port area, which often carries dangerous and toxic cargoes. An emergency steering committee was established with a large range of technical agencies in the city and the port working together. They have identified potential threats, conducted training and developed an emergency response network. The plan has also educated the public on dangers and appropriate courses of action. Weihai was greatly helped here by Kobe’s experience with the Great Hanshin-Awaji Earthquake of 1995 and its subsequent response. Also for natural disaster preparedness and management, two plans established a new government Disaster Prevention Welfare Committee, ten community education centers and a disaster shelter park in the urban area.

Another physical project aimed to improve the treatment of waste water sludge, which is currently overwhelming the sanitary landfill. The project has collected information from abroad (starting with Kobe’s experience presented at the relevant Workshop), undertaken case studies of other cities, and devised a new plan, implemented in 2008.

Further Action Plans initiated a waste disposal and treatment center, and activity programs to improve the health of the city’s elderly.

Chennai, India
AUICK Workshop Action Plan Implementation

The first Action Plan for Chennai was to deal with HIV/AIDS, a growing problem throughout South Asia. It mobilized the city’s health department, NGOs and the local UNICEF office to develop an education campaign and a testing and counseling service center. This was achieved by early 2007. The Plan has been awarded both the ‘World Leadership Award’ by the World Leadership Forum in London, and the ‘Prime Minister’s Award for Excellence in Administration’.

Second came a plan to prepare for the coming growth of the aged population. This is not yet considered an urgent problem, since the numbers remain small and the family structure is still considered capable of managing the numbers that exist. But it is important for the city to look to the future to be better prepared for what will surely come. Thus a survey of the elderly was carried out, meetings were held with the health department, and some training of medical doctors in geriatric medicine has begun. In addition, since the city’s Total Fertility Rate (TFR) is now below replacement level at 1.8, it is redesigning some of its neighbourhood maternal clinics into geriatric clinics. Also to assist older citizens, an additional Action Plan provided more elderly-friendly infrastructure for public buildings, and has advocated for care-worker training, in consultation with the City Health Department.

A subsequent project aimed to increase waste segregation and disposal, environmental education, development of slum area facilities and urban greening. Funding of Rs.255.32 crores (approx USD 50m) was
sanctioned from Jawaharlal Nehru Urban Renewal Mission of the Government of India for the plan’s implementation. This produced a sanitary landfill, power generation from RDF (Refuse Derived Fuel), waste compactors, transfer stations, 1,600 community bins and composting facilities for bio-degradable waste in every ward. Over 100 committees of NGOs and resident welfare associations promoted waste segregation with the local media, and schools incorporated weekly environmental lessons and essay competitions from January, 2008. For urban greening, 150 parks were developed, and trees were planted along all major roads and medians. (A subsequent plan also landscaped a 3km-by-800m beach on the east coast of the city with greenery.)

To increase maternal and child health care during the regular flooding which hits Chennai, an Action Plan incorporated MCH care into the government’s Disaster Coordination Committee, focusing on care provision in the first 48 hours after flooding occurs. The plan also arranged a network of local community trainers on disaster preparedness (who also linked NGO and government services at the local level), zonal maps of dangerous areas during flooding, identification of 43 schools for use as disaster shelters, and stockpiling of medicines, water, machinery and equipment at designated shelter areas. Having been implemented in Chennai City, the plan’s expansion to the Greater Chennai area of 6,200,000 people is proposed.

Surabaya, Indonesia
AUICK Workshop Action Plan Implementation

The first project for Surabaya focused on reproductive health, especially concerning HIV and adolescents. It mobilized both schools and NGOs to address the problem. Health staff and teachers were trained in HIV issues and a peer counseling center was established for out of school adolescents.

Another social problem concerned the aged. Their numbers are not growing as rapidly as those in China and Thailand, but Indonesia is not far behind. At the moment, it is considered that the family and the community have sufficient capacities to provide care for the aged. A further project drew on Indonesia’s strong community organization to mobilize both schools and NGOs to provide a supportive community for the aged. It even persuaded the country’s famous national family planning program, BKKBN, to establish a new unit for the aged. Environmental improvement Action Plans also educated citizens and arranged community greening competitions, which are rewarded by the City Mayor.

In 2008, a Management Information System (MIS) was established, supported by AUICK, to increase population data provision to Surabaya City Government for policy formulation. Overseen by the Office of Technology and Information, the MIS was strengthened through a 2009 AUICK Workshop Action Plan, made by the Deputy Mayor of Surabaya, to formulate regulations for institutional commitment to sustained population data collection and utilization.

Two other projects dealt with urban infrastructure problems. One aimed to promote conservation and better waste management through an education program for the schools and entrepreneurs. It surveyed business establishments, did pollution measurement, and trained new staff in waste management, while another project is improving water quality through building bio-filters in sub-districts and in business establishments.

For maternal and child care and natural disaster preparedness, a government Task Force for Disaster and Casualty Management was set up, health workers were trained, and MCH seminars and media awareness activities were arranged. As a result, staff members of all public health centers are now trained in disaster preparedness, and 120 of Surabaya’s 163 villages are declared ‘ready for disaster control’.

Kuantan, Malaysia
AUICK Workshop Action Plan Implementation

Kuantan’s first Action Plan project was designed to address the growing HIV/AIDS problem. A plan was
made to inform Kuantan’s 80,000 adolescents on sexual and reproductive health issues through youth-friendly clinics, and treat youths with unwanted pregnancies. Its implementation was not necessary though, as a similar project was planned by the Pahang State Health Department.

A second project aimed to ensure 100% enrollment in primary education, speaking to the second of the MDGs. This established committees of teachers and parents in each school to assure that all eligible students attended and did not drop out. It also distributed financial assistance to poorer families to ensure that their children stayed in school.

A third project established a new Reduce-Reuse-Recycle (3R) program for the city, based on many of the excellent activities that Kobe displays. The Mayor’s approval was obtained, a new steering committee was established, the Urban Services and Environment Department was expanded with new staffing and staff training, and a new recycle collection system was planned. This was put into effect in 2008.

A plan was also devised to improve the city’s water system. Shortages have been experienced in part because the water system is old and the city’s demand has grown beyond it. A detailed plan was developed with city engineers, land was acquired and the construction of the new system was begun in 2008.

An Action Plan to improve community care for older persons strengthened coordination among NGOs, Community Based Organizations (CBOs) and the formal sector. The Community Department of Kuantan Municipal Council also arranged data collection to assess the increasing need for elderly care provision.

A National Security Department plan for state and district levels gives Kuantan a well-developed disaster preparedness and management plan, but in 2007 this lacked an MCH component. A Workshop Action Plan thus advocated for its amendment to incorporate monitoring and relocation of pregnant women to hospitals and other safe environments, and provision of specific maternal and child health care items in times of pandemics or natural disasters, such as Kuantan’s regular flooding. The disaster plan is now annually reviewed and updated, and the MCH component was utilized during flooding in 2008. The amended plan is implemented not only in Kuantan, but also at the level of Pahang, the third largest state in Malaysia.

Faisalabad, Pakistan
AUICK Workshop Action Plan Implementation

Faisalabad’s first Action Plan project was to promote condom use as a movement against the spread of HIV/AIDS. The plan developed an adult education campaign, mobilizing the health department, NGOs and local religious leaders.

The second project was to promote universal primary education, especially important for the education of girls. City leaders and teachers were mobilized to raise enrollment, new teacher training courses were established, and data on enrollment were collected.

Subsequent to the plan’s implementation, primary school enrollment in Faisalabad climbed by 9-10% for two successive years, reaching the overall level of 82%, compared with 53% for Pakistan as a whole.

Faisalabad has now begun to tackle one of its most serious environmental problems: sewage. The existing system is well past its age; it has not kept up with growth. During the summer rains, fortunately for only two months and bringing no more than two inches, the sewage system is overwhelmed and raw sewage spills out into the city. Two AUICK Workshop Action Plans conducted surveys on sewer line infrastructure and replacement of outlived/old sewer lines, and advocated for increased supply of clean water and sewerage to cover the entire city. Pumps and disposal station screens were replaced, open channels and drains remodeled or replaced with sewer lines, and sludge machinery purchased. Factories were requested to construct their own treatment plants, and the plan stopped the establishment of new factories in the urban area.

A further plan for an integrated solid waste management system purchased equipment and employed specialist staff for citizen awareness programmes. Door-to-door waste collection piloted in eight union councils was then expanded citywide, including slum areas. The plan arranged waste composting plants, landfill infrastructure, machinery and transportation and an Environmental Impact Assessment (EIA) for a new landfill site.

Prior to 2007, Faisalabad had not developed disaster preparation strategies. An Action Plan established a government Disaster Management Cell, focusing on maternal and child health care. It registered the mothers of children aged 0-5 years, for their health care provision in a disaster situation. This system has also improved health care access in normal time, initiating a large-scale child vaccination programme. It has reduced the previous 30% vacancy in MCH medical worker posts to around 5%, by training community midwives and female doctors. Rural and urban clinics and delivery rooms have been upgraded, and the Action Plan is set to expand to incorporate NGOs and the private sector, while being advocated to the whole Punjab region for replication by other cities.

Olongapo, Philippines
AUICK Workshop Action Plan Implementation

Olongapo City’s first two projects dealt with reproductive health and education. One established an adolescent reproductive health care program. It organized and held classes for the city’s young people, and established a system of adolescent health centers in the rural villages around the city. The Plan advocated successfully for the Department of Education to develop textbooks to incorporate reproductive health and HIV/AIDS into the school curriculum, and Olongapo City passed a resolution for annual budget allocation for HIV testing kits for the Hospital AIDS Core Team (HACT).

The second project pushed for universal primary education, especially among the poor. The plan advocated for increased scholarships under a new Master Plan for Universalization of Education for Urban Poor. As a result, the Mayor raised education...
to the second highest priority of the City’s ten-point agenda, reflected in additional legislation and ordinances. Scholarships were provided to 3,187 students in 2005-06, 3,962 in 2006-7, 1,927 in 2007-8, and 2,882 in 2008-9. The plan also led to the Special Program for Employment of Students (SPES), and arranged volunteer student counseling services.

To assist the aged, another project developed a Senior Citizen Health Care Plan with city funding, and the cooperation and servicing of a tertiary-level hospital which is owned and operated by the City Government of Olongapo. This has now identified and funded health care for some 9,500 senior citizens, an estimated 88% of the total number.

To increase Olongapo’s preparedness for annual typhoons and flooding, an Action Plan set up a Disaster Volunteer Brigade for community-based preparedness, integrated into and trained by the city’s Disaster Management Office to augment its disaster prevention activities.

Additional plans have established an extensive Information, Education and Communication (IEC) campaign to increase environmental awareness in elementary schools, and a senior citizens skills inventory center, based on the Silver College in Kobe.

A further development is important to note. With AUICK assistance, Olongapo received support from The Philippines UNFPA country program to create a city Management Information System (MIS), named the Socio-Economic Information System (SEIS). The project, which generates updated population data to improve service provision by Olongapo City Government, was extremely successful, so much so that UNFPA promotes it as a Country Office best practice. A recent AUICK Workshop Action Plan has also utilized the MIS to formulate a target-based health development strategy, in order to maximize the effective distribution of the city government’s limited budget for health care service provision.

Khon Kaen, Thailand
AUICK Workshop Action Plan Implementation

The first AUICK Workshop Action Plan for Khon Kaen addressed the country’s and the city’s growing HIV/AIDS problem. In effect, three different but related projects for reproductive health were devised. One focused on AIDS and adolescents, developing an educational campaign. A second focused on the problem of unwanted pregnancy among adolescents. This worked with local NGOs to develop a peer counseling center, a website, and expanded services in the government’s excellent primary health care system. A third attacked infant mortality, which is already quite low, but can be improved. This developed a new training program for medical personnel to identify problem symptoms early.

Seven other projects were developed for primary education, the environment, the aged and water.

Though these are not reproductive health issues in the narrow sense, they all have a direct and powerful impact on RH.

An Action Plan for the drive to keep poor children from dropping out of school helped primarily girls, with financial assistance and free education programs. An out-of-school education centre was also established, and volunteer teachers educated and monitored poor, homeless and disabled children.

To address environmental problems, the city developed a bio-diesel project which will both lower city fuel costs and reduce CO² emissions. A bio-diesel plant was constructed with the help of Khon Kaen University engineers, and used oils are collected from local restaurants to produce fuel for the city’s fleet of trucks and busses.

For the growing aged problem, a project mobilized the city health services to address geriatric issues, provided funds for elderly poor and organized a program for senior citizens to educate in municipal schools.

A project was also launched to reduce water consumption in the metropolitan area. Past and current water consumption levels were assessed, business and NGO partners were identified, and a media campaign and citizen awareness activities were conducted.

Action Plans for community 3R awareness campaigns, volunteer health care assistance, and elderly activity clubs for all 88 communities of Khon Kaen Municipality have also been launched.

Danang, Vietnam
AUICK Workshop Action Plan Implementation

The first Action Plan for Danang addressed the rising HIV/AIDS problem. It especially focused on the youth, mobilizing and training health workers and establishing a highly innovative street corner youth counseling program with media campaigns and providing necessary medical supplies. This has been especially successful, and has actually been incorporated into the national Vietnam Family Planning Association.

A second project was formulated to ensure 100% primary school enrollment and maintenance. This began with information gathering on teacher perceptions and needs, identifying at risk children and families, working with parent and teacher organizations, and providing financial assistance to the needy.
A third program concerned waste water treatment, a problem that emerges with rapid population growth. The plan established a new company to manage wastes, developing new training courses for all staff with the help of the university, forming two new NGOs, and advocating for the construction of an industrial and medical waste treatment plant.

A fourth plan addressed the problem of the aged, by providing free medical insurance to the over-80s, and financial assistance and support foundations in each ward of the city. The plan also advocated for a fund for soft loans for the aged who are still actively engaged in what is often called the "informal" sector of the market. The aged will soon begin to grow rapidly due to greatly reduced fertility in the recent past. For the most part it is felt that the family can provide effective services for the aged, but ways are sought to help keep older people active and productive.

Under an additional elderly-care Action Plan, the city’s government collaborated with communities, NGOs and the private sector, to provide funding for elderly citizens living alone or in poor households. Activity clubs increase their physical wellbeing, and financial support is improving welfare centers.

With heavy rains and flooding badly affecting Danang’s wastewater management, another Action Plan selected a pilot resettlement residential area, and designed a central wastewater treatment system as a blueprint for adequate sanitation with minimized land pollution and ground water contamination.

Postnatal health care in Danang

Implementation is now completed and pending expansion.

To improve maternal and child health care during the regular flooding and typhoons, a subsequent plan established a Special Committee for MCH in Natural Disasters. Authorities realized the urgent need for MCH action and strongly supported the plan. Finally, two further plans have arranged environmental education for improved waste management at the community level, and increased housing for poor citizens in two pilot areas, with a view to future citywide expansion.

AUICK Management Information Systems (MIS)
The Importance of Institutional Partnerships between Local Governments and Universities

Mr. Arifin Zaenal, Exchange Student, University of Kobe and University of Pittsburgh, with AUICK

AUICK has developed Management Information Systems in four of its Associate Cities, with the support of UNFPA, through City University Partnerships (CUPs) and AUICK Workshop Action Plans.

I. Background

The concept of building mutual collaboration between governments and universities has increasingly received attention from stakeholders and policymakers. On one hand, the strategy, using the functions of a university, can be considered as an attempt to fulfill the close integration of education, science, technology, economy and politics. At the stage of policy formulation for example, analytical and rigorous study is highly required by local governments in order to achieve sound and feasible policies. On the other hand, the optimal functions of a university as a "think tank" and knowledge producing agent will need policy support of promotion, guidance and financial assistance from its local government. Accordingly, the contribution of each party to the economic development in a local area is highly requisite.

One of the organizations which promotes the establishment of collaboration between local governments and universities is the Asian Urban Information Center of Kobe (AUICK). Established in Kobe in 1989, the organization has become an urban and information network for administrators.
of medium-sized cities in Asia. With the commitment of Kobe City Government and UNFPA, the organization reflects the needs of sharing experiences among cities specifically in the field of population and urban issues. Moreover, the organization has tried to foster the partnership in five of the AUICK Associate Cities (AACs) to establish systems for the provision of data to city governments by local universities. The Management Information System (MIS) has been initiated in the cities of Khon Kaen (Thailand), Danang (Vietnam), Chittagong (Bangladesh), Surabaya (Indonesia), and Olongapo (Philippines). Before profiling the current phase of this initiative in the five cities, this article will first highlight the reasons why some local governments lack access to data on their populations. Second, the importance of population data and how City-University Partnerships (CUP) in developing MIS can contribute to local development will be explained. Lastly, the article will also identify the roles of local governments and universities in the CUP scheme.

II. Limited Access to Population Data and Information

The availability of high quality data and the utilization of ICT (information and communications technology) have been considered a powerful tool in achieving economic performance and meeting development goals, both at the national and local levels. ICT in particular has contributed to increasing government organizations' productivity and to making the policy formulation process more efficient and easier to implement. The growing involvement of communities, private sectors, academics, non-profit organizations and so forth, leads to the willingness of local governments to provide high quality information and to use ICT for the specific purpose of local development.

As a result, a system is required to meet the demand of people participation in consultation and decision making, both in public services and in the allocation of these services to the public. However, there are some constraints which local governments have to encounter to provide high quality data and information. First, insufficiencies of timely, accurate, and official data are seen to be the most serious problem, especially at the local level. Included in this kind of data are population data, such as on births, deaths and migration rates. Second, lack of attention from local governments has caused a number of trained and skilful personnel to move away from the field of population, as their expertise is no longer fully utilized. Low income of personnel in the field of population has been seen to be a cause of the problem. In the case of cities, however, increased populations means the requirement of more personnel to address the impact of urbanization. Furthermore, there are still some logistical problems whenever local governments have established MIS. For example, local governments face the financial burden of upgrading computer software, hardware, lacking networks and internet connection, and providing the required skills to human resources. In this specific area, the significant challenge always faced by local governments of the need for continuous training in the areas of database management, systems testing, data sourcing, validation, standards and analysis, and profiling and/or analysis of data users. Consequently, a more comprehensive management information system and cooperation among local governments and other parties regarding the policies and strategies of the district for the population and local development are urgently required.

III. MIS: Definition and Functions

In the field of population, MIS can be defined as an institutional service unit in a local government which produces and manages population data and information. The system is specifically established for the purpose of the routine collection, processing, storage, utilization and dissemination of population data and information. The data can then be informed to local development stakeholders on a timely, routine, reliable and predictable basis via uncomplicated and user friendly interfaces. With such data, the MIS is expected to play significant roles in various local government policies, including policy formulation, monitoring and evaluation, standard setting, provision of regulatory frameworks, coordination, and optimization of resource use through improved access to and use of MIS across agencies in the local government.

As mentioned earlier, the importance of the MIS is that it employs ICT through computerized systems in its operation. The first component of the system is a population database which includes information on demographic and socioeconomic development. More specifically, this database contains timely and relevant demography statistics and indicators disaggregated by geographic coverage, income level, gender, age groups, and so on. The database can also include sectoral data on factors such as health, infrastructure, economy, education, environment and agriculture.

Moreover, the information in the database of an MIS will be quantitative (statistical and financial), qualitative (textual and descriptive), and geographic (graphical and illustrative). It is expected that the database would be available on-line. In addition, some channels for the dissemination of information can be in the form of websites, e-mail lists and newsgroups. In the case of MIS Development in five of the AUICK Associate Cities (AACs) with the support of AUICK and UNFPA, the MIS is basically designed to be the portal or central source of population data for policy formulation. The cities' governments are encouraged to establish partnerships with local universities in order to make available the population indicator databases. The databases will then become the government's property, but available for public information. In addition to including research and evaluation of the impact of programs and projects in population management program areas, the MIS can also be linked to other existing government databases, both at the local and national levels. For practical reasons, the MIS can be a tool for monitoring and evaluating cities' Action Plans and commitment which have been agreed in the Workshops conducted...
by AUICK.
In line with the above mentioned definition and functions, the MIS will enhance the overall effectiveness and efficiency of the bureaucracy in city governments. Expectations are for the system to promote information exchange among governments and academics, with public access, such as to business entities and the community. Specifically, the MIS promotes awareness among local stakeholders of emerging issues in population and local development. Finally, the system promotes and encourages the use of population data in formulating research and training programs which can be collaboratively conducted among governments, universities, NPOs and NGOs.

IV. Indicators and Sources of Data

There are many sources which can be used to collect the necessary data and information on population and development at the local level. The sources include reports, surveys, census and research studies conducted by various agencies and institutions, such as statistics agencies, ministries, local organizations and research institutes, etc. In this respect, identifying indicators and classifying based on the purpose of the MIS would be mandatory for building the system. The purpose itself can be divided into several steps of policy formulation, from the input to the outcome level. Below are some examples of the indicators which can be included in an MIS.

V. Different Roles of Local Government and University

To fully establish and implement the MIS, it is mandatory to ensure the MIS’ availability and accessibility through a variety of channels. These include websites, databases, local area networks, hard-copy reports, wide area networks, the internet and possibly CD-ROM. With improved population data, not only local, but also national research initiatives on population-related topics are expected to increase. From this stage, outputs of the research will become inputs for formulation of population-related policies, which in turn improve the quality of life of people in cities. To reach these goals, the important roles between local governments and

Table 1. List of Indicators of Management Information Systems

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<td>Development Process</td>
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<td>- Distribution of Local Government Expenditures</td>
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<td>- Distribution of Schools, Hospitals, Health Centers, Water Supply,</td>
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<td></td>
<td>Garbage Disposal, and other basic infrastructure</td>
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<tr>
<td>Development Outcomes</td>
<td>- Unemployment Rate, Total and by Sex</td>
<td>Statistical Agencies, Local</td>
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<td>- Average Family Income</td>
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<td>- Literacy Rate by Sex</td>
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<td>- Morbidity Rates</td>
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<td>- Distribution of Foods and Logistics</td>
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universities within the scheme of the CUP should be clearly distinguished.

A. Government
Local governments play an essential role in advancing mutual collaboration with local universities. In the light of data collection for MIS, for example, provisional assistance concerning population, taxation, administration services, land use, and so forth, is a basic input for the creation of the system. Additionally, local governments can provide sufficient infrastructure to support knowledge technology innovation, including social institutions, university laboratories, and research centers. Cultivating a kind of local culture that can help various stakeholders to communicate and cooperate with each other is also significant. In many cases, however, this effort is less likely to be implemented, as the necessary coordination is constrained in some developing countries. This becomes a burden on the government. Lastly, strengthening personnel training and knowledge building, as well as linking governments with universities and other entities such as industries, NGOs, and other research centers, are necessary for MIS to be sustainable.

B. University
Human resources developed by educational organizations is an essential condition for a city and its development. Obviously, the people who work in universities have the intention of policy research, as well as practical experience and social contribution. In other words, sound policies cannot be developed without proper education systems and research. Through collaboration with local governments, universities will get information fed back to inform them on appropriate innovation items or areas and to increase their research level. As a result, the two-way partnership chain between university and local government will facilitate the feasible implementation of MIS.

VI. Profile of MIS
As mentioned, the MIS can provide data and information in the field of population and local development. By establishing such a system, a local government can gather reliable inputs for formulation and evaluation of policies and programs related to population in order to improve public wealth at the city level. For this reason, AUICK has encouraged the AUICK Associate Cities (AACs) to formulate and maintain MIS through the City University Partnership scheme.

1. Chittagong, Bangladesh
As the Action Plan for Chittagong at the Second 2009 AUICK Workshop, a Management Information System (MIS) was set up between the city’s Premier University and Chittagong City Corporation. The project is based on the concept of the AUICK facilitated City University Partnership (CUP). In Chittagong, the MIS is implemented without direct financial support from AUICK or UNFPA. It facilitates the linking of service statistic data from health centers with Chittagong City Corporation, for improved policy formulation.

2. Surabaya, Indonesia
An MIS project conducted by DAMANDIRI Foundation, the City Government of Surabaya, Airlangga University, and the Indonesian Institute of Human Development in Surabaya, has provided population related data to government agencies within the City Government of Surabaya since May, 2009. The data is processed and utilized for monitoring the respective activities of the agencies, which have also submitted the data to their parent Ministry for policy decision-making purposes.

3. Olongapo, Philippines
Under the leadership of Mayor James Gordon Jr. and the City Planning and Development Office of Olongapo City Government, the Socio-Economic Information System (SEIS) is established in Olongapo since September, 2008, with the support of AUICK and UNFPA. Under the System, data is collected on the ecological profile of the city, its demography and health and education indicators. The data is utilized by the Department of Social Welfare and Development Office (DSWD), the Health Insurance Programme, City Health Officer, Public Employment Service Office, City Public Library, all barangay (local community) chair-persons, Transport and Traffic Planners (TTPI) Inc., Subic Water Company, as well as local academic institutions. The SEIS is listed as a Best Practice of the UNFPA Philippines Country Office.

4. Khon Kaen, Thailand
Under the directorship of the Chairman of Khon Kaen Municipality, an MIS was set up in 2006 for Khon Kaen University project staff to provide data to Khon Kaen Municipality. The Project examined the existing database within the Municipality and relevant agencies; examined data requirements and the culture of data use for decision making by the Mayor and officials; and assessed the existing capacity of the Municipality. It provided data on population, poverty, education, health, HIV/AIDS and environment indicators, from both primary and secondary data, especially for retrospective data. It also arranged training on statistic sample survey and estimation of necessary statistic parameters to Khon Kaen Municipality staff.

5. Danang, Vietnam
In January, 2009, the Danang People’s Committee signed on the approval of completion for the Danang MIS. With the support of UNFPA Vietnam Office, and under its Steering Committee which includes the Vice Chairman of the Danang People’s Committee and the Director of the University of Danang, the MIS provided population related data which have been utilized for policy formulation by the Department of Statistics, the Department of Planning and Investment, the Office of the Danang People’s Committee, the Population and Family Planning Division of the Department of Health. The MIS has also assisted annual socio-economic development planning for Danang.
**Chittagong** - Chittagong Development Authority is planning to build a new 10-metre high dam (and four-lane road) along its coast to cope with rising sea levels and protect the port city from sea surge. The largest project in the Authority’s history is also supported by the Japan International Cooperation Agency (JICA) and Bangladesh Government. Chittagong City Corporation is prioritizing expansion work of roads, new bridges and culverts, and upgrading of drainage systems, in order to permanently remove water logging problems from the city. (www.thedailystar.net)

**Weihai** - Weihai Municipal Government has won the 2010 China City Information Application Award for its implementation of the Intergraph® Incident Management solution for its Emergency Operations Center (EOC). The system utilizes control theory principles and methods, and the inclusion of contingency plans. Its data sources for efficient information-sharing across departments are cost-effective and enhance the decision-making process to meet both emergency command and business needs. (www.prnewswire.com)

**Chennai** - The Tamil Nadu Slum Clearance Board is to begin a GIS-based slum Management Information System (MIS). With one-meter resolution satellite imagery of the city's topography, the system will help examine basic infrastructure in all slum localities, with micro details on roads, sewer, power and water supply available through its centralized system. The data is to be used for preparation of a development chart for every slum, with a 20-digit identity number given to each of an estimated 320,000 households in Chennai and its suburbs' slums. Project work should then be taken up accordingly. (www.hindu.com)

**Surabaya** - Surabaya has been named Best ASEAN Sustainable Environment City. Its environmental management, including policies for green open spaces to cover 30 percent of its urban area, beat 44 other cities in the Asia and the Pacific region. (www.antara.co.id)

**Kuantan** - The Malaysian national government will focus on developing an urban region incorporating Kuantan, Gambang, Gebeng, Kuantan Port and Pekan district, as a major growth location to spur development efforts in the East Coast Economic Region (ECER) and to address imbalances in development within the region. (mysarawak.org)

A new complex to serve as a home and skills training center for the poor and less fortunate has opened in Kuantan. The complex, costing RM3.5 million, was built by the Pahang Islamic Religious and Malay Custom Council (MUIP) on 1.8ha of land. (www.thestar.com.my)

**Faisalabad** - The City District Government Faisalabad targeted slum areas with a 12-day anti-mosquito spray campaign in March 2011, to save people from malaria, dengue and other seasonal diseases. (www.pakistan todays.com.pk)

Also in the Faisalabad, Pakistan’s first-ever model refuse-derived fuel (RDF) plant is being set up on a Design, Build, Finance and Operate basis, under Public-Private Partnership (PPP). It will dispose of tons of the waste produced by the industrial city on a daily basis, giving it a cleaner look and helping to reduce the incidence of diseases like hepatitis. (www.pndpunjab.gov.pk)

**Olongapo** - Recognizing the importance of Civil Society Organizations (CSO) in the successful implementation of government programs, the Department of Social Welfare and Development (DSWD) of Olongapo City Government is seeking to help to stamp out poverty, provide social protection and promote the rights and welfare of the poor, through local government units, non-government organizations, national government agencies, and other members of civil society. The services of volunteers are also required to share knowledge, experience, skills and resources in working with disadvantaged individuals, groups, and families in the DSWD centers and institutions. (www.subicbaynews.blogspot.com)

**Khon Kaen** - Srinagarind Hospital in Khon Kaen is arranging art and drama performances for children with chronic illnesses, given by sufferers of the HIV virus, who have participated in art and drama workshops as part of their holistic care programme. Supported by UNICEF Thailand, the scheme uses creative activities as a means to better communicate with children and help them express their feelings. More than 10 creative workshops have been organized for some 250 children living with HIV nationwide. (www.unicef.org)
The Government of Japan Grant Assistance for Grassroots Human Security Projects Scheme (GGP) is supporting a farmers' group in Khon Kaen Province, through a project called "Promoting Organic Agriculture for the Reduction of Damage to Health and the Environment". Coordinated by the Association of Environmental and Rural Development (AERD), this assists conversion from modern to organic agriculture methods where land is impoverished due to fertilizer and pesticides. The project aims to restore farmland, improve health and contribute to reducing poverty and debt. Cooperative compost production is also expected to contribute to community development and closer ties between farmers. (www.th.emb-japan.go.jp)

Danang - Danang City is establishing ten tsunami warning stations along its coast, and has hosted Vietnam's first tsunami preparation exercise on 1 September. Officials of other coastal towns and provinces attended the event, which was based on a simulated tsunami triggered by an earthquake off the Philippines' western coast. It is hoped that other localities with high tsunami risk will arrange similar exercises and drills. (www.vnnews.net)

AUICK International News

UNEP Billion Tree Campaign - Continuing in the United Nations "Year of the Forest", the Plant for the Planet: Billion Tree Campaign of the United Nations Environment Programme (UNEP) has promoted the planting of 11.8 billion trees. The campaign encourages the planting of trees in four key areas, namely (i) degraded natural forests and wilderness areas; (ii) farms and rural landscapes; (iii) sustainably managed plantations; and (iv) urban environments. Trees have to be well adapted to local conditions, and mixtures of species are preferred over monocultures. Many trees have communal benefits, especially for the poor, and ownership, access and use rights are as important as the number of trees. (www.unep.org/billiontreecampaign)

MDG Progress Report 2011 - According to the World Bank and International Monetary Fund (IMF) publication, Improving the Odds of Achieving the MDGs – Global Monitoring Report 2011, two-thirds of developing countries are on track or close to meeting the Millennium Development Goals (MDGs) by 2015. The report outlines how developing countries will likely achieve the MDGs for gender parity in primary and secondary education and for access to safe drinking water, and will be very close on hunger and on primary education completion. Progress is too slow, however, on health-related outcomes such as child and maternal mortality and access to sanitation, and the world could miss these MDGs by 2015. The fight against poverty is progressing well, with the world on track to reduce by half the number of people living in extreme poverty, especially with rapid growth in China and India, which recorded a 455 million person reduction in extreme poverty rates. Many African countries are behind though, with 17 countries far from halving extreme poverty. (www.worldbank.org)

The United Nations Millennium Development Goals Report 2011 also outlines related progress, stating that the global poverty rate is expected to reach below 15 per cent by 2015, improving on the target of 23 percent set out at the Millennium Summit in 2000. (www.un.org/millenniumgoals)

UNFPA Publication on Sexual and Reproductive Health - UNFPA have published the report Sexual and Reproductive Health Framework - A Reality for All. The publication outlines progress achieved in implementing reproductive health and rights, as well as remaining gaps and priorities for programme planning and implementation. (www.unfpa.org/public/home/publications)

Making Slums History - UN-HABITAT, the agency dedicated for creating human settlements for poor people across the world, is arranging the International Conference: Making Slums History: a worldwide challenge for 2020, from 14-16 November, 2011. The Conference is being jointly organized by the Kingdom of Morocco and UN-HABITAT, and will review at mid-course the achievements towards the Millennium Development Goals (MDGs), to give countries, that have by a long way tackled slum growth and reduced urban poverty, a platform to share their successful practices, principles and policies. (www.unhabitatre.org)

A World Fit for Young People - At the United Nations High Level Meeting on Youth, 25-26 July, twenty-five agencies reaffirmed their commitment to make young people a priority and to incorporate youth perspectives in their work, committing to strengthening cooperation mechanisms at the global, regional and national levels, and recognizing that many important groups are marginalized and that efforts should be made to include them in society and in decision-making. (www.social.un.org/youthyear/)
AUICK’s International Advisory Committee (IAC) held its annual meeting on 14-15 June, 2011, at the Intercontinental Hotel, Bangkok.

On behalf of AUICK, Dr. Hirofumi Ando, President, welcomed the IAC Members, and Mr. Masashi Hashikura, Deputy Executive Director, outlined the completed and proposed activities of 2010-11. Under the Chairmanship of Dr. Gayl D. Ness, the Committee then reviewed the AUICK Program and advised on its future direction.

Members commended the recent implementation of the 2011 Research Dissemination Meeting as a forum for the exchange of information and practices in primary and reproductive health service provision. They also remarked on the successful establishment of Management Information Systems (MIS) in five of the AUICK Associate Cities (AACs), and suggested that more information be disseminated on the MIS to increase awareness on the project (see pages 22-25). They highlighted the importance of AUICK’s Newsletter to disseminate information its activities, and the increased usage of the organization’s website in 2010 by 58%.

For the continuing 2011 Program and beyond, the Members advised on the theme and methodology of future Research Projects and dissemination activities.

IAC Members
Dr. Prem. P. Talwar
Adjunct Professor, School of Public Health, University of North Carolina (India)
Dr. Haryono Suyono
Former Minister Coordinator for People Welfare and Poverty Alleviation (Indonesia)
Dr. Krasae Chanawongse
Founder, College of Asian Scholars, Former Minister of Foreign Affairs (Thailand)
Dr. Gayl D. Ness
Professor Emeritus, University of Michigan (USA)

AUICK Secretariat
Dr. Hirofumi Ando
President
Mr. Masashi Hashikura
Deputy Executive Director
Mr. Toru Fujiwara
Manager
Mr. Benjamin Tams
Staff
Ms. Shimako Clark
Staff