The Study Programme for the Promotion of the Collaboration between Child Welfare and Maternal and Child Health ～What can be done to attain Welfare and MCH collaboration for the benefit of mothers and children～

Country Reports

Japan International Corporation of Welfare Services (JICWELS)

Contents

The Study Programme for the Promotion of the Collaboration between Child Welfare and Maternal and Child Health ～What can be done to attain Welfare and MCH collaboration for the benefit of mothers and children～

Benin

REPORT OF THE COUNTRY: BENIN

Located on the Gulf of Guinea, the Republic of Benin (ex Dahomey) is a state in West Africa. He bounded to the north by Niger, to the north-west by Burkina Faso, to the east by Nigeria to the west by Togo and south by the Atlantic Ocean.

It covers an area of 114,763 km2 and: 9,325,032 inhabitants with a population density of 71.7 inhabitants per km2. The average annual growth rate is estimated at 3.25% for overall and 4.12% for the urban population.

Benin has 12 counties, 77 towns, 546 villages and 3747 Districts and neighborhoods of cities. Its administrative capital is Porto-Novo and Cotonou is the economic capital.

Name and occupation of the candidate

CODJIA Estelle Arlette Déborah

- Midwife graduate of State Technician in Nursing and Midwifery.
- Head of Nursing and Midwifery health zone Ouidah (Whydah Hospital).
- ***Overview of the applicant's organization***

The hospital area Ouidah is a hospital which covers three municipalities that are: Ouidah commune, commune Kpomassè the common Tori-Bossito. This is a hospital that receives the reference cases came from the peripheral centers of the three municipalities that constitute the health area.

Different specialties exist in hospital care which promotes support for references.

- Note that the curative, preventive, rehabilitative and promotional materials are available in the hospital.

Supports visuels sur le pays

DRAPEAU DU BENIN

CARTE DU BENIN

1- GENERAL INFORMATION OF THE COUNTRY PARTICIPANT

According to the Statistical Yearbook 2011, the most frequently reported diseases in the consultations are: malaria 42.8%, 13.5% acute respiratory infections, other gastrointestinal disorders 6.7%, 5.4% Injury, Anemia 4.3%, diarrhea 3.5%
The key indicators identified in the health statistics yearbook 2011 Shows the results of the third Demographic and Health in Benin (EDSB) conducted in 2006 which is as follows:

- Life expectancy: 62ans
- Maternal mortality rate: 397 maternal deaths per 100,000 live births
- Neonatal mortality rate: 32 ‰
- Infant mortality rate: 58.4 ‰
- Rates of child mortality: 88.9 ‰
- Contraceptive prevalence: 18.8%
- Birth rate: 48%

2 - OVERVIEW OF MATERNAL AND CHILD HEALTH

System and current status of maternal health services and child

Benin has good coverage in health infrastructure (89% of the population lives within 5km of a health facility).

In 2011 we noted the following performance indicators:

- Rate of prenatal care: 97.2%
- Percentage of births attended: 94.4%
- Rate of postnatal consultations: 38.9%
- consultation rates healthy children less than one year: 70.4%
- Rate of consultations healthy children 12-35 months: 3.6%
- Prevalence of HIV / AIDS 1.7%
- The high morbidity and mortality with the persistence of communicable diseases and the emergence of non-communicable diseases;

- Despite a good health infrastructure coverage (89%) and an acceptable geographic accessibility, attendance rates have remained low is 45.4%.

Strengths and weaknesses in the area of maternal and child health

Forces

- Free of cesarean section
- Training of maternity active management of the third stage of labor
- Free malaria treatment

Weaknesses

- Technical Equipments often inadequate
- Lack of qualified staff in the health
- Inaccessibility geographical share of the population (lack of facilities)

Strengths and weaknesses in the area of child protection

Forces

- Law on child protection in Benin (Act No. 2006-04 of 5 April 2006 on condition that the displacement of minors and combating child trafficking in Benin)
- Law on child trafficking (Law n ° 2006-04 dated April 5, 2006 on condition of displacement of minors and suppression of trafficking in children in the Republic of Benin)
- Free schooling for children in elementary school: Orientation in education: Education for all: children all children in school

Weaknesses

- After the free, all children are not yet enrolled in rural
- Child abuse
- In Benin, there are still street children

Programs and policies that work in Benin

- Free of cesarean section
- National Program for the Fight against Malaria (free treatment)
- Program of free schooling for children

Issues and Challenges

Difficulties

- Lack of involvement of health workers in the community-level interventions

- No hospital area in several health areas
- Lack of staff
- Shortage of blood products

Challenges

- Recruitment of qualified staff
- Implementation of hospital areas throughout Benin

Difficulties in meeting the challenges

- Depression in Benin

The priorities of health and wellness

1 - Vulnerable groups: pregnant women and children under 5 years

2 - priority health problem: malaria, anemia and malnutrition

3 - At the hospital area Ouidah importance will be given to the refocused antenatal and early care of children, which will detect problems early priority health

4 - Stakeholders hospital, Departmental Directorate of Health, Ministry of Health; Partners: Project-based funding results, Project Accelerated Reduction of Maternal Mortality and Morbidity due to malaria

3 - EXPECTATIONS IN RELATION TO THE FORMATION

Expected results and objectives through the course

• Strengthen my knowledge and skills on the collaboration between the maternal and child health and the protection of children;

• Strengthen my skills on the IEC made on the protection of children.

• Strengthen my skills on the quality of nursing and midwifery.

Involvement after training

• Provision of appropriate care for maternal and child health populations

• Program to reduce morbidity and maternal and infant mortality.

• Restitution or Continuing Education for staff of the hospital s health facilities and quality of Nursing and Midwifery and the protection of children.

• Reduction Strategy child abuse.

The Study Programme for the Promotion of the Collaboration between Child Welfare and Maternal and Child Health ～What can be done to attain Welfare and MCH collaboration for the benefit of mothers and children～

Indonesia

A. Strengths/weaknesses in the field of health and welfare for mothers and children

1. 3 strengths in the field of Maternal and Child Welfare in my country

   a. Policies

   - The Indonesian"s Constitution of 1945, article No. 28

     Every child has the right to survival, grow and develop as well as the right to protection from violence and discrimination

   - State Law No. 23, 2002 about Child Protection

     Every child has the right to live, grow, thrive and participate reasonably in accordance with the dignity and humanity and the protection from violence and discrimination

   - The Indonesian"s Constitution of 1945, article No. 31 :

     Every citizen deserve education and every citizen should obliged to adhere to basic education

   - State Law No 20, 2003 about National Education System article 34 (1)

     every citizen aged 6 years can participate in compulsory education (20) Government and local government guarantees compulsory education are invited, in the level of primary education for free charge

   - State Law No. 36, 2009 about health

     - Article 131 that infant and children health effort, aimed to prepare healthy, smart and qualified future generations, and decrease infants and children's mortality rate.
     - article 133 paragraph (1) that all infants and children are entitled protected from all forms of discrimination and violences that can disturb their health
     - article 136, adolescence health maintenance effort in paragraph (1) should be conducted by central government , local government and public

     - article 139 that the maintenance health effort for children with disabilities should be devoted to keep alive, healthy, and productive in a social and economic manner and dignified

- Government Regulation no. 66 in 2010: (the amandement on government regulation no. 17 of 2010 on education explanation) and the implementation of article 53 A : for secondary education and colleges implementer provided scholarships for students of low-income household have potential academic 20 % of all new students
- MDG's Goals
- Minimum service standards for the health sector

b. Budgeting

- Ministry of Education and Culture ; Education operational aid , school operational assistance (elementary, junior and senior high school)
- Ministry of Health : Social health insurance for delivery care, Operasional health budget for PHC, Social Healt Insurance for the poor
- Ministry of Internal Affairs National Community Empowerment Program and National Community Empowerment Program Smart and Healthy Generation
- Ministry of Social Child Sosial Welfare Program and Program Keluarga Harapan (Family Hope Program)
- National Development Planning Agency PNPM Generasi, PKH Prestasi
- Ministry of Welfare Coordination Pengembangan Anak Usia Dini (PAUD)
- Ministry of women empowering and child protection Child Friendly City

2. Raise 3 weaknesses in the field of Maternal and Child Welfare in your country/province.

- Decentralization Policy since 2000
- Large number of population
- There is no derivated Central Policy in regional (Governor or Mayor Regulation)
- Limited budget alloction for health, percentage of the national health budget has not been increase and still less than 3% since 2006

- double burden in health care(so many communicable diseases that must be handled, on other hand the morbidity and mortality non-communicable diseases are increasing)
- disparity in health status and in community acces toward quality health care

3. 3 strengths in the field of MCH in my country

A. Policies

- State Law No.36 in 2009, about Health
  - Article 131 paragraph (1,2)

    Health maintenance efforts infant and child must: : aimed to prepare future generations of healthy, intelligent, and quality as well as to lower infant and child mortality

    conducted since the child was still in the womb, was born and until 18 years of age.

  - Article 133 paragraph (1) ;

    that all infants and children are entitled protected from all forms of discrimination and violences that can disturb their health

  - Article 136,

    adolescence health maintenance effort in paragraph (1) should be conducted by central government , local government and public

  - Article 139

    that the maintenance health effort for children with disabilities should be devoted to keep alive, healthy, and productive in a social and economic manner and dignified

- Government Regulation of Exclusive breast feeding No. 33 tahun 2011
- National middle term development plan for 2009-2014 (MDGS 2015)
- Presidential Instruction No 3 in 2010

  about equitable development in health as a fulfillment of the child rights for marginal groups, including children in prison, abandoned children/street children and disabled children

- Health Policies in MOH

  - Mission :

  1. To improve health status of the community, through community empowerment, and involvement of private sector and civil society
  2. To protect the community from problems by ensuring the availability of equitable, fair, good quality and comprehensive health services
  3. To ensure availability and equity distribution of health resources
  4. To implement good governance principles

  - Vission :

  an independent and justified healthy community

  - 8 Priorities of Health Development

    a. Improving maternal,infant and under 5 years of age child health and family planning
    b. Improving nutrition status
    c. Controling communicable, non-communicable disease and improvement of enviromental health
    d. Fulfilling and developing health human resources
    e. Enhancing avaibility, affordability, dIstribution , sqfety, quality, utilization and supervision of drugs and foods

f. Health insurance for poor)

g. Communty empowerment, disaster and health crisis management

h. Enhancing primary, secondary and tertiary health services.

B. Budgeting

- Social health insurance program for the poor covers 19,1 million poor and near poor households, total 76,4 million poeple
- Regional social health insurance
- Social health insurance for delivery care
- Operasional health budget for PHC

C. Facilities and infrastructure :

- Desa siaga, Village Health Post, Village Integrated Post,
- Public Health Services (Puskesmas), a referal Hospital, Integrated Service Centre/ one stop service in Hospital.
- Midwives , are almost in every villages

4. weaknesses in the field of MCH in my country

a. Decentralization Policy, since 2000 ➔,
Based on the *Law on Local Government*, all powers of governance are decentralized to the Province and District or Municipal Government. The central Government retains the power of ***defense, security, foreign affairs, justice system, monetary affairs,*** and ***religious affa****irs* - but basically most of the powers of governance are decentralized to the level of District and Municipal Government – including health care. They set up its own region and priority of the construction, so that Regional Policy is not always in line with the policy of the Central Government.

b. Disparities on child health indicators achievement among provincies,socioleconomic and level of community education.

c. Inequity of health personal and distribution,

Administratively, Indonesia is divided into 33 provinces. Each province is divided into districts and municipalities. There are 497 districts and municipalities in the country. The districts and municipalities are divided into Sub-districts and the Sub-district is divided into villages and kelurahans. The large number of districts and municipalities have a difficult geographicalis causing the spread of health workers many concentrated in cities

d. Limited budget allocation for health. Budget allocation which tends to increase nominally (in trillions) every year. However, if we compare to the total national health budget, the percentage of the national health budget has not been increased and still less than 3%.

5. What are successful areas or programmes ? List 3 areas programmes

a. Community empowerment involving private sector andcivil society

b. Increasing of health status by improving thecommunity acces toward quality health care

6. What are issues/challenges? List 3 issues/challenges

Regarding the above-mentioned issues/challenges, explain background, current situation dan reason why those issues/challenges are difficult to solve

a. Stagnancy decrease of MMR and IMR

b. The limited availability of strategic resources for maternal and child health

c. Lack of knowledge and community awareness about maternal and child health.

A) Indicators

1) Crude birth rate (per 1000 population)

	Country overall
1990-1995	24.5
1995-2000	21.9
2000-2005	21.0
2005-2010	19.1

2) Crude death rate (per 1000 population)

	Country overall
1990-1995	8.1

3) Leading causes of death (1990) and (2010)

- 2001 (Household Health Survey (2001)
  1) Cardiac and Blood vessels diseases (26,3%)
  2) Infection (22,9%)
  3) Respiratory Disease (12,7%)
- 2007 (Basic health research 2007)
  1) stroke (15,4%)
  2) tuberculosis (7,5%)
  3) hypertension (6,8%)

4) Infant mortality rate (per 1000 live birth)

	Country overall
1991	68
1997	34
2012	32

5) Leading causes of infants death (1990) and (2010)

- 1991: 1) Prematurity and LBW,
  2) asphyxia
  3) Infection (Household Health Survey 2001)

- 1997 : 1) Neonatus problems (LBW, asphyxia and Infection) 46,2%
  2) Diarrhea (15%)
  3) Pneumonia 12.7% (Household Health Survey 2001)

- 2007 : 1) diarrhea (41,4%)
  2) pneumonia (23,8%)
  3) meningitis (9,3%) (Basic health research 2007)

6) Under-5 mortality rate (per 1000 live birth)

	Country overall
1991	97
2007	44
2012	40

7) Top 3 diseases and morbidity rate of the under-5 of (1990) and (2010)

- 1995: Diseases: 1) Pneumonia
  2) Diarrhea
  3) Acute Respiratory Infection

  Morbidity rate: 1) 22.5%
  2) 19,2%
  3) 7% (Household Health Survey, 1995)

- 2007:Diseases: 1) Acute Respiratory Infection
  2) Pneumonoa
  3) Measles

  Morbidity rate: 1) 25,5%
  2) 2,13%
  3) 1,18%

8) Maternal mortality rate (per 100,000 live birth)

	Country overall
1991	390
2007	228
2011	246

9) Leading causes of maternal death (1990) and (2010)

- 1991:

  1) Direct caused of maternal death almost 90% occurring in the time child birth and immedietly after child birth (Household Survey, 2001)

  2) Indirect cause are 3 delay, delay to know, delay to make decision and delay to take adequate treatment

- 2007: 1) Bleeding 28%

  2) Eclampsia 24%

  3) Infection 11%

10) Is there any national standards for certifying disabilities in your country?

~~Yes~~ / No

(11) Does your country perform any health check for the diagnosis of disabilities in infants and children ?

Yes / No

Yes, it performs by:

- tools monitoring of stimulation, early detection and intervention of child development and growth, by kader and health workers (all of the provinces in Indonesia)
- Hypothyroid Skrining of newborn (in 8 provinces)

(C) Priorities in health and welfare

1) In your country/province, who are the most vulnerable populations that should be covered by mother and child welfare policies? List five vulnerable groups in order of priority.

- fragnancy and post partum mother
- newborn and under 5 children
- Children with special need of health protection (children with disability, children in orphanages, child abused and neglegted, children agains with law in prison)

- poor women and children
- elderly women

2) In your country/province, what are the priority health issues/programmes in the area of maternal and child health? List five issues/programmes in order of priority.

The priority issues are decreasing of Maternal Mortality Rate, Infant Mortality Rate and Under 5 Mortality Rate

The priority programs are:

a. Deployment of Midwive in the villages

b. Community and family empowering by using MCH handbook

c. Birth Preparedness and complication readiness (BPCR sticker)

d. Basic Emergency Obstetric Neonatal Care (BEONC)

e. Comprehensive Emergency Obstetric Neonatol Care (COENC)

3) According to the analyses in (A), (B) and (C), what is a potential area you would like to work on for a collaborative action plan to improve health and welfare services for mothers and children (as a product of this training course). Please note that this is only tentative and you can confirm your topic after the course started.

4) In order to implement your action plan, who are the key stakeholders (including Ministerial departments, local government offices and their departments and NGOs) in your country/province. Please list all key stakeholders and also identify three main partners you will closely work with.

- Ministry of Social
- Ministry of Internal Affair
- Ministry of Woman empowering and child protection
- Ministry of Education dan Culture
- Ministry of Religion
- Family Planning Coordination Agency

PROMOTION OF THE COLLABORATION BETWEEN CHILD WELFARE AND MATERNAL AND CHILD HEALTH

INDONESIA

OUTLINE

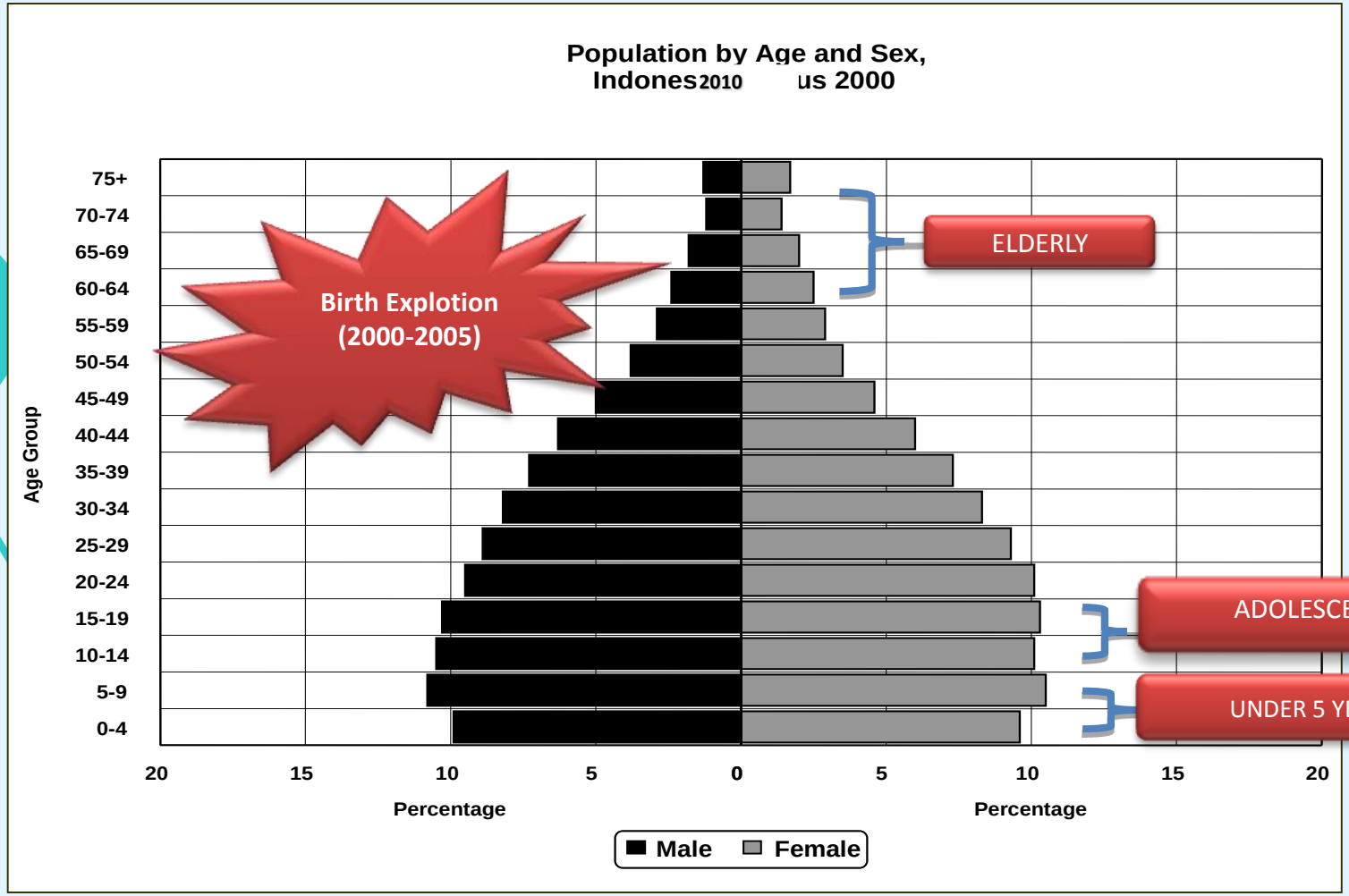
1. CURRENT HEALTH RELATED SITUATION IN INDONESIA
2. MATERNAL AND CHILD HEALTH (MCH) PROGRAM
3. STRATEGIES TO ACCELERATE THE ACHIEVEMENT OF MDG4 AND MDG5

CURRENT HEALTH RELATED SITUATION IN INDONESIA

INDONESIA

Islands : 17.508
Length : 5111 km
Area : 1.910.931 km^2
- 33 provinces
- 497 districts/cities
- 6.487 sub districts
- 76.613 villages

Poppulation of women and children



SOCIO ECONOMIC CONDITION

Population : 237.641.326 (2010)[b]
Pop. Growth : 1.49 % (2010)[a]
Rural Population : 57.7% (2000)
Life expectancy : 69 years[b]
Ethnic groups : 300
Poor people : 30.02 million (2011)[b]
Literacy rate : 92.58% (2009)b
men : 95.65%
women: 89.68%
GDP per capita of 4.428 PPP (2010)[c]
Indonesia ranked 108 (HDI 2010)[d]
National poverty line:13.33% (1 US$ per capita/day in 2010)[e]

HEALTH INFRASTRUCTURE

Number of:*
-Hospitals (*2011) : 1686
-Community Health Centers: 9133 (*2011)
-Integrated service posts : 266.827
- Maternity Huts : 28.558
-Village Health Posts : 51.996

Number of Health Personnel*
-General Practitioners : 25.333
-Medical Specialist : 8.403
-Obstetrician : 1104
-Pediatrician : 1800
-Nurse : 160.074
-Midwife : 96.551

Source: a = Centre of Data and Information MOH (2010)
b = Statistic Indonesia
c = World Bank
d = UNDP
e = MDGs Report 2010

MID TERM DEVELOPMENT PLAN 2010 – 2014

MISSION

- To improve health status of the community, through community empowerment, and involvement of private sector and civil society
- To protect the community by ensuring the availability of equitable, justified, qualified and comprehensive health services
- To ensure availability and an equal distribution of health resources
- To implement good governance principles

VISION

AN INDEPENDENT AND JUSTIFIED HEALTHY COMMUNITY

VALUES : PRO-PEOPLE, INCLUSIVE, RESPONSIVE, EFFECTIVE AND CLEAN GOVERNANCE

MINISTRY OF HEALTH REPUBLIC INDONESIA STRATEGIC PLAN 2010-2014

1. Enhancing the community empowerment, private sector and civil society in health development through national and global cooperation
2. Improving health care services which are equitable, affordable, good quality and moderately implemented and planned that based on evidence focusing on promotive and preventive measures
3. Increasing health budget and improving health financing, primarily to support the universal coverage of social health insurance
4. Improving the capacity and competency and equity of distribution and utilization of human resource for health
5. Increasing availability and affordability of drugs and medical equipment and ensuring safety, efficacy, usefulness and quality of pharmaceuticals, medical devices and foods.
6. Improving health management which is accountable, transparent, efficient and effective to strengthen the decentralization of health

8 NATIONAL HEALTH PRIORITIES

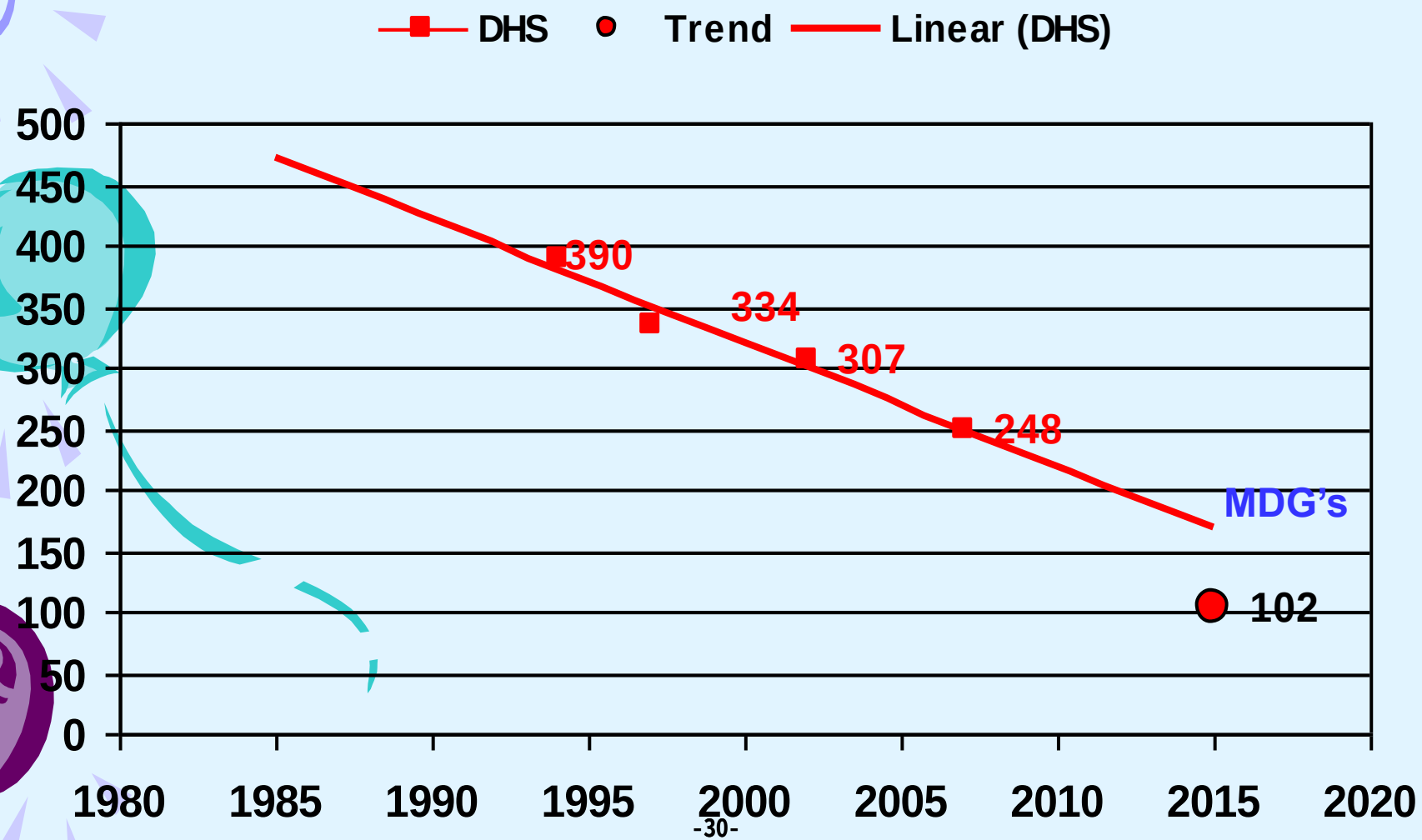
1. Improving maternal, infant and under 5 years of age child health and family planning
2. Improving nutrition status
3. Controling communicable, non – communicable diseases and improvement of environmental health
4. Fulfilling and developing human resources of health
5. Enhancing the availability, affordability, distribution, safety, quality, utilization and supervision of drugs and food
6. Health Insurance for the poor
7. Community empowerment, disaster management and health crisis
8. Enhancing primary, secondary and tertiary health services

MATERNAL AND CHILD HEALTH (MCH) PROGRAM

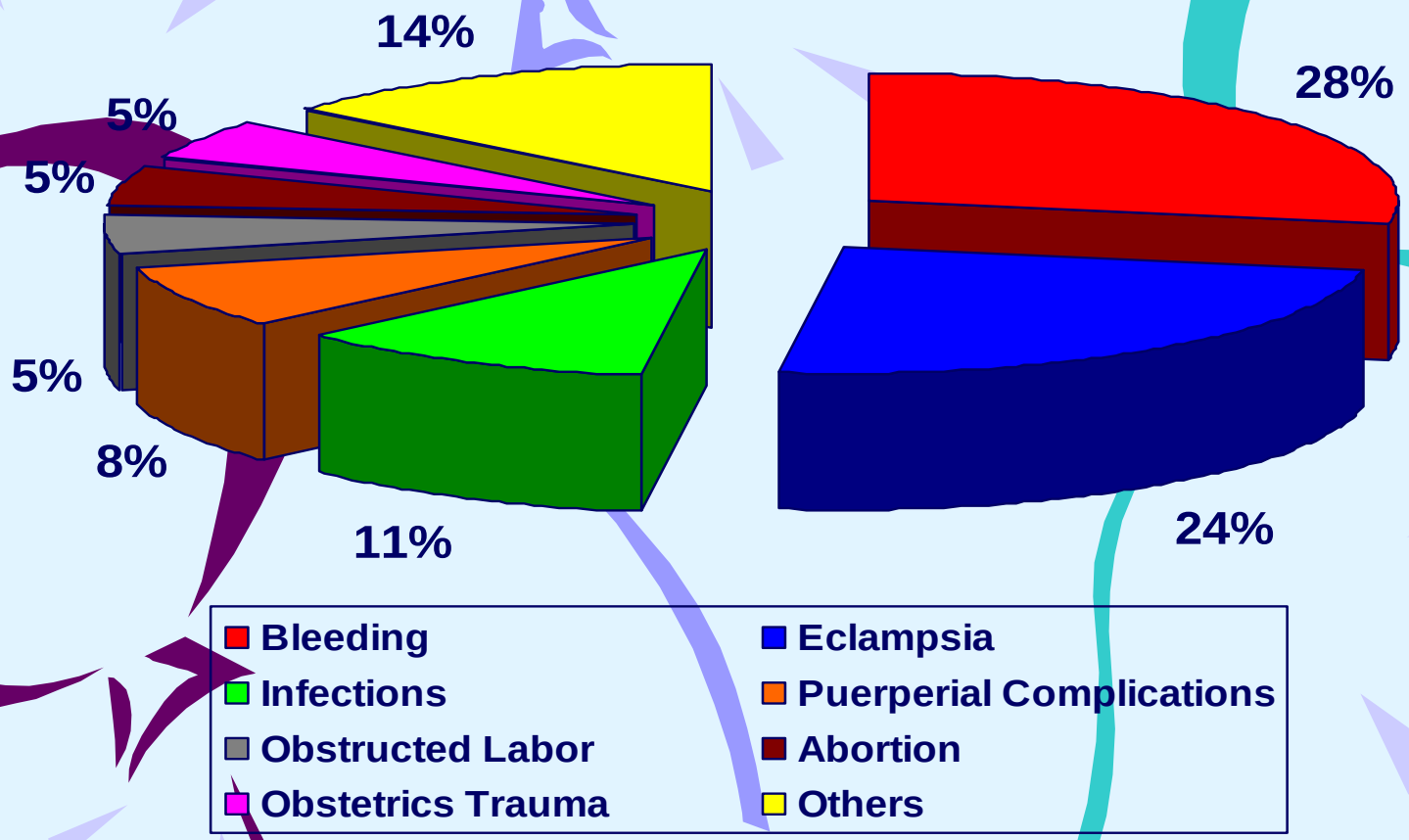
MDG 2015

National Development Plan: 2010 – 2014 PRed No: 5/2010	MDGs 2015 Target	Achievement 2007
Improving life expectancy to 72 years old		--
Decreasing IMR to 24 per 1000 livebirths	IMR 23 per 1000 livebirths	34 per 1000 livebirths (IDHS)
Decreasing MMR to118 per 100.000 livebirths	MMR 102 per 100.000 live births	228 per 100.000 livebirths (IDHS)
Decreasing prevalence of under five malnutrition to 15 %	Prevalence of under five malnutrition 18,8%	18,4% of under five (Basic Health Research)

MATERNAL MORTALITY RATIO

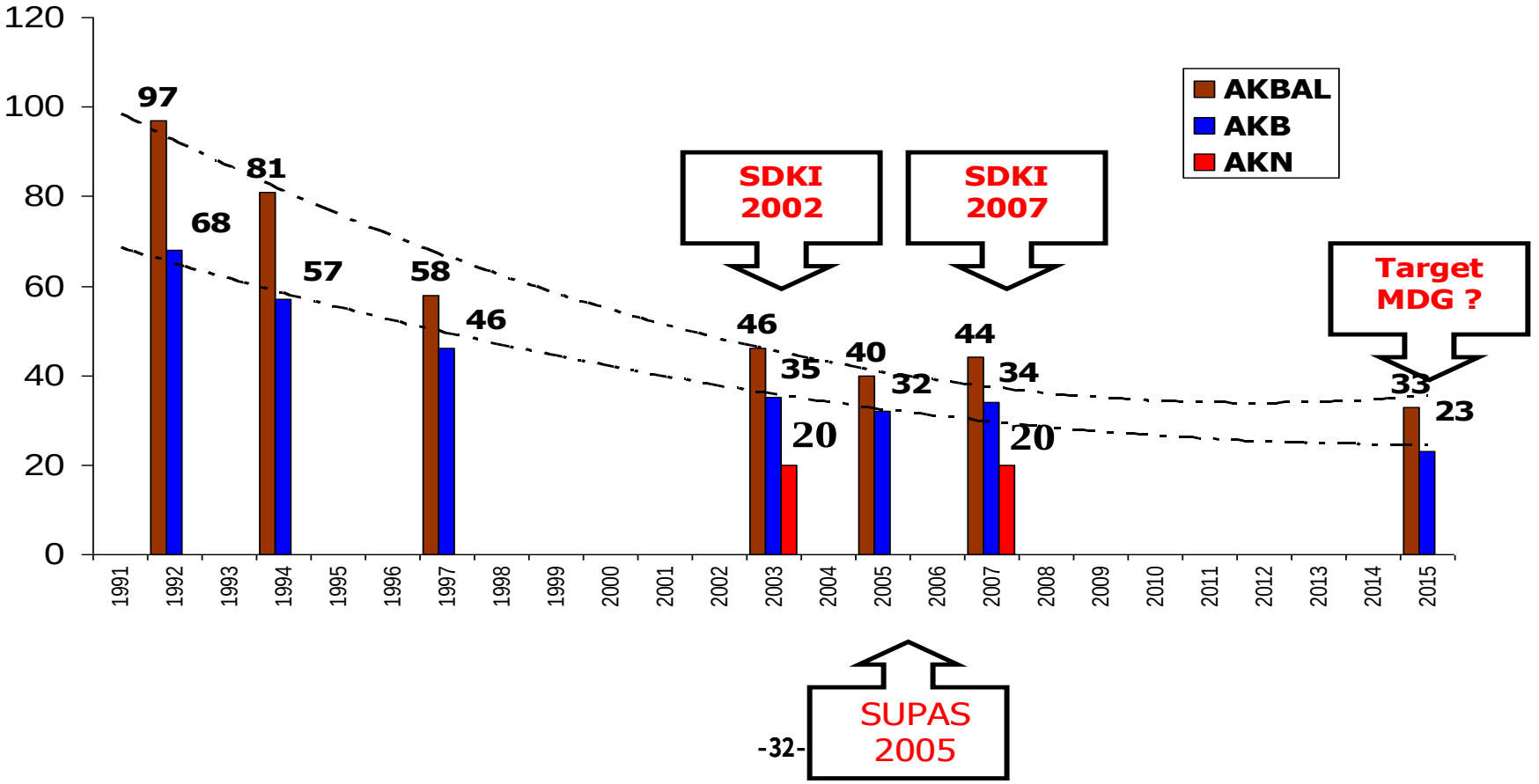


Problem : Main Cause of Maternal Mortality



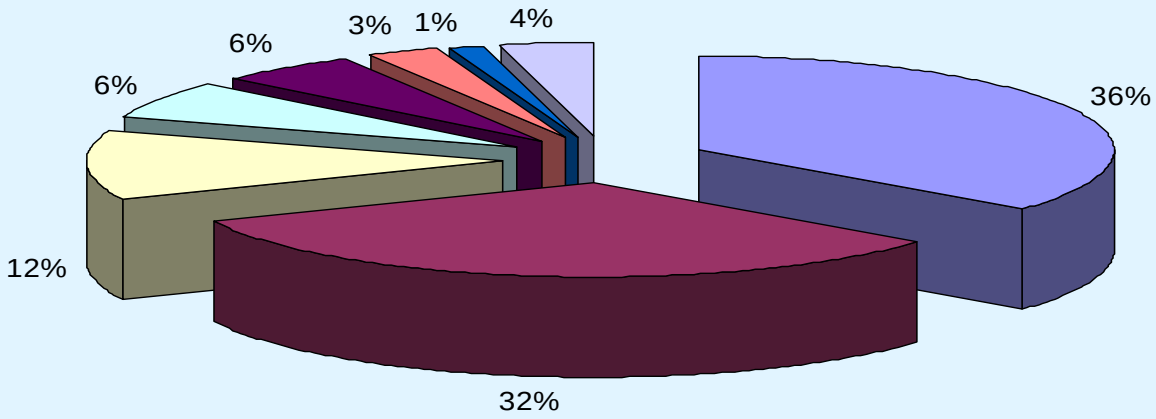
Source: Basic Health Research of MOH 2007

TREND OF NEONATAL, INFANT AND U-5 MORTALITY RATE & TARGET of MDG 4



PROBLEM

- The main causes of neonatal deaths is related to prematurity/low birth weight. Prevalence of low birth weigt is 11,5%.

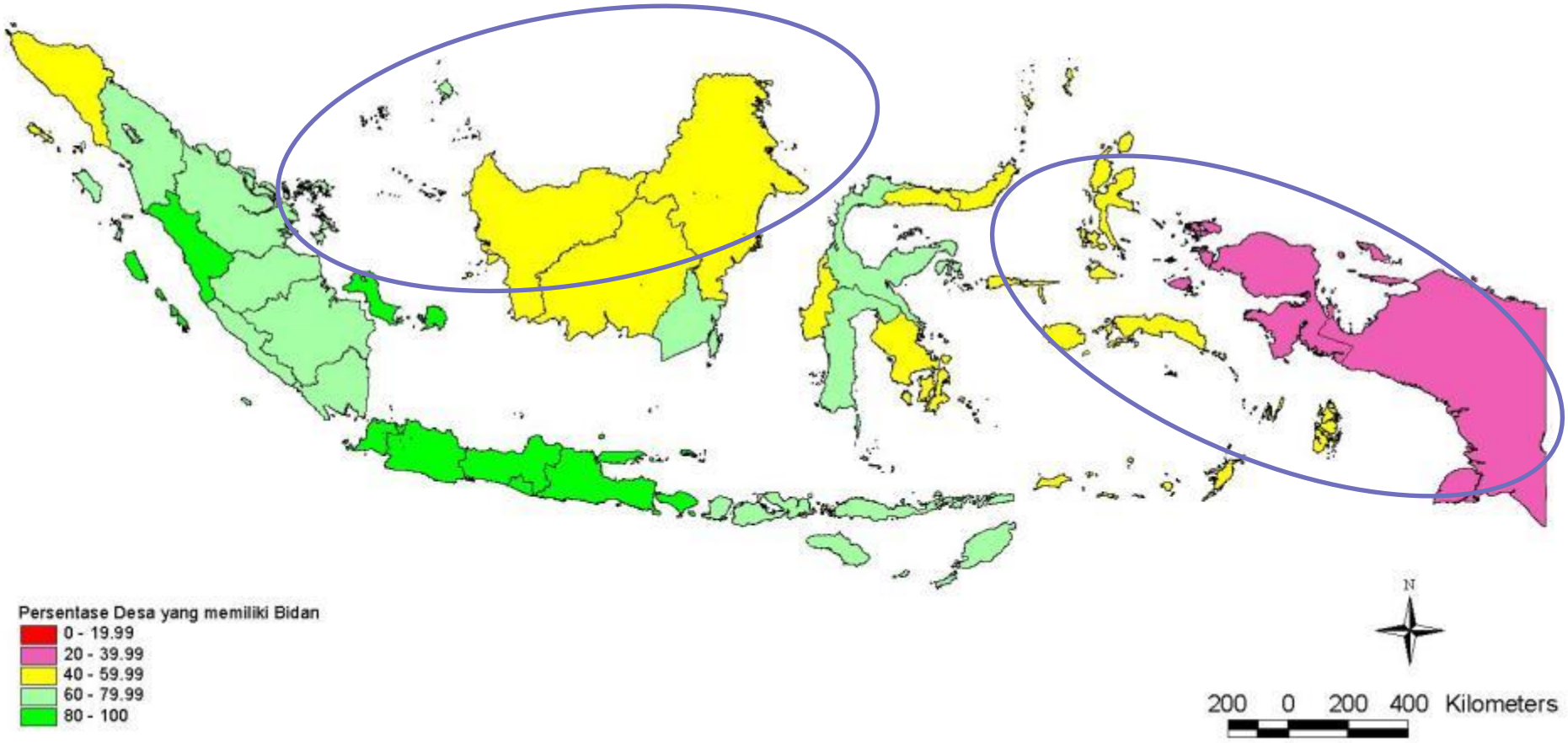


Source: Basic Health Research of MOH 2007

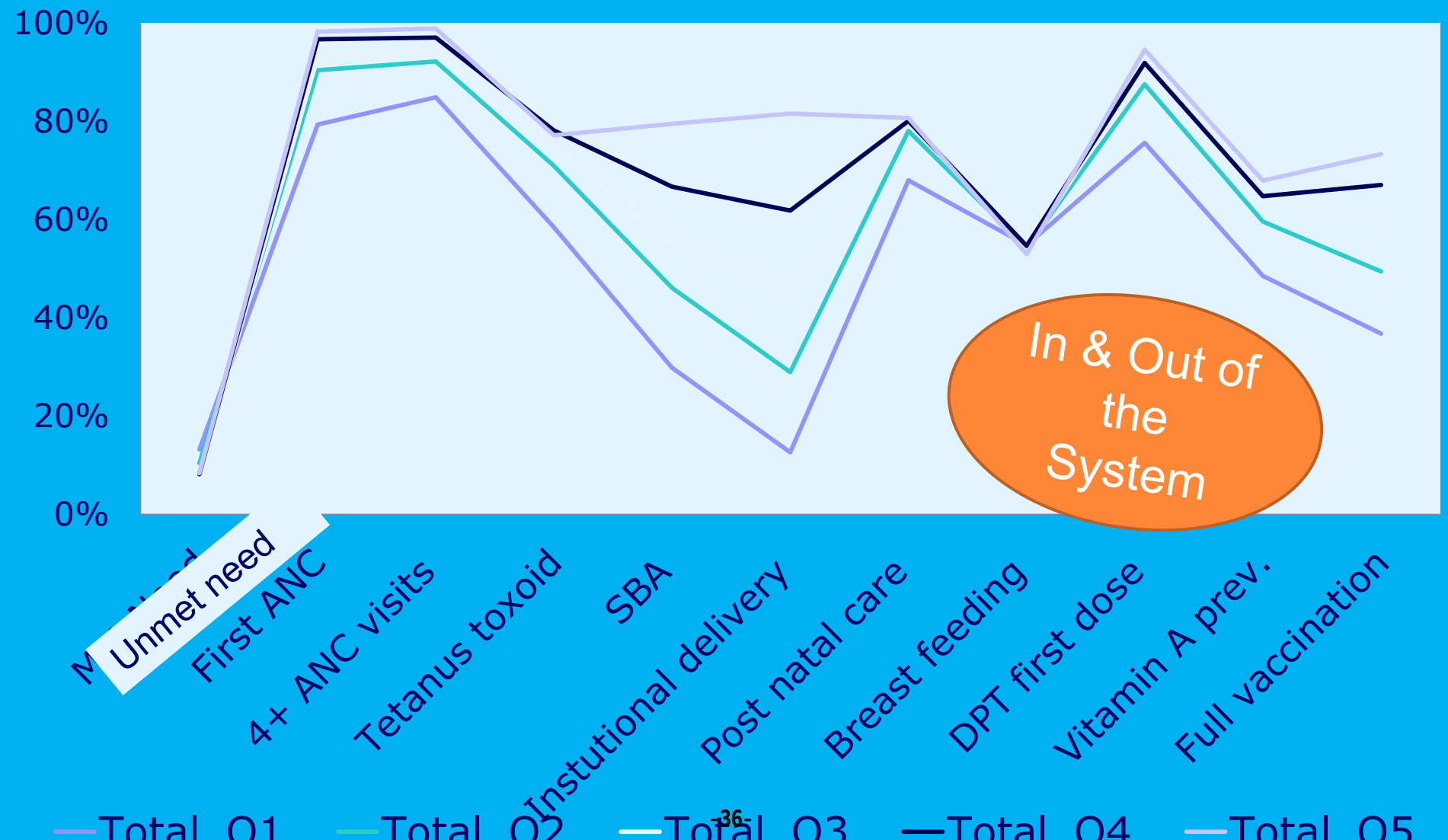
CHALLENGES

1. Disparities
2. Not optimal achievement of continuum of care indicators
3. Availability of health facility, especially in under-develop, remote, border and island areas (DTPK)
4. Universal coverage of health insurance
5. Decentralization

Availability of midwife at village level



Continuum of Care – Wealth Quintiles



3. STRATEGIES TO ACCELERATE THE ACHIEVEMENT OF MDG4 AND MDG5

1. Improving accessibility & quality health services
2. Community empowerment
3. Strengthening capacity of province and district
4. Strengthening health financing
5. Partnership

IMPROVING ACCESSIBILITY & QUALITY HEALTH SERVICES

1. DeploymeVillage Midwife in every villagent of
2. Deployment trained doctor at BEONC public health center and specialist at CEONC hospital
3. Improving of primary health care and hospital facilities, and in-service training
4. Special intervention in in under-develop, remote, border and island areas (DTPK)

COMMUNITY EMPOWERMENT

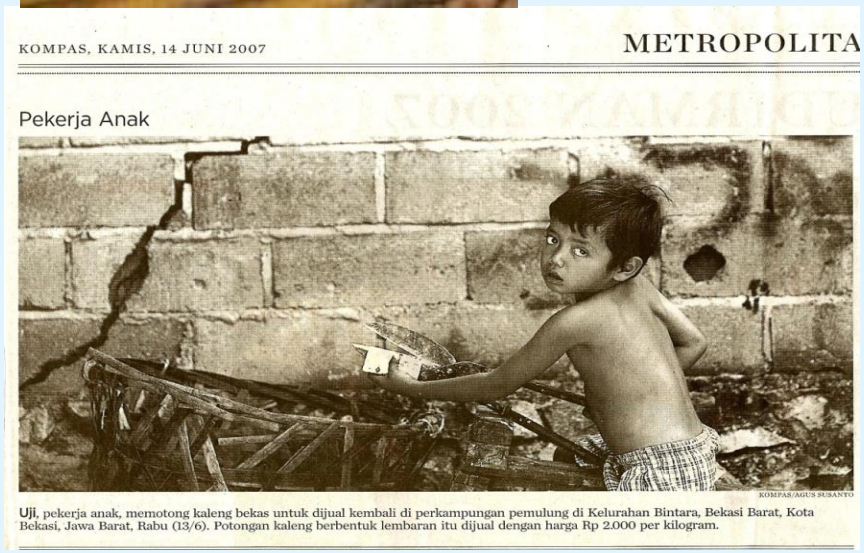
1. MCH Handbook
2. Integrated Health Post (Posyandu)
3. Village Health Post
4. Birth Preparedness and Complication Readiness (BPCR)
5. Midwife and TBA Partnership

STRENGTHENING OF PROVINCE AND DISTRICT

1. Enhancing Provincial and District Government role in MGDs achievement through advocacy
2. Improving the capacity of PHO and DHO (Integrated planning through DTPS)
3. Strengthening the coordination with clear role and responsibility of central, province and district level
4. Strengthening surveillans, monitoring and evaluation using MCH local monitoring (PWS KIA), child cohort recording, and maternal-perinatal audit to improve quality of services

STRENGTHENING HEALTH FINANCING:
Breakthrough in MNCH

1. Improving budget for program activities which related with the Minimum Standard of Services to achieve MDG (Deconcentration Allocation Budget)
2. Improving budget for health insurance for the poor (Jamkesmas)
3. Increasing the operational budget for Primary Health Centre (BOK)
4. Increasing insurance for maternal health (Universal Delivery Assurance)
5. Increasing Special Allocation Budget for health services infrastructure (medical equipment, public health center and hospital facilities, and drug)


KOMPAS, KAMIS, 14 JUNI 2007 METROPOLITA

Pekerja Anak

KOMPAS/AGUS SUSANTO

Uji, pekerja anak, memotong kaleng bekas untuk dijual kembali di perkampungan pemulung di Kelurahan Bintara, Bekasi Barat, Kota Bekasi, Jawa Barat, Rabu (13/6). Potongan kaleng berbentuk lembaran itu dijual dengan harga Rp 2.000 per kilogram.

Arigato Gozaimasu

The Study Programme for the Promotion of the Collaboration between Child Welfare and Maternal and Child Health ～What can be done to attain Welfare and MCH collaboration for the benefit of mothers and children～

Moldova

REPUBLIC OF MOLDOVA
COUNTRY REPORT

PREPARED FOR THE

JICA training course

"Promotion of the Collaboration between Child Welfare and MCH"

(JFY 2012)

(A) Strengths/Weaknesses in the field of Health and Welfare for Mothers and Children

① Raise 3 strengths in the field of Maternal and Child Welfare in your country/province.

1. In Moldova there is already a wide range of government departments, institutions and civil society engaged in the issues relating to Maternal and Child Welfare including: Ministry of Health, Ministry of Labor, Social Protection and Family, Ministry of Education, Parliamentary committee for Health and Social Protection, National Council for Children's Rights. Policies in social protection sector has improved in the last years and as a result many reforms were approved by the Government: National program on creating of an integrated system of social services 2008-2012 (2008), Law on social services (2010), Law on the accreditation of social services providers (2012), UN Convention on the rights of persons with disabilities (ratified in 2010), Strategy on social inclusion of persons with disabilities (2010), Law on social inclusion of persons with disabilities (2012). Regulations and Minimum quality standards for the development of the system of family support services and alternatives to residential care institutions were created and are in the process of implementation. In 2012 the Nomenclature of social services was approved. In the period 2010-2012 the Regulations on Community homes for persons with disabilities, as well as such services as "personal assistant", "mobile team" and "respite care" were developed and approved.

2. The social security benefits system reform was launched as an element of preventing the separation of children from family because of poverty (families with children account for more than 70% of social aid beneficiaries). The Expenditures ceilings for benefits and material support for orphan schoolchildren and students and those under guardianship that continue their education have been substantial increased.

3. Cross-sectorial cooperation mechanism for establishing and developing sustainable and effective partnership in medical-social issues for preventing and reducing infant mortality rate and mortality of children up to 5 years of age is one of the on-going reform on the track. A first example of the cooperation between health and social sectors is the Regulation on the mechanism of cross-sectorial cooperation for preventing and reducing the rates of infant and under five years mortality at home, approved in 2010 by the Ministry of Health and Ministry of Labor, Social Protection and Family.

② Raise 3 weaknesses in the field of Maternal and Child Welfare in your country/province.

1. The system of early detection and intervention is fragmented and is mostly based on detection than on early intervention. This system does not assure the continuity of these services.

2. There are not clear criteria for determining the vulnerability level. These criteria are interpreted differently by different stakeholders.

3. There is a low level of the mother and child social protection, and namely: maternal aid, single aid at delivery, attendance allowance for sick child. The existing payment scales represent a barrier for expanding foster care to include children under 3 and children with disabilities.

③ Raise 3 strengths in the field of MCH in your country/province.

1. *Policies in MCH / Mandatory Health Care Insurance*. MCH is a priority in major policy documents: Law on healthcare (1995), Law on mandatory health insurance (1998), Law on the protection of reproductive health and family planning (2001), National Health Policy (2007), Healthcare system development strategy for 2008-2017 (2007), National strategy for reproductive health (2005), National perinatal care program for 1997-2002 (1997), Program for supporting and encouraging breastfeeding during the first year of a child's life (1998-2003), National immunization program 2011-2015 (2010), Integrated management of childhood diseases strategy (IMCI), National healthy lifestyle promotion program 2007-2015 (2007). The international and bilateral donors financially support programs derived from these strategic documents. According to the Unic Program of Health Insurance MCH is covered by the Government inclusively for: a) children under 18 years; b) pupils and students, including post university education and c) pregnant women, parturients and women recently confined.

2. *Qualitative perinatal and pediatric health care*. The reforms implemented in the field of perinatal care have contributed to the achievement of MDGs 4 and 5. Numerous strategies have been implemented: regionalization of care, elaboration of national policies, capacity building, community mobilization, developing of monitoring and surveillance system, etc**.** As a result three levels regionalized system was built, referral criteria for pregnant women and newborns have been set up. The proportion of *"in utero"* transfer to level 3 has increased to 84% (2011). 180 clinical protocols on obstetrics and neonatology have been elaborated and implemented. Implementation of Confidential Inquires on the maternal and perinatal death at national level have contributed to the improvement of standards of obstetrical and neonatal care. Since 2006 the phase of modernizing and restructuring the service with the implementation of modern technologies in neonatal intensive care started, a post-NICU follow-up service has been created, the concepts of Health Management Technologies and the Quality Management are in process of implementation. Since 2009 through Telemedicine there were consulted 83 pregnant women and 670 children with severe pathologies by the specialists from level 3. These achievements have contributed to the increase of survival of ELBW children from 5,4% to 51% and VLBW from 60,1% to 87,7% (at the end of early neonatal period), to the reduction of perinatal mortality from 15,2‰ to 12,5‰ (with 17,7%) and of early neonatal mortality from 8,5‰ to 5,4‰ (with 36,4%) during 2000-2011.

Since 2008 the pediatric hospital care is in a reforming process: the regionalized pediatric intensive care and emergency services have been created at national and regional levels in order to improve the access of sick babies to specialized medical care. The processes of

capacity building of family doctors and pediatricians in issues of pediatric life support and of development of protocols in pediatric emergencies started and are in progress.

3. *Integration of Follow up Concept in Child Early Intervention Concept*. Elaboration of the Concept on neurodevelopmental Follow-up, creation of the Follow up Center for children from risk groups of neurodevelopment in the first 2 years of life were prerequisites for the elaboration and approval by the Moldovan Parliament of the Law no. 60 from 30.03.2012 on social inclusion of people with disabilities (Art. 44 regulating early intervention for children under 5 years).

④ Raise 3 weaknesses in the field of MCH in your country/province.

1. Insufficient cooperation between primary health care system and maternities, insufficient knowledge by pregnant women of danger signs for their own health and the health of future children, especially those from vulnerable groups, contribute to the fact that women in risk groups are not referred in time to health care facility, which leads to antepartum stillbirths and severe maternal complications. 20% of deaths in children under five occur at home, most of them are avoidable. Injuries, poisoning and respiratory diseases represent the main causes of infant mortality and mortality of children aged 1-5 years at home and in the first 24 hours of hospitalization, death cases are largely determined by social and cultural factors, low level of knowledge of danger signs for baby health by mothers / caregivers and families / communities.

2. Despite the high coverage of institutional deliveries the quality of maternal and neonatal care is not always done according to standards (according to the data of the Confidential Inquires into perinatal deaths at national level the medical care was suboptimal, grade 3, in 28,5% cases, 2010). The Needs Assessment study (carried out in the framework of Modernising perinatal system in Moldova program, 2011) has emphasized that the standard conduct in obstetric and neonatal severe pathologies was estimated as corresponding to standard in about 60-84% of cases.

3. The process of migration of health professionals related to economic situation in the country, as well as the completion of the institution’s states with new untrained cadres leads to medical errors, substandard care and low satisfaction of patients with provided medical services. Although undergraduate and postgraduate training programs for obstetricians and neonatologists meet European standards, the training process is mainly theoretical, being oriented towards the specialists from the same field. The approaches to conduct obstetrical cases are given differently at the Departments of Obstetrics from the Medical University. The training process does not draw attention to the co-working of specialists within multidisciplinary team. Obstetrical care, especially the emergency care, as well as the collaboration among members of the multidisciplinary team remain weak areas that need to be strengthened using new approaches.

In implementing health/welfare policies and services by your organization,

⑤ What are successful areas or programmes? List 3 areas or programmes.

1. Research Institute for Mother and Child Healthcare occupy a hierarchic (three) level in the regionalized perinatal system in the country and plays an important role in the implementation of the *Modernising perinatal care program* and *Regionalized pediatric intensive care and emergency services program*. Institute provides specialized medical care to newborns, children 0-18 years and pregnant women. Thus the most severe maternal, neonatal and pediatric cases are focused here. From 2008 Republic of Moldova implemented European standards and criteria on official registering of birth and children from 500 gr. and 22th week of gestation. Thus, about 400 children with VLBW (below 1500 g) are born and referred each year to the Institute (in utero or postnatal). Thanks to the implementation of modern technologies the survival of babies born with birth weight below 1000g has increased in Institute from 44,2% in 2011 to 51,0% in 2012 (with 6 ,8%).

2. Based on the international experience the Follow up center for babies at high risk for neurodevelopmental problems was created in the Institute in 2008. Until 2011 1500 babies were included in the follow-up program. Center provides specialized care to babies in their first two years of life: assessment of neurodevelopment using BSID-III, EEG, audiometric, ophthalmologic exams, brain and cardiac ultrasound examinations. Out of those 520 babies were referred to the rehabilitation institutions.

3. The Institute is an organizational and consultative center in maternal and child health care in the country. 111 doctors-curators (pediatricians, obstetricians, neonatologists, surgeons) provide methodological support to maternities and pediatric departments of the hospitals and 86 doctors-consultants of the emergency transportation services (obstetricians, neonatologists, pediatricians, neuro-pediatricians, surgeons, neurosurgeons, anesthesiologist) provide transportation of patients to level III.

⑥ What are issues/challenges? List 3 issues/challenges.

1. Old infrastructure and equipment, lack of financing. Although the Institute's budget has increased in the last years, 70% of money is spent for infrastructure maintenance. The buildings have not been renovated since the opening of the Institute (1980), there is no ventilation system in surgery theatres, IT units. Actually there are two NICUs (for inborn and outborn babies) and two PICUs (for somatic and surgical pathologies). In case when departments lack some equipment positions, the latter are borrowed from the departments where the equipment is available, which leads to the spread of resistant microbes. In Perinatal centre there are several departments of pregnant women pathology whose rationality is discussible. The Institute's equipment is quite old beside the equipment owned by perinatal centre and both PICUs.

2. Lack of medical personnel, its low managerial capacity. There are insufficient skilled health personnel, especially neonatal nurses. There is reduced managerial capacity at unit level. There is reduced level of preparedness for emergency situations. Some technologies, even those simple, cost-efficient, are slowly implementing because of the medical personnel old-fashioned mentality.

3. Although efforts made in order to reach all babies included in Follow up program, the

proportion of premature newborns in follow up (versus all newborns in FU) having completed all visits during 2 years is only 40%.

⑦ Regarding the above-mentioned issues/challenges, explain background, current situation and reason why those issues/challenges are difficult to solve.

1. The sources received by the Institute from the National Insurance House are limited and are not intended for renovations. Clear mechanisms should be identified and approved for the rationale use of accumulated extra resources as well as better management of the Institute finances will allow to ensure the needed materials, consumables etc. The Institute is in its restructuring phase, it is planned to combine both NICU units in a larger section for the rational use of equipment. It is planned to launch a campaign on collection of sources necessary for this renovation. Departments of pregnancy pathology will be closed (these departments were inherited from soviet-period). The third grant from the Japanese Government will allow equipping the institute with modern equipment.
2. Although trainings dedicated to quality assurance/quality management were provided for managerial and medical staff from perinatal service, such trainings have not been conducted for other services/specialties. Clinical Internal Audit Service of the Institute is rather a mechanism of control than of support for clinical Departments.
Although perinatal service staff has been trained on the use of cost-effective interventions recommended by WHO, the over-medicalization still persists. Elaborated clinical protocols are not always complied with, because medical staff, especially aged personnel, is based more on its personal experience rather than on scientific evidences. There is a very little experience in providing medical staff, especially the medium one (nurses, midwives) with in-service trainings. Multidisciplinary team work is insufficient due to lack of this kind of experience.
3. Parents with children enrolled in Follow up program do not have sufficient sources to attend regularly (systematically) the Follow up Center, and many children leave the program not reaching the age of 2 years because of other barriers/ economical costs.

⑧ Describe your expectations to the training course in detail.

Participating in the training and dialogue program I intend to learn the experience of Japan and of the countries whose participants will attend this training in providing accessible and qualitative health services for woman and newborn/child, as well as in strengthening mechanism of cooperation between primary health care facilities, maternities / pediatric units / hospitals, families / communities and social sector. This knowledge will be adjusted to the local needs and implemented in Institution where I work as well as will be disseminated at the national level.
The experience of international practice in the field of mother and child health care, gained during the training and dialogue program Promotion of the Collaboration between Child Welfare and Maternal and Child Health will be used:

- To increase the survival and better development (inclusively neurodevelopment) of high

risk babies (especially ELBW and VLBW babies) through better functioning of post-NICU Follow-up service and its harmonious integration into Early Childhood Development / Intervention programs;

- To identify and implement mechanisms of better collaboration between health professionals in the hospital as well as between different institutions of health sector as a team for improving quality of MCH care and access to it;
- To involve family, community, health care and social sectors in rise awareness process on MCH status and in providing support to women and families at risk to overcome health and social problems;
- To strengthen the role of family and community in the supervision and monitoring of children development;
- To define and implement appropriate approaches of community mobilization for Mothers and Children Health and Welfare assurance;
- To define appropriate mechanisms for human resources motivation (non financial) in order to involve them in solving Mothers and Children Health and Welfare problems.

(B) Indicators

(1) Crude birth rate (per 1000 population)

	Country overall
1990	**17,7**
2000	**10,2**
2010	**11,4**

(2) Crude death rate (per 1000 population)

	Country overall
1990	**9,7**
2000	**11,5**
2010	**12,3**

(3) Leading causes of death (1990) and (2010)

1990:	1) cardio-vascular diseases (424,9/100.000 population)	2) tumors (132,3/100.000 population)	3) digestive diseases (90,1/100.000 population)
2010:	1) cardio-vascular diseases (688,1/100.000 population)	2) tumors (160,0/100.000 population)	3) digestive diseases (121,9/100.000 population)

(4) Infant mortality rate (per 1000 live birth)

	Country overall
1990	**19,0**
2000	**18,3**
2010	**11,8**

(5) Leading causes of infants death (1990) and (2010)

1990:	1) perinatal conditions (5,9/1000 live born)	2) respiratory diseases (4,7/1000 live born)	3) congenital malformations (4,6/1000 live born)
2010:	1) perinatal conditions (4,7/1000 live born)	2) congenital malformations (3,5/1000 live born)	3) respiratory diseases (1,6/1000 live born)

(6) Under-5 mortality rate (per 1000 live birth)

	Country overall
1990	**25,2**
2000	**23,2**
2010	**13,6**

(7) Top 3 diseases and morbidity rate of the under-5 of (1990) and (2010)
(These indicators begin to be registered from 2000)

2000:	**1)**	**2)**	**3)**
Diseases:	Respiratory diseases	Anemia	Perintal conditions
Morbidity rate:	476,5 / 100.000 population	74,1 / 100.000 population	66,3 / 100.000 population
2010:			
Diseases:	Respiratory diseases	Anemia	Infectious and parazitary diseases
Morbidity rate:	594,95 / 100.000 population	116,24 / 100.000 population	74,76 / 100.000 population

(8) Maternal mortality rate (per 100,000 live birth)

	Country overall
1990	**52,9**
2000	**27,1**
2010	**44,5**

(9) Leading causes of maternal death (1990) and (2010)

1990:	1) hemorrhage	2) puerperal sepsis	3) high risk abortions
2010:	1) hemorrhage	2) puerperal sepsis	3) post abortion complications

(10) Is there any national standards for certifying disabilities in your country?
Yes. List of diseases and pathological states that establish children disability status is approved by the Government Decision. The decision about certifying disabilities is taking by the Medical Consultative Committee at the municipal/district Center of Family Doctors. Medical Consultative Committee certifies disability in the form of Medical conclusion (form approved by the Ministry of Health) and sends it to social insurance authority.
However the existing national standards don't correspond to WHO standards, they contain only medical criteria, not medico-social and behavioral ones. Actually these criteria are in the revision process in order to add the lacking criteria, as well as evaluation of the level of individual integration into society. These new criteria will be based on functionality / abilities of person and not on disease with clear recommendation for integration into society and will be based on ICF classification of health, disabilities and functionality.

(11) Does your country perform any health check for the diagnosis of disabilities in infants and children?
Yes. Children health state is checked according to the child growth monitoring standards, approved by the Ministry of Health. Starting with 2013 the screening for autism and referral to social services for vulnerable children has been added.
Children with high risk at birth to develop neurological disabilities are included in the Republican service of post-NICU follow-up. In 2012 the Regulations on Early Intervention System for children with disabilities were developed, whose part is Follow-up service, which is in the process of approval.

(C) Priorities in health and welfare

(1) In your country/province, who are the most vulnerable populations that should be covered by mother and child welfare policies? List five vulnerable groups in order of priority.

- Social risk families/children (one-parent families; numerous families (3 and more

children); teen parents; families where parents had been left abroad for more than 6 months; parents with disabilities; drug addicted parents, alcoholics)
- Low-income families
- Families with children with disabilities and these children
- Rural population, especially from regions far from a capital (extremely northern or southern areas)
- Some ethnical groups

(2) In your country/province, what are the priority health issues/programmes in the area of maternal and child health? List five issues/programmes in order of priority.

- Modernizing perinatal care in Republic of Moldova program, phase 3 (2011-2014) supported by Swiss Agency for Development and Cooperation
- Regionalized pediatric intensive care and emergency services program, phase 2 (2010-2013), supported by Swiss Agency for Development and Cooperation
- Young generation program, phase 1, supported by Swiss Agency for Development and Cooperation (2011-2013)
- Elaboration of Regulation of Early Intervention system for children with disabilities in Moldova, 2012
- Elaboration and implementation of Child and Maternal Handbook, UNICEF, 2011-2012
- Development of perinatology system in Transnistria, 2010, UNDP

(3) According to the analyses in (A), (B) and (C), what is a potential area you would like to work on for a collaborative action plan to improve health and welfare services for mothers and children (as a product of this training course). Please note that this is only tentative and you can confirm your topic after the course started.

- Improvement of collaboration between PHC and hospital care in order to timely refer pregnant women at high risk to appropriate medical care / elaboration, piloting and implementation of electronic register of pregnant women which would allow to share information about her health between different sectors and levels of MCH care.
- Improvement of counseling skills of medical staff from hospitals and PHC facilities (in cases of deaths or severe pathologies by providing the needed support) and of social workers on mother and babies health and welfare issues.
- Implementing special approaches/tools to identify high risk pregnant women (drinkers, drug-addicted, etc) and prevent their potential health problems, and the problems of fetus (stillbirth, Intrauterine Growth Restriction) and of newborn baby health and wellbeing (sudden infant death) by providing appropriate counseling (ex. on fetal alcohol syndrome) and offering special support.
- Antepartum stillbirths (AS) represents the *opportunity gap* to reduce perinatal deaths in the country (AS accounts for 47% of perinatal mortality rate). Common efforts of PHC, social sector, local public authority, family, community, local NGOs through auditing of AS cases and making specific recommendation for each sector could help avoiding these cases.

- Defining ways to make it possible for families with children with disabilities to have possibility to regularly attend the Follow up service during 2-years follow-up period.

(4) In order to implement your action plan, who are the key stakeholders (including Ministerial departments, local government offices and their departments and NGOs) in your country/province. Please list all key stakeholders and also identify three main partners you will closely work with.

key stakeholders	main partners
MoH, Department of primary health care	MoH, Department of hospital and emergency medical care
MoH, Department of hospital and emergency medical care	Local public administration, inclusively social workers
Ministry of Labor, Social Protection and Family, Social Assistance Policy Department	Hospitals and Primary health facilities
Ministry of Labor, Social Protection and Family, Disabled People Social Protection Policy Department	
Local public administration, inclusively social workers	
Hospitals and Primary health facilities	
NGOs	

The Study Programme for the Promotion of the Collaboration between Child Welfare and Maternal and Child Health ～What can be done to attain Welfare and MCH collaboration for the benefit of mothers and children～

Nepal

Promotion of the Collaboration between Child Welfare and MCH

Country Report of Nepal

1. Introduction

Situated in the northern hemisphere, known as a land of Mt. Everest and the birth place of Lord Buddha, Nepal is tiny landlocked country between the two most populous and big countries of the world, India in the east, south, west and China in the north. Nepal is a land locked country and home place of natural beauty with traces of artifact. The northern range (Himalaya) is covered with snow over the year where the highest peak of the world, the Mount Everest stands. The middle range (Hill) is captured by gorgeous mountains high peaks hills, Valleys and lakes. The southern range (Terai) is the gangitic plain of fertile soil and consists of dense forest area national parks, wildlife reserves and other conservation areas. The temperature and rainfall differ from place to place.

Geographically, the country is divided in three ecological zones; Mountain, Hill and Terai. Similarly, there are five development regions; Eastern, Central, Western, Mid-western and Far-Western development regions. Further, there are 75 administrative districts. Districts are again divided into smaller units called Village Development Committee (VDC) and Municipality. Currently, there are 3913 VDCs and 58 municipalities in the country. Each VDC is composed of 9 wards, municipality ward ranges from 9 to 35. Kathmandu is the capital city of the country.

The provision of vital information and data is central importance to the country's planning for development programs as well as tracking and monitoring of progress towards the Millennium Development Goals (MDGs) within the national Poverty Reduction Strategy Paper (PRSP) and other the development plan frameworks. So regarding the importance of vital data, Nepal has collected information through Nepal Demographic Health Survey in 5 years interval and Census in each 10 years interval.

Geographical Location and Area:

Latitude : 26°22' North to 30°27' North
Longitude: 80°04' east to 88°12' east
Area : 147181 sq. km
Boarder :North – Tibet, Autonomous Region of China, East, west and South-India

Population :

Population	Year	
	2001	2011
Total population	23251423	26620809
Male	11563921	12927431
Female	11587502	13693378
Total famly	4253220	5659984
Annual population growth	2.25	1.4
urban population growth	13.9	17

Vital Statistics

Indicators	2001	2006	2011
Crude Birth Rate	33.1	27.7	24.3
Crude Death Rate	9.6	8.3	
Average life Expectancy			
Total	60.4	64.1	
Male	60.1	63.6	
Female	60.7	64.5	
Total Fertility Rate	4.1	3.1	2.6
Infant Mortality Rate(per 1000 Live Birth)	64	48	46
Under 5 Mortality Rate (per 1000 Live Birth)	91	61	54

Mean Age at Marriage :

Year	Male	Female
1991	21.4	18.1
2001	21.9	19.5

A) Strengths/Weakness in the field of health and Welfare for Mothers and Children

1. 3 strengths in the field of Maternal and Child Welfare in your country/province:
   - Child friendly local governance and GESI Strategy to avoid women discrimination and violence
   - Child Right Commission and National Women Commission
   - Expansion of Maternal and Child Health Services throughout the country

2. 3 weakness in the field of Maternal and Child Welfare
   - Domestic and women violence increasing
   - Weak monitoring and proper implementation of legal provisions
   - Inequity in health services distribution specially to DAG(Dis advantage Group)

3. 3 strengths in the field of MCH
   - Promotion of Institutional Delivery and Safe delivery incentive package
   - Female Community Health Volunteers as the key public health social mobilizers
   - Free essential and basic health services

4. 3 weakness in the field of MCH
   - Low ANC and coverage of institutional delivery
   - Low Coverage and quality of service in hard-to-reach areas
   - Early Marriage

In implementing health /welfare policies and services by organization,

5. 3 successful areas/ programmes
   - Free Health Services all over the country
   - Free immunization, childhood illness management, malnutrition control and prevention, safe motherhood program throughout the country
   - Early Child Care and Development program through out the country

6. 3 issues/challenges in country.
    - ❖ Inadequate trained Human resources
    - ❖ Sustained and predictable financing to up-scale priority cost-effective evidence based interventions
    - ❖ Inadequate health infrastructure up to community level
7. Reason why those issues/challenges are difficult to solve.
    - Current infrastructure and HR are placed as per Nationa health policy of 1991
    - From that period to now population has increased; public demand has been remarkably increased, but the number of health institutions post of health workers has remained same.
    - Donor dependency is increasing

B. Indicators

1. Crude birth rate (per 1000 population)

Year	Country overall
1990	41
2000	33
2010	24

2. Crude death rate (per 1000 population)

Year	Country overall
1990	16
2000	10
2010	-

3. Under 5 mortality rate (per 1000 live birth)

Year	Country overall
1990	148
2000	91
2010	54

4. Infant mortality rate (per 1000 live birth)

Year	Country overall
1990	97
2000	60
2010	46

5. Maternal mortality rate (per 100,000 live birth)

Year	Country overall
1990	-
2000	539
2010	281

6. Leading cause of death

Year	Leading cause of death		
1990	1	2	3
2010	1	2	3

7. Leading cause of infants death (1990 and 2010)

Year	cause of infant death		
1990	1 CDD	2 ARI	3 Malnutrition
2010	1 Pneumonia	2 CDD	3.Malnutrition

8. Top 3 diseases and morbidity rate of the under 5 of 1990 and 2010.

Year	Diseases and morbidity rate of the under 5			
1990	Diseases	1.CDD	2. ARI	3. Malnutrition
	Morbidity rate	1. -	2 -	3 -
2010	Diseases	1 ARI	2 CDD	3 Malnutrition
	Morbidity rate	1 -	2 -	3 -

9. Leading cause of maternal death (1990 and 2010)

Year	Cause of maternal death		
1990	1. PPH	2 APH	3Preeclampsia
2010	1. PPH	2 APH	3 Abortion

10. National standards for certifying disabilities

We have. There are some criteria in issuing disability certificate in District level.

- Definition of disability category and level of disability by the Disable Person Protection and Welfare Act 1992

Process:

- VDC recommendation
- Medical Doctors recommendation
- Citizenship if not available birth certificate
- 3 copy photo

11. Health check for the diagnosis of disabilities in infants and children

we have some organizations working under the government.

1. HRDC (Hospital for Rehabilitation and Development of Children) is one.
2. Nepal Red Cross Society seeks the blind
3. Government hospitals- Kanti child hospital

C) Priorities in health and welfare.

1. Five most vulnerable groups that should be covered by mother and child welfare policies in order of priority.

- Street children
- Trafficking girls
- Children living with HIV/AIDS

- Children of imprisoned mothers
- Widows

2. 5 priority health issues/programmes in the area of MCH in order of priority.
- Free of delivery services including CS with transportation allowances to all over the country
- Immunization programme
- Community based neonatal care programme
- National Nutrition Program
- FCHV programme

3. Potential area to work on for a collaborative action plan to improve health and welfare services for mothers and children
    - Safe motherhood Program
    - Acute malnutrition management
    - Neonatal Care Program
    - Awareness against Gender based violence

4. Key stakeholders/partners to implement action plan are:

Central Level:

- Ministry of Health and Population
- Ministry for women, children and social welfare
- Local development and its departments
- WHO
- UNICEF
- Global Fund
- DFID
- SCF

Region/ District level:

- District Development Committee
- District Health Office
- Women and Child Office
- Mission Hospital
- Civil Society
- Clubs

4. Main partners will be closely worked in implementation level :

- District Development Committee
- Women and Child Office
- Mission hospital/ INGO and NGO

Conclusion: Promotion of the Collaboration between Child Welfare and MCH program is to be highly prioritized. We have the good principle and activities of Child welfare and MCH program in different level but one thing is still inadequate is collaborative activities. Different organizations have been working the same function but they don't know one another; collective approach is nearly nil. After the training it is hopefully thought to make good collaboration among the government and non government agencies at different level for the betterment of Child Welfare and MCH.

Thanking you.

The Study Programme for the Promotion of the Collaboration between Child Welfare and Maternal and Child Health ～What can be done to attain Welfare and MCH collaboration for the benefit of mothers and children～

Philippines

ANNEX-1

Suggested Guideline for Country Report
for JICA training course
"Promotion of the Collaboration between Child Welfare and MCH"
(JFY 2012)

Philippines

(A) Strengths/Weaknesses in the field of Health and Welfare for Mothers and Children

Please describe the following items within 2-3 pages (A4 size / typed)

① Raise 3 strengths in the field of Maternal and Child Welfare in your country/province.
   a. There are existing policies on child protection, child development, violence against women and children.
   b. Institutionalized Day Care Program for children below 10 years old.
   c. Conditional Cash Transfer for the poorest of the poor families.

② Raise 3 weaknesses in the field of Maternal and Child Welfare in your country/province.
   a. There are no existing facilities or centers for mentally challenged children/mothers or no centers for children in conflict with law.
   b. No structured follow up programs for children who have just been released from detention facilities (for children in conflict with law).
   c. It is difficult to identify families that can serve as foster homes for abandoned infants/children.

③ Raise 3 strengths in the field of MCH in your country/province.
   a. Existing ordinance supporting MCH e.g. facility based deliveries and newborn screening. The approved reproductive health bill which is basically on safe motherhood and healthy children.
   b. Deployment of active community health teams that track pregnant women in the community.
   c. Institutionalized Garantisadong Pambata Program which aims to give children below 5 yrs old health services and monitor their growth & development

④ Raise 3 weaknesses in the field of MCH in your country/province.
   a. Some municipalities have unsuccessful nutrition program for the children.
   b. Interrupted supply of antigens for children's immunization in 2011 and 2012.

c. Unmet need for birth spacing/limiting because of inadequate supply of free family planning commodities and couples cannot afford to buy it on their own.

In implementing health/welfare policies and services by your organization,

What are successful areas or programmes? List 3areas or programmes.

1. Expanded Program on Immunization
2. Day Care Program for children 10 yo & below.
3. Garantisadong Pambata – twice a year (April &October) immunization, giving of Vit. A, deworming, weighing, etc are done in the communities

⑤ What are issues/challenges? List 3 issues/challenges.

1. Sustainability of Community Health Teams (CHT)
2. Strict implementation of local policies on MCH.
3. Staff in Day Care Centers and community volunteers are changed whenever there is a change in political leaders.

⑥ Regarding the above-mentioned issues/challenges, explain background, current situation and reason why those issues/challenges are difficult to solve.

1. On CHTs, economic difficulties hinder the team to do their responsibilities of home visitation without money for fare to move around and to buy pens, notebooks.
2. Some local chief executives do not implement local ordinance hence violations are not appropriately reprimanded.
3. Newly elected local leaders identify new community health volunteers after election. New members need to be trained again (which needs funds again). Thereby, committed former members are demoralized.

⑦ Describe your expectations to the training course in detail.

✓ I am looking forward to learning systems on the collaboration of child welfare and maternal & child health, improve monitoring our pregnant women especially with regards to quality prenatal visits to health facilities (4 visits).

✓ To know programs that will improve the care of our children with disability, mentally challenged children.

✓ How to access probable development partners who can help train our mothers in the proper care of their mentally challenged/physically disabled children.

✓ Identify practicable models or best practices that can work in our local situation.

(B) Indicators

(1) Crude birth rate (per 1000 population)

	Province	Country overall
1990	No data	
2000	23.31	
2010	24.01	

(2) Crude death rate (per 1000 population)

	Province	Country overall
1990	No data	
2000	4.16	
2010	3.75	

(3) Leading causes of death (1990) and (2010)

2000: 1) Pneumonia
2) Hypertensive Cardiovascular Diseases
3) Pulmonary Tuberculosis

2010: 1) Hypertensive Cardiovascular Diseases
2) Acute Respiratory Diseases
3) Malignant Neoplasms, all forms

(4) Infant mortality rate (per 1000 live birth)

	Province	Country overall
1990	No data	
2000	10.09	
2010	6.02	

(5) Leading causes of infants death (1990) and (2010)

2000: 1) Pneumonia
2) Prematurity
3) Congenital Debelity

2010: 1) Pneumonia
2) Prematurity
3) Neonatal Asphyxia

(6) Under-5 mortality rate (per 1000 live birth)

	Province	Country overall
1990	No data	
2000	No data	
2010	No data	

(7) Top 3 diseases and morbidity rate of the under-5 of (1990) and (2010)

1990: No Data
Diseases: 1) 2) 3)
Morbidity rate: 1) 2) 3)

2010: (Available Data is on top ten causes of mortality)

Diseases	Mortality Rate (per 1,000 live births)
1. Pneumonia	3.3
2. Prematurity	1.10
3. Asphyxia	0.65

(No Data for morbidity)
Diseases: 1) 2) 3)
Morbidity rate: 1) 2) 3)

(8) Maternal mortality rate (per 100,000 live birth)

	Province	Country overall
1990	No data	
2000	45.0	
2010	74.49	

(9) Leading causes of maternal death (2000) and (2010)

2000: 1) Postpartum Hemorrhage
2) Placental Retention
3) Uterine Rupture

2010: 1) Pre-eclampsia/Eclampsia
2) Placenta Previa/Postpartum Hemorrhage/Uterine atony/Placental retention
3) Ruptured Ectopic Pregnancy

(10) Is there any national standards for certifying disabilities in your country?
Yes / No

If yes, please explain briefly.

(11) Does your country perform any health check for the diagnosis of disabilities in infants and children ?
Yes / No

(C) Priorities in health and welfare

(1) In your country/province, who are the most vulnerable populations that should be covered by mother and child welfare policies? List five vulnerable groups in order of priority.

- Infants
- Children below 5 y.o.
- Indigent mothers
- Children with disability/mentally challenged/street & abandoned children

- Teenage mothers

(2) In your country/province, what are the priority health issues/programmes in the area of maternal and child health? List five issues/programmes in order of priority.
    - Family planning
    - Facility based deliveries
    - Functionality of the community health teams
    - Nutrition program in some municipalities
    - Incentives for CHTs

(3) According to the analyses in (A), (B) and (C), what is a potential area you would like to work on for a collaborative action plan to improve health and welfare services for mothers and children (as a product of this training course). Please note that this is only tentative and you can confirm your topic after the course started.

(4) In order to implement your action plan, who are the key stakeholders (including Ministerial departments, local government offices and their departments and NGOs) in your country/province. Please list all key stakeholders and also identify three main partners you will closely work with.

    - Provincial Health Office
    - Department of Social Welfare and Development
    - Philippine National Police, Bureau of Corrections
    - Department of Education
    - Local Government Units
    - TESDA
    - NGOs like parents organizations, development partners, rotary clubs, local organizations

Suggested Guideline for Country Report
for JICA training course
"Promotion of the Collaboration between Child Welfare and MCH"
(JFY 2012)

Position: Nurse III
Name of Office: PROVINCIAL HEALTH OFFICE BANGUED, ABRA, PHILIPPINES

(A) Strengths/Weaknesses in the field of Health and Welfare for Mothers and Children

3 Strengths on the field of Maternal and Child Welfare in the Province of Abra

a. Presence of trained health personnel and social welfare service workers in the different municipalities of Abra committed to render services to the communities.
b. Presence of health facilities and existing health programs in the municipalities
c. Presence of Center-Based Programs of the Social Welfare office at the Regional Office to cater to the needs of women and Children in especially difficult circumstances.

3 Weaknesses in the field of Maternal and Child Welfare in the Province

a. Weak collaboration between agencies like the Health sector, Social Services and other agencies concerned on protecting women and children.
b. Women crisis center in the province is not used solely for its purpose and no permanent employees trained to man the center.
c. Services rendered to women and children are not holistic. The health sector provides the health concerns not integrating other concerns of the welfare of the clients.

3 Strengths in the field of Maternal and Child Health Programs in the Province

a. Presence of policies concerning women and child health regarding Family Planning, Annual Pap Smear Screening of Women, Immunization.
b. Support from the Department of Health in Upgrading Health facilities in terms of providing equipment and the repair and construction of the facilities. The Province receives annual MNCHN Grant from the DOH.

c. Presence of the support of the JICA Project in 6 municipalities to support the MCH program of the Province.

3 Weaknesses in the field of Maternal and Child Health

a. There are only 10 out of 27 municipalities in Abra with permanent Municipal Health Officers. The RHUs are manned by Nurses and in one municipality by a Rural Health Midwife.
b. There is no existing referral system in the Province.
c. There are no accredited Rural Health Units on Maternal and Child Package of the Phil Health.

In the implementation of health/welfare policies and services:

A) What are the successful areas or programs list 3 areas or programs

a) One of the successful areas is on the facility based deliveries attended by health workers. There is a significant increase from home delivery to facility based delivery from 40% in 2006 to 70% in 2011.

b) The use of the Family Health Diary to tract the record of the pregnant woman and the Newborn.

c) The enrolment of the indigent families to Phil Health for free hospitalization in government hospitals and no excess bill payment under this program.

B) What are the issues/Challenges and explain background, current situation and why this issue is difficult to solve.

a. The challenge in promoting facility based deliveries is the presence of traditional birth attendants especially on the remote areas of the province. The families in the communities still prefer to go to the traditional birth attendants especially so when they do not have health insurance and are not ready to shoulder cost of hospitalization. The Traditional Birth Attendants were trained to handle uncomplicated deliveries but were not allowed then to handle deliveries in early 2000. Only few Rural Health Units handle deliveries in the center. Its either because buildings are due for repair or equipment and essential medicines and supplies are not available.

b. The use of the Family Health Diary is at place. However, in some cases clients do not take care of this document and some Obstetricians especially the private sector use other forms for recording and so follow up of cases is very difficult. Proper referral is not in place.

C .Under the Indigency Program of Phil Health, the poor families is enrolled either by the National Government, Provincial or municipal. At the municipal level, there was a decrease in the enrolment due to increase in premium payments set by the Phil Health.

Describe your expectation to the Training Course in Detail.

I express my appreciation to all those who made possible my attendance to this Training course. I am very grateful and in return I will do my best to make a difference or to implement whatever learnings I will acquire in the training.

I expect in this training, of course that it will enhance my knowledge and capabilities in terms of delivering health and welfare services to the mothers and children. The present situation in our province is, the services to mothers and children in the aspect of health are provided by the health sector and their welfare services are provided for by the social welfare sector. In rare instances, there is collaboration between health and welfare office when clients are referred for medical examination due to violence or abuse. What I expect to learn and to be able to apply in my province is how to integrate the health and welfare services in our daily activities. I expect also to be able to integrate into the Family Health Diary the Women and Child Welfare Services or if not into the daily treatment record of individual patient in a health facility.

(B) Indicators

(1) Crude birth rate (per 1000 population)

	province
2007	17.05
2008	20.25
2009	19.31
2010	21.51
2011	20.33

(2) Crude death rate (per 1000 population)

	province
2007	1.8
2008	2.8
2009	4.3
2010	4.24
2011	20.33

(3) Leading Causes of Death

Causes	2009	2010	2011
Pneumonia	274	250	440
Cardio Vascular Accident	81	161	165
Cerebro Vascular Accident	77	87	55
Cancer(all types)	60	78	96
COPD	44		39
Diseases of the Heart	36		114
Hypertension	35		
Myocardial Infarction	33	31	
Cardio Respiratory Arrest	25		
Senility	25	32	47
Sepsis		50	
Gunshot Wound/Stabbed		55	82
HPN/Renal Failure		36	40
Peptic Ulcer Disease		30	
Asthma			34

(4) Infant Mortality Rate (per 1000LB)

year	Province
2007	23.58
2008	6.23
2009	8.60
2010	3.42
2011	12.32

(5) Leading Causes of Infant Deaths

Causes	2009	2010	2011
Pneumonia	11		12
Diseases of the Heart	7		15
Sepsis	3	11	6
Prematurity	3	25	16
Sudden Infant Death Syndrome	2		
Meningitis	2		
Meconium Aspiration Syndrome		5	
Congenital Heart Disease		2	

(6) Under-5 mortality rate (per 1000 live birth)

	Country overall/province
2007	13.58
2008	8.72
2009	11.61
2010	14.65
2011	0.89

(7) Top 3 diseases and morbidity rate of the under-5

No Data available			

(8) Maternal mortality rate (per 1,000 live birth)

	Country overall/province
2007	.95
2008	1.03
2009	0.43
2010	0.19
2011	0.41

(9) Leading causes of maternal deaths

2009
1. Chronic HPN, Pre-eclampsia
2. Pulmonary Edema sec. to Severe Pre-eclampsia

2010
1. CVA, Hemorrhage, PIH, Pulmonary Edema

2011
1. Multiple Organ Failure disseminated intra-uterine atony, hypovolemic shock sec. to amniotic embolism.
2. Post partum sepsis

(10) Is there any national standard for certifying disabilities in your country?

Yes, the Municipal Social Worker identifies the persons with disability and coordinates with the Municipal Health Officer in the area to determine the type of disability the person has. The Municipal Social Worker then issues the Certificate of disability to the disabled person.

(11) Does your country perform any health check for the diagnosis of disabilities in infants and children?

Yes, health facilities perform health check for the diagnosis of disabilities in infants and children

. **C) Priorities in health and welfare**

(1) In your country/province, who are the most vulnerable populations that should be covered by mother and child welfare policies? List five vulnerable groups in order of priority.

The most vulnerable population are the:

a. Under Five Children
b. Pregnant and lactating mothers
c. Adolescent
d. Newborns
e. Disabled persons

(2) In your country/province, what are the priority health issues/programmes in the area of maternal and child health? List five issues/programmes in order of priority.

a. Immunization
b. Facility based Deliveries and Skilled Birth Attendants
c. Enrolment of poor families to NHIP (National Health Insurance Program)
d. Upgrading/accreditation of health facilities to be CEmONC/BEmONC capable
e. Organization of Community Health Team

(3)According to the analyses in (A), (B) and (C), what is a potential area you would like to work on for a collaborative action plan to improve health and welfare services for mothers and children (as a product of this training course). Please note that this is only tentative and you can confirm your topic after the course started.

As per analyses of the above data, the services on Maternal and Child Health Welfare are in place, however, there is no system on the proper referral to concern agencies to be able to strengthen collaborative efforts in the delivery of services to mothers and children. I also would like to think of including information to be asked during a health check regarding social welfare services.

(4)In order to implement your action plan, who are the key stakeholders (including Ministerial departments, local government offices and their departments and NGOs) in your country/province? Please list all key stakeholders and also identify three main partners you will closely work with.

List of Key Stakeholders

1. Provincial Social Welfare Office
2. Provincial Health Team Leader
3. Rural Health Unit
4. Municipal Social Welfare Office
5. Community Health Teams

Three Main Partners

1. Provincial Social Welfare Office
2. Rural Health Units
3. Municipal Social Welfare Office

The Study Programme for the Promotion of the Collaboration between Child Welfare and Maternal and Child Health ～What can be done to attain Welfare and MCH collaboration for the benefit of mothers and children～

Thailand

Country report for JICA training course

"Promotion of the Collaboaration between Child Welfare and MCH"

(A)Strengths/Weaknesses in the field of Health and Welfare for Mothers and Children

Please describe the following items within 2-3 pages (A4 size / typed)

1. Raise 3 strengths in the field of Maternal and Child Welfare in your country/province.

1. Regulation and policy that support sustainable working in the field of Maternal and Child welfare
   - The National Economic and Social Development Plans No.11(2012-2016) have placed people at the centre of the development, focusing on their holistic development, physically, intellectually and mentally. Office of the National Economic and Social Development Board, the national focal point for MDGs, is responsible for coordinating among many public, private and civil society and the UN agencies.
   - In education, policies aimed at education reform, expansion of education opportunities and improvement of education quality, supported by the National Education Act of 1999, and strategies aimed at improving access and quality of education at various levels, ranging from small-sized schools to tertiary and non-formal education, as well as education for specific groups of children. Currently, the National Education Act of 2012-2016, free of charges in first 12 years of education for Thai children.
   - In the Child Protection Act of 2003, Child and Youth Development Plan of 2002-2006, National Plan on the Prevention and Solutions for Children in Especially Difficult Circumstances (2002-2006).
   - Plan of Action of "a world fit for children" in 2007-2016.

2. We have the King of Thailand who is a great man and centre of Thai people
   - Based on the principle of economic sufficiency by our king. Thai people realize capacity building of families and communities under concept of economic suffiency.

3. In the be violated maternal and child, the collaborative team among MOPH, Ministry of Justice, Ministry of social development and human security, Ministry of education, and NGOs develop One Stop Crisis Center (OSCC).

2. Raise 3 weaknesses in the field of Maternal and Child Welfare in your country/province.

1. Migration of people increased in the period of time association with the rapid growth of economy then it is difficult to provide any welfare

2. Changing of family' s structure in Thailand. In the past, extended family was the major type. There were many people who could support the government policy and take care of family member.

In present, Most of family in Thailand is single family and aiming in earn money for living. So, concerning about others especially it spend significant times.

3. Quality of government unit ,which supports maternal and child welfare, has a wide range of variation. For example, limitation of staff in some area must associated with stricted area of evaluation and assistance.

3. Raise 3 strengths in the field of MCH in your country/province.

1. Regulation and policy

- Policies on public health reform, improvement of access and quality of health services, and health promotion as provided for in the National Health Act of 2007.
- HRH Princess Srirasm, Royal consort to HRH the Crown Prince Maha Vajiralongkorn is president in saiyairak hospital project that ministry of health is main responsible which create and support maternal and child health promotion in hospital and their community.
- Primary care unit is a good integration system between health system and community so it looks like a tailor made for health in their context.

2. Significant improvement of national database and reaccreditation systems to follow up patients and evaluate the strategy.

3. Cooperation between community and government section. Most of people in community would be encouraged to participate the programmes or activities which are generated by local officers.

4. Raise 3 weaknesses in the field of MCH in your country/province.

1. Reproductive education in teenage children don't suitable for them because of the lacking in well-trained staff who can suggest the good advice about sexuality and contraception. That had been shown as high rate of teenage pregnancy and increase rate of unintended pregnancy.

Premature sexual relations and early marriage are also a problem that needs attention.

2. Migration of people increased in the period of time association with the rapid growth of economy , so it is not correlate to national registry and effect health care accessability and universal health care coverage of population .

The policy of Thailand is local health care system by primary health care unit in community before transfer to tertiary care hospital. If patients are not start at their local hospital, they can not get coverage by universal health care program except emergency situation.

3. The Limitation of coordination between organization especially government and private company.

It is recommended to analyze those strengths/weaknesses through the discussion with the authorities concerned (health and welfare) before coming to Japan in order to facilitate to find the way for the collaboration between health and welfare for mothers and children. Preferably country report should be prepared in collaboration with authorities.

In implementing health/welfare policies and services by your organization,

5. What are successful areas or programmes? List 3areas or programmes.

Child health and welfare

1. One stop service care for disabled child include all aspect of health care and performed identification cards
2. Bye Bye Bottle campaign in well child clinic.
3. Development model collaborates with relevant health units for surveillance campaign about lead exposure in Thai children and pregnancy in high risk area.

Maternal health

1. Breast feeding programme.
2. Referral system for complicated maternal complication.
3. Risk reduction of postpartum hemorrhage.

What are issues/challenges? List 3 issues/challenges.

Child health and welfare

1. Lead screening in population at risk.
2. Promote Breast feeding in sick baby, teenage mother.
3. Implement Bye Bye bottle campaign in child aged 1-1 1/2 year old success in other hospital.

Maternal health

1. Teenage pregnancy
2. Late antenatal care and No antenatal care
3. Postpartum clinic

Regarding the above-mentioned issues/challenges, explain background, current situation and reason why those issues/challenges are difficult to solve.

1. Teenage pregnancy

Background and current situation : Prevalence of teenage pregnancy in Thailand was around 10-13% which was higher than other countries. This rate increased over a few years. Teenage pregnancy is associated with obstetric complication and family problems.

Solving problem : Difficult to implementing education about sexuality to school-age population and modernization from western countries make change to culture.

2. Late antenatal care and No antenatal care

Background and current situation : In present, There are 40% of pregnant women come to antenatal clinic after 12 weeks of gestational age and more than 5% with never get antenatal care before delivery. These are associated with bad obstetric outcome and also maternal and child health.

Solving problem : Accessibility of health care unit and poverty are the important factors that involed.

3. Postpartum clinic

Background and current situation : There was a small number of mothers which came back to postpartum and family planning clinic. So, important informations , such as breast feeding and contraception, could not eduacate to women to taking care her baby.

Solving problem : Most of the mothers who delivered in our hospital has distance hometown (moved to city for jobs and went back during baby's care).

Describe your expectations to the training course in detail.

- To learning about improvement of MCH in Japan in health services and social welfare.
- Disabled group, the process of screening, diagnosis, intervention and the social support_education,trasnsport, budget to develop them in the way a full potential human being.
- Knowledge from this course would help us to initiate new programme in maternal and child health.

(B)Indicators

(1) Crude birth rate (per 1000 population)

	Country overall
1990	17.0/1000
2000	12.7/1000
2010	12.0/1000

(2) Crude death rate (per 1000 population)

	Country overall
1990	4.5/1000
2000	5.9/1000
2010	6.5/1000

(3) Leading causes of death (1990) and (2010)

1990:

1) The Heart disease 51.3/100000 population

2) Accident and Poisoning 41.9/100000 population

3) Malignant neoplasm 39.3/100000 population

2010:

1) Neoplasm 91.2/100000 population

2) Infectious and parasitic disease 64.9/100000 population

3) Accident and external cause 62.7/100000 population

(4) Infant mortality rate (per 1000 live birth)

	Country overall
1990	8.0/1000
2000	6.2/1000
2010	7.0/1000

(5) Leading causes of infants death (1990) and (2010)

1990:

1. certain condition originating in the perinatal period 1.8/1000 live birth

2. congenital anomaly 1.5/1000 live birth

3. disease of the respiratory tract system other than the upper respiratory tract 0.7/1000 live birth

2010:

1. certain condition originating in the perinatal period 3.4/1000 live birth

2. congenital malformation, deformation and chromosomal abnormalilties 1.2/1000 live birth

3. Disorders relating to length of gestational and fetal growth 1.1/1000 live birth

(6) Under-5 mortality rate (per 1000 live birth)

	Country overall
1990	12.8
2000	11.9
2010	9.8

(7) Top 3 diseases and morbidity rate of the under-5 of (1990) and (2010)

no record

1990:

Diseases: 1) 2) 3)

Morbidity rate: 1) 2) 3)

2010:

Diseases: 1) 2) 3)

Morbidity rate: 1) 2) 3)

(8) Maternal mortality rate (per 100,000 live birth)

	Country overall
1990	0.2/1000 live birth
2000	13.2/100000
2010	10.2/100000

(9) Leading causes of maternal death (1990) and (2010)

1990:

1) Obstruct labor
2) Haemorrhage
3) Toxemia

2010:

1) Complication of labor and delivery
2) Hypertensive disorder
3) Abortion

(C) Priorities in health and welfare

(1) In your country/province, who are the most vulnerable populations that should be covered by mother and child welfare policies? List five vulnerable groups in order of priority.

The most vulnerable populations depend on use either money metric indicators measure levels of deprivation based on income or the quality of life calculated by consumption expenditure or non-monetary indicators measure deprivation based on opportunities to access or receive essential basic services, or vulnerability of life situations, such as loss of parents and disability.

1. Low socioeconomic status
2. People who need special support /care
3. Underprivileged / Disadvantaged

- Orphans
- Without nationality / Immigrant or refugees / people who lived in border

4. Maternal and child HIV infection
5. Teenage pregnancy

(2) In your country/province, what are the priority health issues/programmes in the area of maternal and child health? List five issues/programmes in order of priority.

- In 2013-2016, one of flagship project in Thailand labels about quality of life of thai people include all life expectancy. The area of maternal and child health, MOPH creates concept “EWEC = every woman every child” is flagship project in this year and continue to 4 year in the future. Encorage health care accessibility in every populations and improvement of policy ”Universal health insurance coverage”

Aim: improved maternal health, reduced child mortality rate, improved child health and development

1. Promote maternal and child health care with various indicators

Indicators	**AIM (percent)**			
	2553	2554	2555	2556
1. Rate of antenatal care before GA 12 weeks	50	55	60	65
2. Pregnant women with iodine deficiency				<50
3. Iodine use in household				90
4. Birth asphyxia				30
5. Low birth weight (BW < 2500 gm)	<8.5	<8	<7.5	<7
6. Breast feeding	20	30	40	50
7. Weight for age	70	72	78	85
8. Height for age	83	85	88	93
9. Normal posture for age	78	80	82	85
10. Normal development for age in 0-5 years	90	90	90	90
11. Teeth cleaning with fluorinated toothpaste everyday in child care	99	99	99	99
12. Teeth cleaning before bedtime to children 1-2 years by parent everyday	70	75	80	85

- Saiyairak , Family’s health : Increase Breast feeding rate from 20% to 60%

2. Improvement of intelligence quotient of Thai children

3. Support the violence victims

4. Improve antenatal care programme and generate effective guideline for intrapartum care to decrease perinatal morbidity and mortality

5. Support antiretroviral drug to HIV-infected mothers, decrease neonatal HIV infection from 3.5% to 1.5% in 2015

6.Thalassemia screening during pregnancy

(2) According to the analyses in (A), (B) and (C), what is a potential area you would like to work on for a collaborative action plan to improve health and welfare services for mothers and children (as a product of this training course). Please note that this is only tentative and you can confirm your topic after the course started.

Child health and welfare

- To develop and implement a new screening / preventive model in the field of maternal and child health by integration relevant systems among government bodies concerning children issues especially teenage group who have risk to be unplanned pregnancy, the environment hazards example lead exposure; carcinogen from food contamination, table ware; micronutrient deficiency or depletion such as iron; birth defect registry;. How to dissemination of knowledge and development of suitable system for population at risk in service.
- Improvement of maternal & baby friendly services by setting up high quality well child clinic, learning center for family in order to educate them on particular issues such as raising a child in safety environment, healthy and happy home/community, breast feeding corner and collaboration of child welfare in home care patient, and a good data base system.
- To support mother and child who need special help for independent living in their community/social by improvement of equally accessing into health care services, education and referral system especially those who need special supports such as disable children, single parent and teenage parent in respect of friendly environment for maternal and child by employing QNISCH as a pilot case.

Maternal health

- Teenage pregnancy

Thailand is the second most country that has high rate of teenage pregnancy. These risk is associated with obstetrics complication and significant effect on community problems such as preterm birth, low birth weight, perinatal mortality and especially unintended pregnancy leading to illegal abortion. Teenage mothers trend to be sperated from normal educational systems and leading to child care problems and social problems. This problem could not be solved in few years or by single organization. However, we can implement education or important information to teenage mothers for good taking care with her pregnancy and her child after delivery.

Knowledge course at first visit of antenatal care could help to educated her and families.

(A) Strengths/Weaknesses in the field of Health and Welfare for Mothers and Children

Please describe the following items within 2-3 pages (A4 size / typed)

①Raise 3 strengths in the field of Maternal and Child Welfare in your country/province.

1. Regulation and policy that support sustainable working in the field of Maternal and Child welfare

- The National Economic and Social Development Plans No.11(2012-2016) have placed people at the centre of the development, focusing on their holistic development, physically, intellectually and mentally. Office of the National Economic and Social Development Board, the national focal point for MDGs, is responsible for coordinating among many public, private and civil society and the UN agencies.
- The policies aimed at education reform, expansion of education opportunities and improvement of education quality are supported by the National Education Act of 1999. There are strategies aimed at improving access and quality of education at various levels, ranging from small-sized schools to tertiary and non-formal education, as well as education for specific groups of children. Currently, the National Education Act of 2012-2016 provides education for Thai children free of charge in first 12 years.
- We have specific regulation& policy for child and youth protection and development including Child Protection Act of 2003, Child and Youth Development Plan of 2002-2006, National Plan on the Prevention and Solutions for Children in Especially Difficult Circumstances (2002-2006), and the newest policy, Plan of Action of “a world fit for children” in 2007-2016.

2. Based on the principle of economic sufficiency advised by our king. Thai people realize significance of capacity building of families and communities under that concept.

3. The collaborative team among Ministry of Public Health(MOPH), Ministry of Justice, Ministry of social development and human security, Ministry of education, and NGOs have developed One Stop Crisis Center (OSCC) for abused maternal and child.

②Raise 3 weaknesses in the field of Maternal and Child Welfare in your country/province.

1. The migration of people has increased during the period of time association with the rapid growth of economy, making it difficult for the government's MCH to reach people working outside of their coverage area.
2. The changing of family's structure in Thailand, from extended family to single family effect to detach the community.
3. Unstable government causes inconsistencies in implementation and development of maternal and child welfare policy, there are a wide range of variation.

③Raise 3 strengths in the field of MCH in your country/province.

1. Regulation and policy

- Policies on public health reform, improvement of access and quality of health services, and health promotion as provided for in the National Health Act of 2007.
- HRH Princess Srirasm, Royal consort to HRH the Crown Prince Maha Vajiralongkorn is president in saiyairak hospital project that ministry of health is main responsible which create and support maternal and child health promotion in hospital and their community.

2. Primary care unit is a good integration system between health system and community and it helps to communicate about health education for people in their context especially some area have unique culture and belief.
3. The improvement of national database system makes us to evaluate health problem and the strategies.

④Raise 3 weaknesses in the field of MCH in your country/province.

- Reproductive education in teenage children don't suitable for them because of the lacking in well-trained staff who can suggest the good advice about sexuality and contraception. That had been shown as high rate of teenage pregnancy and increase rate of unintended pregnancy.
- The migration of people increased, effecting the health care access and universal health care coverage of population .
- The policy of Thailand, local health care system in community are main responsible for taking care their local people. If patients are not start treatment at their local hospital, they can not get coverage by universal health care program except emergency situation.

- The Limitation of coordination between organization especially government and private company.

In implementing health/welfare policies and services by your organization,

⑤What are successful areas or programmes? List 3areas or programmes.

Child health

1. QSNICH provides One stop service care for disabled child that included all aspect of health care and performed identification cards to them.
2. Development model collaboration with relevant health units for surveillance campaign about lead exposure in Thai children and pregnancy in high risk area.
3. Health promotion: We have started campaign “Bye Bye bottle for thai children aged 1-11/2 years old” to promote healthy eating behavior and oral health.

Maternal health

1. Breast feeding programme.
2. Referral system for complicated maternal complication.
3. Risk reduction of postpartum hemorrhage.

⑥What are issues/challenges? List 3 issues/challenges.

Child health

1. Health screening: Implementation about blood lead screening in population at risk.
2. Promote Breast feeding in sick baby, teenage mother.
3. To Support the Bye Bye bottle campaign in child aged 1-1 1/2 year old in hospital.

Maternal health

1. Teenage pregnancy
2. Late antenatal care and No antenatal care
3. Postpartum clinic

⑦Regarding the above-mentioned issues/challenges, explain background, current situation and reason why those issues/challenges are difficult to solve.

Child Health

1. Lead exposure screening

Background and current situation : Lead toxicity effects to health and intelligence and lifelong effect especially children aged the first 5 years old. Due to low level of lead is asymptomatic, moreover no safety level for lead in human so prevention and health education are the next actions which should be taken in order to eliminate lead exposure. In Thailand, we don't know prevalence of lead exposure in general children population and the high risk group, we have only several study reported to show that Thai children were exposed to lead toxicity.

Solving problem:

1. Blood lead screening in well child clinic for the children aged 1-2 years old.

2.To create the questionnaires for finding the risk group

Limitation: budget, unrecognized this problem, No database to show magnitude of this concerning

2. Promote breastfeeding / Bye Bye Bottle

Background and current situation: Breastfeeding decreased infection rate in children and promote bonding and attachment between maternal and child, additionally, public hospital are baby friendly hospital. The preterm baby and teenage pregnancy are active health problem in Thailand which breastfeeding could improve maternal and child health outcome and family's economic.

Solving problem:

1. To set the health policy and guideline for these unique group.
2. To create model development (pilot study to implement)

Limitation: limited of well trained staff, old culture and belief, labor laws do not support for working mother.

Maternal health

1.Teenage pregnancy

Background and current situation : Prevalence of teenage pregnancy in Thailand was around 10-13% which was higher than other countries. This rate increased over a few years. Teenage pregnancy is associated with obstetric complication and family problems.

Solving problem : Difficult to implementing education about sexuality to school-age population and modernization from western countries make change to culture.

2.Late antenatal care and No antenatal care

Background and current situation : In present, There are 40% of pregnant women come to antenatal clinic after 12 weeks of gestational age and more than 10% with never get antenatal care before delivery. These are associated with bad obstetric outcome and also maternal and child health.

Solving problem : Accessibility of health care unit and poverty are the important factors that involed.

3.Postpartum clinic

Background and current situation : There was 30% of mothers which came back to postpartum and family planning clinic. So, important informations , such as breast feeding and contraception, could not eduacate to women to taking care her baby.

Solving problem : Most of the mothers who delivered in our hospital has distance hometown (moved to city for jobs and went back during baby's care).

⑧Describe your expectations to the training course in detail.

- To learning about improvement of MCH in Japan in health services and social welfare.
- For disabled group, the process of screening, diagnosis, intervention and the social support: education, trasnsportation, and budget to develop them in the way a full potential human being.

(B)Indicators

(1) Crude birth rate (per 1000 population)

	Country overall
1990	17.0/1000
2000	12.7/1000
2010	12.0/1000

(2) Crude death rate (per 1000 population)

	Country overall
1990	4.5/1000
2000	5.9/1000
2010	6.5/1000

(3) Leading causes of death (1990) and (2010)

1990:

1) The Heart disease 51.3/100000 population

2) Accident and Poisoning 41.9/100000 population

3) Malignant neoplasm 39.3/100000 population

2010:

1) Neoplasm 91.2/100000 population

2) Infectious and parasitic disease 64.9/100000 population

3) Accident and external cause 62.7/100000 population

(4) Infant mortality rate (per 1000 live birth)

	Country overall
1990	8.0/1000
2000	6.2/1000
2010	7.0/1000

(5) Leading causes of infants death (1990) and (2010)

1990:

1. certain condition originating in the perinatal period 1.8/1000 live birth
2. congenital anomaly 1.5/1000 live birth
3. disease of the respiratory tract system other than the upper respiratory tract 0.7/1000 live birth

2010:

1. certain condition originating in the perinatal period 3.4/1000 live birth
2. congenital malformation, deformation and chromosomal abnormalilties 1.2/1000 live birth
3. Disorders relating to length of gestational and fetal growth 1.1/1000 live birth

(6) Under-5 mortality rate (per 1000 live birth)

	Country overall
1990	12.8
2000	11.9
2010	9.8

(7) Top 3 diseases and morbidity rate of the under-5 of (1990) and (2010)

I'm sorry that I could not find top 3 diseases and morbidity rate of the under-5, however, this table showed the data of the year loss to disability (injury and illness) of the under-5 in 2003.

10 Leading Cause of YLD

YLD(3,0) 0-4 Year						
rank	male			female		
	disease	YLD	% of total	disease	YLD	% of total
1	Low birth weight	14430	13.3%	Low birth weight	14543	15.3%
2	Anaemia	8887	8.2%	Anaemia	8347	8.8%
3	Congenital heart disease	8523	7.8%	Congenital heart disease	8004	8.4%
4	Mental retardation not classified elsewhere	6421	5.9%	Protein-energy malnutrition	5593	5.9%
5	Protein-energy malnutrition	5995	5.5%	Mental retardation not classified elsewhere	5223	5.5%
6	Down syndrome	5813	5.4%	Down syndrome	4428	4.6%
7	Birth trauma & asphyxia	3800	3.5%	Birth trauma & asphyxia	3132	3.3%
8	Lower respiratory tract infections	1654	1.5%	Thalassaemia	1509	1.6%
9	Thalassaemia	1603	1.5%	Lower respiratory tract infections	1112	1.2%
10	Diarrhoea	1226	1.1%	Spina bifida	1076	1.1%
	other	50254	46.3%		42377	44.4%
	total	108607		total	95344	

(8) Maternal mortality rate (per 100,000 live birth)

	Country overall
1990	0.2/1000 live birth
2000	13.2/100000
2010	10.2/100000

(9) Leading causes of maternal death (1990) and (2010)

1990:

1) Obstruct labor
2) Haemorrhage
3) Toxemia

2010:

1) Complication of labor and delivery
2) Hypertensive disorder
3) Abortion

(10) Is there any national standards for certifying disabilities in your country?

Yes

If yes, please explain briefly.

1. The regulation for disabled mentions
- To support and promote quality of life in 2007.
- To provide and administer education for disabled in 2008
2. The regulation of Identification card for disabled มีอายุ 6 ปีนับตั้งแต่วันออกบัตร
3. Type of disabled in Thailand is
- Blindness/visual impairment
- Deafness/communication disorder
- Physical disability
- Mental or behavior disorder or autistic
- Cognitive deficit / mental retardation
- Learning disorder

(11) Does your country perform any health check for the diagnosis of disabilities in infants and children ?

Yes

(C) Priorities in health and welfare

(1) In your country/province, who are the most vulnerable populations that should be covered by mother and child welfare policies? List five vulnerable groups in order of priority.

- The most vulnerable populations depend on use either money metric indicators measure levels of deprivation based on income or the quality of life calculated by consumption expenditure or non-monetary indicators measure deprivation based on opportunities to access or receive essential basic services, or vulnerability of life situations, such as loss of parents and disability.

1. Low socioeconomic status
2. People who need special support /care
3. Underprivileged / Disadvantaged
   - Orphans
   - Without nationality / Immigrant or refugees / people who lived in border
4. Maternal and child HIV infection
5. Teenage pregnancy

(2) In your country/province, what are the priority health issues/programmes in the area of maternal and child health? List five issues/programmes in order of priority.

- In 2013-2016, one of flagship project in Thailand labels about quality of life of thai people include all life expectancy. The area of maternal and child health, MOPH creates concept "EWEC = every woman every child" is flagship project in this year and continue to 4 year in the future.
- Encourage health care accessibility in every populations and improvement of policy "Universal health insurance coverage"

Aim: improved maternal health, reduced child mortality rate, improved child health and development

1. Promote maternal and child health care with various indicators

Indicators	AIM (percent)			
	2553	2554	2555	2556
1. Rate of antenatal care before GA 12 weeks	50	55	60	65
2. Pregnant women with iodine deficiency				<50
3. Iodine use in household				90
4. Birth asphyxia				30
5. Low birth weight (BW < 2500 gm)	<8.5	<8	<7.5	<7
6. Breast feeding	20	30	40	50
7. Weight for age	70	72	78	85
8. Height for age	83	85	88	93
9. Normal posture for age	78	80	82	85
10. Normal development for age in 0-5 years	90	90	90	90
11. Teeth cleaning with fluorinated toothpaste everyday in child care	99	99	99	99
12. Teeth cleaning before bedtime to children 1-2 years by parent everyday	70	75	80	85

- Saiyairak , Family's health : Increase Breast feeding rate from 20% to 60%

2. Improvement of intelligence quotient of Thai children

3. Support the violence victims

4. Improve antenatal care programme and generate effective guideline for intrapartum care to decrease perinatal morbidity and mortality

5. Support antiretroviral drug to HIV-infected mothers, decrease neonatal HIV infection from 3.5% to 1.5% in 2015

6.Thalassemia screening during pregnancy

(2) According to the analyses in (A), (B) and (C), what is a potential area you would like to work on for a collaborative action plan to improve health and welfare services for mothers and children (as a product of this training course). Please note that this is only tentative and you can confirm your topic after the course started.

- To develop and implement a new screening / preventive model in the field of maternal and child health by integration relevant systems among government bodies concerning children issues especially teenage group who have risk to be unplanned pregnancy, the environment hazards example lead exposure; carcinogen from food contamination, table ware; micronutrient deficiency or depletion such as iron; and birth defect registry. How to dissemination of knowledge and development of suitable system for population at risk in service.

- Improvement of maternal & baby friendly services by setting up high quality well child clinic, learning center for family in order to educate them on particular issues such as raising a child in safety environment, healthy and happy home/community, breast feeding corner and collaboration of child welfare in home care patient, and a good data base system.

- To support mother and child who need special help for independent living in their community/social by improvement of equally accessing into health care services, education and referral system especially those who need special supports such as disable children, single parent and teenage parent in respect of friendly environment for maternal and child by employing QNISCH as a pilot case.

- Teenage pregnancy: Thailand is the second most country that has high rate of teenage pregnancy. These risk is associated with obstetrics complication and significant effect on community problems such as preterm birth, low birth weight, perinatal mortality and especially unintended pregnancy leading to illegal abortion. Teenage mothers trend to be sperated from normal educational systems and leading to child care problems and social problems. This problem could not be solved in few years or by single organization. However, we can implement education or important information to teenage mothers for good taking care with her pregnancy and her child after delivery. Knowledge course at first visit of antenatal care could help to educated her and families.

出典：平成 24 年度 JICA 集団研修カントリーレポート

- 平成 24 年度 JICA 集団研修「母子保健福祉行政」

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公益社団法人国際厚生事業団（JICWELS）は、国際的な保健・福祉分野の国際協力に貢献することを目的として、1983 年（昭和 58 年）7 月 7 日に厚生省（現厚生労働省）から社団法人の認可を受け設立されました。開発途上国の行政官研修や WHO フェローの受入れ、調査企画や研究開発並びに情報の交換及び広報活動など、海外諸国との国際交流活動を推進しています。

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