Countermeasure for Maternal and
Child Health and Child Welfare

Country Reports

Japan International Corporation of Welfare Services (JICWELS)

Contents

Countermeasure for Maternal and Child Health and Child Welfare

Cambodia

Preparation for Course in Japan 2014

Title: **ARI/CDD PROGRAM OFFICER**
Organization: **National Maternal and Child Health Centre, Ministry of Health**

1) Cambodia Indicators:

a) Crude birth rate (per 1000 population)
- CDHS 2000: 27.7 (CDHS 2000, page 58)
- CDHS 2005: 25.6 (CDHS 2005, page 61)
- CDHS 2010: 24.2 (CDHS 2010, page 57)
- UN data 2011: 22 http://data.un.org/Data.aspx?d=SOWC&f=inID%3A90

b) Crude death rate (per 1000 population)

- CIPS 2013: Total:3.95; Urban: 2.48; Rural: 3.64
- Adult mortality rates[1]: (15-49y)
    1. CDHS 2000: Male = 4.8, Female = 3.5 (CDHS 2000, page 116)
    2. CDHS 2005: Male = 5.2, Female = 3.1(CDHS 2005, page 118)
    3. CDHS 2010: Male = 4.1, Female = 2.5 (CDHS 2010, page 111)
- Crude death rate: http://data.un.org/Data.aspx?q=Crude+death+rate&d=PopDiv&f=variableID%3a65
    1. UN data 1995-2000: 9.5(Medium variant)
    2. UN data 2000-2005: 7.6 (Medium variant)
    3. UN data 2005-2010: 6.4 (Medium variant)

c) Leading causes of morbidities and of deaths (all ages)

- From 2001–2010, the 10 leading causes of morbidity in the country are:

    1. Acute respiratory infection;
    2. Diarrhea;
    3. Malaria;
    4. Cough (at least 21 days);
    5. Gynaeco-obstetric issues;
    6. Tuberculosis;
    7. Road accidents;
    8. Measles;
    9. Dengue hemorrhagic fever; and
    10. Dysentery.

Communicable diseases are thus a leading cause of morbidity and dominate all age groups, accounting for 83% of the reported disease burden, with 67% among the elderly and 96% among the 0–5 year age group. Non-communicable diseases (NCDs) are increasing significantly, now causing an estimated 53% of deaths per year *(Source: WHO 2012).*

[1] Estimated adult mortality rates for women andmen for the period 0-6 years prior to thesurvey, Cambodia 2010

- Cambodia total deaths by cause in 2011:

	Death causes	Deaths	%
1.	Influenza & Pneumonia	15,751	15.18
2.	Tuberculosis	11,627	11.21
3.	Coronary Heart Disease	9,144	8.81
4.	Stroke	6,933	6.68
5.	Hypertension	4,147	4.00
6.	Diarrhoeal diseases	4,114	3.97
7.	Low Birth Weight	3,464	3.34
8.	Birth Trauma	3,153	3.04
9.	Diabetes Mellitus	3,122	3.01
10.	HIV/AIDS	3,029	2.92

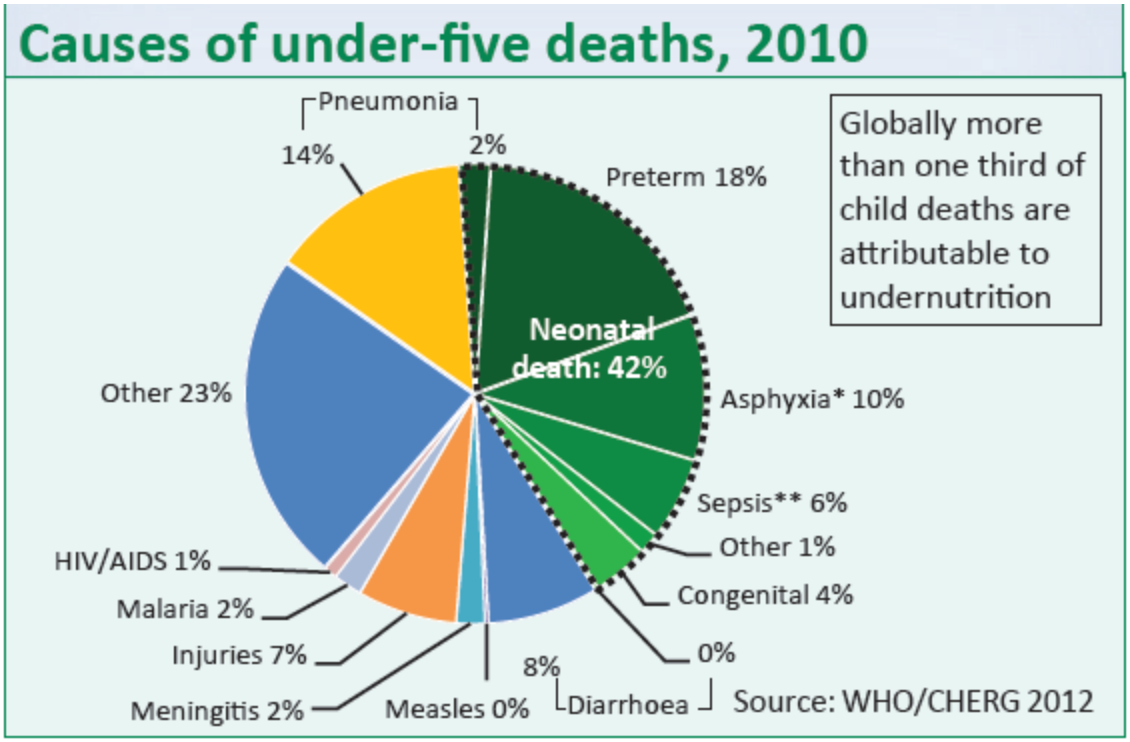
(Source: http://www.worldlifeexpectancy.com/country-health-profile/cambodia

d) Infant mortality rate (per 1000 live birth)
- CDHS 2000: 95 (CDHS 2000, page 124)
- CDHS 2005: 66 (CDHS 2005, page 2)
- CDHS 2010: 45 (CDHS 2010, page 2)

e) Leading causes of infants death

No specific data of the leading causes of infant deaths are available. Below are the causes of under-five death in Cambodia.

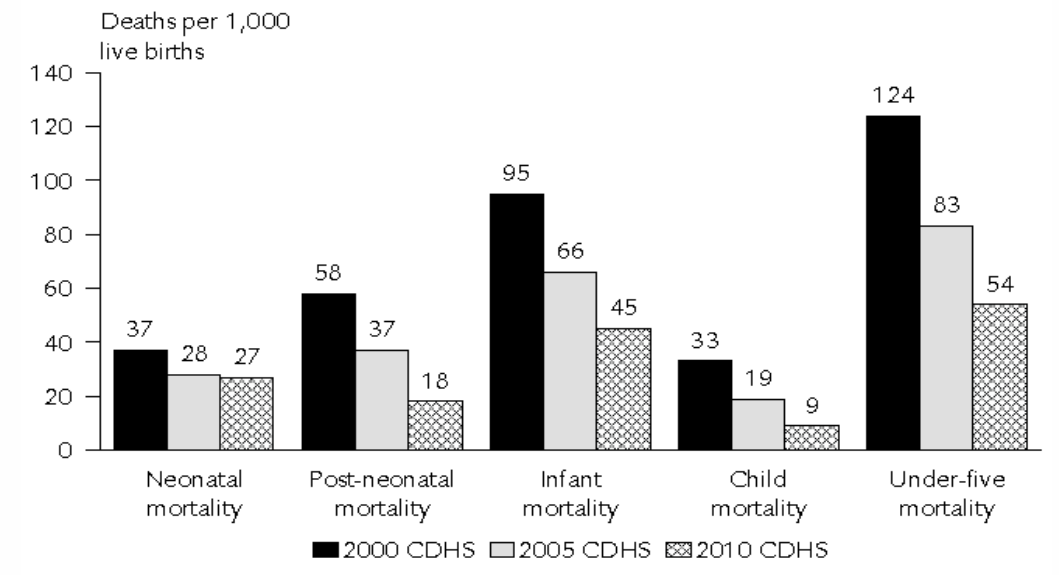
The important causes of child death in Cambodia are neonatal death (42%), of which premature births are the leading causes of death for newborn babies, followed by asphyxia (18%), sepsis (6%), and congenital (4%). Pneumonia and diarrhea are the second and third causes of death for children under five years; while Injuries are the fourth causes of death for those children.



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

- CDHS 2000: 124 (CDHS 2000, page 124)
- CDHS 2005: 83 (CDHS 2005, page 2)
- CDHS 2010: 54 (CDHS 2010, page 2)

CHILD MORTALITY RATE
from 2000 to 2010

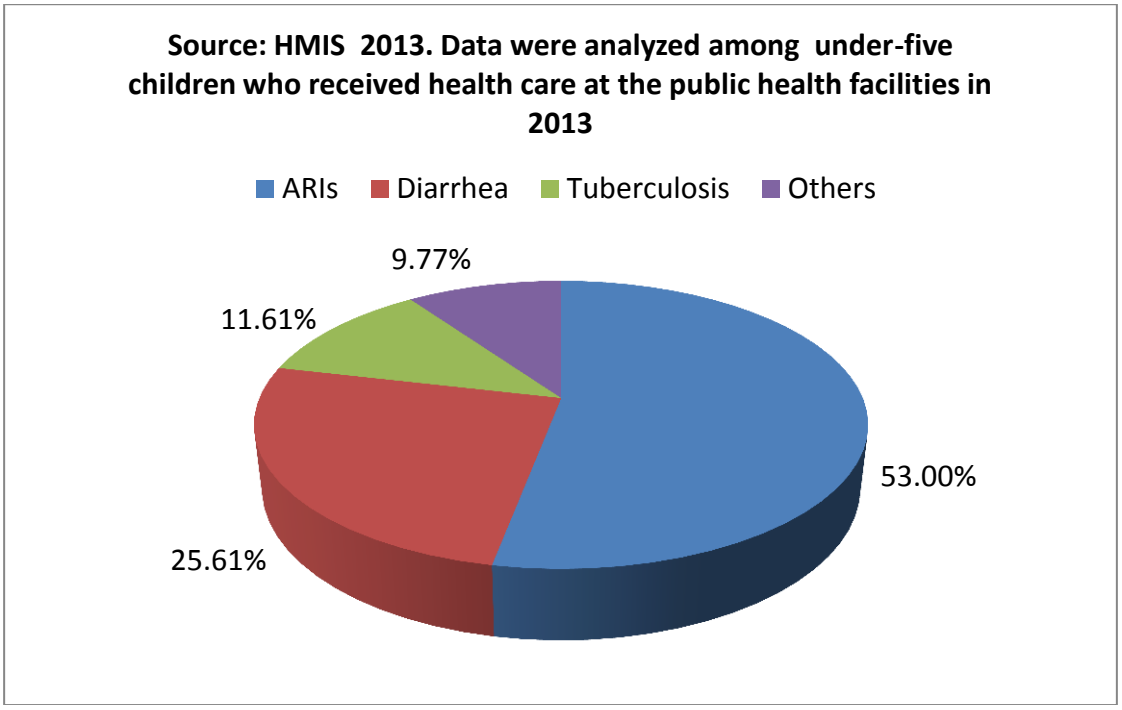


g) Top 3 diseases and morbidity rate of the under-5

The Ministry of Health has classified 10 top diseases for children seeking care at the public health facilities including acute respiratory infection, diarrhea, tuberculosis, road traffic accidents, injuries, high blood pressure, typhoid fever, head traumatic, gynecological diseases, and dengue fever.

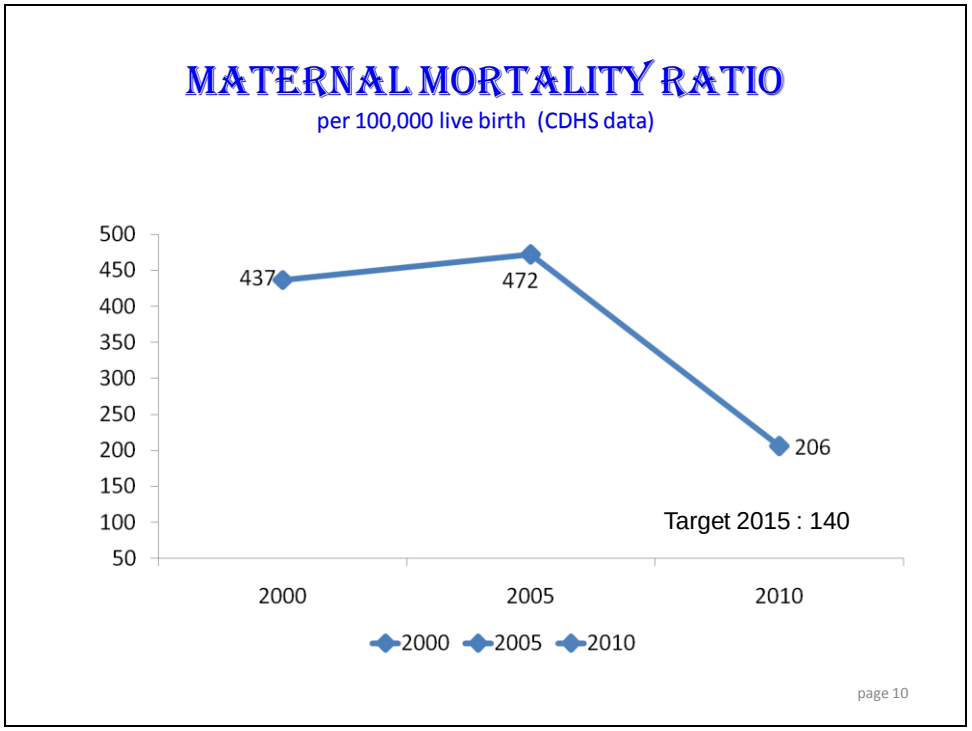
Among the top 10 diseases, pneumonia is the first leading cause of morbidities, followed by diarrhea the second cause of morbidity. The third cause of morbidity is tuberculosis (HIS 2013 Report).

Diseases	<5 years old			
	Cases		Total	%
	M	F		
1. ARIs	27329	19895	47224	53.00%
2. Diarrhea	12921	9900	22821	25.61%
3. Tuberculosis	5936	4410	10346	11.61%
4. All road traffic accidents(affecting head excluded)	991	680	1671	1.88%
5. Other Injuries(mine & traffic acc. excluded)	751	473	1224	1.37%
6. High Blood Pressure	0	0	0	0.00%
7. Typhoid fever	610	626	1236	1.39%
8. Road traffic accidents affecting head	610	401	1011	1.13%
9. Gynecological Pathology	0	3	3	0.00%
10. Dengue fever	1907	1656	3563	4.00%
Total			89099	100.00%



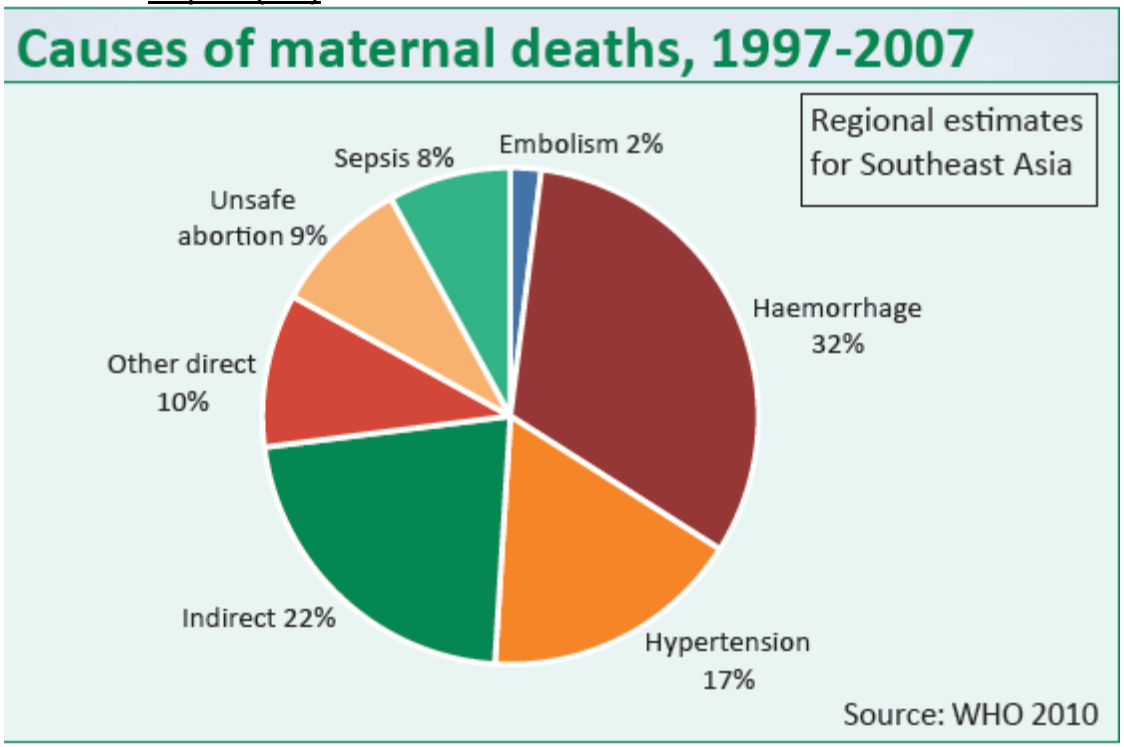
h) Maternal mortality rate (per 100,000 live birth)

- CDHS 2000: 437 (CDHS 2000, page 2)
- CDHS 2005: 472 (CDHS 2005, page 120)
- CDHS 2010: 206 (CDHS 2010, page 112)



i) Leading causes of maternal death

1. Hemorrhage (32%)
2. Hypertension (17%)
3. Unsafe abortion (9%)
4. Sepsis (8%)



j) Does your country perform any health check for infants and children?

Yes (X) / No

If 'Yes',

-When (at how many months)?

- after birth within 24 hours, 6 weeks, 10 weeks, 14 weeks, and 9 months.

-How many times?

- as many as possible and depends on parents/care givers

-What kinds of contents include in each?

- Measure weight and height
- Check for malnutrition
- Immunization

k) In the case any diseases or disabilities is confirmed, is there any support services on them? Describe the services, if any.

- No special care for disable children as our country treats all children the same.

l) Are there national standards for certifying disabilities in your country?

Yes / No (x)

If yes, please explain briefly.

2) Preliminary Analysis

1. Please try to describe the followings on the surroundings mothers and children.

① Three (3) Strengths in your country / region.

1. Strong commitment from and the leadership of the government especially the Ministry of Health to improve the health system. As a results high coverage has been significant increased in the terms of immunization, ANC2, Skilled Birth Attendants, exclusive breast feeding, complementary food feeding message and family planning.

2. Policy and guidelines for the sub-national implementation including:
   (a) National Reproductive Health Strategy
   (b) National Child Survival Strategy
   (c) Policy on ARI/CDD Program
   (d) IMCI clinical Guidelines
   (e) Clinical Practice Guidelines for Hospitals

3. Strong partnership with INGOs and NGOs that could contribute in providing technical and financial supports.

② Three (3) Weaknesses/Challenges in your country / region.

1. Limitation of resources including human resources (staff retired and turned over), financial resources and medical equipments for support mother and their newborns.
2. limitation of skill practices in caring newborn babies
3. Limitation of community participation. This requires to have a strategy for demand creation.

2. In your country / region, who are the most vulnerable populations? Please list three (3) groups in order of priority. ex) groups living rural areas? with low-income? with disabilities?

    - Disable and poor children living in the remote and rural areas
    - Children living with HIV
    - Orphan/street children

3. What kinds of services are there for the above mentioned groups?
    - No special care as above mentioned. At the public health facilities, all children are treated equally without discrimination.

3) Documents to bring

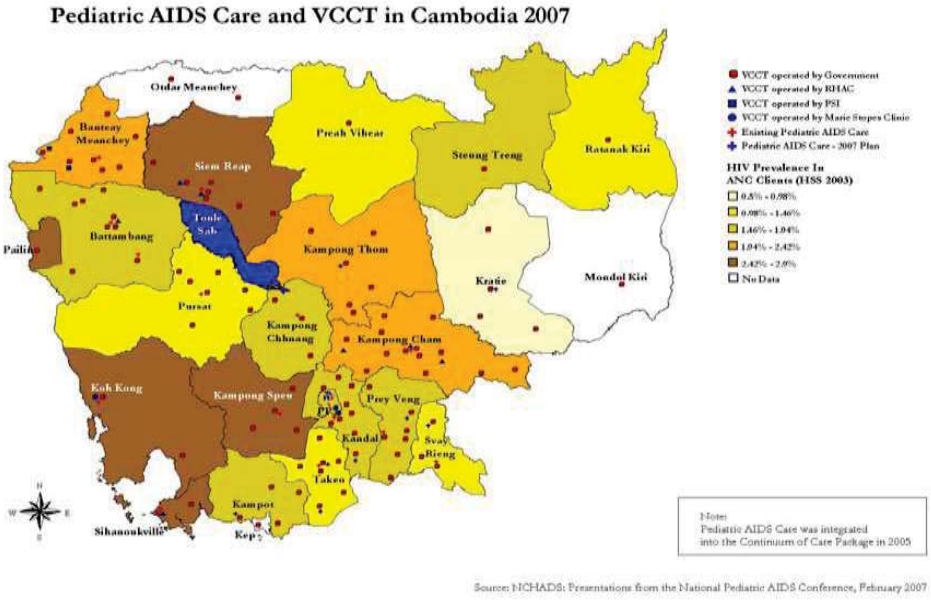
- Policies of your country (MCH) — Please print them out.
- Policies of your country (Child Welfare) — Please print them out.
- MCH handbook (if any)
- MCH Records kept at home (if any)
    - Records of Check-Ups (for mothers and child)
    - Record of Delivery
    - Records of Immunizations
    - Records of Weight and Height graph
    - Records of Development of child

CAMBODIA

JICA TRAINING COURSE
"COUNTERMEASURE FOR MATERNAL AND CHILD HEALTH AND CHILD WELFARE"
(JFY 2013)

02 February 2014 – 01 March 2014

Tokyo, Japan



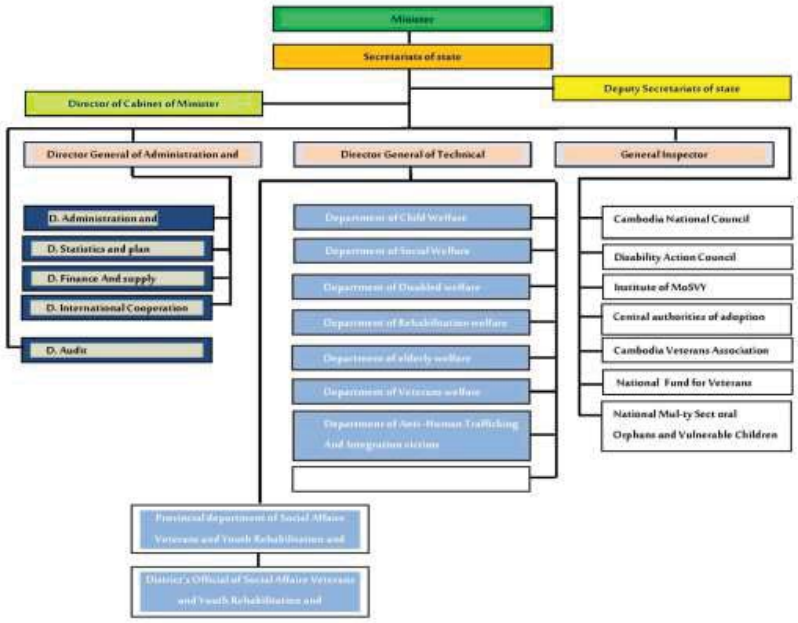
CONTENTS

1. BACKGROUND OF CAMBODIA

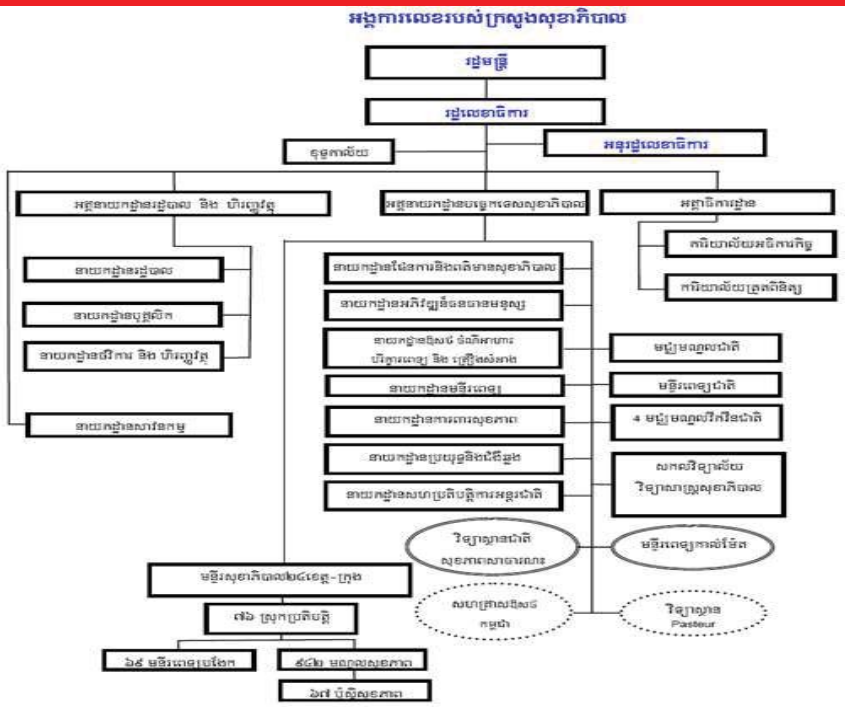
BACK GROUND OF CAMBODIA

1	**Area**	**181,035 sq km**
2	Coastline	443 km
3	Highest point Phnom Aural	1,813 m
4	Population	13,607,069 (2005)
5	Population density	77 persons per sq km
6	Urban population distribution	19 percent (2003)
7	Rural population distribution	81 percent (2003
8	Official language	Khmer
9	Infant mortality rate	72 deaths per 1,000 live births (2005
10	Gross domestic product (GDP in U.S.$)	$4.23 billion
11	Unemployment rate	1.8 percent (2001)

MoSVY's Structure



Ministry of Health (Structure)



2. JICA

PART A (INDICATORS)

N	Indicators , sours (CDHS)	2000	2005	2010
1	Crude birth rate (per 1000 population) -	27.7	25.6	24.2
2	Crude death rate (per 1000 population) - CDHS	8.3	8.3	6.6

3 *Leading causes of death*

From 2001–2010, the 10 leading causes of morbidity in the country are:

1. *Acute respiratory infection;*
2. *Diarrhea;*
3. *Malaria;*
4. *Cough (at least 21 days);*
5. *Gynaeco-obstetric issues;*
6. *Tuberculosis;*
7. *Road accidents;*
8. *Measles;*
9. *Dengue hemorrhagic fever; and*
10. *Dysentery.*

2. JICA

PART A (INDICATORS)

N	Indicators , sours (CDHS)	2000	2005	2010
4	Infant mortality rate (per 1000 live birth)	95	66	45

5 *Leading causes of infants death*

No specific data of the leading causes of infant deaths are available. Below are the causes of under-five death in Cambodia.

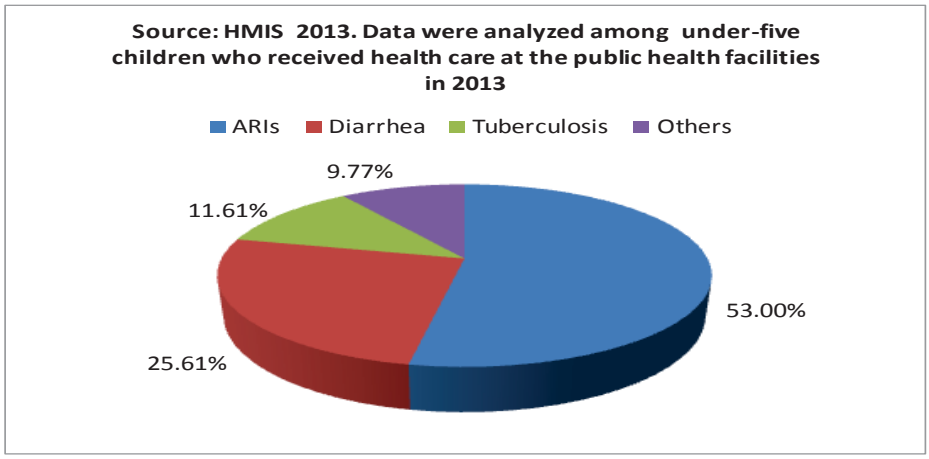
The important causes of child death in Cambodia are neonatal death (42%), of which premature births are the leading causes of death for newborn babies, followed by asphyxia (18%), sepsis (6%), and congenital (4%). Pneumonia and diarrhea are the second and third causes of death for children under five years; while Injuries are the fourth causes of death for those children.

2. JICA

PART A (INDICATORS)

N	Indicators , sours (CDHS)	2000	2005	2010
6	Under-5 mortality rate (per 1000 live birth)	124	83	54

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



2. JICA

PART A (INDICATORS)

N	Indicators , sours (CDHS)	2000	2005	2010
8	Maternal mortality rate (per 100,000 live birth)	437	472	206

9 *Leading causes of maternal death*

- Hemorrhage (32%), - Hypertension (17%), - Unsafe abortion (9%)

Three (3) Strengths in my country / region

- law, Policy, Standard, Guideline,…….were establish
- We have the structure form National and sub-National level.
- we have the stage for Government, Partnership, NGOs are met and share some information every month and Quarter through NOVCTF..

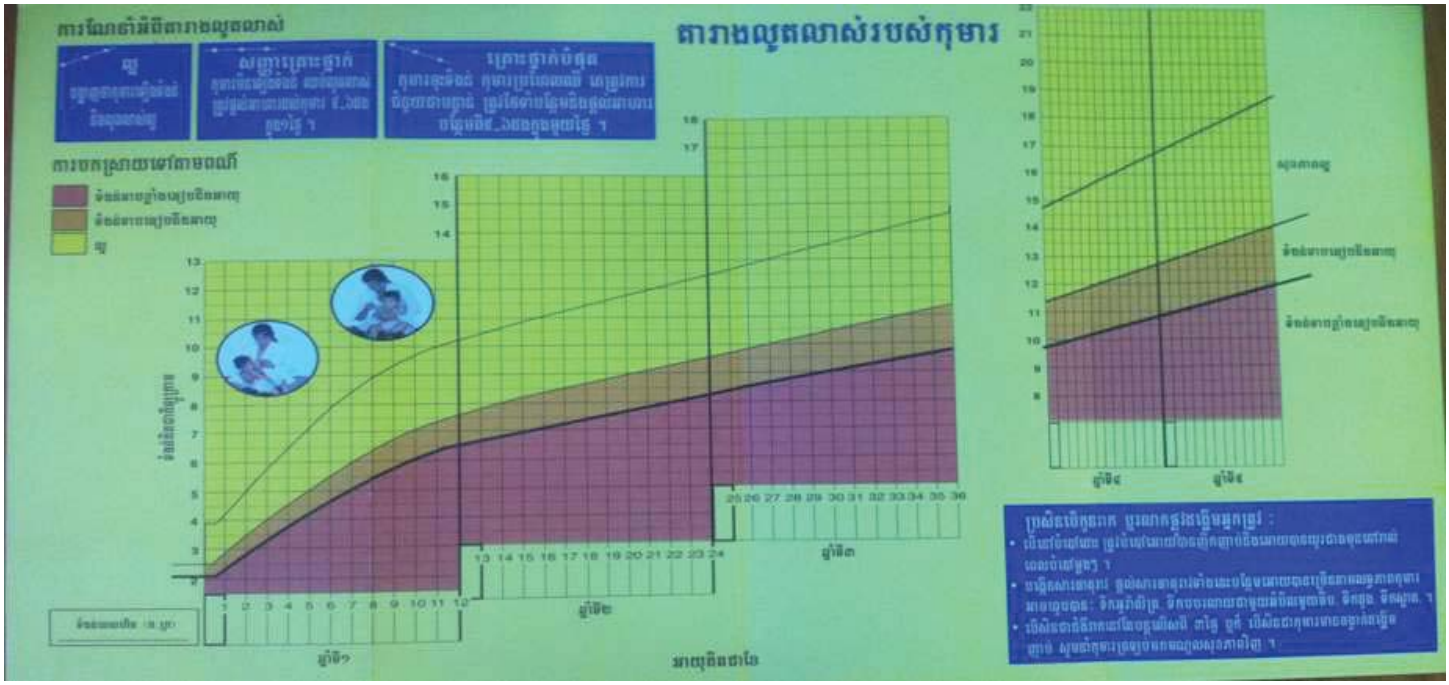
Three (3) Weaknesses/Challenges in my country

- The implementation on the law, Policy, Standard, Guideline are not completed
- M&E Data collection are not work in the hold country
- Resource of Budget, human, equipments and knowledge are limited

10 *Does your country perform any health check for infants and children?*

THE TABLE OF CHILDREN GROW UP UNDER 5 YEAR.

THE TABLE OF CHILDREN GROW UP UNDER 5 YEAR.



2. JICA

THE HEALTHIEST FOODS ON THE PLANET

PART B (STANDARD GUIDELINE &POLICY)

I. Minimum Standards on Alternative Care for Children

- **MINIMUM STANDARDS ON RESIDENTIAL CARE FOR CHILDREN**
- **MINIMUM STANDARDS ON ALTERNATIVE CARE FOR CHILDREN IN THE COMMUNITY**

II. Policy on Alternative Care for Children

- Non-residential care (a. Foster care, b. Kinship care, c. Adoption ,d. Pagoda (Wat) and other faith based care , e. Children headed household, f. Group-home based care
- Residential care (a. Recovery or child protection centers , b. Orphanages)
- Minimum standards of alternative care

III. Standards and Guideline for the Care Support and Protection for OVC

a, General, b. Food and Nutrition, c. Health, d. Education, e. Social, Emotional, and Psychological, f. Economic, and lively hood and Strengthening, and Other.

National Strategic plan for OVC (OVC Indicators)

1. Percentage of OVC whose households received income generation and livelihood support and success
2. Percentage of caregivers trained in caring for OVC
3. Percentage of service provider trained to provide care and support for OVC
4. Percentage of communes/sangkat with at least one organization providing care and support to OVC
5. percentage of communes/sangkat that integrated OVC's issues into its CIPs and CDPs
6. Percentage of institutional care center/community and families' compliance with the minimum standards of alternative care for children
7. Percentage of OVCs who successfully reintegrated with their families

National Strategic plan for OVC (OVC Indicators)

8. Percentage of household with OVC receive equity card
9. OVC whose households received at least 3 type of external care and support
10. Percentage of children with advanced HIV infection receiving ART
11. Level of implementation of policies, guidelines, and laws related to the care, support, and protection of the orphans and vulnerable children
12. Level of OVC participation in planning, implementing, and monitoring and evaluating of response mechanism related to orphans and vulnerable children
13. Progress made in strengthening the OVC M&E system at all levels (measured by the 12 Components Systems Strengthening Tool)
14. Effectiveness score for national, sub-national, and community coordination mechanism for OVC
15. Total number of POVCTF established


THANKS FOR ATTENTION

KINGDOM OF CAMBODIA

COUNTRY REPORT

JICA Training
<Countermeasure for MCH and Child Welfare>

CAMBODIA'S PROFILE

- Areas: 181,035 square/Km
- Population: 14.6 million (ICPS 2013)
  - Urban: 21.4% (ICPS 2013)
  - Children <15 y: 29.4% (ICPS 2013)
  - Disabilities: 2.1% (<15 y = 11.31%)
- Annual grow rate: 1,46% (ICPS 2013)
- Density: 82/ sq.Km^2
- Literacy rate of pp >15 and more (ICPS 2013)
  - Total: 79.7% (Urban: 90.3%; 76.5%)
- Capital City: Phnom Penh
- Language: Khmer
- Religion: 90-95% (Buddhist);
- Government: Constitutional monarchy
- GDP: $805 (International Monetary Fund, 2010)
- Population under the poverty line: 30% (MoP*, 2011)
- Life expectancy: Male: 60.5 ; Female: 64.3 (Census 2008)

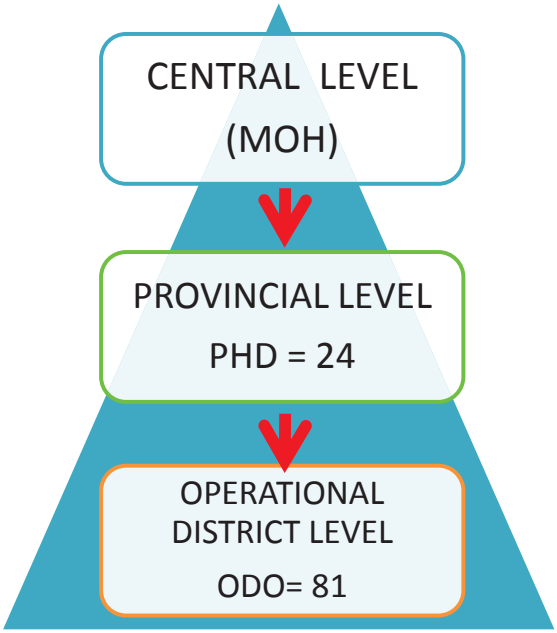
* Ministry of Planning

BASIC CHARACTERISTIC OF ADMINISTRATIVE

- Number of municipality: 1
- Number of province: 24*
- Number of Cities/Krong: 26
- Number of Khan: 9
- Number of Districts: 159
- Number of Sangkats: 204
- Number of Communes: 1,429
- Number of villages: 14,119

-Source: ICPS 2013
*One new province is established

HEALTH STRUCTURE AND ADMINISTRATION



- Public Health Facilities
  - National Hospital: 8
  - Provincial Hospitals: 24
  - Referral Hospitals: 62
  - Health Centres: 1,024
  - Health Post: 121

(source: National Health Congress Report , 2012)

HEALTH INDICATORS

Indicators	RESULTS /YEARS				Sources
Crude Birth Rate (per 1000 population)	27.7 (2000)	25.6 (2005)	24.2 (2010)		CDHS
				22 (2011)	UN Data
Crude Death Rate (per 1000 population)	9.5 (2000)	7.6 (2005)	6.4 (2010)		UN Data
				3.95 (2013)	ICPS
Adult Mortality Rate (15-49 y)	M: 4.8 F: 3.5 (2000)	M: 5.2 F : 3.1 (2005)	M: 4.1 F: 2.5 (2010)		CDHS

LEADING CAUSES OF DEATH

	Death causes	Deaths	%
1.	Influenza & Pneumonia	15,751	15.18
2.	Tuberculosis	11,627	11.21
3.	Coronary Heart Disease	9,144	8.81
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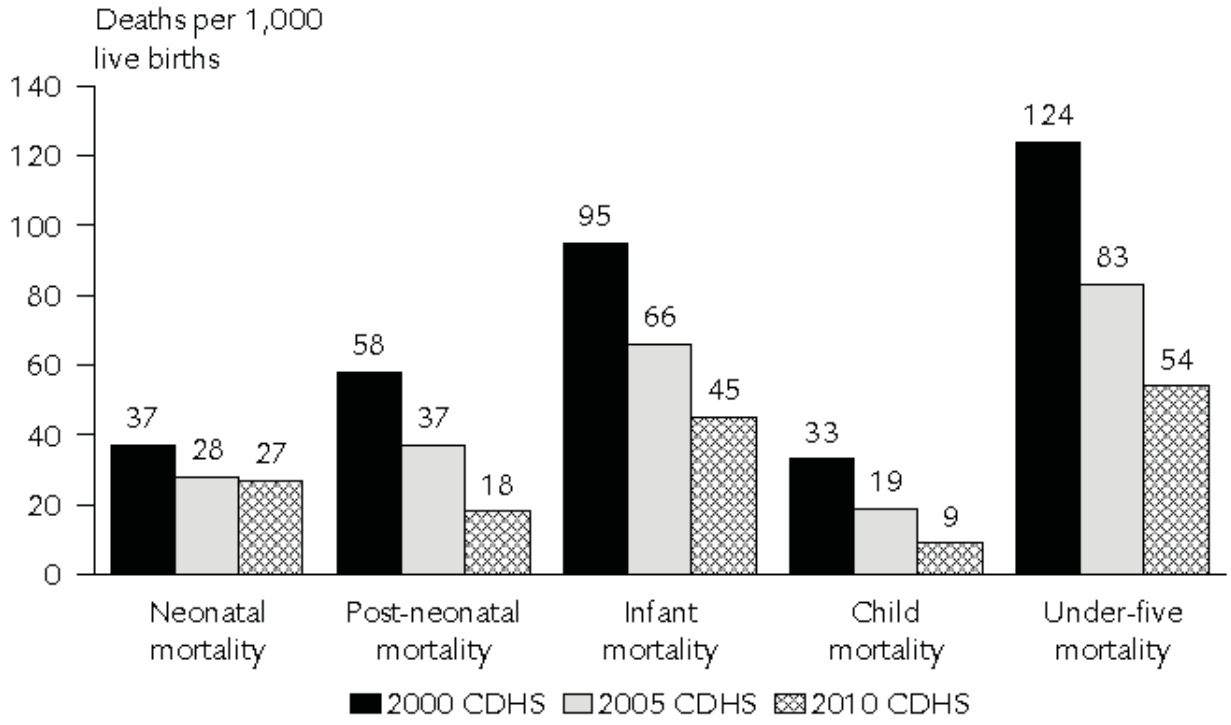
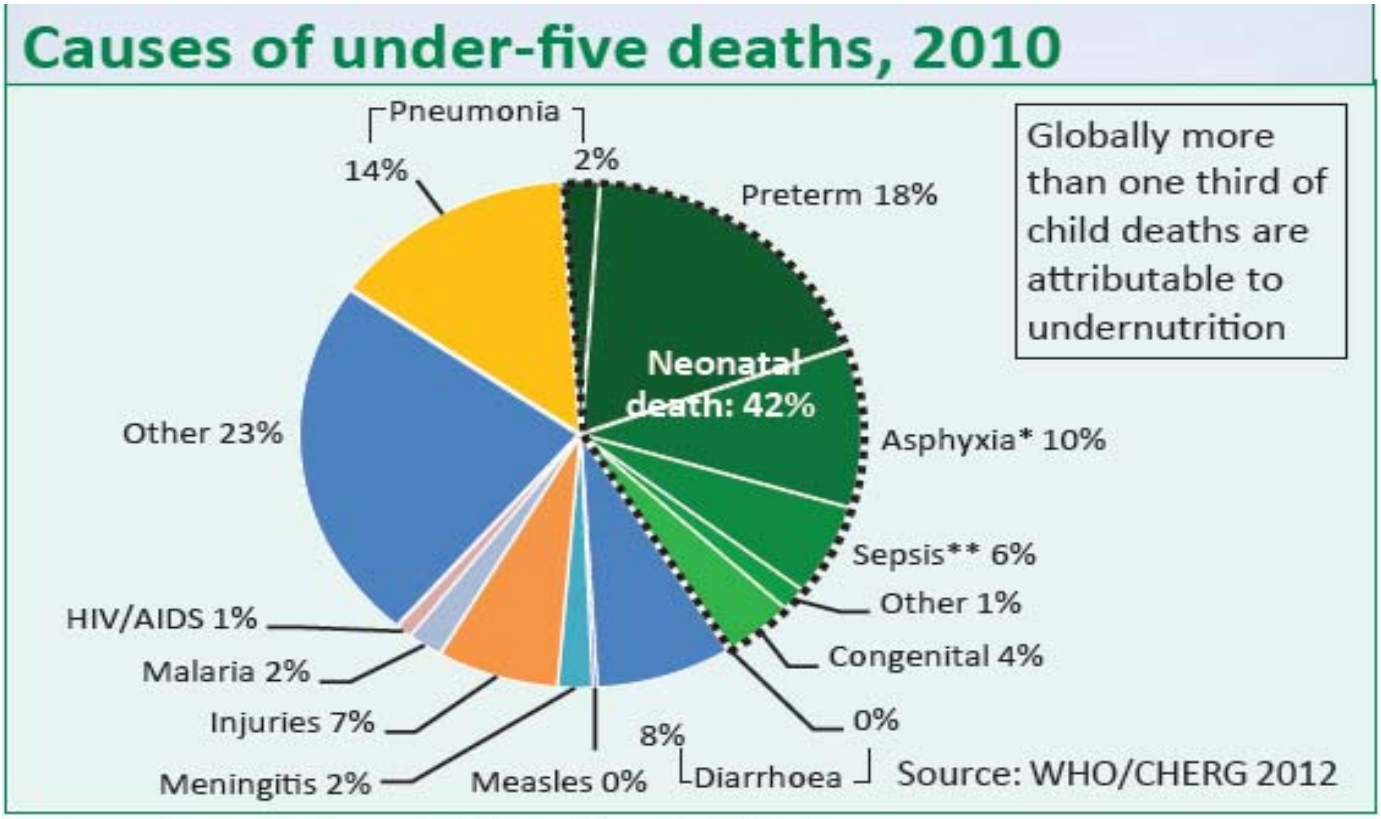
Source: www.worldlifeexpectancy.com/country-health-profile/cambodia

CHILD MORTALITY RATE



CAUSES OF UNDER-5 DEATHS

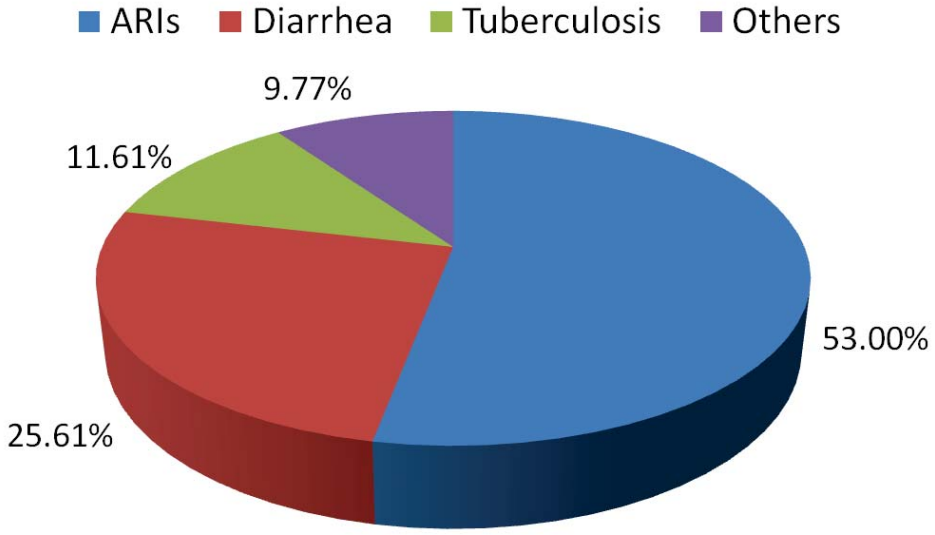


*Intrapartum-related events **Sepsis/meningitis/tetanus

Source: Countdown to 2015

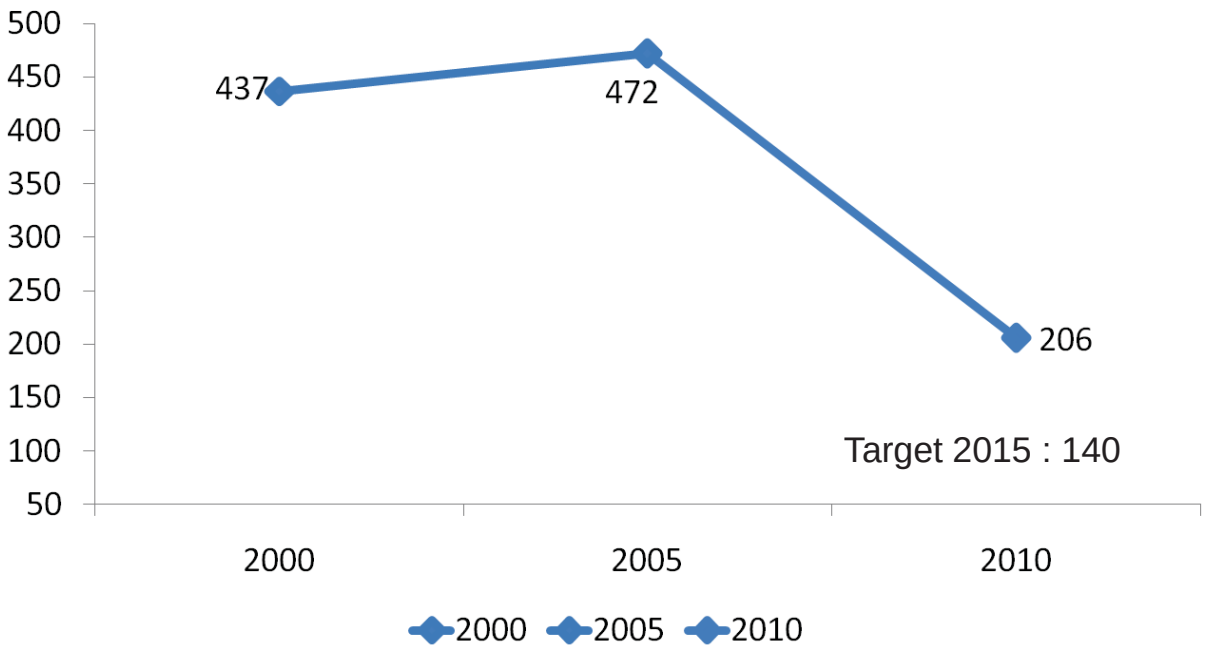
TOP 3 DISEASES AND MORBIDITY RATE OF THE UNDER-5

Source: HMIS 2013. Data were analyzed among under-five children who received health care at the public health facilities in 2013

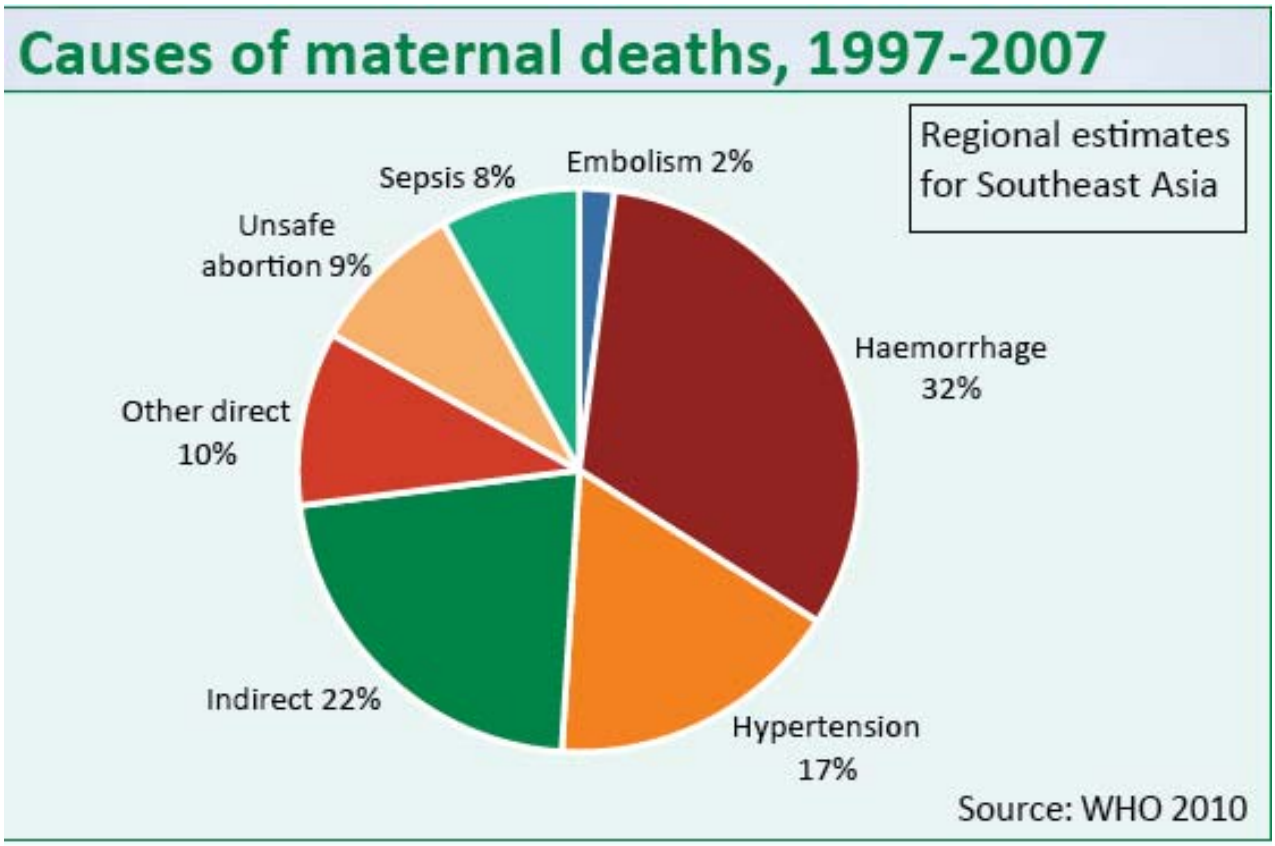


MATERNAL MORTALITY RATIO

per 100,000 live birth (CDHS data)



LEADING CAUSES OF MATERNAL DEATHS



HEALTH PROBLEMS HAVE BEEN ADDRESSED

- Prevention before birth: FP, ANC campaign, birth preparedness education
- Prevention during birth: EmONC
- Prevention after birth:
  - Immunization: polio and measles elimination);
  - Vit A; exclusive breast feeding and complementary feeding
  - PNC visit (withing 24 h afterbirth)
  - ARI/CDD prevention and malnutrition measure
- Care & Treatment & Rehabilitation in connection with the community.

STRENGTHS

- Strong commitment from and the leadership of the government especially the Ministry of Health to improve the health system
- Policy and guidelines for the sub-national implementation including:
  - National Reproductive Health Strategy
  - National Child Survival Strategy
  - Policy on ARI/CDD Program
  - IMCI clinical Guidelines
  - Clinical Practice Guidelines for Hospitals
- Strong partnership with INGOs and NGOs.

KEY CHALLENGES

Health service delivery and access to services

- Limitation of resources: human resources, financial and medical equipments barriers for survival of mothers, newborns and children.
- limitation of qualified health staff in caring newborn babies and sick children => poor quality of care
- Limitation of community participation and inadequate of referral systems. This requires to have a strategy for demand creation.
- Poor collaboration between MoH and MoSVY

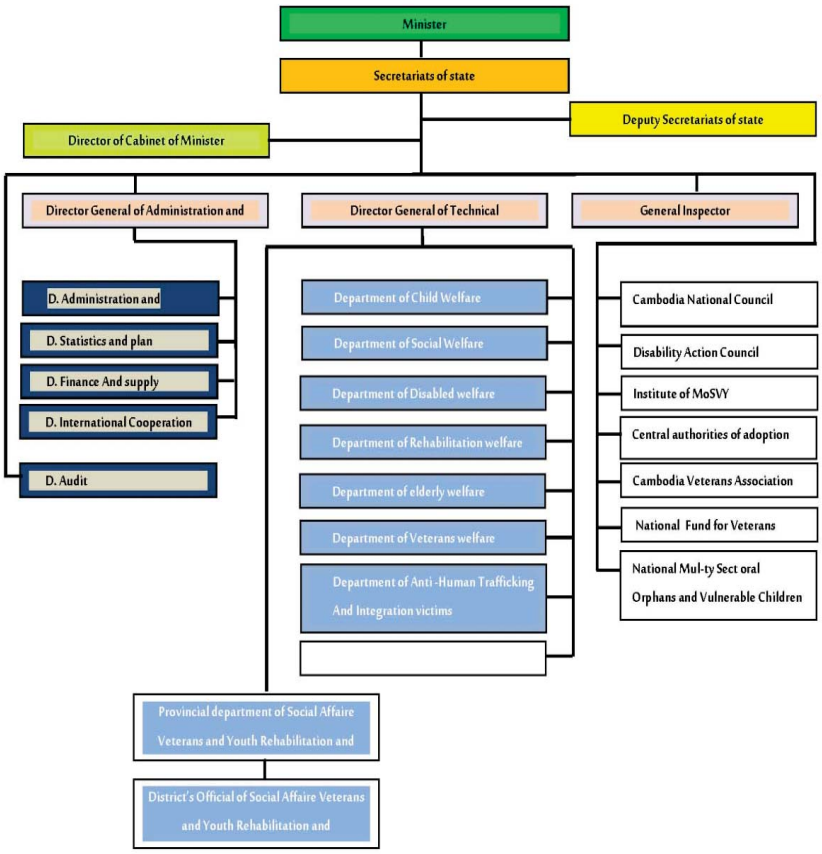
STEP FORWARD

- Build capacity of health staff
- Build on the existing partnership with NGOs/INGOs for further support on MCH
- Strengthen the referral system and the coordination between health care services and the community.
- Possibility of linkages MCH and Child welfare activities.

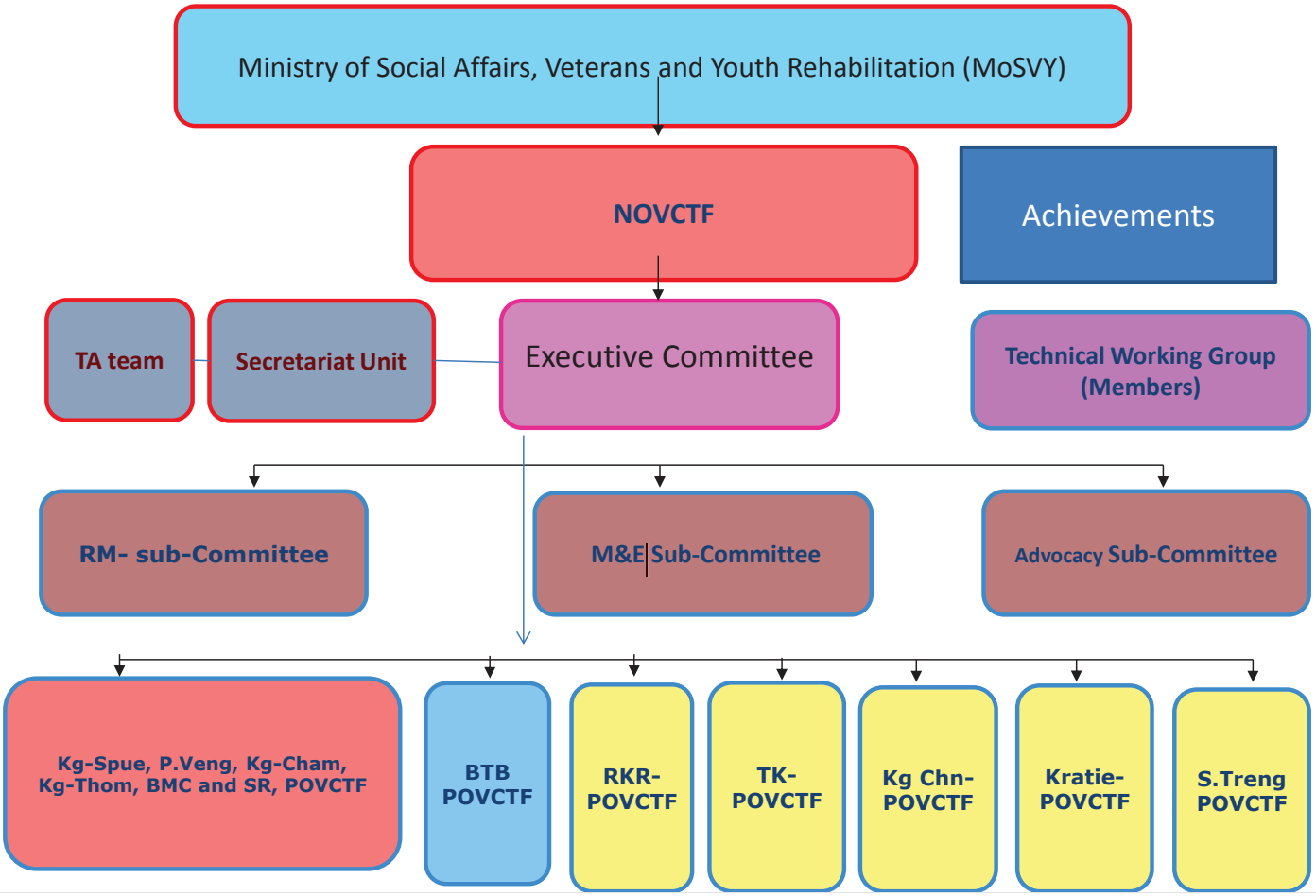
Ministry of Social welfare Veterans, and Youth Rehabilitation

The National Multi-Sectoral Orphans and Vulnerable Children (NOVCTF)

MoSVY's Structure



1- Coordination System Structure of NOVCTF



Structure of NOVCTF System coordinator(Prakas)

Secretariat of State is Chairman

Vice Chair : NAA, NCHAD, CNCC, Director general of technical Affairs

Secretariat

Ministries are Work with OVC		Partner Ship édKU GPivDÆn_	Civil Society GgÁkar sgÁmsuIvil	All Provincial level POVCTF
•MoI. MoH. •MoEYS •MoWA •(CARD) •NAA	- MoCR, - MoLVT - MoP - MoJ - MoT			

Structure of POVCTF System coordinator(Decision)

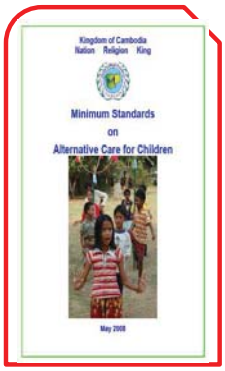
Government of the Provincial is Chairman

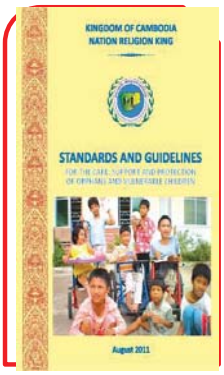
Department of Social Affair Veterans, and Youth Rehabilitation (Permanent)

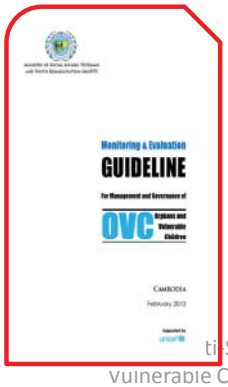
Secretariat of POVCTF

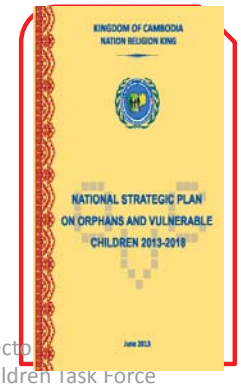
Departments are Work with OVC In the province	Civils sociality Are work with OVC In the province	DoSVY	Districts NCDD	Commune CWCC

3. Key achievement









I. Minimum Standards on Alternative Care for Children

- RESIDENTIAL CARE FOR CHILDREN
- ALTERNATIVE CARE FOR CHILDREN IN THE COMMUNITY

II. Policy on Alternative Care for Children

- Non-residential care (a. Foster care, b. Kinship care, c. Adoption ,d. Pagoda and other faith based care , e. Children headed household, f. Group-home based care
- Residential care (a. Recovery or child protection centers , b. Orphanages)
- Minimum standards of alternative care

III. Standards and Guideline for the Care Support and Protection for OVC

a, General, b. Food and Nutrition, c. Health, d. Education, e. Social, Emotional, and Psychological, f. Economic, and lively hood and Strengthening, and Other.

IV. Service directory for Vulnerable People

V. M&E Guideline for OVC

National Strategic plan for OVC (OVC Indicators)

1. Percentage of OVC whose households received income generation and livelihood support and success
2. Percentage of caregivers trained in caring for OVC
3. Percentage of service provider trained to provide care and support for OVC
4. Percentage of communes/sangkat with at least one organization providing care and support to OVC
5. percentage of communes/sangkat that integrated OVC's issues into its CIPs and CDPs
6. Percentage of institutional care center/community and families' compliance with the minimum standards of alternative care for children
7. Percentage of OVCs who successfully reintegrated with their families

National Strategic plan for OVC (OVC Indicators)

8. Percentage of household with OVC receive ID Poor card
9. OVC whose households received at least 3 type of external care and support
10. Percentage of children with advanced HIV infection receiving ART
11. Level of implementation of policies, guidelines, and laws related to the care, support, and protection of the orphans and vulnerable children
12. Level of OVC participation in planning, implementing, and monitoring and evaluating of response mechanism related to orphans and vulnerable children
13. Progress made in strengthening the OVC M&E system at all levels (measured by the 12 Components Systems Strengthening Tool)
14. Effectiveness score for national, sub-national, and community coordination mechanism for OVC
15. Total number of POVCTF (Provincial Multi-Sectoral Orphan and Vulnerable Children Task Force) established.

THANKS

For

ATTENTION

Countermeasure for Maternal and Child Health and Child Welfare

India

Part A

1) crude birth rate-22/1000 (2009),21/1000(2012)(2) crude death rate-8/1000 (2009),7.4/1000(2012)(3) leading cause of death-non communicable diseases (in general population)(4) infant mortality rate-49/1000 (2009),44/1000(2012)(5) leading cause of infant death-(a) prematurity/LWB (perinatal conditions 28%),(b) pneumonia (15%) (c) diarrhea(11%)(6) under 5 mortality rate 64/1000(2009),56/1000(2012)(7) top 3 diseases and morbidity rate of the under 5 (a) perinatal conditions(52%) (b) respiratory conditions(15%) (c)diarrhea(11%)(8) maternal mortality rate 212/100000(2009) to 178/100000(2012)(9) leading cause of maternal death - direct cause heamorrhage(37%), indirect cause anemia(10) in India there is as such no routine health check up for infants and children.

Children only come for routine immunization in health clinics. Government of India has recently started in 2013 Rashtriya Bal Swasthya Karyakram (RBSK) for child health screening and early intervention services under national rural health services(11) in cases of disability govt. of india has laid down specific laws and regulations under persons with disability act,1995.(12) there is a disability act,1995 for certifying disability in india. The act has provisions for following services. (a) Early detection and prevention (periodic screening of children at risk and training of health staff at primary health centers (b) free education for disabled children (c) employment provision for disabled persons (d) affirmative actions (e) provisions in relation to non discrimination

Part B

Strengths in our country(1) Ample amount of human resources.(2) Well developed Public Health infrastructure.(3) Govt. policies especially targeting the
underprivileged and low socio-economic group

Weaknesses in our country(1) Illiteracy(2) Various social stigmas related to health and lack of health seeking behavior in our community(3) Huge burden of Population explosion.

2. Most vulnerable population

a) Low Socioeconomic status.

b) Rural population.

c) People with disability.

3. Government of India have started various programs specialy targeting the most vulnerable groups. Some of these programs are as follows:

a) Janani Suraksha Yojna - To promote institutional delivery among people of socioeconomic data.

b) Laadli Yojna - To promote girl child education.

c) Rashtriya Bal Swasthya Karyakram for child health screening.

d) National Rural Health Mission.

Maternal and Child health.

India.

Demographic profile of India.

- Second most populated country , with over **1.21 billion** people (2011 census), a sixth of world .
- India occupies **2.4%** of the world's land area and supports over 17.5% of the world's population.
- There are 35 states and union territories .
- **72.2%** of the population lives in about 645,000 villages and the remaining **27.8%** lives in more than 5,100 towns and over 380 urban agglomerates.
- India has more than two thousand ethnic groups, and every major religion is represented.
- Religions 75.5% hindus, 17.4% muslims, 3.3% of christians and 1.9% of christians (rest are minors).

Comparative demographics

(World bank Indicator databank 2012)

Category	**Global Ranking**	Notes
Area	7th	2010
Population	2nd	2010
Population growth rate	102nd of 212	2010
Population density (people per square kilometer of land area)	24th of 212	2010
Male to Female ratio, at birth	12th of 214	2009

Demographic profile of india.

Growth rate	1.51% (2009 est.)
Birth rate	20.22 births/1,000 population (2013 est.)
Death rate	7.4 deaths/1,000 population (2013 est.)
Life expectancy	68.89 years est.)
• male	67.46 years (2009 est.)
• female	72.61 years (2009 est.)
Fertility rate	2.5 children born/woman (SRS)

Rural Health Infrastructure in India

- **Subcenters**- most peripheral center and provide primary health care. There are 1-2 ANMs or Midwifes.
- Total no. of subcenter 1,48,124.
- It cover 5000 pop. in plains and 3000 in hills
- **Primary Health Centers-** 6 sub center.
- Total no. in india 23,887.
- It covers 30,000 pop in plains and 2000 in hills.
- It has 4-6 beds. There is one MBBS Medical Officer.
- **Community health centers** – covers 4 PHCs.
- Total no in India 4,809.
- Specialist in Obstetrics, Medicine, Surgery and Pedia. are available.
- 20- 30 beds available.
- **First referral Units –** Distict hospitals.
- **Second referral Units**

Maternal Mortality

- Globally 287,000 maternal death occurred in 2010.
- India accounted for 19% of all.

MMR	Year
480	1995
254	2005
212	2009
176	2012

Maternal deaths are segregated into 2 groups

Direct obstetric causes

- Pregnancy
- Labor
- Postnatal period
- Incorrect treatment

Indirect obstetric causes

- Resulting from previous existing disease
- Or disease that developed during pregnancy

Medical causes

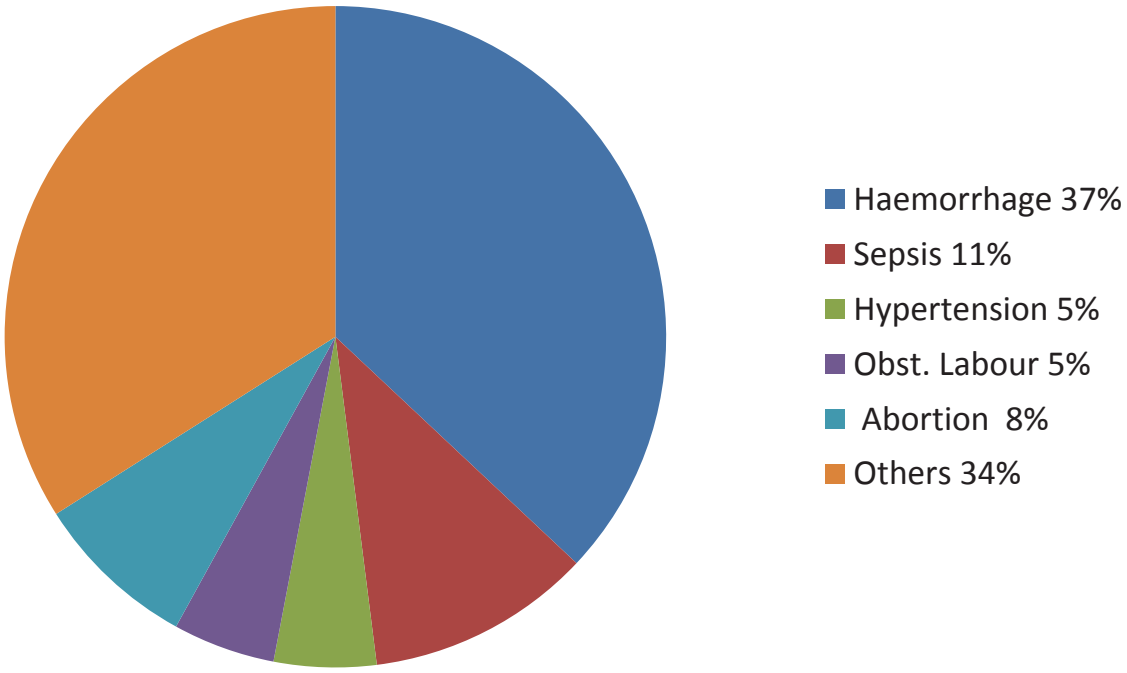
Obstetric cause

- Sepsis 11%
- Hemorrhage 37%
- Hypertension 5%
- Obstructive labor 5%
- Unsafe abortion 8%
- Other 34%

Non obstetric cause.

- Anemia (most common)
- Malaria.
- Associated diseases: cardiac, renal, metabolic, infection.
- Malignancy
- Accidents

Major causes of Maternal Mortality.



Social causes

- Young age at child birth.
- Parity
- Too close pregnancy, unmet need for contraception.
- Family size
- Malnutrition
- Poverty
- Illiteracy
- Ignorance
- Delivery by untrained birth attendants.
- Poor communication and transport facility
- Social customs
- Poor environmental sanitation

Preventive and social measures to reduce MMR:

- Early registration of pregnancy.
- At least 3 antenatal checkups.
- Risk screening and timely referral to higher center.
- Dietary supplements: iron folic acid.
- Prevention of infection and hemorrhage during labor
- Prevention of complications eg. Eclampsia, malpresentation and ruptured uterus.
- Treatment of medical conditions.
- Tetanus prophylaxis.
- Clean delivery practices.
- Training to local dais.
- Promotion of institutional delivery.
- Promotion of family planning.
- Identification of every maternal death and searching for its cause.

Infant mortality rate.

- Globally 76 lakh children died in 2010.
- India, Nigeria, Democratic Republic of Congo, Pakistan and China accounted for half.
- India alone accounts for 20%.

IMR	Year
1998	70
2005	56
2009	49
2012	44

Medical causes of Infant Mortality

Neonatal mortality

- LBW and prematurity 51%
- Diarrhea 15%
- Pneumonia 11%
- Tetnus.
- Birth injury and difficult labor.
- Sepsis.
- Congenital anomalies.
- Hemolytic disease of newborn.
- Conditions of placenta and cord.

Postneonatal mortality

- Diarrhea
- ARI
- Malnutrition
- Congenital anomalies
- accidents

Factors affecting infant mortality

BIOLOGICAL FACTORS

- Birth weight
- Age of mother
- Birth order
- Birth spacing
- Multiple births
- Family size
- High fertility

Economic factors

Cultural and social factors

Breast feeding

Early marriage

Sex of child

Quality of mothering

Maternal education

Quality of health care

Broken families

Brutal habits and customs

Untrained dais

Bad sanitation

Preventive and social measures

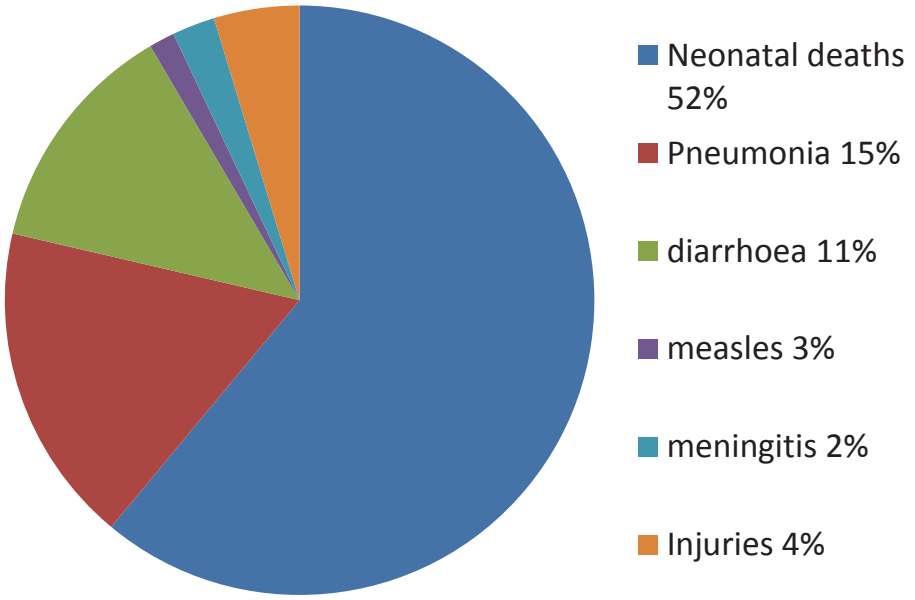
Multipronged approach

- Prenatal nutrition.
- Prevention of infection – clean delivery practices.
- Breast feeding.
- Growth monitoring.
- Family planning.
- Sanitation.
- PHC- high risk approach.
- Socioeconomic development.
- Education.

Under 5 mortality rate

- UNICEF considers this as best single indicator of social development and well being as it reflects income, nutrition, health care and basic education.
- Developed countries – 7 /1000 LB
- **India – 56 /1000 LB (2012).**

Cause for under 5 mortality 2010.



Strengths in India.

- Ample amount of human Resources.
- Well developed Public Health Infrastructure.
- Govt. Policies especially targeting the low socioeconomic group and under privileged section of indian society.

Weakness in India.

- Illiteracy and ignorance
- Various social stigmas related to health services.
- Huge burden of population explosion.

Programs of Indian Govt. for most vulnerable groups

- National Rural Health Mission 1995.
- Janani Suraksha Yojna 2005.
- Laadli Yojna 2008.
- Rastriya Bal Swasthya Karyakram 2013.

Countermeasure for Maternal and Child Health and Child Welfare

Myanmar

Overview of Maternal and Child Health in Myanmar

Department of Health
Ministry of Health
Myanmar

Contents

Objectives

General Objective

- **To improve the health status of mother and children including newborn by reducing maternal, neonatal and child mortality and morbidity**

Specific Objectives

- **To increase access to universal coverage of quality maternal and newborn health services in Myanmar through**
  - **antenatal care**
  - **deliveries by skill birth attendant**
  - **Emergency Obstetric Care**
  - **Post abortion Care and Birth Spacing**
  - **Essential Newborn Care**

Policies and Strategies

Policy guidelines

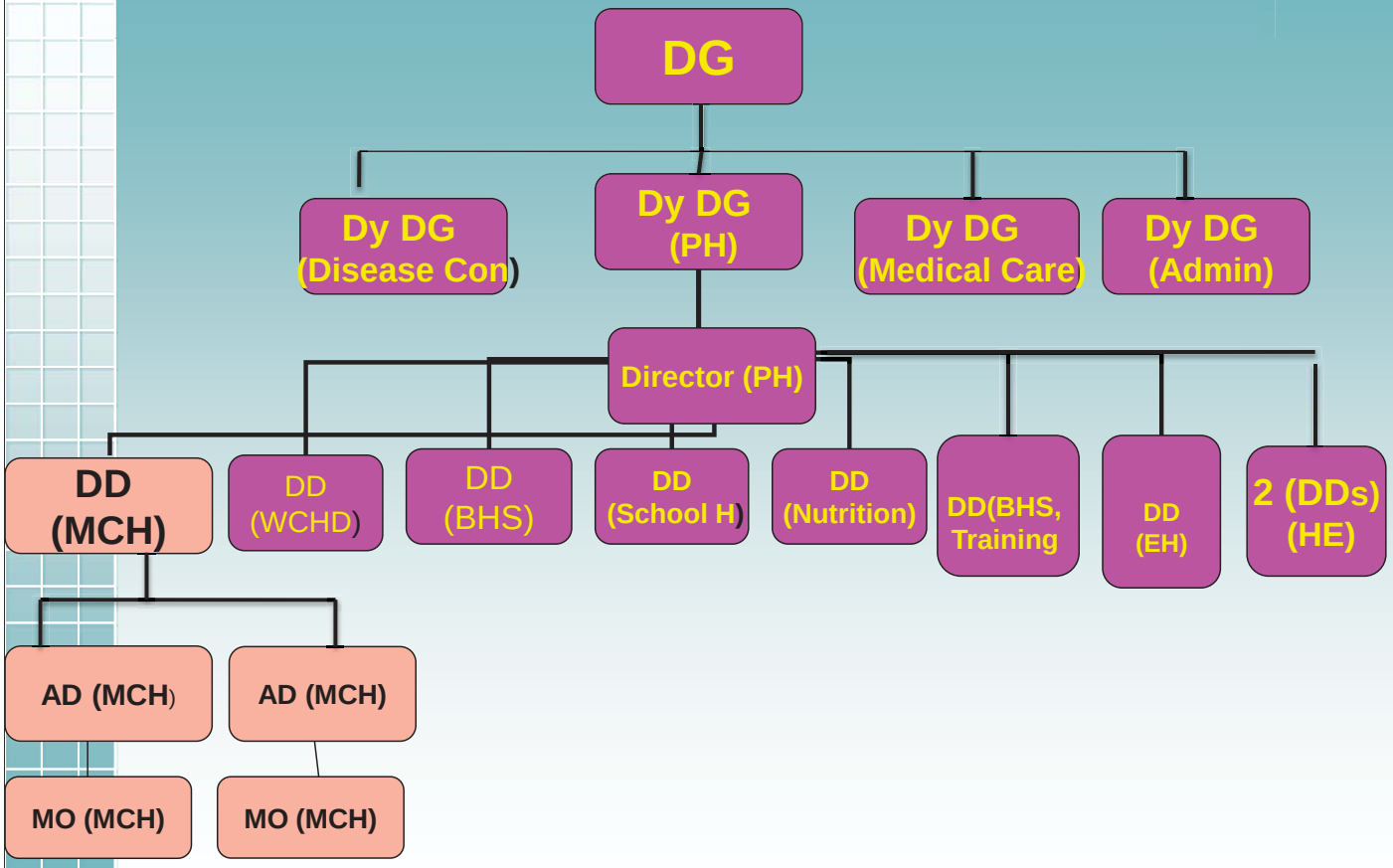
- **National Health Policy**
  - Guidelines of National Population Policy
- **National Population Policy**
  - Awareness promotion on reproductive responsibility and paternal involvement
- **Myanmar Reproductive Health Policy**

Strategic Approach for Reproductive Health

1. Setting enabling environment;
2. Improving information base for decision making;
3. Strengthening health systems and capacity for delivery of quality reproductive health services;
4. Improving community and family practices.

Organization Set up

Organization Set Up (Central level)



Activities for MCH

1) Training
2) Provision of supply and equipment
3) IEC development and distribution
4) Research
5) Infrastructure development
6) Supervision, monitoring and evaluation
7) Community empowerment and strengthening of referral system
8) Integration with other health services and partnership

(1) Type of Training conducted by MCH section
Pregnancy Childbirth, Postpartum and Newborn Care
Essential Newborn Care
Post Abortion Complication and Birth Spacing
IUD insertion training
Emergency Obstetric Care Training (Comprehensive/Basic)
AMW training
AMW Refresher training, MCHP training
Male involvement for RH through effective BCC strategy
Adolescent RH counseling
Quality RH Training

(2)Provision of Supply & Equipment

IEC and Books for Quality AN Care
AN Registers
Home Based Maternal Record (HBMR)
MCH handbook
Pregnancy calendar
Equipments for Quality AN Care
Urine Test Strips (100 pcs/ pack)
Pregnancy Test Strips (100 pcs/pack)
Hb Colour scale
Rapid Plasma Reagent Test (RPR test)
Rapid test kit for Syphilis

(2)Provision of Drug Supply

Drugs for Emergency Obstetric Care
Injection magnesium sulphate
Misoprostol
Injection Oxytocin
Contraceptive Commodities
OC pills- Microgynon
Injection Depo
Mulitload
Commodities for safe and clean delivery
CDK
MW kit
AMW kit
Partograph

(2) Provision of Equipment

Item name
Spot light
Sterilizer
Labour bed and Baby Cot
Trolley with stretcher
Vacuum aspirator
Zoe gynecological simulator

(3) IEC Development and Distribution

- Development of TV Spot and Media for Community
- Vinyl Billboard for Health Education for Antenatal, Delivery , Postnatal and Newborn Care
- Poster on Danger Signs, Safe Motherhood, Congenital Syphilis
- Pamphlets and Posters
- MCH handbook

(4) Research

- Base line survey for Essential Newborn Care
- Effectiveness of provision of Trollergies for referral
- MCHPs system assessment
- Training Need Assessment for Emergency Obstetric Care
- End line survey for Male involvement
- End-line research on ENC in first phase townships
- Assessment of AMW Training Package
- Providers' perceptions and problems in providing Newborn Health services in selected townships

(5)Renovation of Infrastructures

- Renovation of Rural Health Centers, Sub Centers and MCH centers with support of some donor agencies

(6) Supervision and monitoring

- Monitoring and Supervision with Supervisory check list by Central and S/D MCH MOs and Monitoring Field Officers
- Supervision on Training and Training records
- Post training assessment

(7) Community empowerment and strengthening of referral

Conducted Advocacy meeting at different levels for

- Increased AN care coverage Increased utilization of Skill Birth Attendants
- Post Abortion Care and Birth Spacing
- Emergency Obstetric Care
- Essential Newborn Care

Establishment of Community Health Volunteer System

e.g Maternal and newborn team, Community Support Group, MCH promoters

MCH Promoter system

- Community Health Volunteers (1 in each 30 households) started in two townships with support of JICA/JOICFP and expanded to 32 townships
- Bridging between BHS and Community
- Increased community awareness and referral
- Increased MCH health care coverage and reduced MMR and U5MR
- 17,000 MCHP in 34 townships

(8) Integration with other health services and Partnership

- (1)Inter-Departmental
  - e.g - HIV/ AIDS (NAP) - PMCT, syphilis screening and treatment)
  - Nutrition (B1, Iron, F/A, Deworming, Prevention and treatment of Anaemia)
  - EPI

(2) Local NGOs

e.g (MMCWA)

(3) Other Ministries

Local authority (Generral Administration Department)

(4) UN Agencies

UNFPA, WHO, UNICEF

Grassroot Level Community Health Education

Growth Monitoring Programme

Community Nutrition Centre

Awareness Raising Health Talks at Village Food Bank

Immunization Programme

Providing Measles Vaccine for Mass Measles Immunization

Project Funded MMCWA's Health Activities

IPPF- Adolescents and SRH
AIDS/ HIV
Abortion (prevention of unsafe abortion)
Access to birth-spacing & SRH services
Advocacy

UNFPA - RH/IEC/BCC Project
- Scaling up of existing RH Services project
- Maternity Waiting Homes Project

Maternity Waiting Homes Project (MMCWA +DoH+ UNFPA)

- With UNFPA providing service for hard to reach community in risk pregnancies for safe delivery. Project

Maternity Waiting Homes Project (MMCWA +DoH+ UNFPA)

- With UNFPA providing service for hard to reach community in risk pregnancies for safe delivery. Project

Viewing the display of Sewing Performance at Vocational Training Class by CEC Members (2012)

Volunteerism

Performing an act of kindness , freely giving of talent , time , effort for the simple fulfillment of community expectations.

Outcomes and Indicators

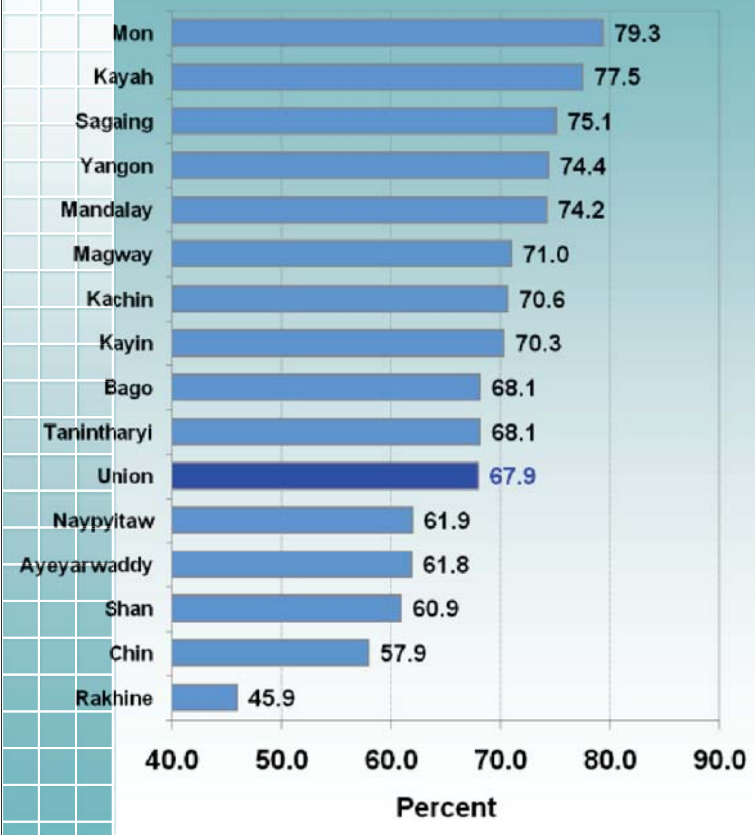
Midwives Coverage and Institutional Delivery

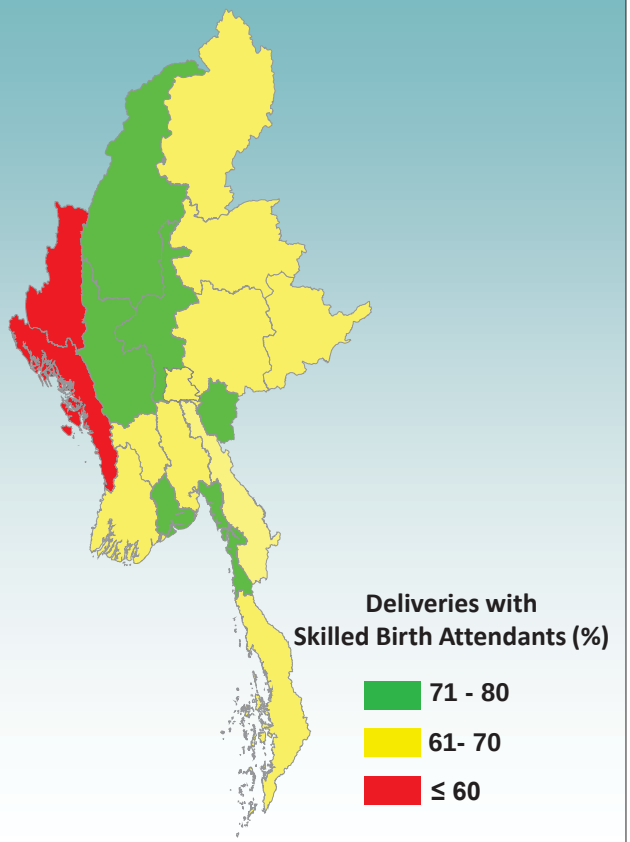
- AMW : Villages – 1:3
- MW : Villages – 1:7
- MW+AMW : Villages – 1:2

(No of villages – 64910, No of AMWs – 19,974, No of MWs – 11,000)

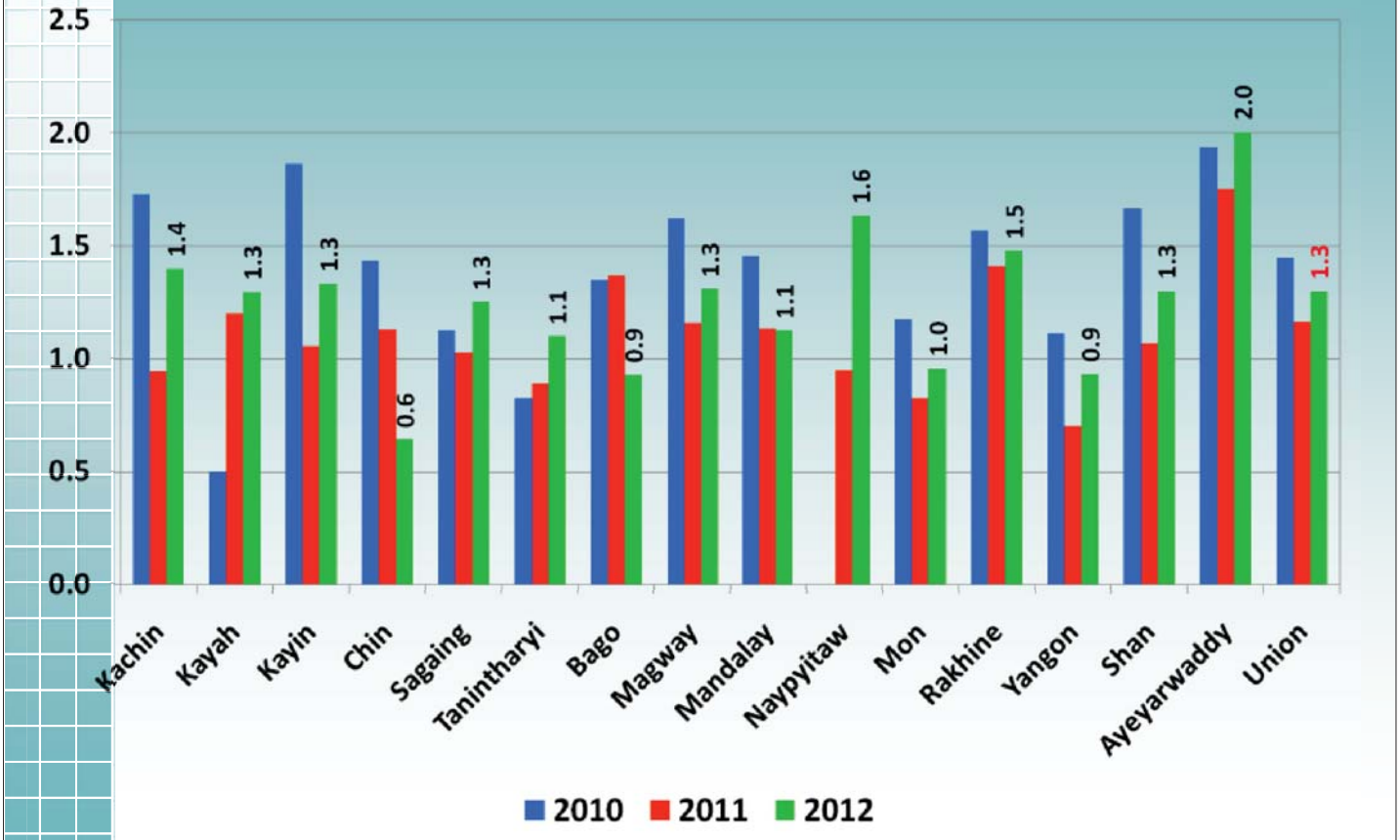
	2003	2009
Rural Health Centers or Sub Centers with labour room	120	295

Deliveries with Skilled Birth Attendants (%) (2012)

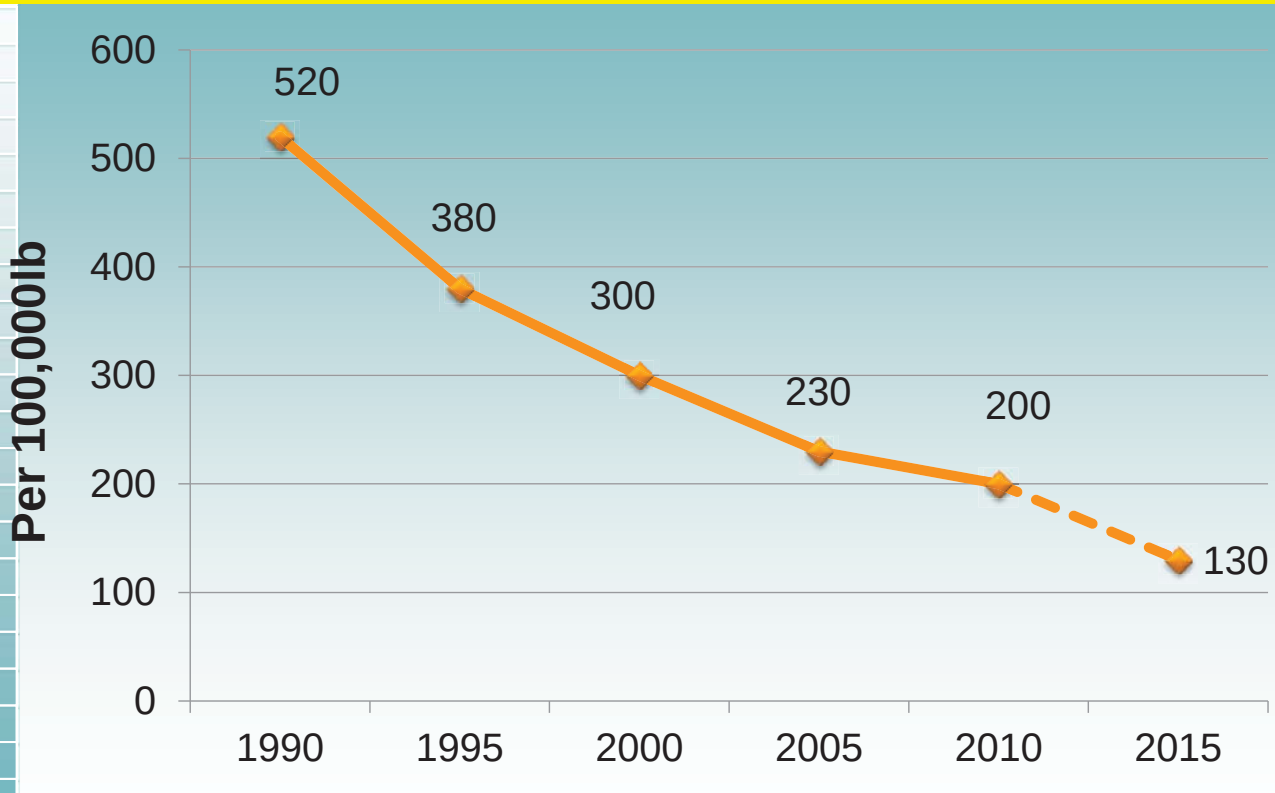




Maternal Mortality Ratio (per 1000 LBs) (2010 – 2012)

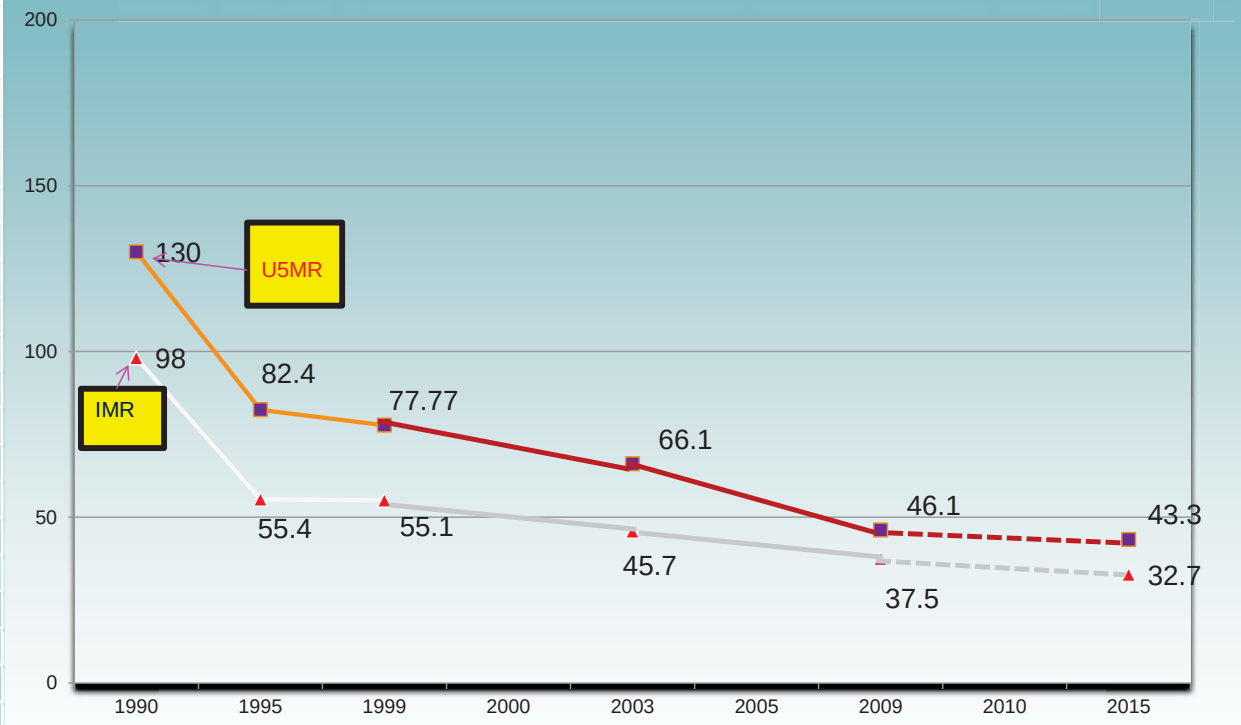


Maternal Mortality Ratio in Myanmar



Source: UN interagency estimate, 2010

Infant and under 5 mortality



Source: MICS 2010

Leading Causes and Disparity

Vulnerable populations in Myanmar

- Mothers and Children (60% of total population)
- Poor people who live in rural area and urban slum
- Those who live with disabilities

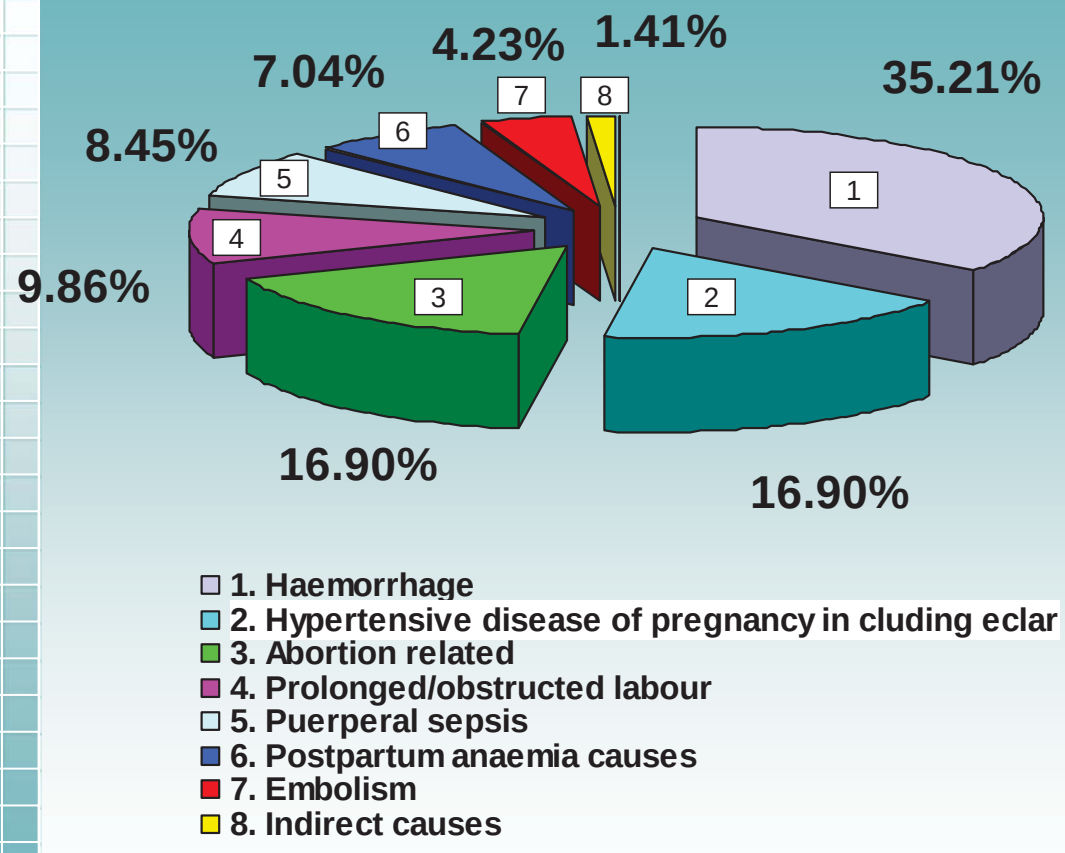
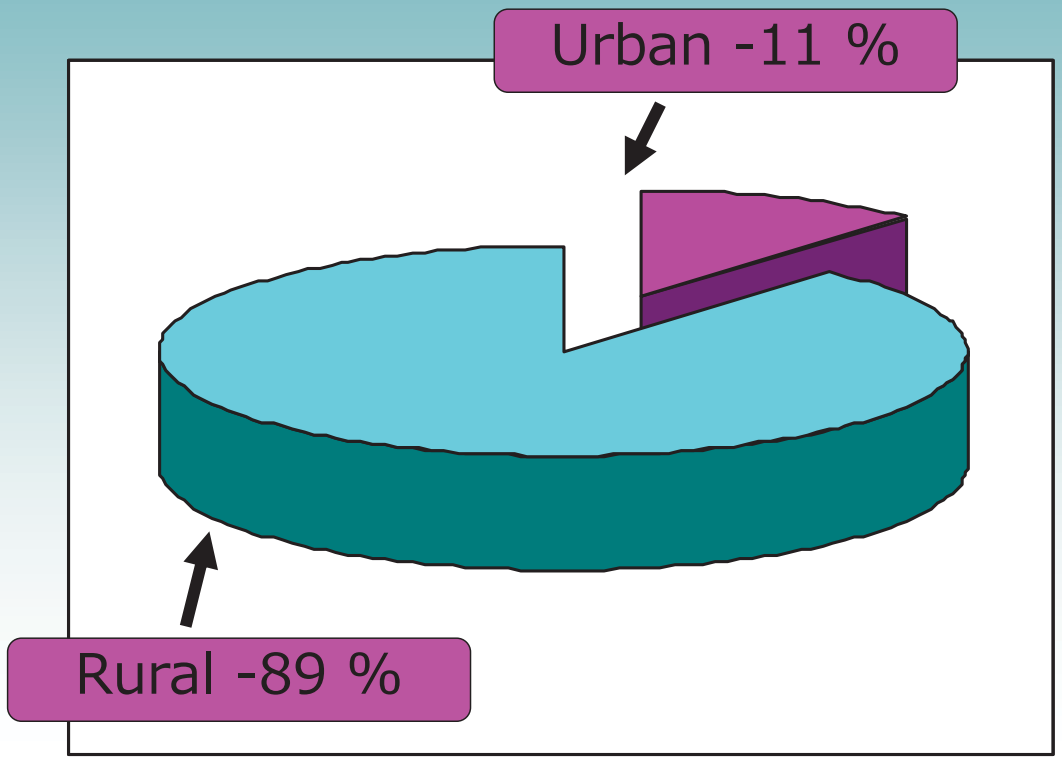
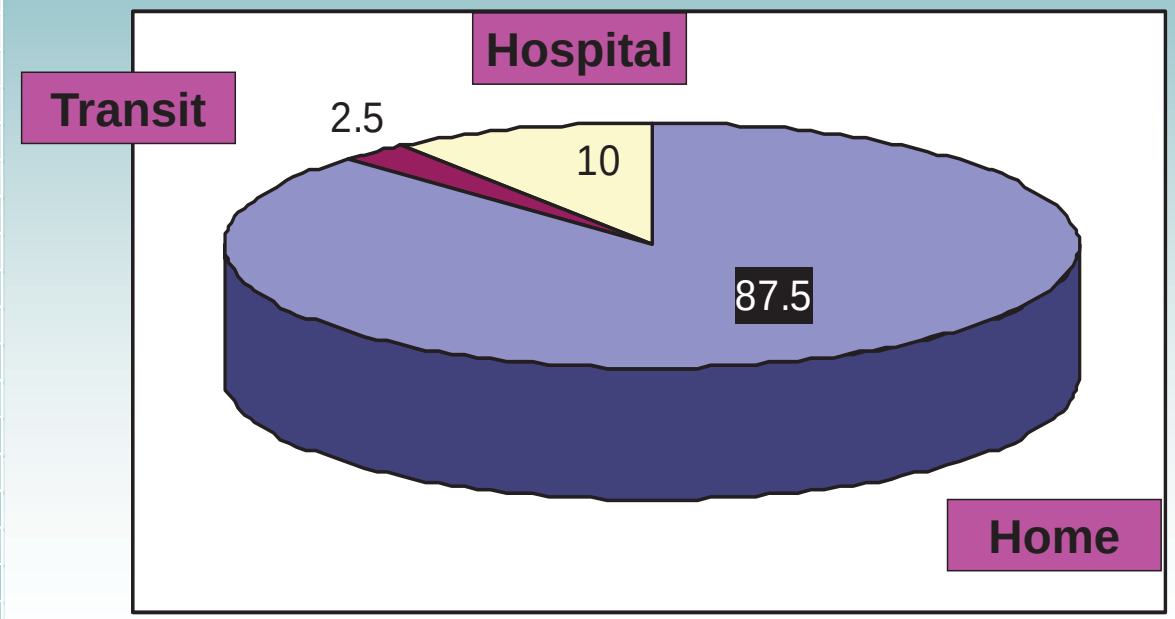


Figure3. Causes of Maternal Death (n=71)

Maternal Mortality by Urban-Rural Residence



Maternal Deaths by Place of Delivery (%)

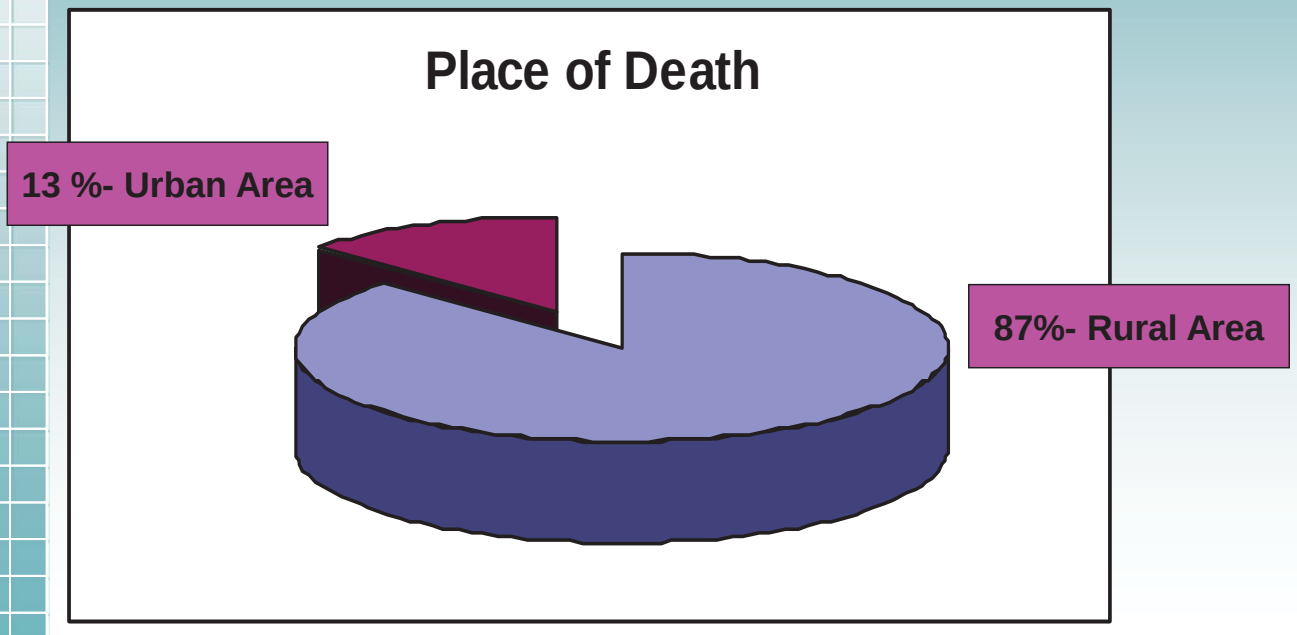


U5MR by Region

Region	U5MR
1. Hilly	66.3
2. Coastal	58.7
3. Delta	59.0
4. Central Plain	76.8
Union	66.1

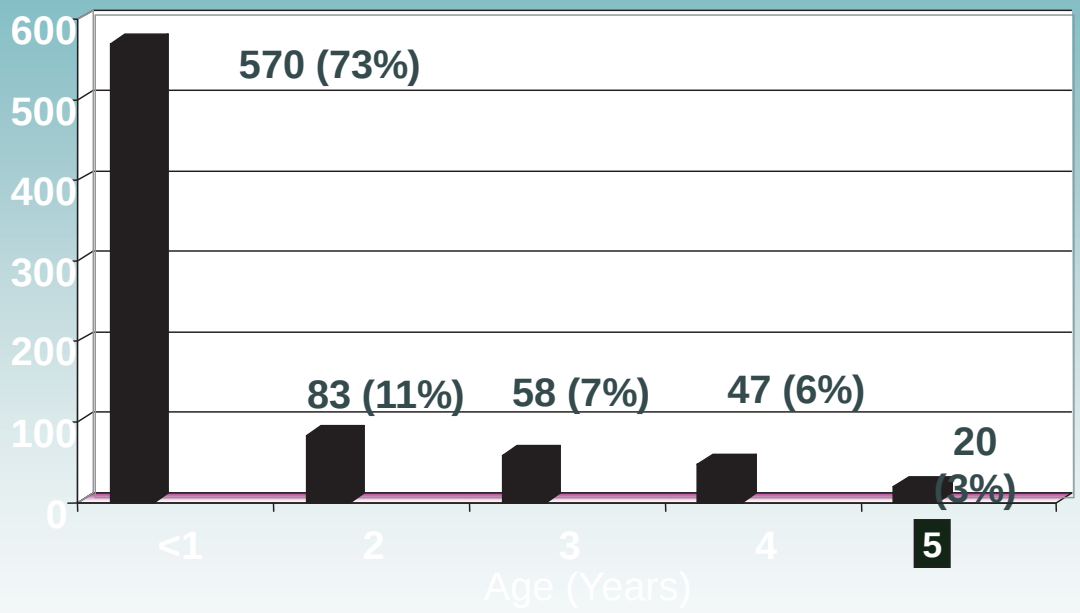
Place of Death (U5MR)

- Disproportionately higher in rural areas (87%) compared to that of urban areas(13%)



Distribution of Under 5 Deaths By Age (Years)

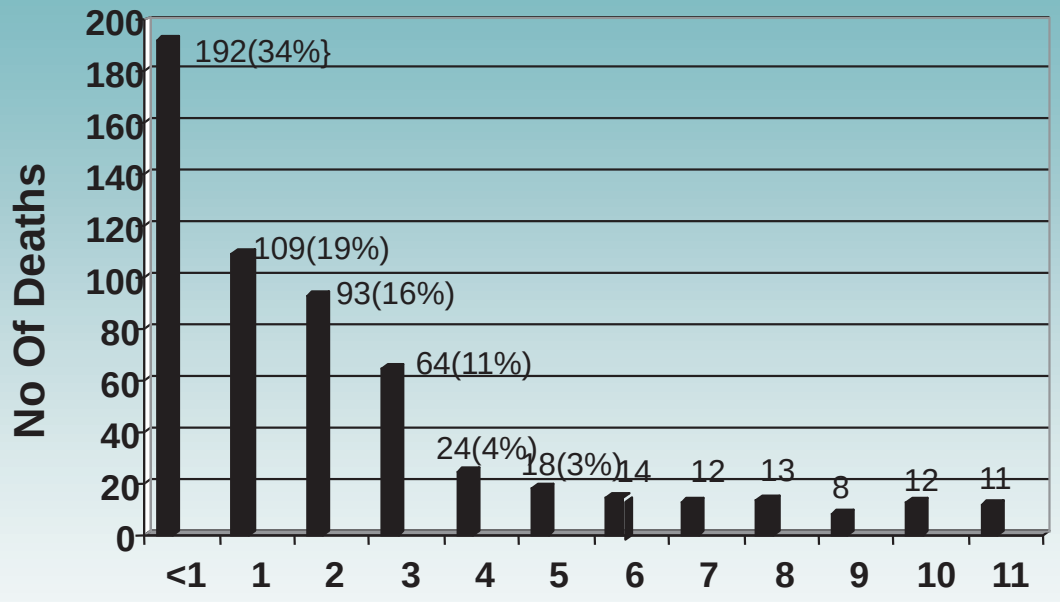
(n =778)



73 % of Death Occurs Under One Year

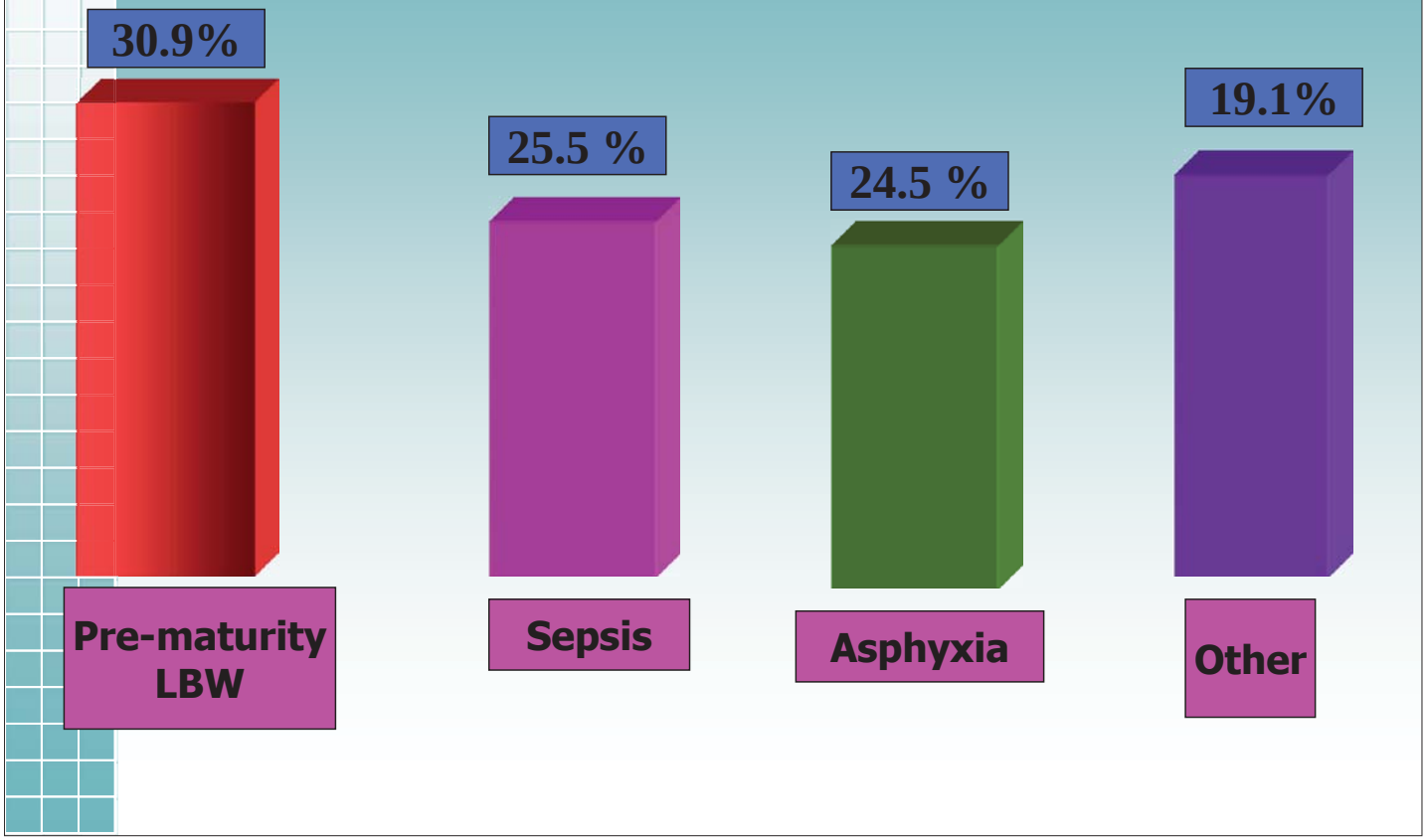
Distribution of Under 1Year Deaths by Age in Months

(n=570)

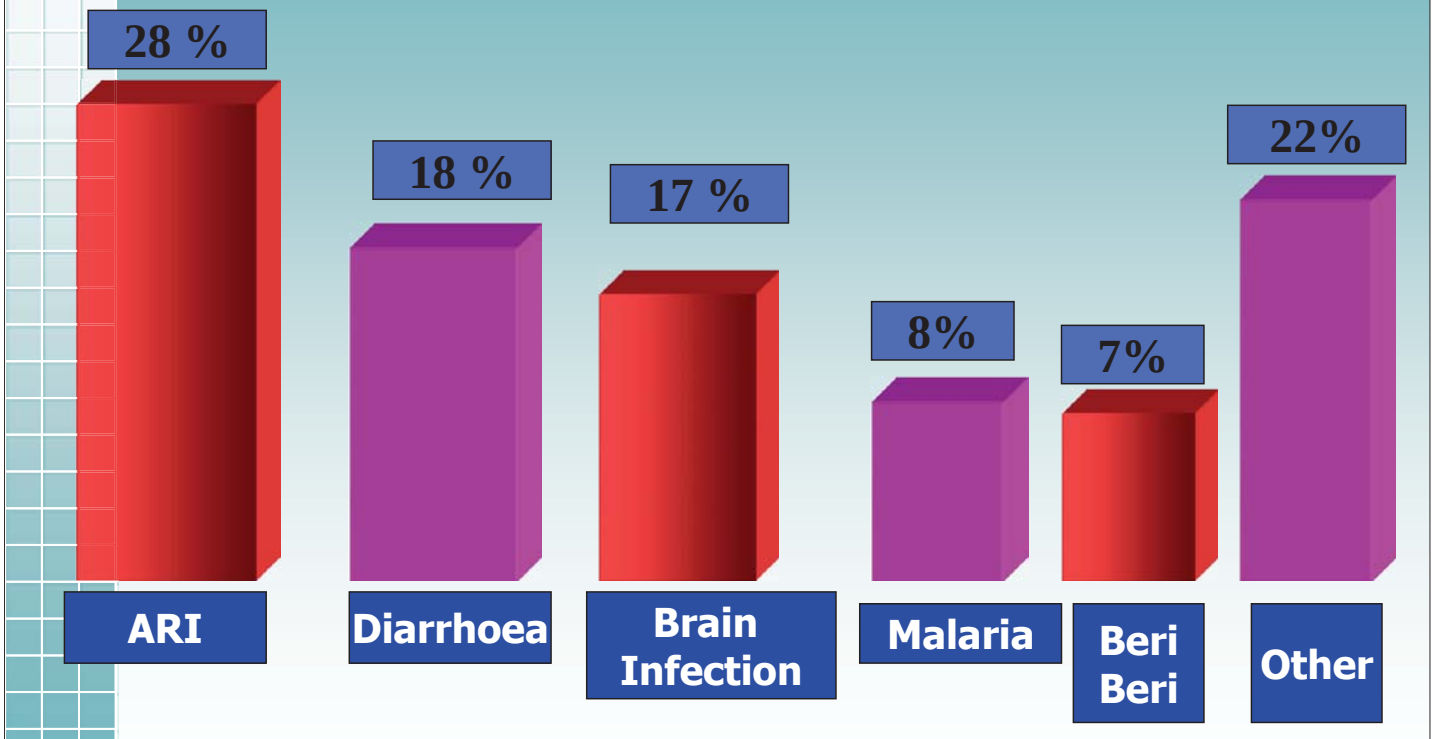


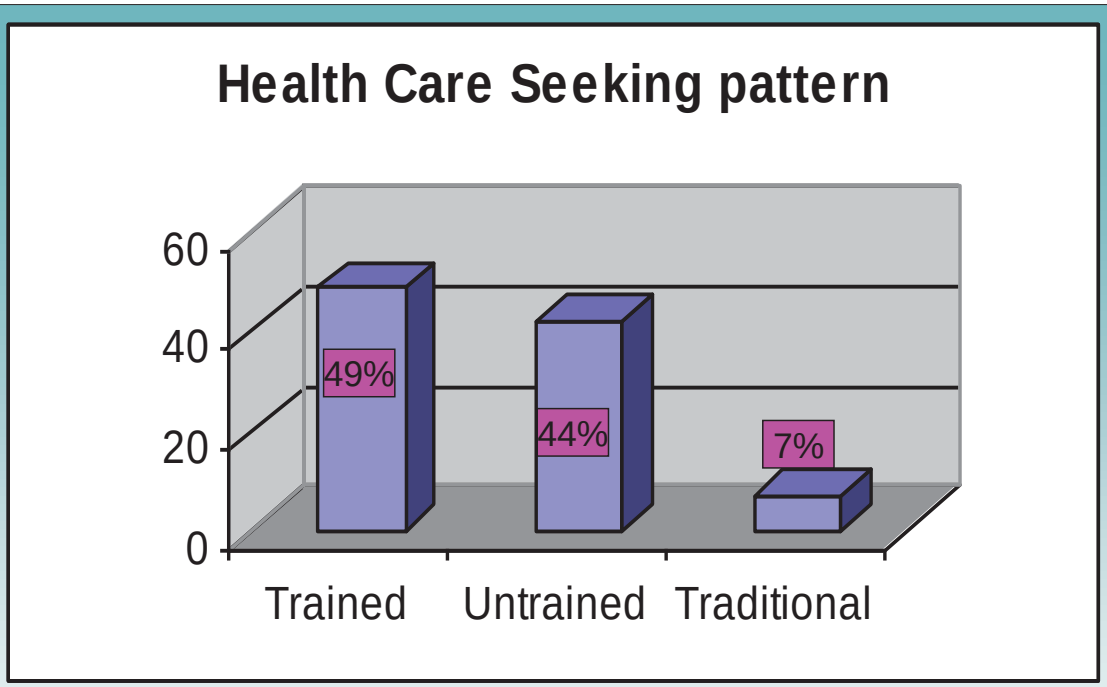
70 % of Death Occurs Under Three Months
34% Death Occurs Under One Month

Leading Causes of Neonatal Deaths



Leading Causes of Post Neonate Deaths





44 % treated with untrained persons before death.

Summary

Main causes of deaths for MMR were

- **PPH**
- **Severe PET or Eclampsia**
- **Abortion complications**

Main causes of deaths for U5MR were

- **Neonatal Diseases**
- **Infectious diseases which can be preventable and curable**
- **Strongly related to key family practices**

Most of the deaths occurred

- **In rural area**
- **Young infants and Neonate**

Challenges and Strengths

Challenges

- Monitoring and supervision mechanism
- Inadequate man power/human resource at different levels
- Over workload of BHS
- Reporting status
- Not well established infrastructure (ambulance, communication tools, facilities)
- Less health expenditure

Challenges in country and region

- Rural resident is high 75%
- Different racial groups and languages (135)
- Geographical barriers (hilly and delta)
- Insufficient health manpower
- Weak Infrastructure and communication

Strengths in Country

- Reform moment in Social Sector (including health sector)
- Increase in government expenditure for health
- More investments and partnerships in health by international organization

Thank You

Countermeasure for Maternal and Child Health and Child Welfare

Timor-Leste

TIMOR – LESTE COUNTRY INDICATOR

PART (A) INDICATORS

- Under-5 mortality rank 51
- Under-5 mortality rate (U5MR), 1990 180
- Under -5 mortality rate (U5MR) 2011 54
- U5MR by sex 2011, male 57
- U5MR by sex 2011, female 51
- Infant mortality rate (under 1), 1990 135
- Infant mortality rate (under 1), 2011 46
- Neonatal mortality rate 1011 24
- Total population (thousands)2011 1154
- Annual no. of births (thousands) 2011 44
- Annual no. of under-5 deaths (thousands) 2011 2
- GNI per capita (US$) 2011 2730
- Life expectancy at birth (years) 2011 62
- Total adult literacy rate (%) 2007-2011* 58
- Primary school net enrolment ratio (%) 2008-2011* 86

DEMOGRAPHIC INDICATOR

- Population (thousands) 2011, total 1154
- Population (thousands) 2011, under 18 616
- Population (thousands) 2011, under 5 201
- Population annual growth rate (%), 1990-2011 2
- Population annual growth rate (%), 2011-2030 3
- Crude death rate, 1970 23
- Crude death rate, 1990 18
- Crude death rate, 2011 8
- Crude birth rate, 1970 42
- Cude birth rate, 1990 43
- Crude birth rate, 2011 38
- Life expectancy, 1970 40
- Life expectancy, 1990 46
- Life expectancy, 2011 62
- Total fertility rate, 2011 6
- Urbanized population (%), 2011 28
- Average annual growth rate of urban population (%), 1990-2011 4
- Average annual growth rate of urban population (%), 2011-2030 4

- Concraptive prevalence (%) 2007-2012* 22
- Antenatal care (%) 2007-2012*, At least one visit 84
- Antenatal care (%) 2007-2012*, At least four visits 55
- Delivery care (%) 2007-2012*, Skilled attendant at birth 29
- Delivery care (%) 2007-2012*, institutional delivery 22
- Delivery care (%) 2007-2012*, C section 2
- Maternal mortality ratio, 2007-2011*, Reported 560
- Maternal mortality ratio, 2010, adjusted 300
- Maternal mortality ratio, 2010, Lifestime risk of maternal death (1 in:) 55

Nutrition

- LOW birthweight (%) 2007-2011* 12
- Early initiation of breastfeeding (%), 2007-2011* 82
- Exclusive breastfeeding <6 months (%, 207-2011* 52
- Introduction of solid, semi-ssolid or soft foods 6-8 months (%), 2007-2011* 82
- Breastfeeding at age 2 (%), 2007-2011* 33
- Underweight (%) 2007-2011*, moderate & severe 45
- Underweight (%) 2007-2011*, severe 15
- Stunting (%) 2007-2011*, moderate & severe 58
- Wasting (%) 2007-2011*, moderate & severe 19
- Overweight (%) 2007-2011*, moderate & severe 6
- Vitamin A supplementation full coverage (%) 2011 59
- Iodized salt consumption (%) 2007-2011* 60

Immunization

- Routine EPI vaccines financed by government (%) 2011 100
- Immunization coverage (%) 2011, BCG 68
- Immunization coverage (%) 2011, DPT1 69
- Immunization coverage (%) 2011, DPT3 67
- Immunization coverage (%) 2011, polio3 66
- Immunization coverage (%) 2011, MCV 62
- Immunization coverage (%) 2011, HepB3 67
- Immunization coverage (%) 2011, Hib3 -
- Immunization coverage (%) 2011, Newborns protected against tetanus 81

- Pneumonia (%) 2007-2012*, Care seeking for suspected pneumonia 71
- Pneumonia (%) 2007-2012*, Antibiotic treatment for suspected pneumonia 45
- Diarrhoea (%) 2007-2012*, Treatment with oral rehydration salts (ORS) 71
- Malaria (%) 2007-2012*, Antimalarial treatment among febrile children 6
- Malaria (%) 2007-2012*, Children sleeping under ITNs 42
- Malaria (%0 2007-2012*, Households with at least one ITN 42

LEADING CAUSES OF MATERNAL DEATH

- Haemorrhage 35%
- Hypertension 18 %
- Unsafe abortion 9 %
- Sepsis 8 %
- Indirect 18 %
- Other direct 11 %
- Embolism 1 %
- Anaemia

LEADING CAUSES OF CHILD UNDER 5 DEATH

- Malnutriton
  46% are underweight-for-age;
  15% are severely underweight-for-age;
  49% of the children under five are stunted;
  28% are severely stunted
- Diarrhoe
- Malaria
- Pneumonia

LEADING CAUSES OF INFANTS DEATHS

- Diarrhoe
- Pneumonia
- Tetanus

Yes In Timor Leste we perform health check for infant and children through monthly visit to health facilities or SISCa for Immunization, weighing also for consultation

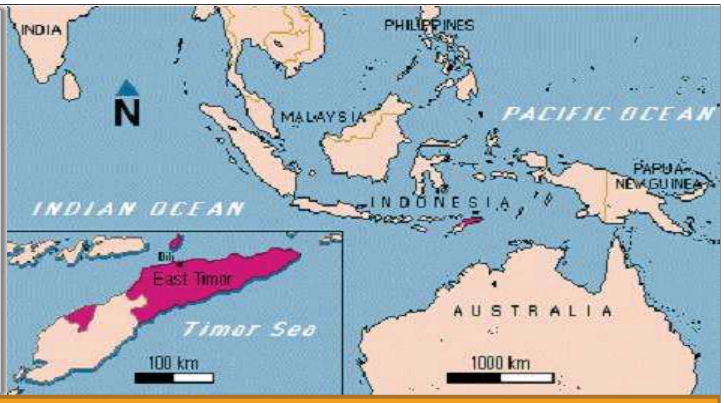
In case of any diseases or disabilities : Diseases giving treatment based on the diseases or diagnosis or it may refer to Hospital for further diagnosis or treatment. However if the cases of disability we have one NGOs that running to support disability children.

At moment we haven't had any standard for certifying disabilities children.

PART (B) Preliminary Analysis

1. Three Strengths in my Country
   a. Availablelity of Health facilities
   b. Accessibility of the health services
   c. Affordablelity of the community (free of charge)
2. Weaknesses or challenges
   a. Awareness of Community to use health facilities still low
   b. Attitude of health workers still questioning by community
   c. Health workers not providing services as schedule.

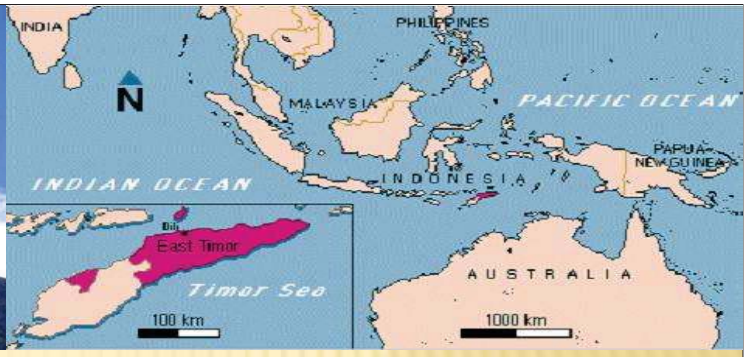
3. Vulnerable population :
   a. Pregnant women in very remote areas lack of access to professional services
   b. Disabilities children who live in remote areas
   c. Infant and children under 5 who live in remote areas
4. Kinds of services that available for the above mentioned group such as services are provided in monthly bases we called SISCa this services conducted every month in every Village, however sometimes health workers not visiting the village as been schedule, for this reason most of pregnant women, infant, children will not accesses to the service and they must wait for next month.



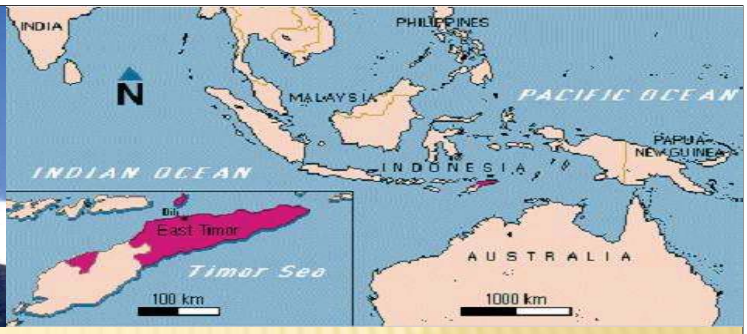
COUNTRY PRESENTATION

Countermeasure for Maternal and Child and Child Welfere

Formosa Community Health Center



TIMOR LESTE

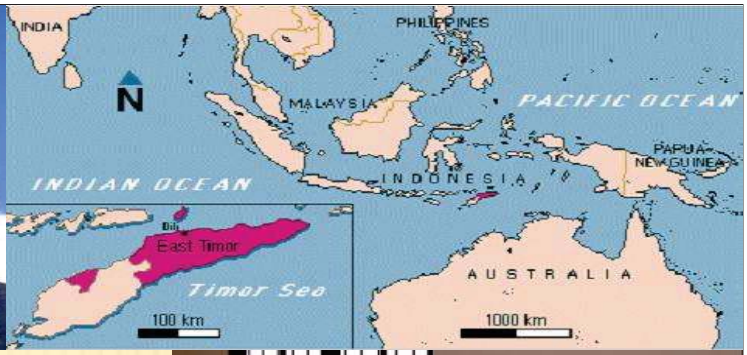


INTRODUCTION

AREA: 15.410 SQ KM (5,400 SQ MI), LOCATED ABOUT 640 KM (400 MI) NORTHWEST OF DARWIN AUSTRALIA

COLONIZED BY PORTUGAL IN 16TH CENTURY

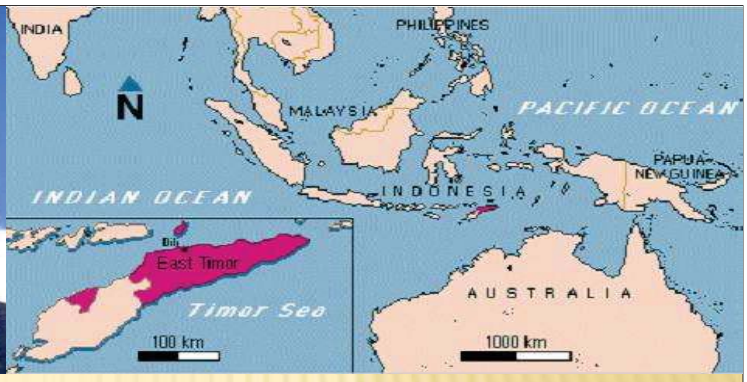
IN 1975 DECLARED ITS INDEPENDENT BUT LATER THAT YEAR WAS INVADED AND OCCUPIED BY INDONESIA AND WAS DECLARED INDONESIAN'S 27TH PROVINCE THE FOLLOWING YEAR.



Popular Consultation
August 30, 1999

Result :
78.5% of East Timorese are voted for the Independence

Indonesia relinquished control of the territory and Timor Leste be come the first new sovereign state of the 21st century on May 20, 2002

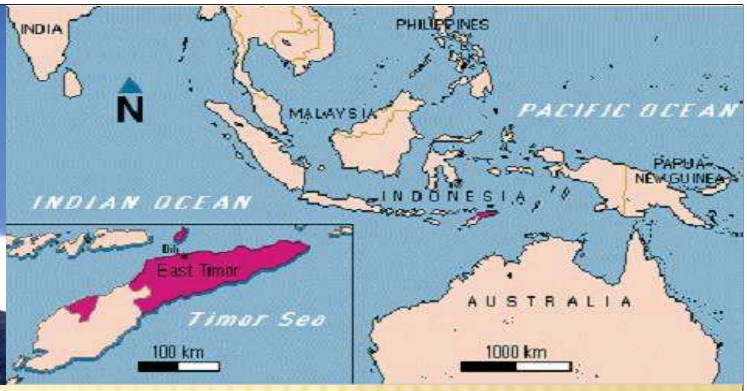


Name of the Country: Republic Democratic of Timor Leste (East Timor)

Population: 1,200,000 (2011 census)

Capital City: Dili

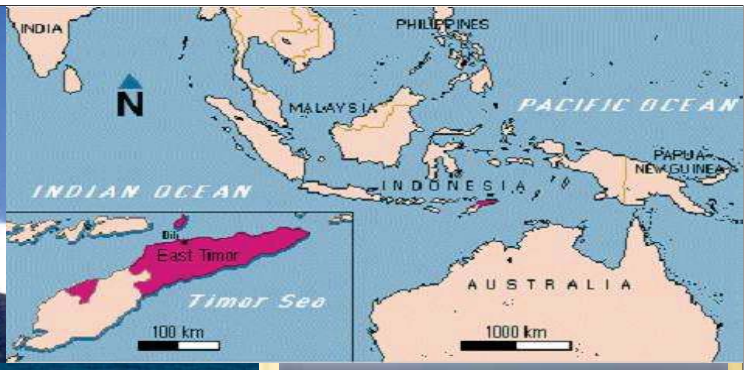
13 Districts, 65 Sub Districts, 442 Villages



Languages: Official languages: Tetum and Portuguese.

Also spoken: Bahasa Indonesia, English and Spanish and 13 local languages, 99% Catholic.

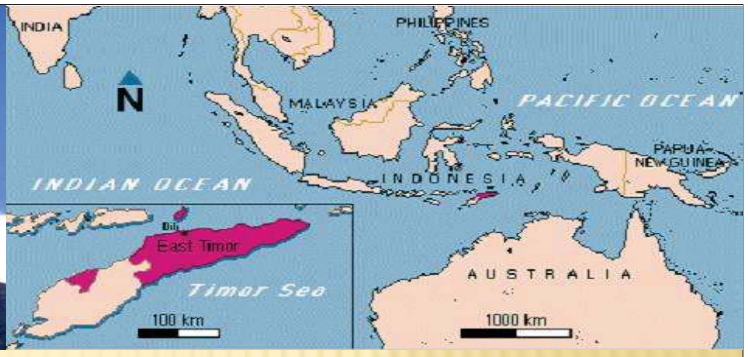
Currency: US Dollar



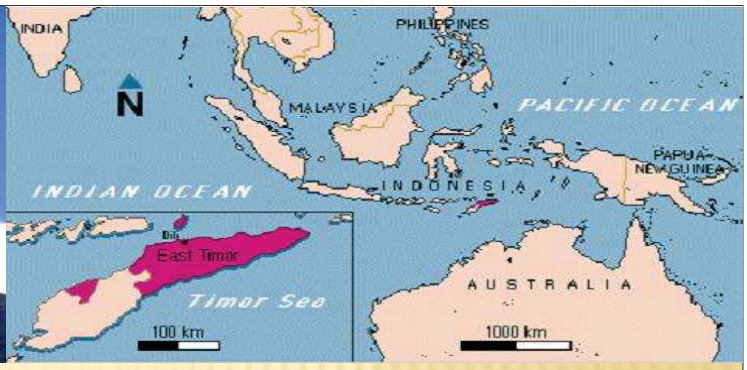
Major Exports: Oil and natural gas, coffee

East Timor's petroleum reserves are the potential key to the country's prosperity. The government has established a trust fund to manage its petroleum revenues sustainably.

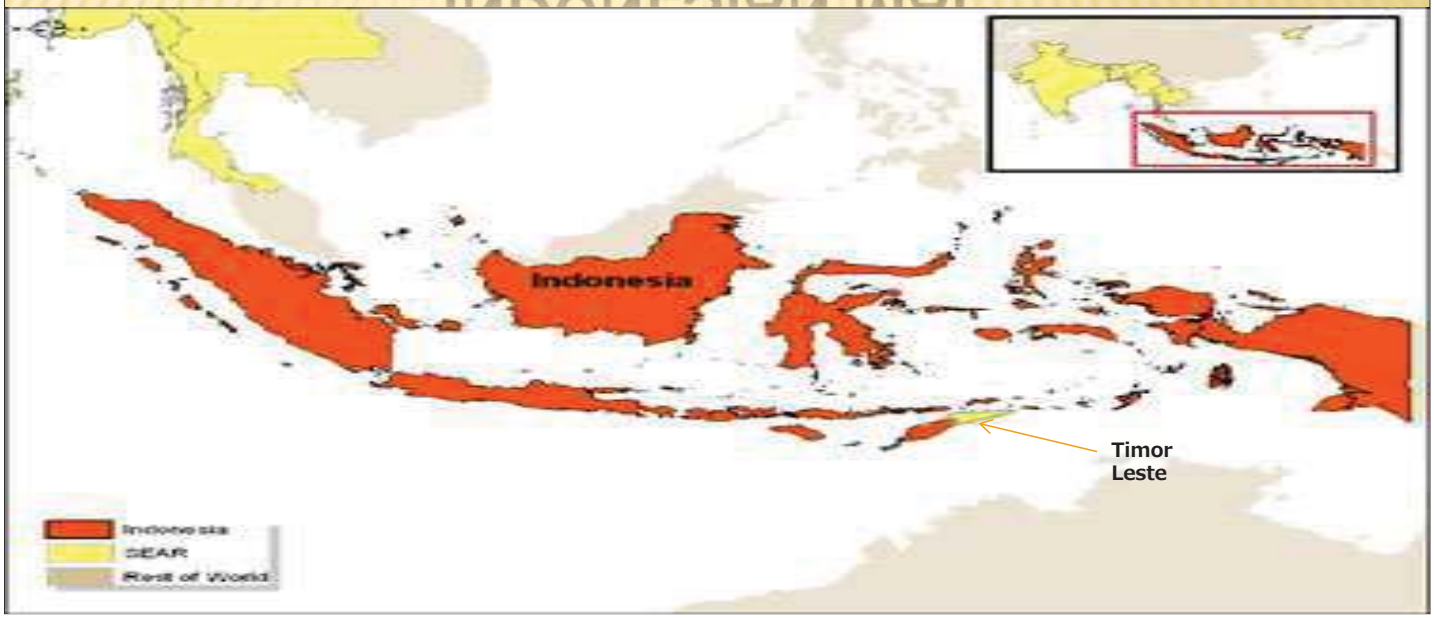
At the end of December 2010 the fund's balance stood at US$ 6.9 billion.

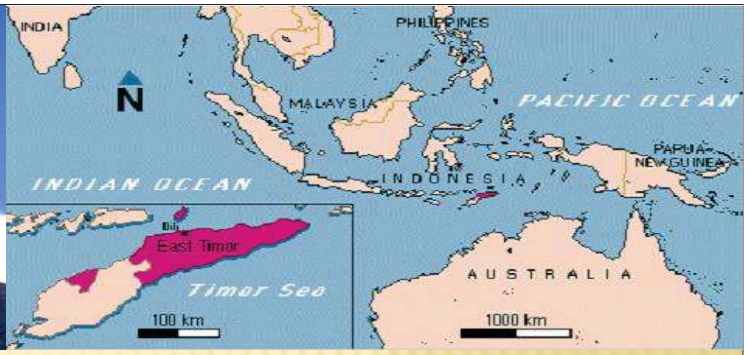


WORLD MAP

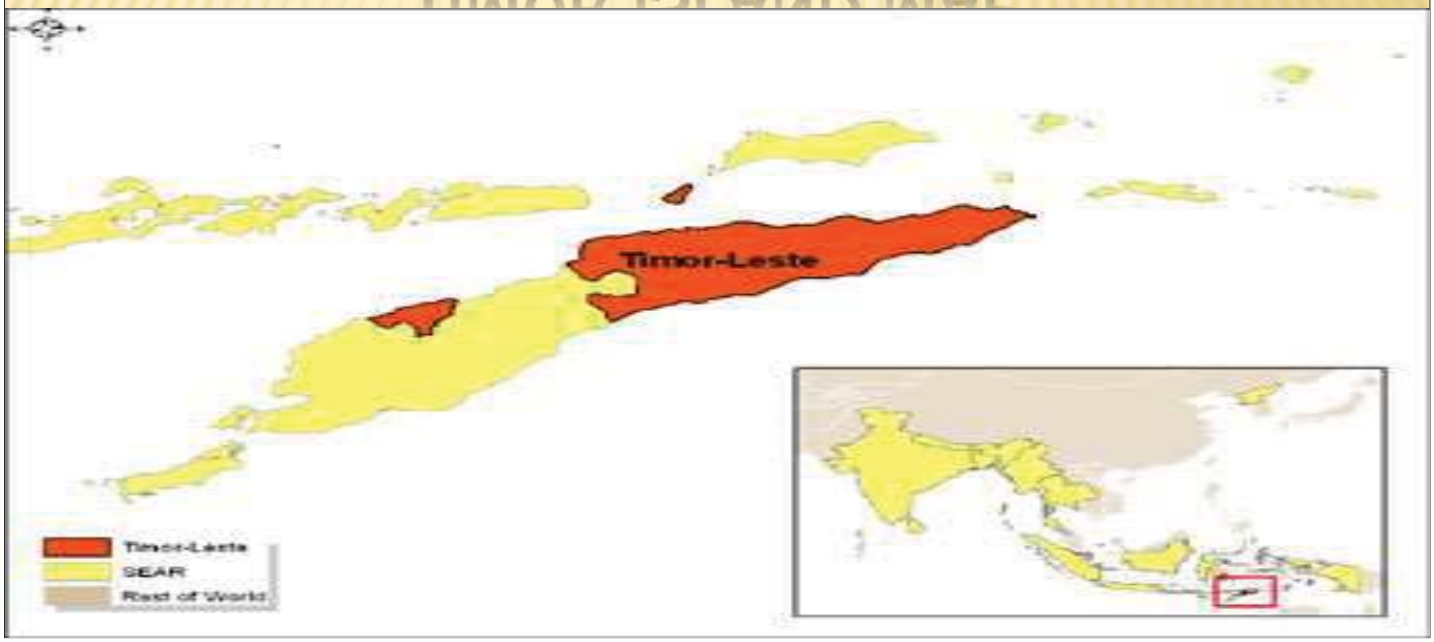


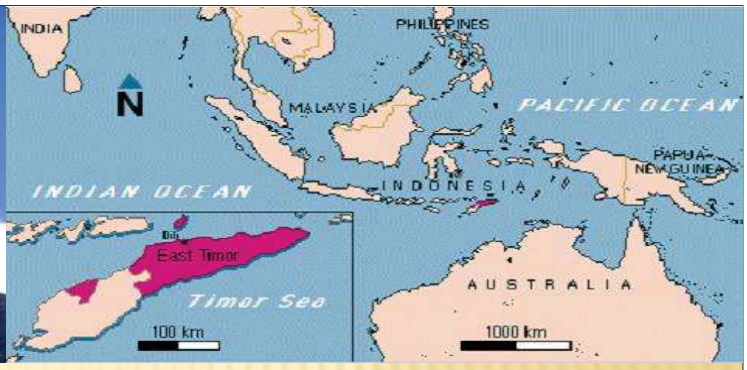
INDONESIAN MAP





TIMOR ISLAND MAP



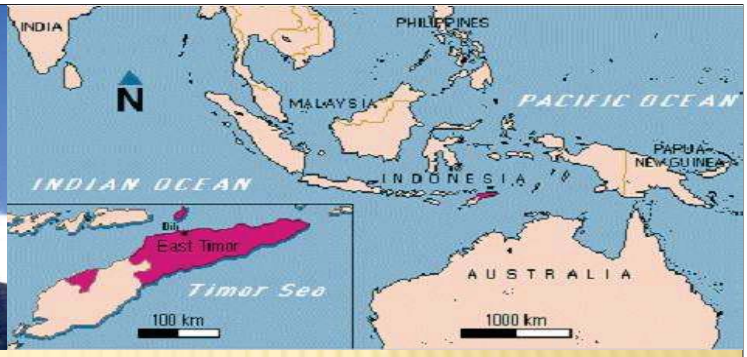


GEOGRAPHY

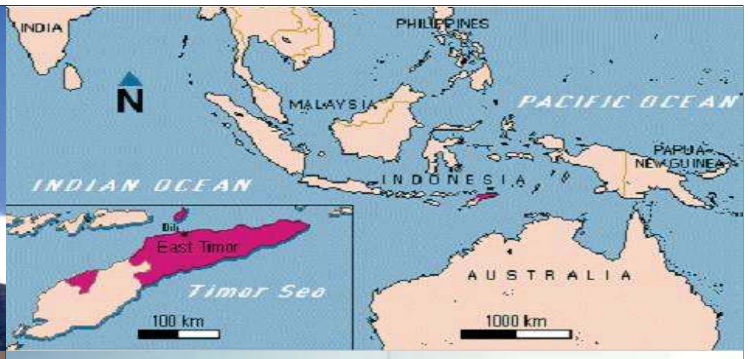
Timor is an island 1,000 miles south of the Philippines and about 400 miles north-west of Australia.

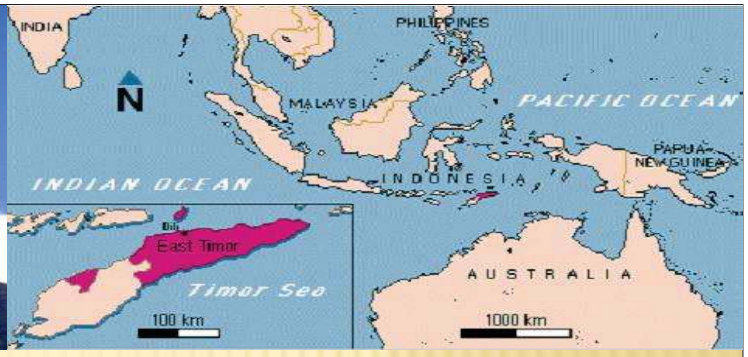
Timor is approximately 185 miles long and 45 miles wide. East Timor occupies the eastern half of the island, and has a boundary with West Timor, which is part of Indonesia.

The enclave of Oecussi, which on its land side is surrounded by West Timor, is also part of East Timor.

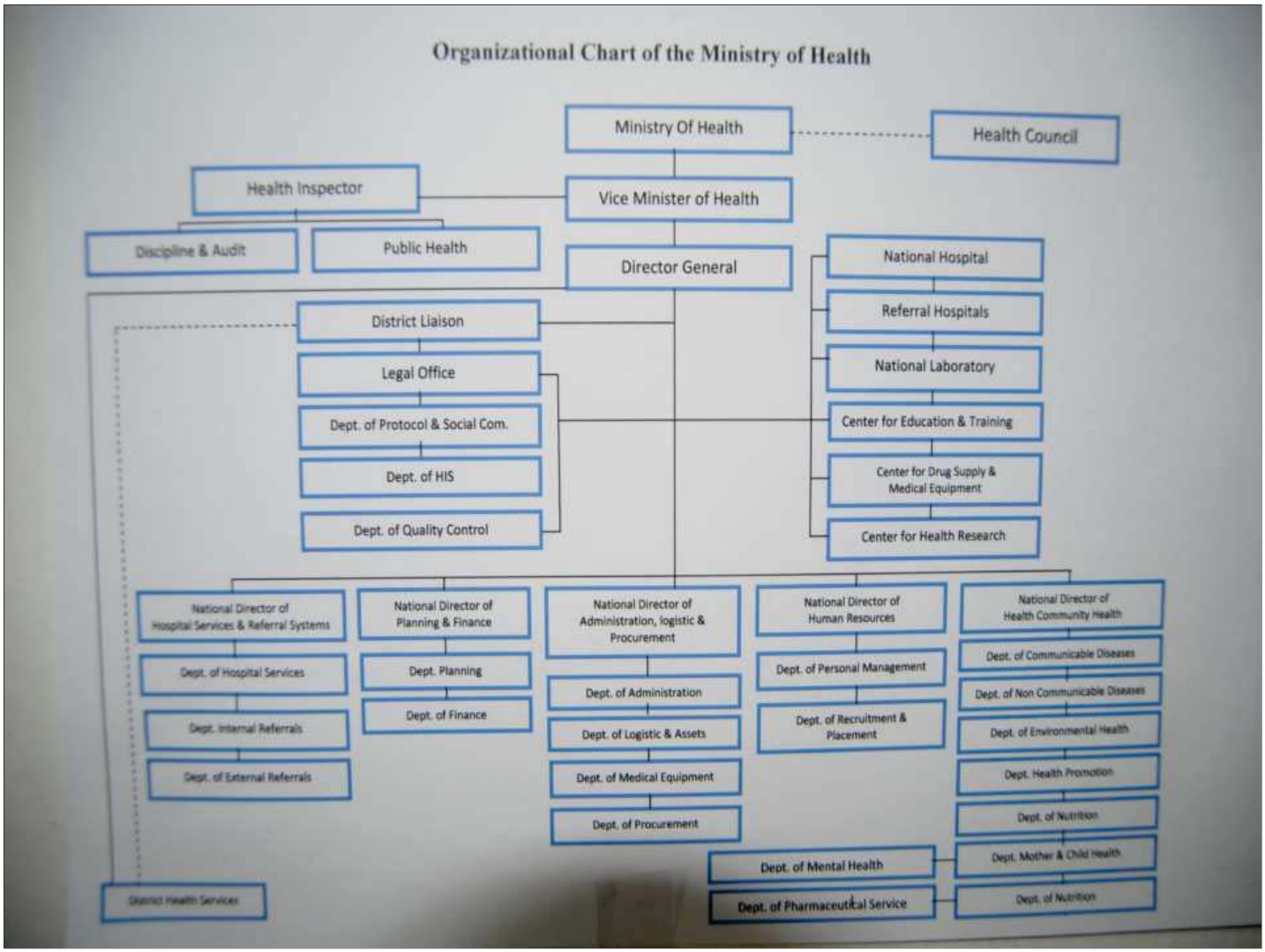


HEALTH SECTOR DEVELOPMENT IN TIMOR-LESTE

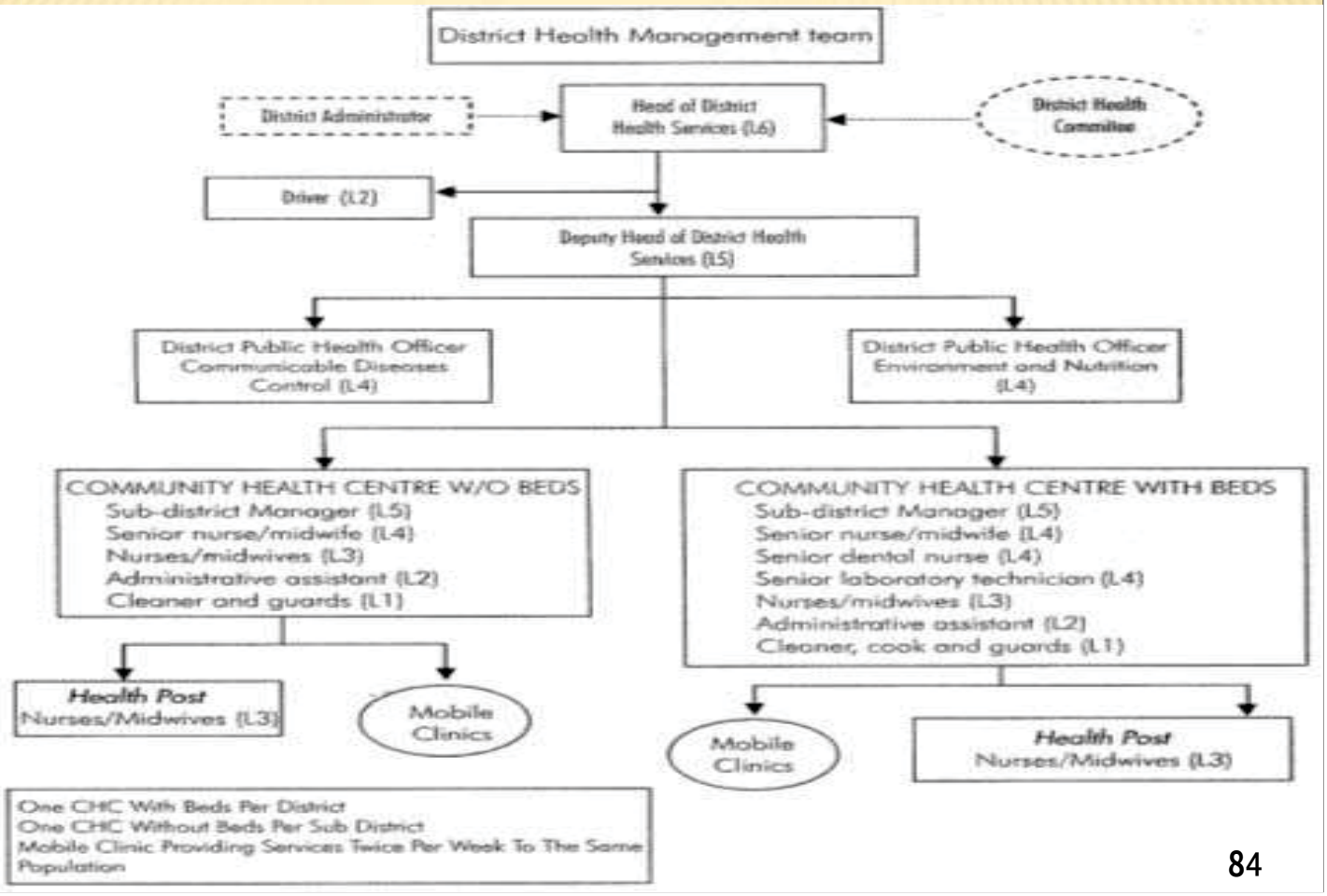




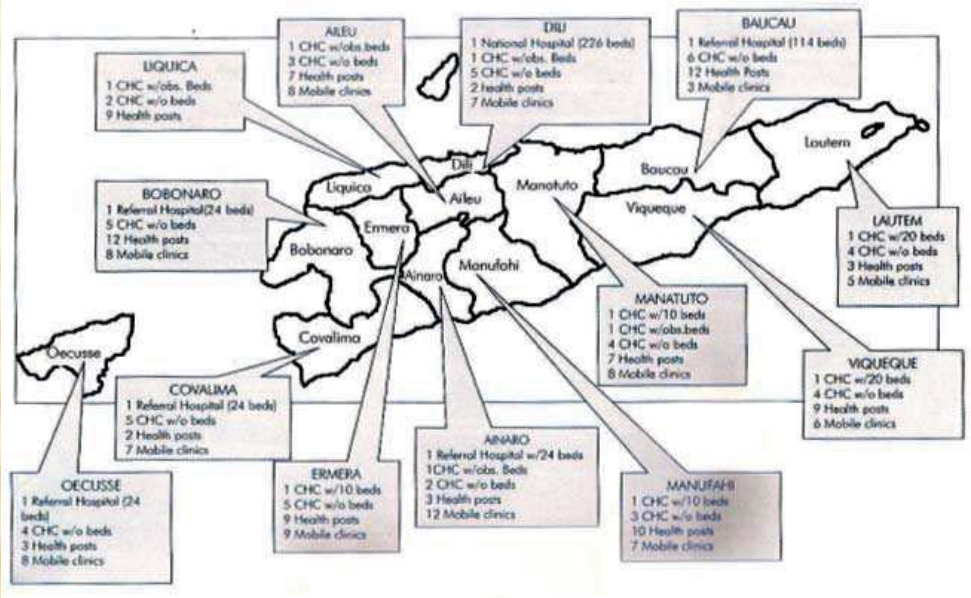
Establishment Of the Ministry of Health



ORGANIZATION CHART OF DISTRICT HEALTH SERVICES



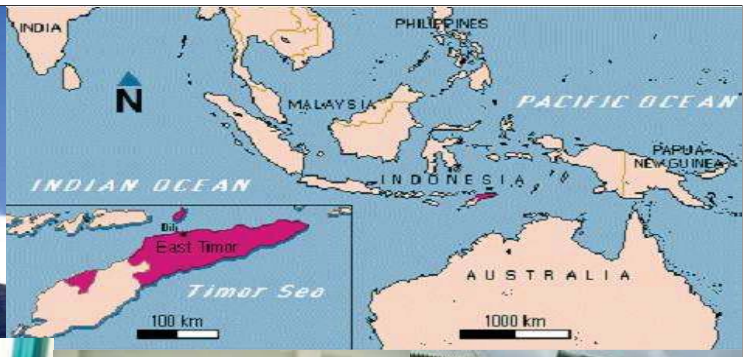
DISTRIBUTION OF HEALTH FACILITIES IN TIMOR LESTE



Health policies and strategies

The Ministry of Health came into being in September 2002 with following objectives:

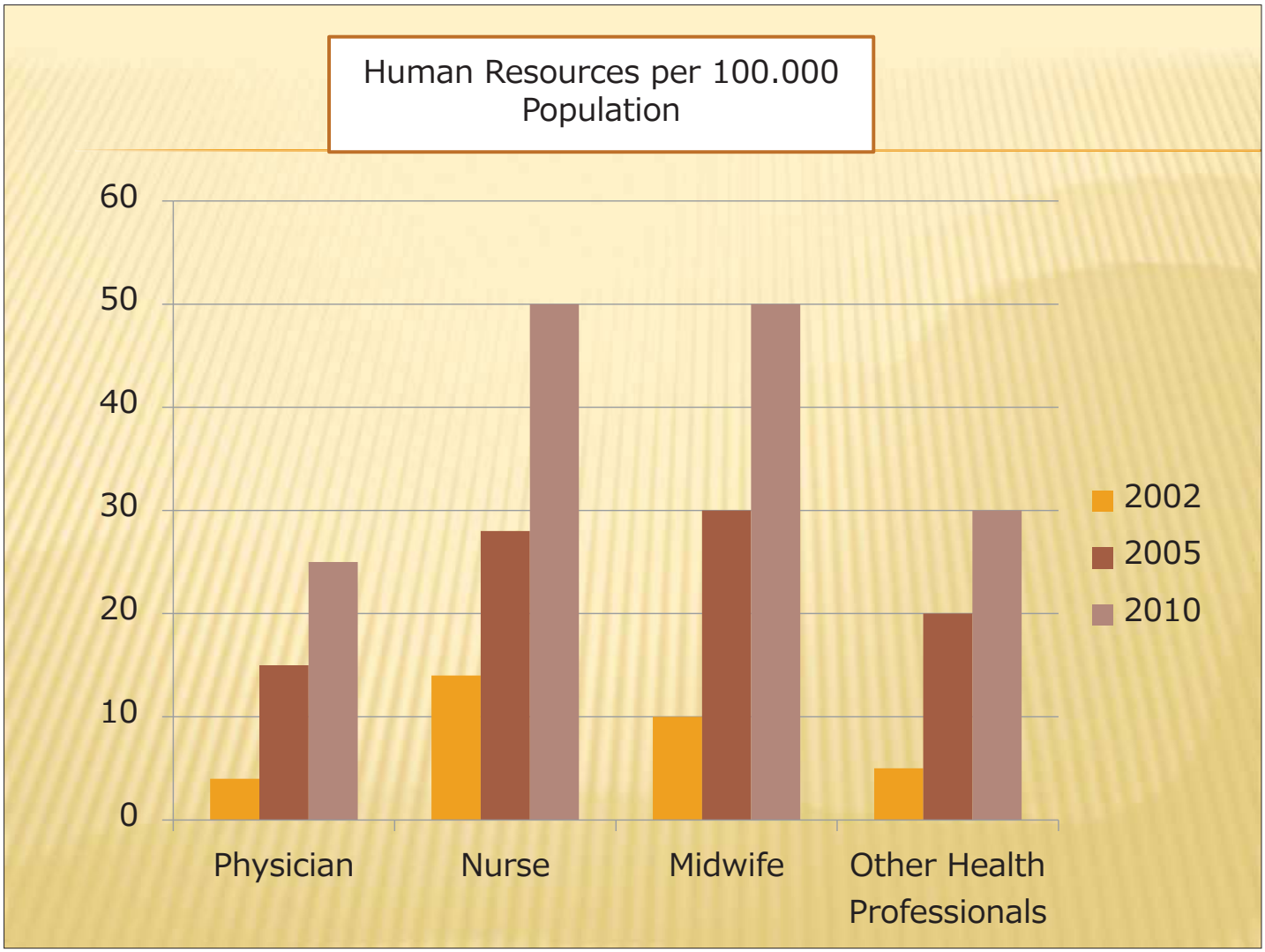
- Establish, National Hospital, Referral Hospitals, Community Health Centres and Health Post in cities and villages
- Enabling the community to accesses to the health services
- Provide free health services health services to all community in territory
- Reduce levels of maternal and infant mortality
- Reduce the incidence of illness and death due to preventable communicable and non-communicable diseases, including HIV/AIDS
- Improve the nutritional status of mothers and children
- Improve reproductive health in Timor-Leste
- Ensure that all people have access to health services
- Ensure the delivery of a minimum healthcare package at all levels of services
- Collaborate with all stakeholders in the health sector to achieve national goals for health
- Ensure that sufficient and adequate training for health professionals is undertaken to meet national requirements
- Regulate the employment of all health professionals to ensure minimum standards of professional practice
- Increase woman's access, both to health information and to quality health services
- Increase the availability of mental and dental heath services. (Democratic Republic of Timor Leste Health Profile August 2002)

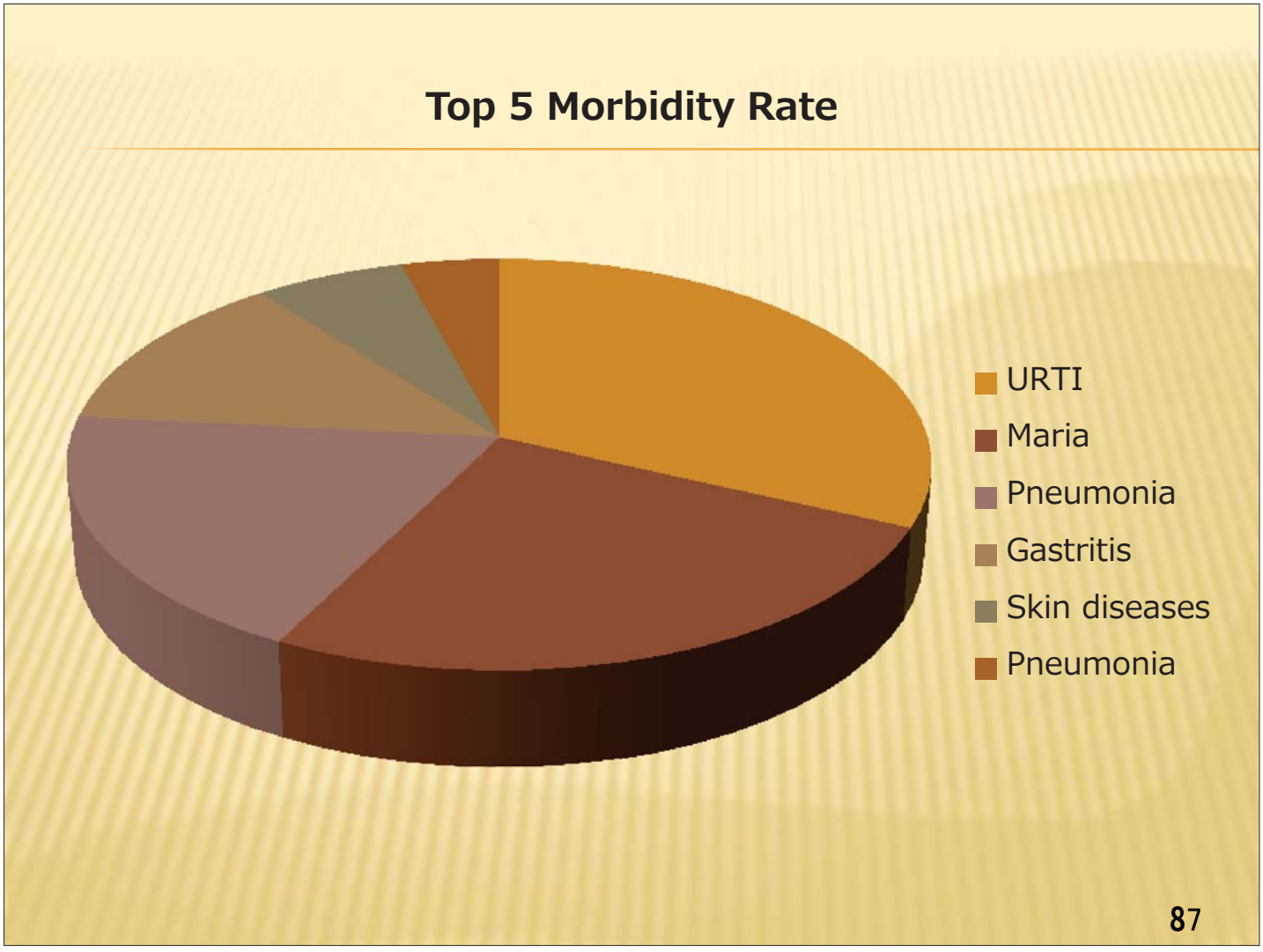


WHERE WE ARE NO

Health Facilities

Health Facilities	2002	2005	2010
National Hospital	1	1	1
Referral Hospitals	2	4	5
Community Health Centers	20	37	65
Maternity Clinic	0	15	48
Health Post	50	100	260


Human Resources per 100.000 Population
60
50
40
30
20
10
0
Physician
Nurse
Midwife
Other Health Professionals
2002
2005
2010


Top 5 Morbidity Rate
URTI
Maria
Pneumonia
Gastritis
Skin diseases
Pneumonia

Top 5 Mortality Rate

Selected 2010 health indicators:

Life expectancy at birth	60.2 (females) 58.6 (males)
Total fertility rate	5.7
Maternal Mortality ratio	557 deaths per 100.000 live births
Infant mortality rate	44 deaths per 1.000
Under-five mortality rate	64 deaths per 1.000 live births
Percentage of children < 5 years with stunting	53%
Percentage of children who are under weight	52%
Tuberculosis incidence rate	133 per 100.000 population
Malaria incidence rate	104.2 per 1,000 population
HIV sero-prevalence rate	Low (only indicative figure Available) but with high level risk behaviour

Moternal Health

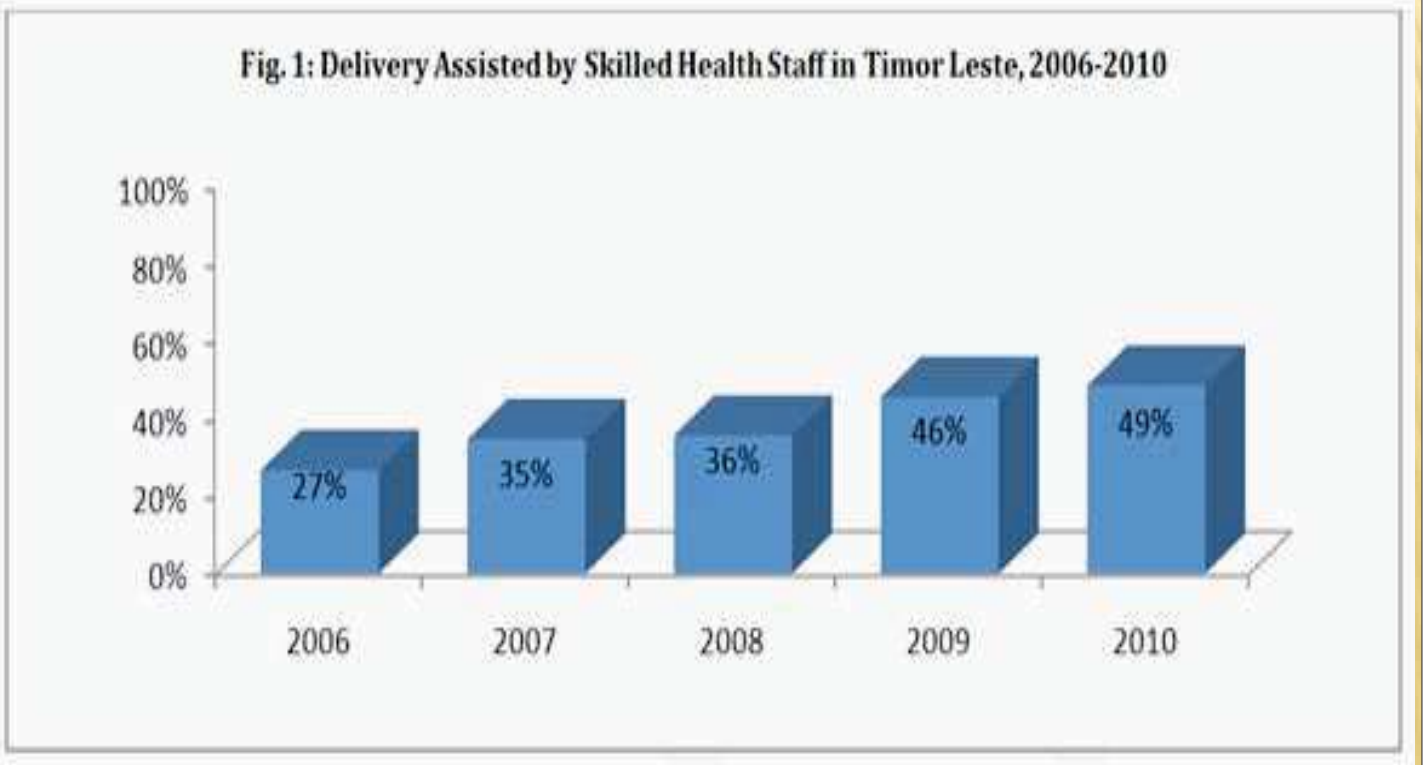


Figure above shows progressive increase in assisted deliveries from 27/ in 2006 to an average of 49.3% reported in 2010

Comparison between Timor Leste and Australia

Category	Timor Leste	Australia
Population	1,2 million	21.5 million
Urban population	28.1%	89.1%
GNI Per capita (US$ PPP)	$ 5.303	$38.692
Population have access to an water resource	69%	100%
Adult Literacy Rate	50.1%	99%
Population living below US$ 1.25 (PPP) per day	37.2%	0%
Under 5 Mortality Rate	93%	6%
Life expectancy of birth	62.1 year	81.9 year

Population who live in the city, in the mountains or in the valley, must receive the same quality of health assistance.

"Healthy East Timorese in a healthy Timor Leste"

THANK YOU

Countermeasure for Maternal and Child Health and Child Welfare

Viet Nam

Maternal and Child Health in Vietnam

Vietnam

Presentation Outline

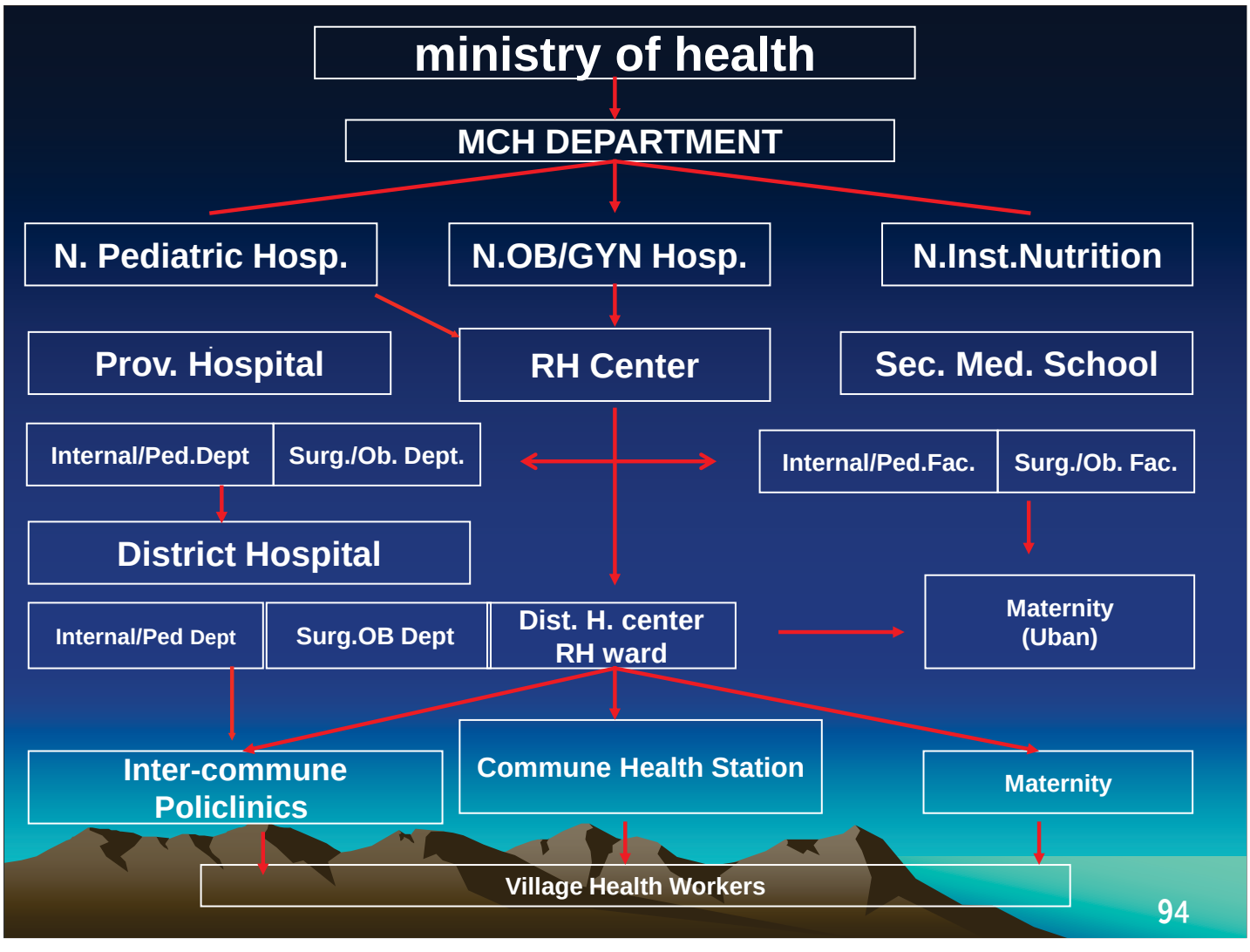
- Country Profile.
- MCH Services.
- Challenges and existing
- Solution
- Conclusion.

Country Profile

- **Location:** Southeastern Asia, bordering the Gulf of Thailand, Gulf of Tonkin, and South China Sea, alongside China, Laos, Cambodia.
- **Area:** total: 329,560 sq km, land: 325,360 sq km, water: 4,200 sq km.
- **Climate:** tropical with hot, rainy season (mid-May to mid-September) and warm, dry season (mid-October to mid-March).
- **Population:** 90M.

Country Profile

- Women at reproductive ages (15-49) 28%; Adolescent ~ 23%; Adolescent and youth ~ 32%;
- ~ 70% living in rural area.
- HDI: 0.572 ~113/169 nations
- Adult literacy rate: 93.3%
- GDP/capita: ~ 2050 USD
- Health expenditure: 8% of GDP (education: 13%);
- Life expectancy: 74.9 (71.9 M & 75.7 F)
- % of HHs living <1.25 USD/day: 21.5%



RH services

- % of communes having midwife: > 95%;
- % of HHs access to clean water: 85%;
- % of HHs having appropriate latrine: 61%;
- EPI coverage: 97% (measles: 95%).
- CPR: ~ 72% (model methods).
- ANC 3+: 86% (at 3 trimesters)
- Delivery attended by SBA: 97%
- PNC: 87% (at first week)

RH INDICATORS

	1990	2012	Target 2015 (MDGs)
CBR (%)	18,6 (2001)	16,9	
CDR (%)	5,3 (2005)	7	
TFR	3,5	2,01	
MMR (per 100.000LB)	244	62	58,3
NMR (‰)	N/A	12	<10
IMR (‰)	44	15	14,8
U5MR (‰)	58	22,5	19,3
UWP (U5)	32	16	15

Challenges (1): Disparities

	Plain	Mountain (minorities)
MMR (per 100.000 lb)	36	108
IMR (‰)	12	26
U5R(‰)	18	38

Challenges (2)

- The reduction of MMR is low after 2010. Main causes are: serious bleeding, eclampsia, infection (in moutain), embolus, obstructed (in plain).
- IMR, U5MR has been reduced, but neonatal death rate is till high with main causes as asphixia, premature, congenital malformation, infection...
- Underweigth prevaence has been reducing but still high. Stunting prevalence is very high. Overweight and obeisity as well as NCDs has been increasing (double burden on nutrition).
- Sex ratio at birth is high (113) and increasing

Existing

- MCH netwrok and quaity of services has not met the demands particularly in emergency and referal system for mother and newborn care.
- M & E system are stll weak. Data collection is less reliable.
- BCC activities and services available is not strong enough then the service utilization is still low at mountainous areas
- Buget invested is very limited, not meet the demands.

Solutions (1)

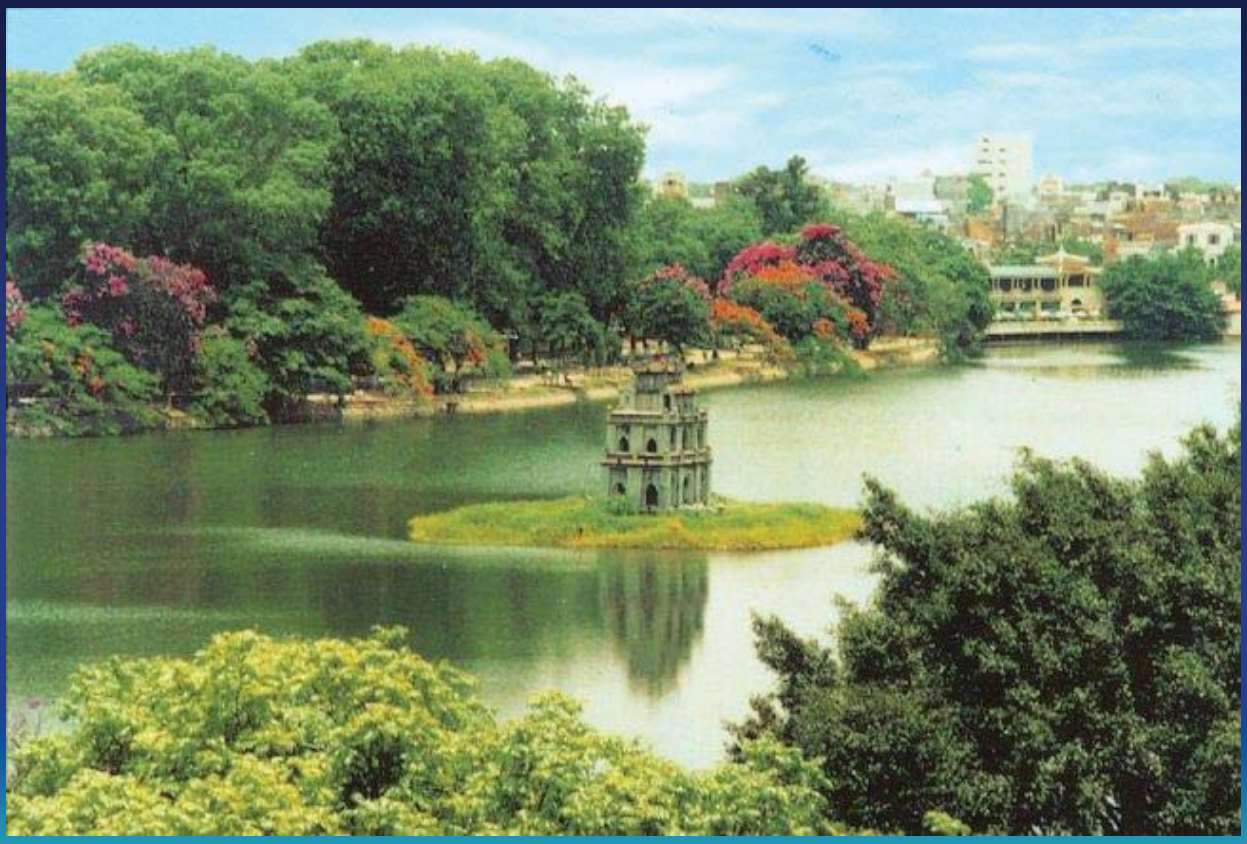
- Improve quality of services and accessibility to the MCH services. High priority for remote areas:
  - Bridges the gap of human resources, upgrade facilities, equipment for district hospital in remote area to perform EmOC (incl. emergency operation & blood transfusion and newborn care (NICU) including referral system
  - Increase the coverage of ANC, PNC and deliveries assisted by SBA.
  - Training of Village minority ethnic trained birth attendants for hard-to-reach areas
  - Set up the mobile team to provide RH services in remote areas .

Solutions (2)

- For the rest areas: Improving the accessibility in order to have universal access to all the RH services.
- Prioritize investment for high risk people like the poor, migrants, pregnant women having high risks such as having chronic, and heart diseases, and HIV (+) people.
- Improve M & E system including data collection, conducting operational research for making appropriate interventions.
- Strengthen BCC activities integrated with services provision.

Conclusion

- MMR, IMR, U5MR have been reducing remarkbly. VN could reach the MDGs 1, 4, and 5.
- Neonatal death in VN is still high and accounted for 70% of IMR, 50% of U5MR. The reduction is still slow.
- Disparity bt socio-economic regions is large.
- Improvement of accessibility and quality of services should be paid more attention, especially for the remote areas, and for vulnerable groups.
- Commitments and supports from local governments will determine the successfulness' of the MCH program.



The Turtle Tower in the Sword Lake

One Pillar Pagoda

Thank you for your attention!

Have fun!

Countermeasure for Maternal and Child Health and Child Welfare

Yemen

Preparation for attendance JICA training course.

Part (B) Preliminary Analysis:

NO	Data information		
1	Crude birth rate (per 1000 population)	39.7 According to 2004 census	
2	Crude death rate (per 1000 population)	9 According to census 2004	
3	Leading causes of death	pneumonia (22%), diarrhoea (11%), neonatal sepsis (6%) and malaria (1%) accounted for 40% of all deaths which occurred in children under 5 in Yemen in 2010. Prematurity was responsible for 18% and birth asphyxia for 13% of under	
4	Infant mortality rate (per 1000 population)	75 (2003)	68.5(2006)
5	Leading causes of infant death	• Preterm 34 % • Asphyxia 24% • Infections 22 %	
6	Under-5 mortality rate (per 1000 live birth)	102(2003)	78.2(2006)
7	Top 3 diseases and morbidity rate of the under-5	• Diarrhea • Pneumonia • Malnutrition	
8	Maternal mortality rate (per 100,000 live birth)	430(2003)	366(2006)
9	Leading causes of maternal death	• Hemorrhage 32 % • Hypertension 13 % • Abortion 9% • Sepsis 7 %	
10	Does your country perform any health check for infants and children? If "yes" * When (at how many months?) * How many times? * What kinds of contents include in each? Yes , at the exposure to the Health facilities		
11	In cases any diseases or disabilities is confirmed, is there any support services on them? Describe the services , if any. Yes , through the disability centers in the big Cities , but there is a chronic shortage		
12	Are there national standards for certifying disabilities in your country? Yes / No If yes explain briefly. Yes, through a team in the big hospital , but in limited areas		

1- Mothers and children health care strong and weak points.

Strong points;

- Well functioning vaccination system (routine and campaigns).
- Functioning IMCI program.
- Reproductive program.
- Integrated primary health services.

Weak points;

-Limitations in mother and child health services as a result to lack of infrastructures.

-Illiteracy and low social awareness about maternal and child health.

- Deficiency in qualified health personnel.

2 - Most vulnerable populations;

- Homeless and people with no constant income (daily workers)
- IDPs (internal displaced peoples) at Harad IDPs camps displaced from their original locations in Sa`ada governorate (north of yemen) because of the war and the resultant complicated social context.
- Poor farmers in Rural areas 70% of Yemeni population are living in countryside mainly in western coast low lands (Alhodaida governorate).

3- Kind of services exist for above mentioned groups.

- Charity local societies.
- Governmental and NGOs (nongovernmental organizations)e.g WHO, Unicef, WFP MSF …
- National fund for social care.

出典：平成 25 年度 JICA 集団研修カントリーレポート

- 平成 25 年度 JICA 集団研修「母子保健福祉行政」

International Corporation of Welfare Services (JICWELS) was established with the sanction of the Minister for Health, Labour and Welfare in July 1983 and implements international technical cooperation programmes with purpose of contributiing to the promotion of health and social welfare activities in the friendly nations.

Japan International Corporation of Welfare Services (JICWELS)
Toranomon YHK Bldg. 4F, 2-3-20, Toranomon
Minato-ku, Tokyo 105-0001 JAPAN
Phone: +81-(0)3-6206-1137
Fax: +81-(0)3-6206-1164
http://www.jicwels.or.jp

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。

公益社団 国際厚生事業団 JICWELS
広報活動委員会

〒105-0001
東京都港区虎ノ門 2-3-20 虎ノ門ＹＨＫビル 4 階
電話 03-6206-1137（事業部）　Fax03-6206-1164
http://www.jicwels.or.jp