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

～Part (A) Indicators～

Please confirm data of following Indicators: Not only data of 'country overall' but also its "Changes" compared with previous data and "Disparities within the country". The Latter is much important for the coming discussion.

(1) Crude birth rate (per 1000 population)

	Country overall
1990	43.6
2000	27.1
2010	22.5

(2) Crude death rate (per 1000 population)

	Country overall
1990	12.3
2000	9.6
2010	8.0

(3) Leading causes of death (1990) and (2009)

1990: 1) Diseases (Bacteria, virus and micronutrient deficiency) 2) Hygiene and poverty 3) Environment and low knowledge

2010: 1) Diseases (Bacteria, virus and micronutrient deficiency) 2) Hygiene 3) Environment and low knowledge

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

	Country overall
2000	95
2005	66
2010	45

(5) Leading causes of infants death (1990) and (2009)

2000: 1) Diseased 2) Infection 3) Anemia

2010: 1) Diseased 2) Infection 3) Anemia

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

	Country overall
2000	124
2005	83
2010	54

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

2000:

Diseases: 1) Acute respiratory illness (ARI) 2) Fever 3) Diarrhea

Morbidity rate: 1) ARI 6% 2) Fever 28% 3) Diarrhea 15%

2010:

Diseases: 1) Acute respiratory illness (ARI) and fever 2) Sever acute malnutrition and anemia 3) Diarrhea

Morbidity rate: 1) ARI 6% and fever 28% 2) sever acute malnutrition 2.5% and anemia 55% 3) Diarrhea 15%

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

	Country overall
2000	437
2005	472
2010	206

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

2000: 1) Hemorrhage 2) Eclampsia 3) Infection

2010: 1) Hemorrhage 2) Infection 3) unsafe abortion

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

Yes /

If yes, please explain briefly.

To certify the disabilities, the Royal Government of Cambodia has issued Inter-Ministerial Declaration (Prakas) between Ministry of Social Affairs, Veterans and Youth Rehabilitation on Classification and Type of Disabilities. This Prakas aim to define national definition for collecting statistic and data to implement laws, policies and programs related to disability. Disabilities were classified 4 kinds as following:

1. Physical Disability
2. Intelligent Disability
3. Mental Disability
4. Other Disability.

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

Yes /

If 'Yes',

-When (at how many months)? Every month

-How many times? One time per month

-What kinds of contents includes in each? scalp, yellow card for children, mother card…..

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

- Treatment through IMCI
- For sever acute malnutrition refer to hospital for treatment
- For pregnancy and post partum women we provided iron/folic acid and mebendazol

～Part (B)　Preliminary Analysis～

※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.

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

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

- ⇒Maternal and Child Welfare：(1.Family planning/birth spacing　2. Safe abortion and post-abortion contraceptive
- 3. Care for the Infants and young children.)

⇒Maternal and Child Health：(1.ANC and PNC 2. Provided vaccine 3.Provided micronutrient (Iron/Folic Acid, Vitamin A, Multiple Micronutrient Powders) and Mebendasol)

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

⇒Maternal and Child Welfare：(1. Financial barriers to access health services. 2.Hygiene. 3. Environment and poverty)

⇒Maternal and Child Health：(1. Limited capacity in Leadership and governance among provincial and district in planning of MNCH activities. 2. Insufficient skills and knowledge of service providers for MNCH activities. 3. Limited access to MNCH care)

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?

(1.People are living in rural areas　2. People are poverty　3. Pregnancy and post partum women and children under five years)

3. What kinds of services are there for the above mentioned groups?

- Health center staff conducted outreach activities at villages far from health center.
- To provide vaccine, vitamin A, Mebendazol, multiple micronutrient powders, iron/folic acid.
- To conducted ANC and PNC at health center and community
- We have to provide fund for people who have poverty
- To provide services to orphan and vulnerable children (OVC) and poor children.

4. In implementing health/welfare policies and services by your organization：

⇒to develop these strengths and improve these weaknesses,

⇒to develop the services for the most vulnerable populations,

①In your country/province, what are the priority issues/programmes in the area of maternal and child health/welfare? List five issues/programmes in order of priority.

（1.Emergency Obstetric and Newborn Care 2.Skilled Birth Attendance 3. Promote Child Care Services in Orphanage and Community
4.Safe Abortion 5.To provide vaccine and micronutrient）

②What are successful areas or programmes? List 3 areas or programmes.

（1.National Immunization Program 2.National Reproductive Health Program 3. National Nutrition Program）

②What are these challenges? List 3 challenges.

（1. Financial barriers to access health services. 2. Lack of human resources 3. Lack of good quality and adequately equipped health facilities to provide comprehensive health services.）

③ Regarding the above-mentioned issues/challenges, explain background, current situation and reason why those issues/challenges are difficult to solve.

- National policies and guidelines were not widely disseminated.
- Awareness of the limited special people in remote areas of praise.
- Funding for health service providers is limited.
- Guidelines and policies of providers of services outreach activities give priority to villages far.
- HC times do not have enough staff for service providers, especially not enough midwifes.

④Describe your expectations to the training course.

- I will gain an understanding of the concept related to maternal and child health/welfare to improve and promote the social service to poor children and orphans and vulnerable children (OVC).
- I will understand how to write a good report related to maternal and child health/welfare sector.
- I will get the new experience from others countries, especially Japan from this training and I will share my experience to my coworkers.

Countermeasure for Maternal and Child Health and Child Welfare

MYANMAR (1)

Maternal and Child Health in Myanmar

Township Health Department
Taunggyi, Shan State
Myanmar

Maternal and Child Health

Overview and Disparities

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**

3

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**

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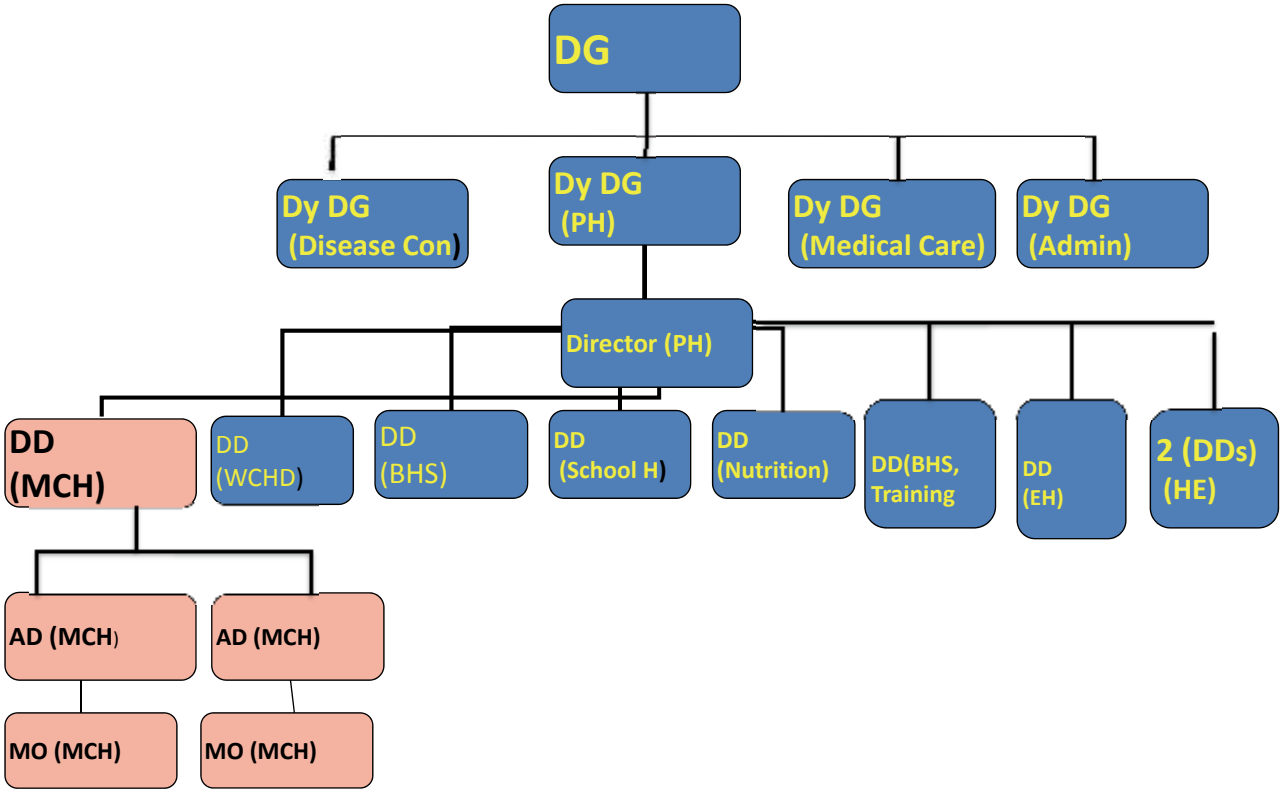
Strategic Approach for Reproductive Health

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.

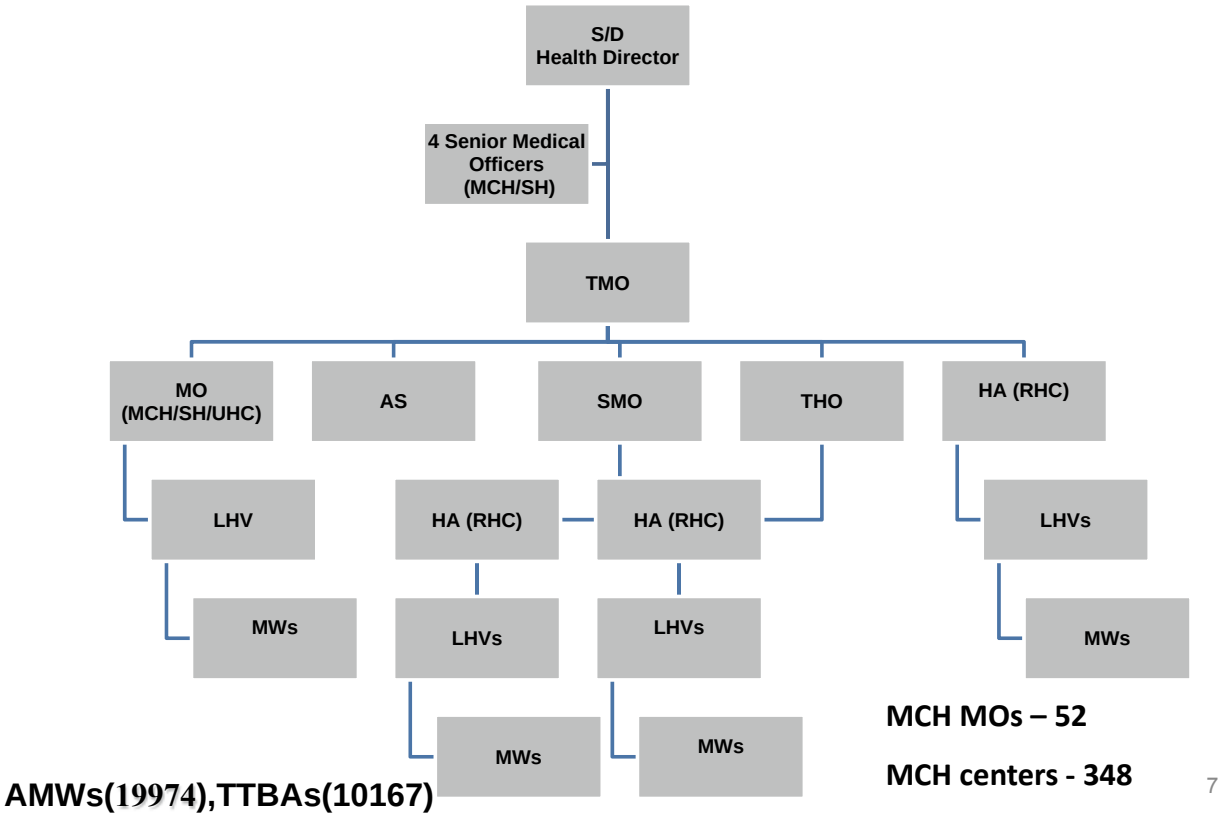
5

Organization Set Up (Central level)



6

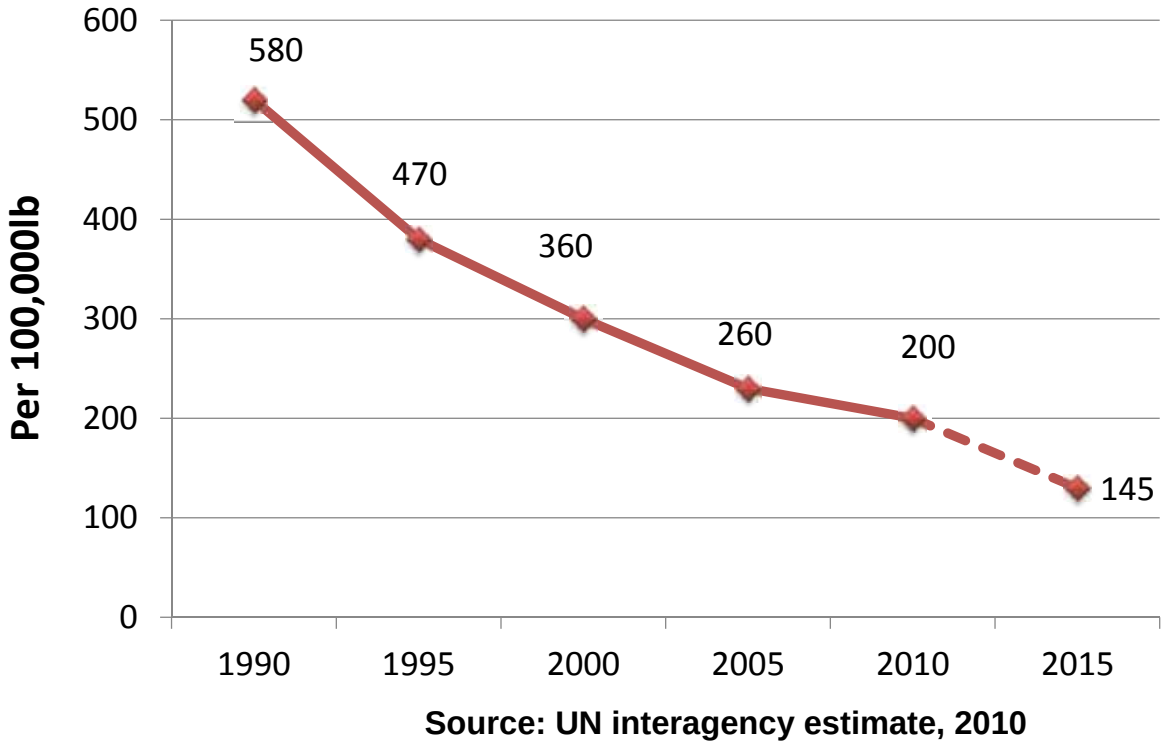
Organization Set Up for Public Health
(State/ Regional level)



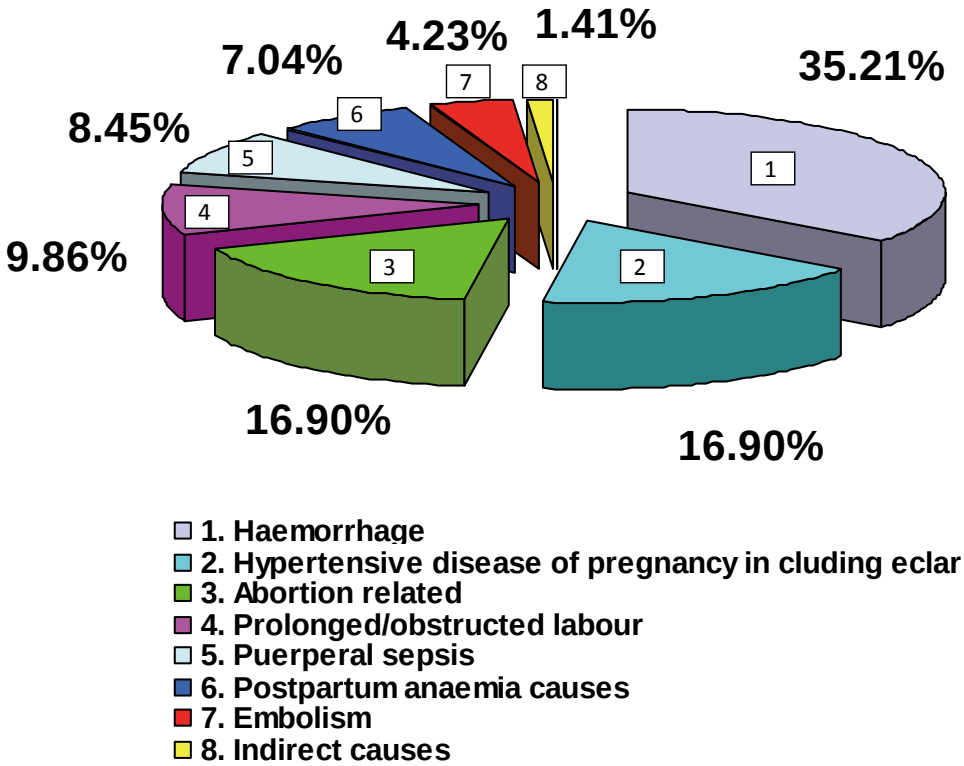
Indicators

Health Index		1988	1999	2010
Crude Birth Rate	Urban	28.6	24.5	15.4
	Rural	30.5	27.1	16.6
Crude Death Rate	Urban	8.9	6.0	5.2
	Rural	9.9	7.8	6.1
Infant Mortality Rate	Urban	47.0	55.1	25.6
	Rural	49.8	62.5	27.8
Under five Mortality Rate	Urban	72.9	65.12	34.43
	Rural	-	85.16	35.11
Maternal Mortality ratio	Urban	1.0	1.8	1.12
	Rural	1.9	2.8	1.54

Maternal Mortality Ratio in Myanmar



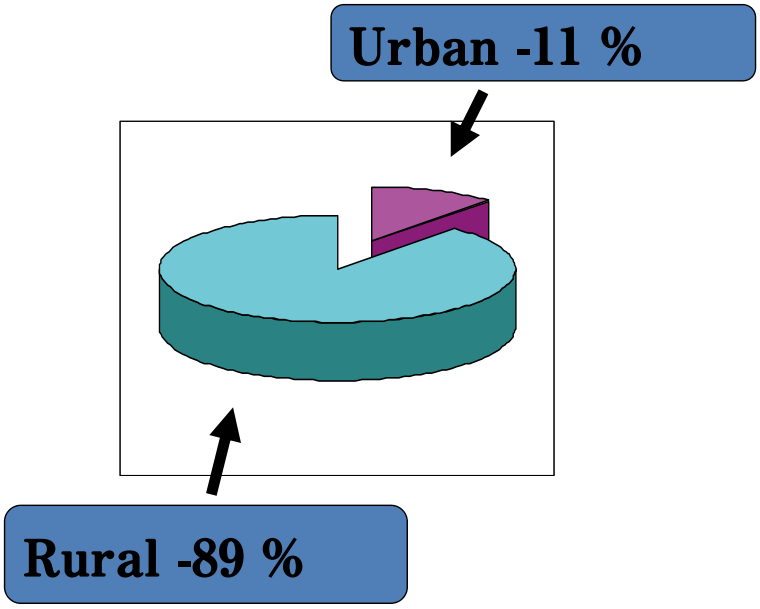
Source: UN interagency estimate, 2010



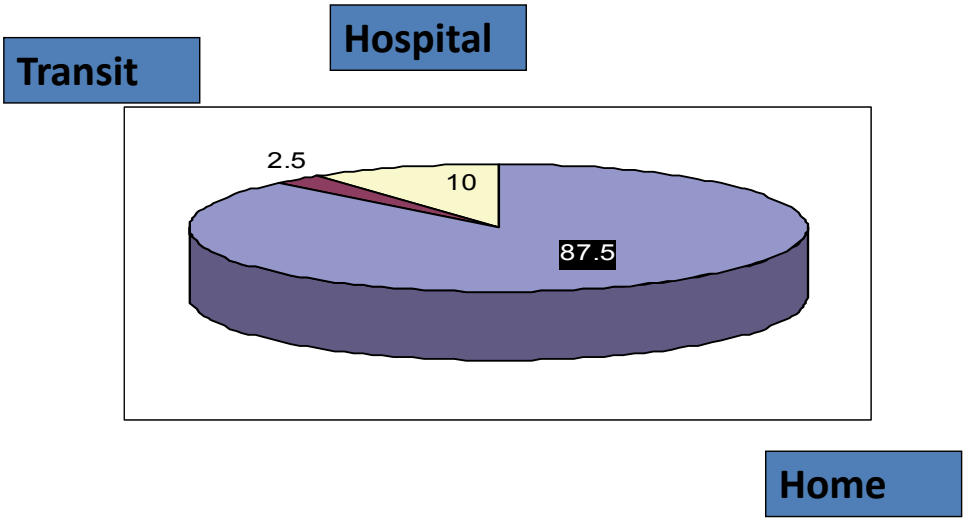
1. Haemorrhage
2. Hypertensive disease of pregnancy in cluding eclar
3. Abortion related
4. Prolonged/obstructed labour
5. Puerperal sepsis
6. Postpartum anaemia causes
7. Embolism
8. Indirect causes

Causes of Maternal Death (n=71)

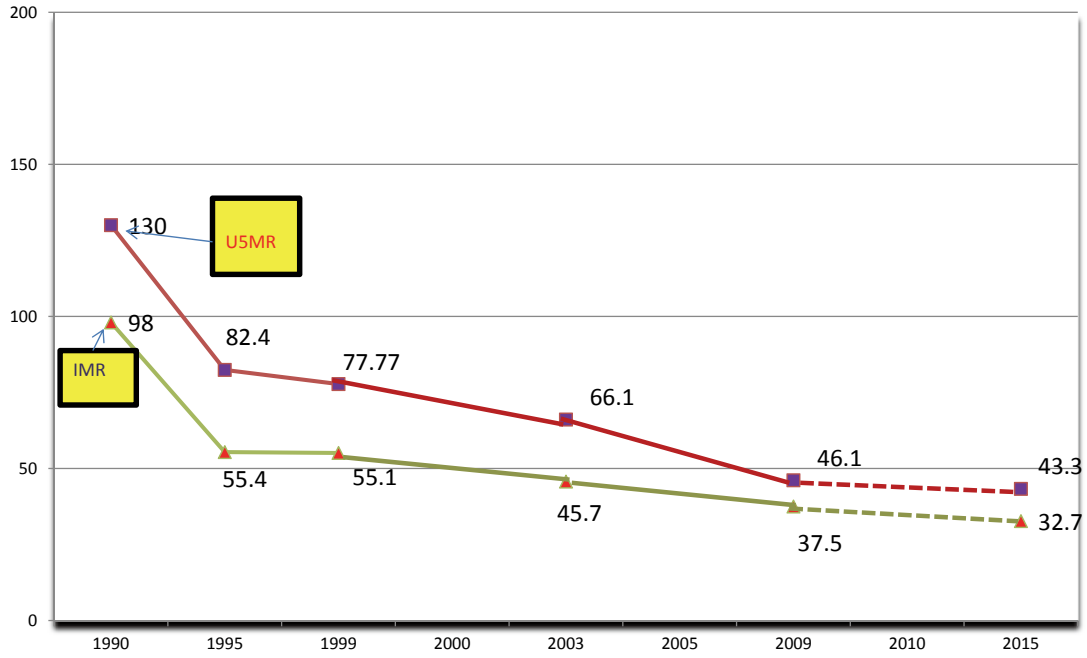
Maternal Mortality by Urban-Rural Residence



Maternal Deaths by Place of Delivery (%)



Infant and under 5 mortality



Source: MICS 2010

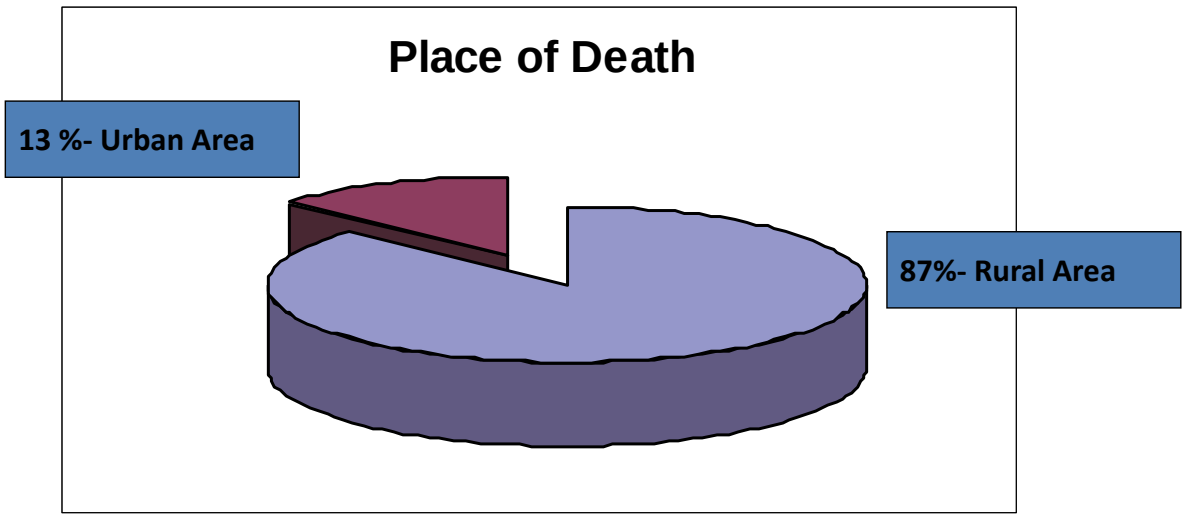
Causes of Death in children under five years age

Causes	Neonates (less than 28 days) in %	Above 28 days and less than 5 years age (%)
Prematurity	30.9	
Birth Asphyxia	24.5	
Sepsis	25.5(include pneumonia)	5.8
Pneumonia		27.6
Diarrhoea		17.6
Brain Infection		17.1
Malaria		7.6
Beri Beri		7.1
Others		17.2

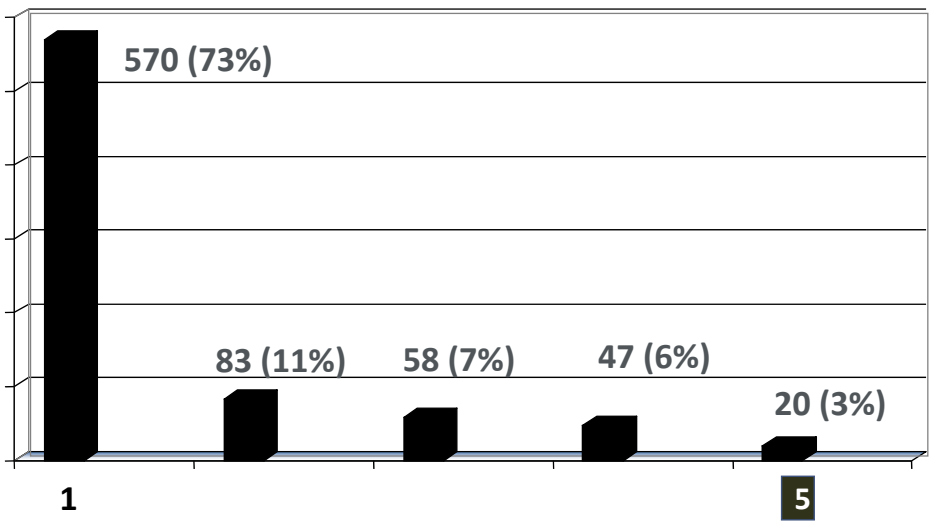
Place of Death (U5MR)

- Disproportionately higher in rural areas

(87%) compared to that of urban areas(13%)

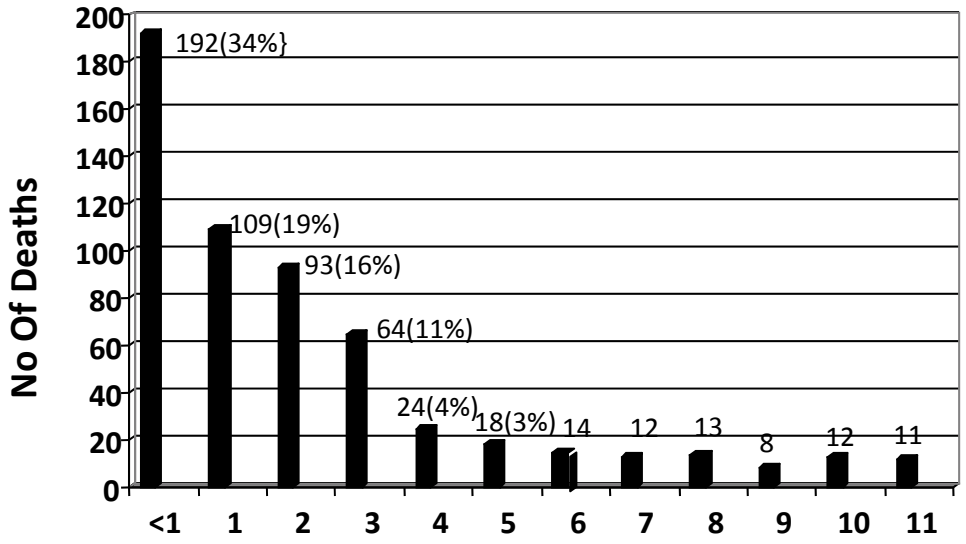


Distribution of Under 5 Deaths By Age (Years)

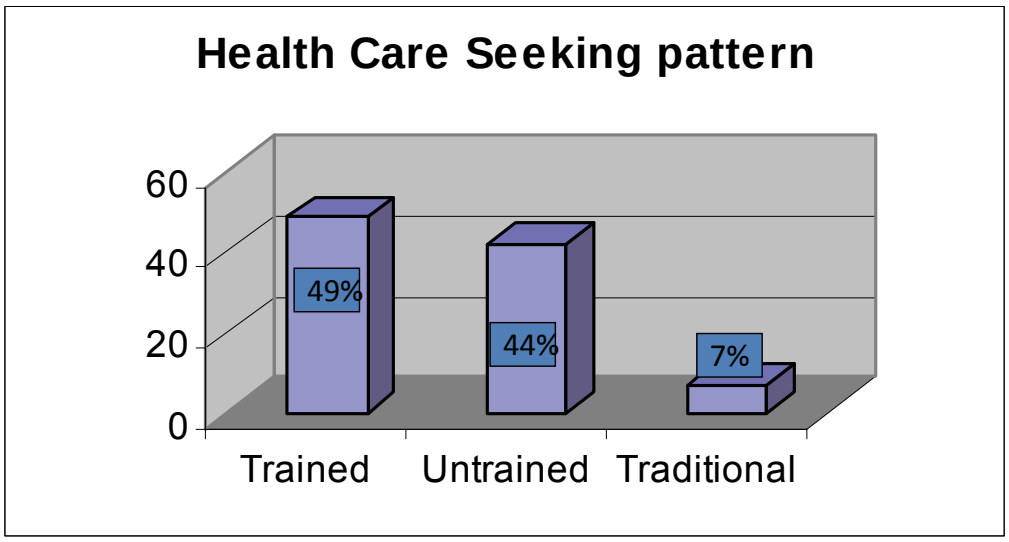


73 % of Death Occurs Under One Year

Distribution of Under 1Year Deaths by Age in Months (n=570)



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



44 % treated with untrained persons before death.

Summary

Main causes of deaths for MMR were

- **PPH**
- **Severe PET or Ecla**
- **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**

MCH activities needed to be strengthened in order to achieve the MDG 4 and 5

- **Providing proper antenatal care**
- **Promoting skilled and institutional delivery and post natal care**
- **Expansion of post abortion care and quality birth spacing services**
- **Ensuring Emergency Obstetric Care**
- **Providing new born care**
- **Strengthening adolescent reproductive health**
- **Promoting male involvement in RH**
- **Focusing cervical cancer screening, early Dx and Tx**
- **Promoting referral system and community volunteers**

Five year Strategic Plan for Child Health Development

- **The continuum of care for the mother and child (life cycle approach)**
- **The continuum of care across the health system (home and community, first-level health facilities and referral facilities)**

Interventions most effective in improving child survival

Intervention	Reduction in under five deaths (%)
Antenatal care	4
Skilled care at birth	13
Postnatal care: routine care for newborns,additional care for LBW, treatment of neonatal sepsis	13
Exclusive breast feeding	13
Appropriate complementary feeding, including micronutrients	6
Immunization	5
Insecticide- treated bednets	7
ORT and zinc for diarrhoea	19
Treatment of suspected pneumonia	6
Treatment of malaria	5

Challenges/Weaknesses

- **Inadequate health workforce at different levels**
- **Over workload of the BHS especially the midwives**
- **Regular and systematic monitoring and supervision mechanism**
- **Reporting status**
- **Harmonization of data and activities**
- **Linkage of health service provision**
- **Geographical and coverage gaps**

Strengths

- **The financial allocation to health sector has been increased – free of charge services/ essential medicines supplies**
- **Decentralization of the authority upon health expenditure at each State/Region according to the bottom up plans**
- **Integration and coordination with other programs bring opportunities for child health development**
- **Health volunteers were trained for community health care services(by government as well as the NGOs/INGOs)**

Countermeasure for Maternal and Child Health and Child Welfare

MYANMAR (2)

Overview of Maternal and Child Health in Myanmar

Department of Food and Drug Administration
Member, MMCWA, Bago Region
Myanmar

Contents

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Objectives

Policy Guidelines

Organization setup

Activities of MMCWA

Output and Indicators

Challenges

Future Plan

Objectives

3

- To carry out operation to achieve its mission with focus on mothers and children;
- To carry out education, health, economic and social activities down to grassroots level and keep it as priority;
- To provide necessary assistance at various levels;
- To cooperate with related governmental and non-governmental organization.

Policy guidelines

4

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

Organizationl Structure

5

Working Committees

6

(i) Working committees for Health Activities

(ii) Working committees for Educational Activities

(iii) Working committees for Economic Activities

(iv) Working committees for Social Activities

(v) Working committees for International Activities

Activities of MMCWA

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A. Health Activities

B. Education Activities

C. Economic Activities

D. Social Acitivities

E. International Relations

A. Health Activities

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1. To carry out activities for health education
2. To carry out community based health activities in collaboration with Department of Health
3. To implement activities for reduction of maternal mortality ration and infant mortality rate through Maternity Homes.
4. To promote capacity building, training of auxiliary midwives and ten-household-in-charge-volunteers.

A. Health Activities

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5. To carry out early detection of female reproductive tract cancer and referral to the nearest health centres for further management.
6. To carry out nutrition promotion activities for "under 5" children.
7. To improve knowledge on indigenous medicine among women and promote practising thereof.

B. Education Activities

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1. To carry out early childhood development programme by establishing community based day-care centres and pre-schools.
2. To ensure all children of school going age complete their primary education.
3. To provide financial aid for formal education.
4. To participate in literacy campaign activities.
5. To promote evening classes and community learning centres.

C. Economic Activities

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1. To provide vocational training courses on sewing, knitting, cooking, etc. appropriate to the respective region in order to generate family income.
2. To carry out Micro credit and small loan scheme.
3. To assist in house-hold agriculture/ livestock breeding.
4. To assist in small scale home industries.
5. To find appropriate job offers for the needy women who want to work.

D. Social Acitivities

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1. To provide assistance to mothers and children with difficulties in health care and education.
2. To assist in activities for safeguarding cultural heritage.
3. To assist in programme for "elderly care".

E. International Relations

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1. Implementation of projects on Health in co-ordination and collaboration with UN agencies and some International Non-government Organizations.
2. PMCT project and EBF Project with UNICEF.
3. RH, ARH and Maternity Waiting Home projects with UNFPA.
4. 5 A' s with IPPF
   Adolescent, AIDS, Abortion, Access, Advocacy
5. Community Based HIV/ AIDS care with NAP/ DOH.
6. Community Based TB care with NTP/DOH.

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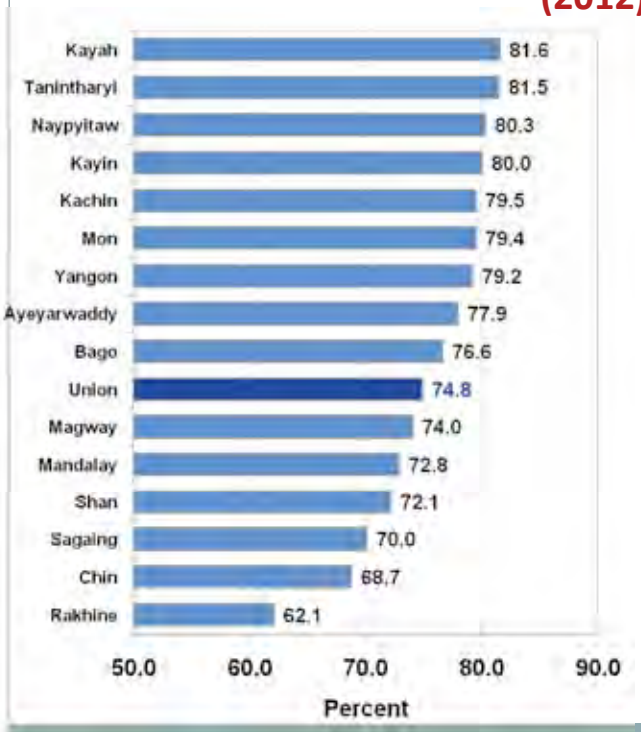
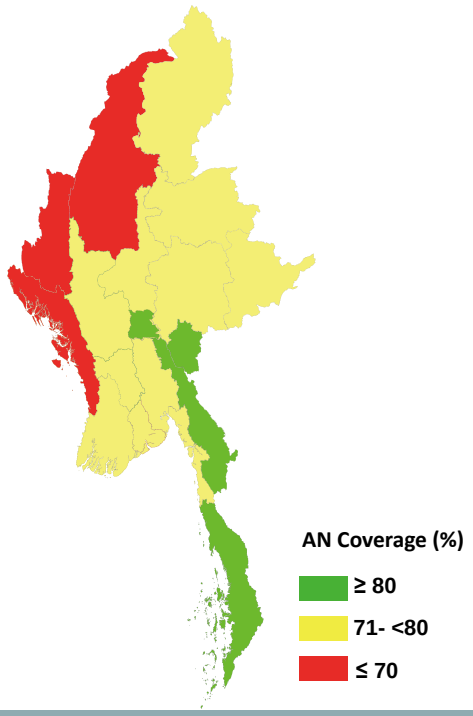
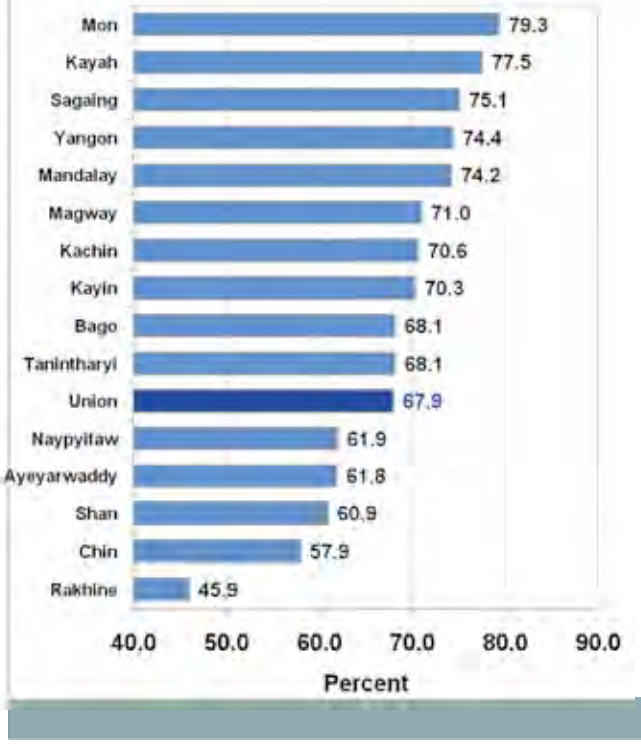
Output and Indicators

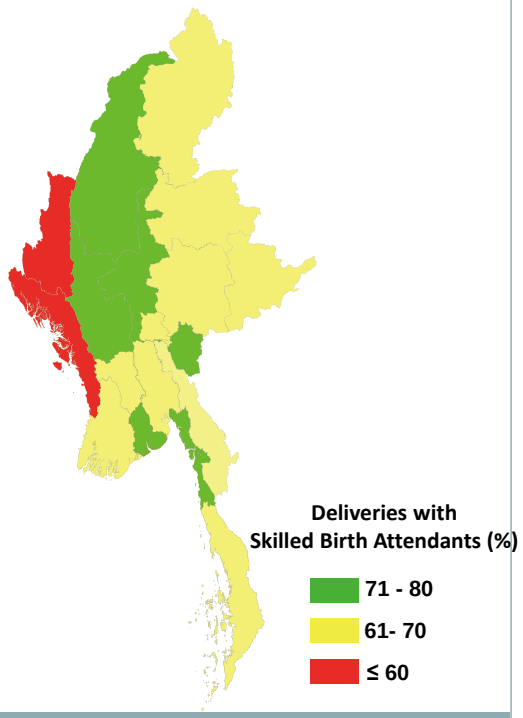
Antenatal Care Coverage (%) (2012)

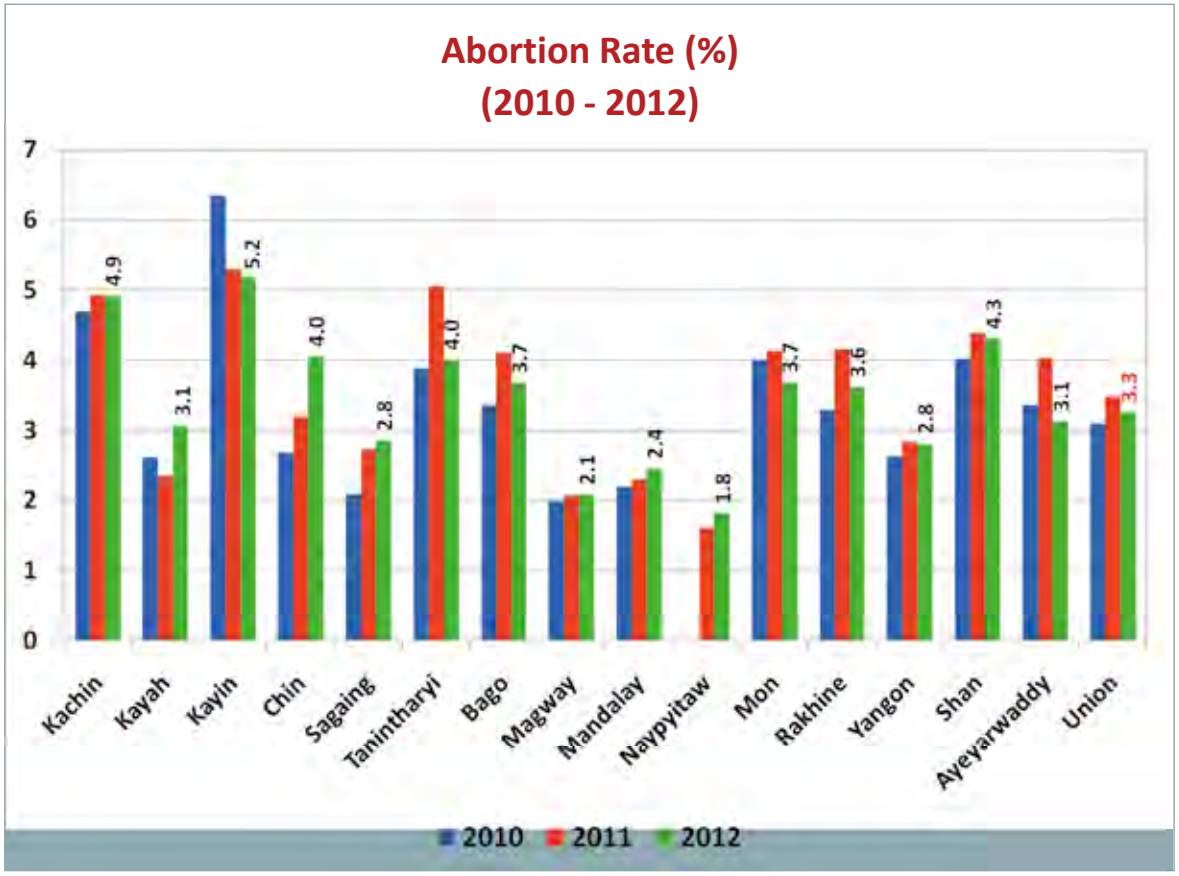


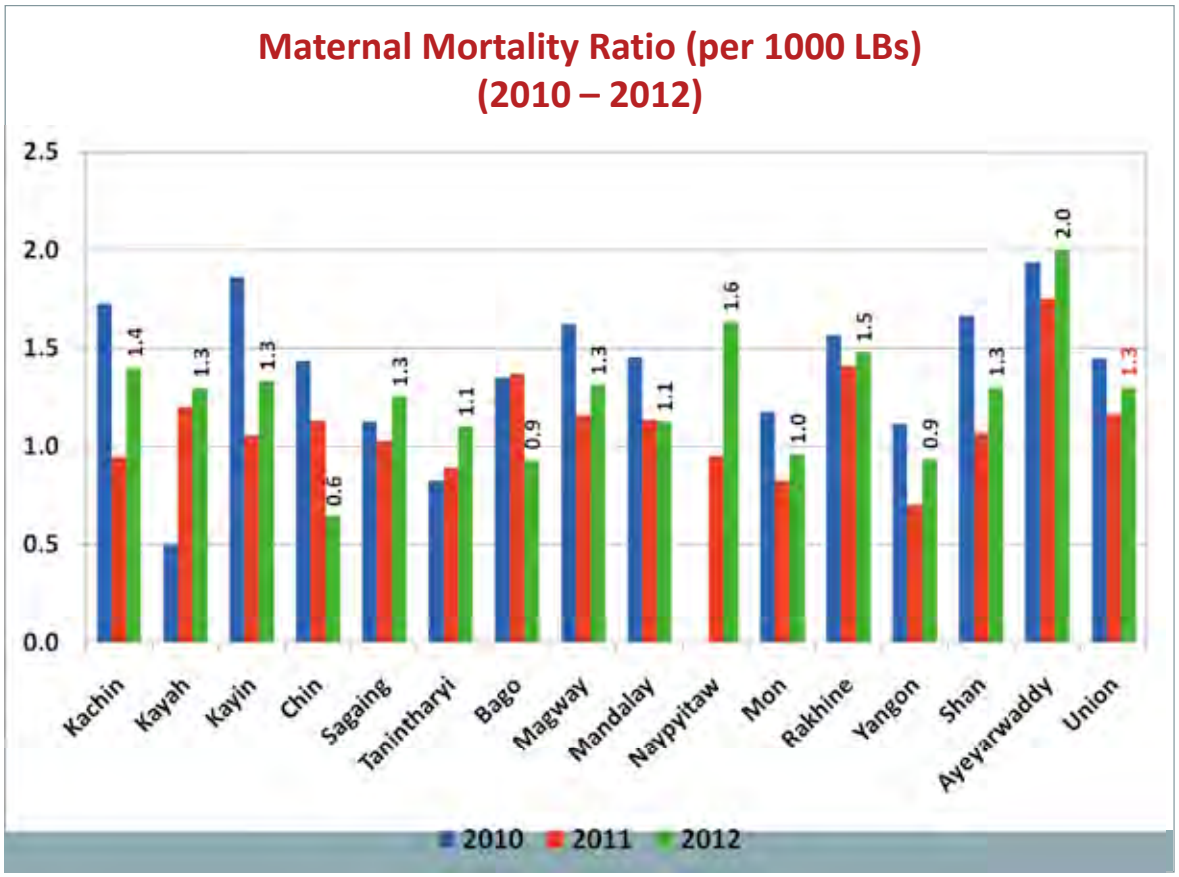


Deliveries with Skilled Birth Attendants (%) (2012)

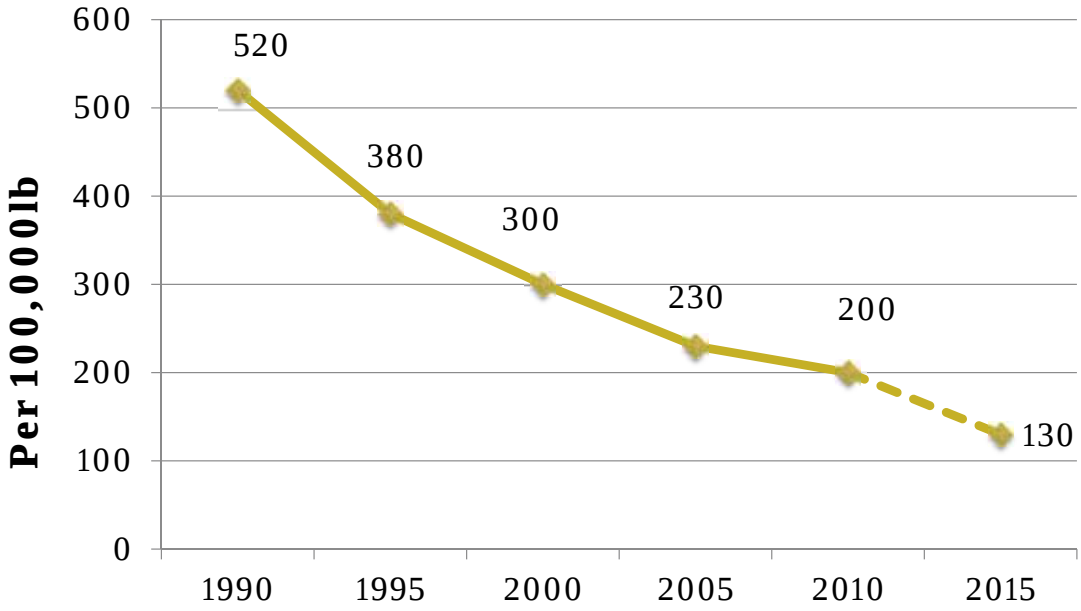





Abortion Rate (%)
(2010 - 2012)
7
6
5
4
3
2
1
0
4.9
3.1
5.2
4.0
2.8
4.0
3.7
2.1
2.4
1.8
3.7
3.6
2.8
4.3
3.1
3.3
Kachin
Kayah
Kayin
Chin
Sagaing
Tanintharyi
Bago
Magway
Mandalay
Naypyitaw
Mon
Rakhine
Yangon
Shan
Ayeyarwaddy
Union
2010
2011
2012

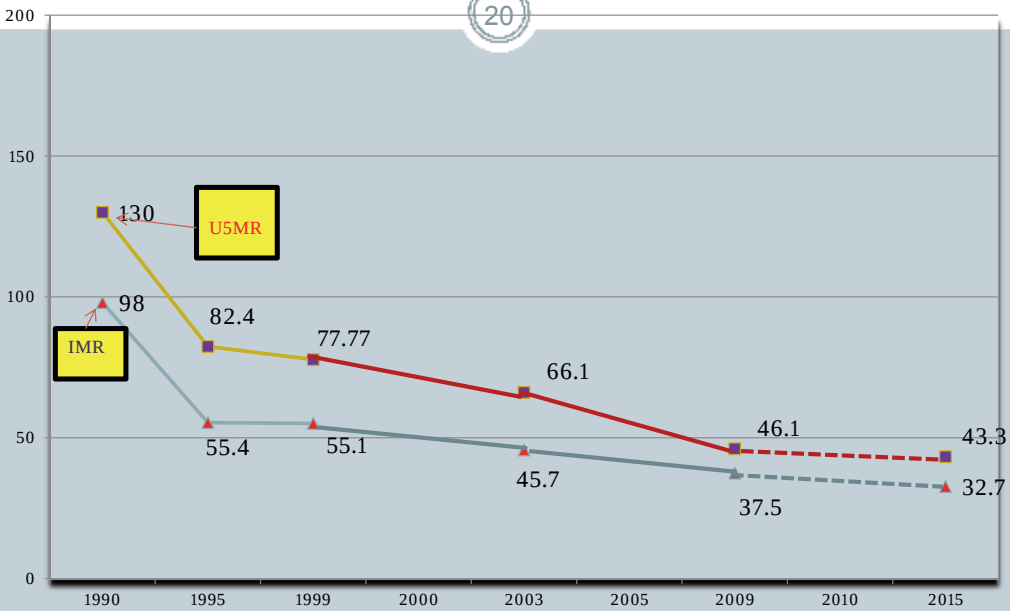

Maternal Mortality Ratio (per 1000 LBs)
(2010 – 2012)
2.5
2.0
1.5
1.0
0.5
0.0
1.4
1.3
1.3
0.6
1.3
1.1
0.9
1.3
1.1
1.6
1.0
1.5
0.9
1.3
2.0
1.3
Kachin
Kayah
Kayin
Chin
Sagaing
Tanintharyi
Bago
Magway
Mandalay
Naypyitaw
Mon
Rakhine
Yangon
Shan
Ayeyarwaddy
Union
2010
2011
2012

Maternal Mortality Ratio in Myanmar



Source: UN interagency estimate, 2010

Infant and under 5 mortality



Source: MICS 2010

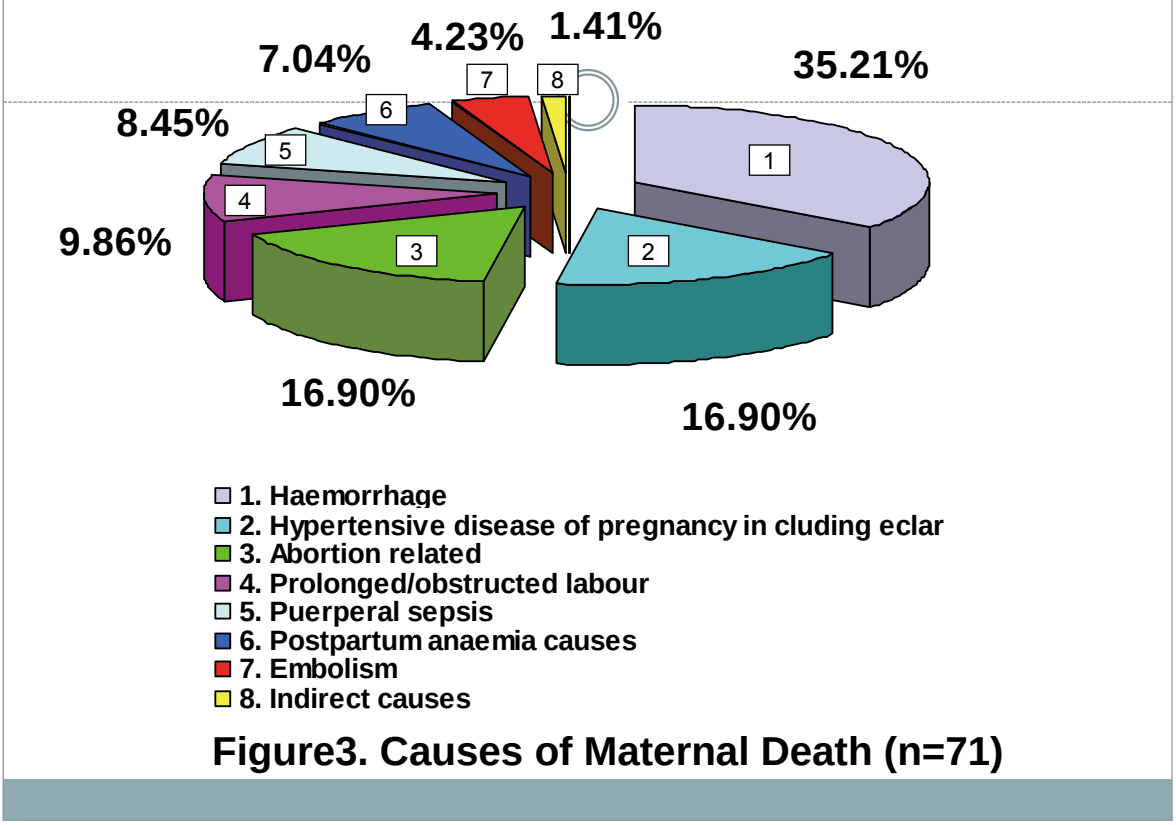
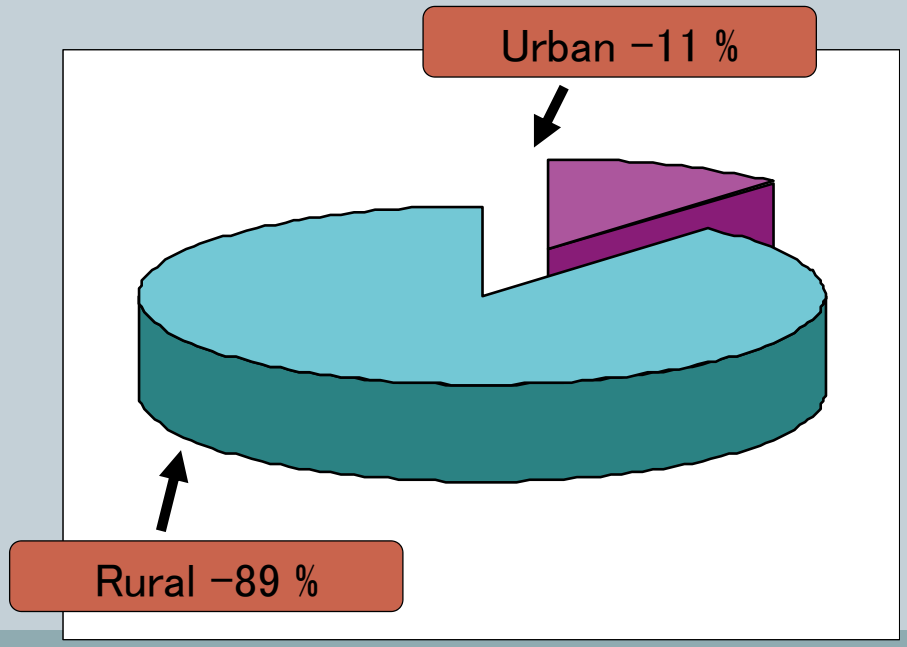


Figure3. Causes of Maternal Death (n=71)

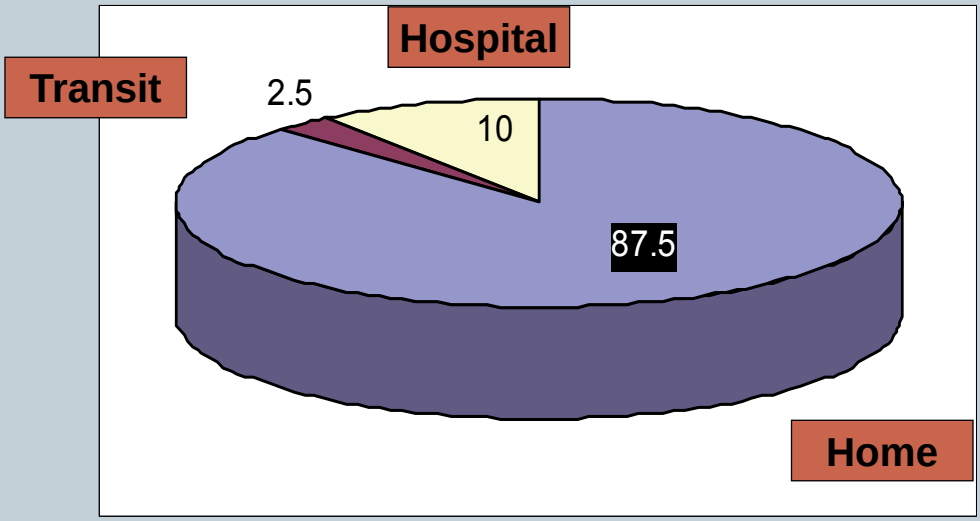
Maternal Mortality by Urban-Rural Residence

22



Maternal Deaths by Place of Delivery (%)

23



U5MR by Region

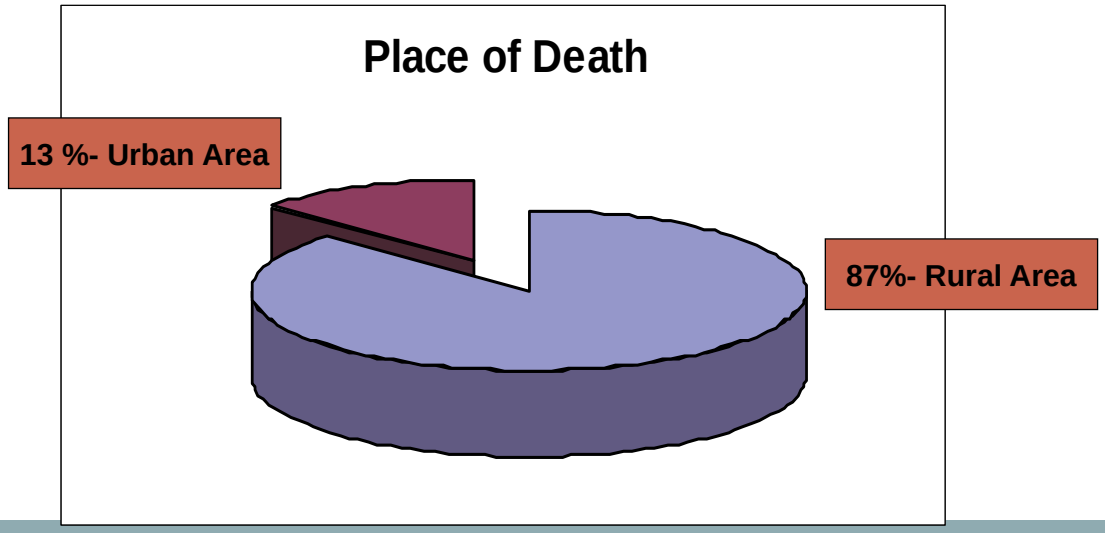
24

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

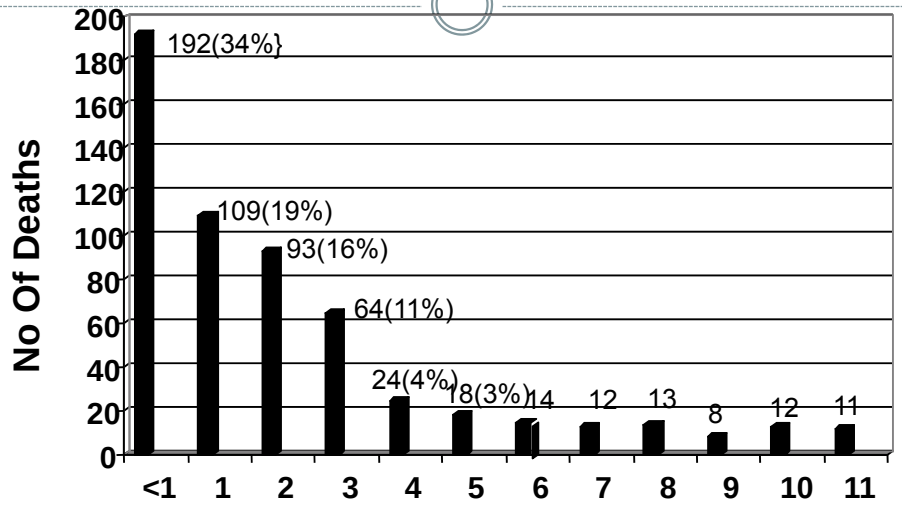
Place of Death (U5MR)

25

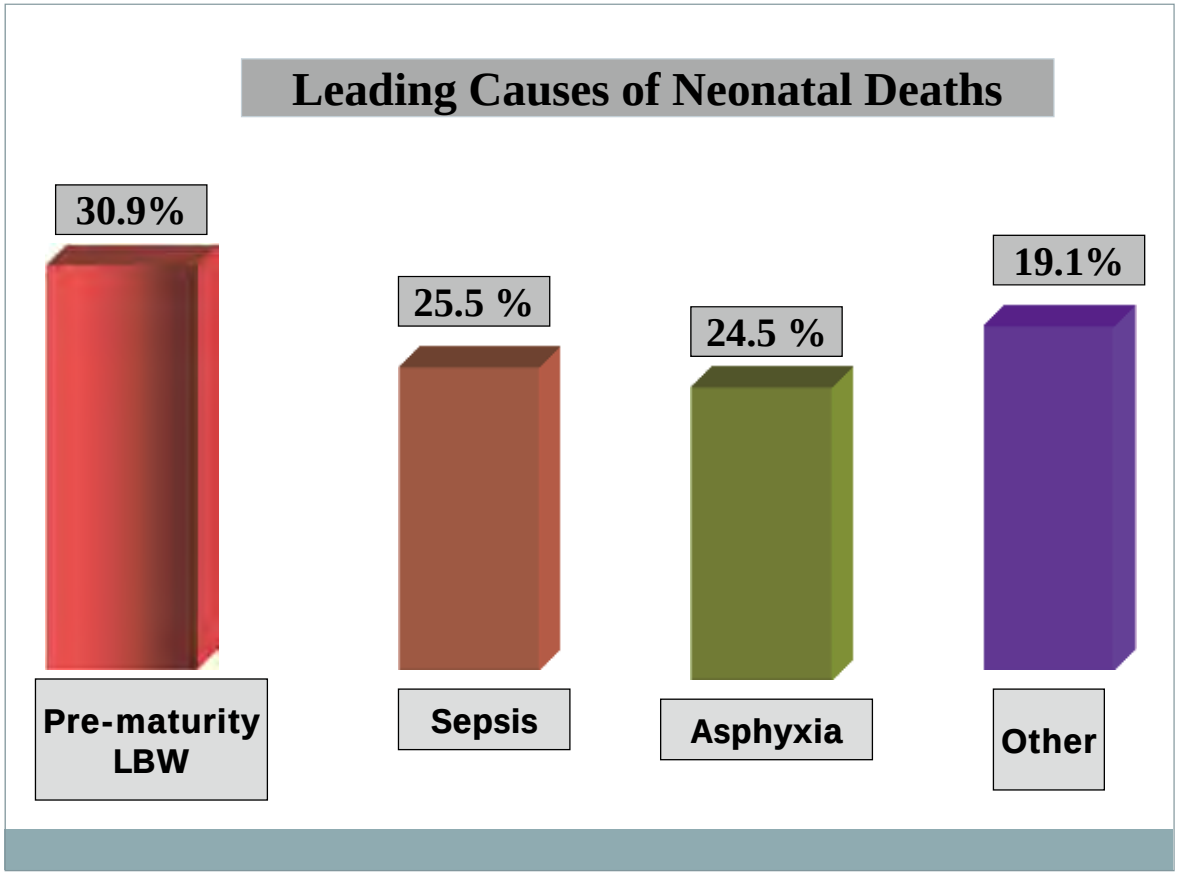
- Disproportionately higher in rural areas (87%) compared to that of urban areas(13%)

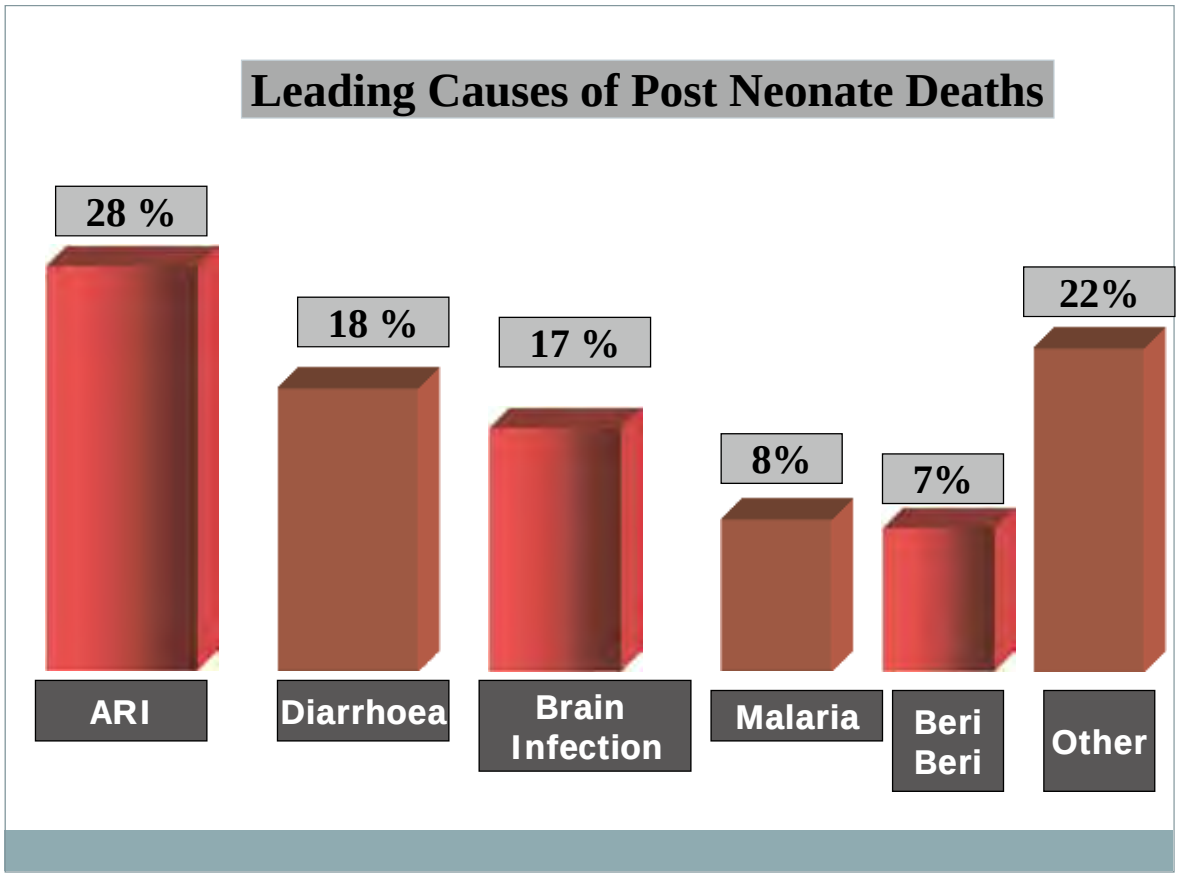


Distribution of Under 1Year Deaths by Age in Months (n=570)

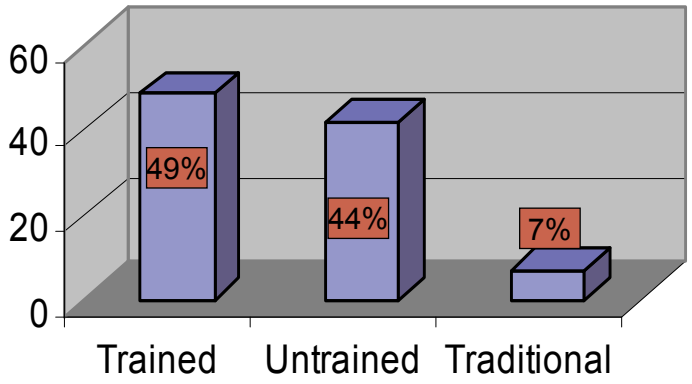


70 % of Death Occurs Under Three Months
34% Death Occurs Under One Month


Leading Causes of Neonatal Deaths
30.9%
25.5 %
24.5 %
19.1%
Pre-maturity LBW
Sepsis
Asphyxia
Other


Leading Causes of Post Neonate Deaths
28 %
18 %
17 %
8%
7%
22%
ARI
Diarrhoea
Brain Infection
Malaria
Beri Beri
Other

Health Care Seeking pattern



44 % treated with untrained persons before death.

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**

30

Challenges

31

- Monitoring and supervision mechanism
- Volunteer work, no regular payment for staffs
- Reporting status
- Not well established infrastructure (Office, communication tools, facilities)
- Health expenditure depends on donor

Future Plan

32

- Health promotion and health education up to suburban and rural area.
- Help for early referral of pregnant mothers, neonate, < 1 and < 5 children to reach hospitals and clinics.
- Training and capacity building of local AMW, Ten household leaders, MCH promoters and MMCWA members
- Infrastructure and facility promotion of labor room of MMCWA.

Future Plan

33

- Reproductive Health promotion.
- Coordination with BHS and Health education dissemination of vaccine preventable diseases.
- Coordination and Cooperation of diseases control activities of TB, Malaria and HIV, AIDS
- Nutrition promotion activities
- Coordination with related department in disaster management
- Environmental sanitation activities

Future Plan

34

- Growing of Herbal medicine plants and giving knowledge to family about traditional medicine
- School health activities for healthy environment of school children
- Health education to parents of pre school children
- Helping every children for primary education
- Micro financing activities
- Social activities
- Awarding of model MMCWA members

Countermeasure for Maternal and Child Health and Child Welfare

THAILAND (1)

Country Report for JICA training course (2015)
"Countermeasure for Maternal and Child Health and Child Welfare"

～Part (A) Indicators～

(1) Crude birth rate (per 1000 population)

	Country overall
1990	19
2000	15
2010	11

Source: http://data.worldbank.org/indicator/SP.DYN.CBRT.IN

(2) Crude death rate (per 1000 population)

	Country overall
1990	6
2000	7
2010	7

Source: http://data.worldbank.org/indicator/SP.DYN.CDRT.IN/countries

(3) Leading causes of death per 100,000 population (1999) and (2009)

1999: 1. NCD 89% 2. CD 6.7% 3. Accident 3.5%
2009: 1. NCD 71.5% 2. Accident 14.7% 3. CD 13.8%

In 2009, the leading causes of deaths by diseases
1) Cerebrovascular disease 28%, 2) cardiovascular disease 16.6%,
3) Diabetes 13.4%, 4) accident 11%, 5) CA liver 11%
Source: Burden of Disease Thailand, 2009 (http://thaibod.net/en/report.html)

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

	Country overall
1990	30
2000	19
2010	13

Source: http://data.worldbank.org/indicator/SP.DYN.IMRT.IN/countries

(5) Leading causes of infants death (2004)

2004: 1) Death during labour 2) Prematurity 3) Birth asphyxia
Source: Ministry of Public health Thailand, 2008

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

	Country overall (WB)	Country overall (MOPH)
1990	37	12.8
2000	23	11.9
2010	15	9.5

Source: WB: http://data.worldbank.org/indicator/SH.DYN.MORT/countries
MOPH: Thailand Health Profile 2009, MOPH, Thailand

(7) Top 3 diseases of the under-5 of (2000), (2005), and (2009)
2000:
Diseases: 1) neonatal causes 2) Infection (diarrhea/pneumonia) 3) HIV
Source: Ministry of Public Health Thailand, 2008
2005:
Diseases: 1) Birth asphyxia 2) Obstetric condition 3) Drowning
Source: Thailand Health Profile, 2009, MOPH, Thailand
2010
Diseases: 1) Infection 2) Obstetric condition and Perinatal deaths 3) Malnutrition
Source: Burden of Disease Thailand, 2009 (http://thaibod.net/en/report.html)

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

	Country overall
1990[1]	42
2000[1]	40
2010[1]	28
2013[2]	26

Source: 1) http://data.worldbank.org/indicator/SH.STA.MMRT/countries
2) http://apps.who.int/gho/data/node.country.country-THA?lang=en

(9) Leading causes of maternal death (2002) and (2007)
2002: 1) Delivery cause 2) maternal disorders predominantly edema, proteinuria, and hypertension in pregnancy 3) Pregnancy with abortive outcomes
2007: 1) Delivery cause 2) other maternal disorders predominantly related to pregnancy (except hypertensive disorders) 3) Pregnancy with abortive outcomes

Source: Health Information Unit, Bureau of Health Policy and Strategy, MOPH Thailand

(10) Are there national standards for certifying disabilities in your country?
Yes / No If yes, please explain briefly.

There are 7 types of disabilities in Thailand

1. Visual Impairment
2. Hearing Impairment
3. Physical Disabilities
4. Psychiatric Disabilities
5. Intellectual Disabilities
6. Learning Disabilities
7. Autism Disorder

Source:Notification of Ministry of Social Development and Human Security, Subject: Classification and measurement on disabilities (issue 2)

(11) Does your country perform any health check for infants and children?
Yes / No If 'Yes', When (at how many months)? -How many times?

For pregnancy woman → at least 5 times, adapted from WHO new ANC guideline

No.	Gestational age	Contents (screening + treatment + parental school)
1	Before 12 weeks	History taking+ PE+ initial lab test
2	18 – 20 weeks	History taking + PE + ultrasound for GA estimation
3	26 weeks	History taking + PE + routine lab
4	32 weeks	History taking + PE + routine lab + 2nd lab test
5	38 weeks	History taking + PE + routine lab + ultrasound

For infant and children

No.	Age
1	1 month (+-7 days)
2	2 months (+-7 days)
3	4 months (+-15 days)
4	6 months (+-15 days)
5	9 months (+-15 days)
6	12 months (+-15 days)
7	18 months (+-1 month)
8	2 years (+-1 month)
9	3 years (+-1 month)
10	4 years (+-1 month)

Thailand has MCH book that covers both records of mothers and children as shown picture.

(12) In the case any diseases or disabilities are confirmed, is there any support

services on them? Describe the services, if any.]

1. National health insurance.
2. Monthly allowance for disabilities 800 Baht/month (2015).
3. Temporary shelter for children and families.
4. Public Health Volunteer System.
5. Social welfare and services within local authority.

Source: Ministry of Public and Ministry of Social Development and Human Security

～Part (B)　Preliminary Analysis～

※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.

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

① Three (3) Strengths in your country / region.
⇒Maternal and Child Welfare：

1) National framework/ agenda/ strategy focusing on MCH welfare

2) Family and Community Support.

3) Re-structure of Welfare Department.

⇒Maternal and Child Health：

1) Benefit package in terms of health care for mothers and children

2) Certified MCH-standard in all public hospitals

3) High coverage of MCH health services

② Three (3) Weaknesses/Challenges in your country / region.
⇒Maternal and Child Welfare：

1) Nuclear family.

2) Single parents.
3) Teenage pregnancy.

⇒Maternal and Child Health：

In terms of MCH issues

1. Low birth weight
2. Lowest rate of exclusive breastfeeding in ASEAN
3. Teenage pregnancy

In terms of Health system

1. Inaccuracy of health management and information system

2. Low public-private partnership and private hospital participated in national program

(2) In your country / region, who are the most vulnerable populations? Please list three (3) groups in order of priority.

1. Low-income people

2. People with disabilities

3. Psychiatric disabilities

(3) What kinds of services are there for the above mentioned groups?

- In terms of health services, those above mentioned groups can access to health care for free under the universal health coverage schemes.
- In terms of social welfare, those people with disabilities will receive monthly allowance 800 bath/person

(4) In implementing health/welfare policies and services by your organization:

By health sectors;

⇒to develop these strengths and improve these weaknesses,

MOPH should work with multi-partner to raise the important of mothers and children at top priority of national agenda. Then, all stakeholders review and implement necessary benefit packages for MCH health as regular.

To improve the weakness, the national authority should review past and current situation in order to find gaps of existing policies and determine the solutions to improve weakness especially how to involve private hospitals to take part in national program.

⇒to develop the services for the most vulnerable populations,

Thailand has universal health coverage scheme which covers all people who are not covered by civil servant medical schemes and social security scheme. So, all low-income people could access to health services for free especially maternal and child health care in public hospitals wherever they live.

What should be developed is the quality of health care. All people should receive good care regardless of their abilities to pay and the type of health care facilities. The MOPH tries to set standard and guidelines and also monitoring system to monitor health services delivered by health care facilities.

(5) In your country/province, what are the priority issues/programmes in the area

of maternal and child health/welfare? List five issues/programmes in order of priority.

1. Prevention and protection on teenage pregnancy.
2. Improve child rearing practices and increase child development
3. Surrogate mother issue.
4. Temporary shelter for children and families.
5. Child protection system.

(6) What are successful areas or programmes? List 3 areas or programmes.
In terms of health;

1. Prevention of Mother-to-Child HIV transmission
2. Certified MCH-standard in all public hospitals
3. MCH handbook

(7) What are these challenges? List 3 challenges.
In terms of health;

1. Low birth weight
2. Low exclusive breastfeeding
3. Teenage pregnancy.

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

For Low birth weight, LBW, (less than 2500 gram at birth), it is one of major public health problem which causes morbidity and mortality in infant and children in Thailand. It also affects child development in early childhood. Currently, the rate of LBW infant is around 10.9% in 2011 (National Health Security Office, 2011) and show no signs to decreased. To solve the problem, it is necessary to 1) improve maternal nutritional status and 2) improve the quality of antenatal cares. As there are many factors related to maternal nutritional status especially social determinants of health and social welfare, that is why this problem is difficult to solve.

For breastfeeding issues, the MICS 4 surveyed in 2012 showed that only 12% of mothers exclusively breastfed their children. This is the lowest rate of EBF among ASEAN countries which is really need to be improved. From national research, the main reasons why mother discontinue breastfeeding are 1) returning to works, 2) misunderstanding and improper attitudes towards breastfeeding and 3) lack of supports. The challenge for this problem is how to raise awareness of other sectors on the important of breastfeeding and seek their cooperation in order to build enabling environment for promoting breastfeeding practices, for example, how to deal with the labor sector to increase maternity leave to 6 months, how to deal with the company to control their advertisement about infant formula.

(9) Describe your expectations to the training course.

1. To learn how to integrate Child welfare to maternal and child health

2. To learn the best practices and experiences from Japan and other countries
   2.1 The Japanese health and welfare programmes for MCH on
      2.1.1 The MCH book
      2.1.2 The promotion of breastfeeding in Japan
      2.1.3 How to promote reading culture for children in Japan
      2.1.4 MCH major health problems and how to solve it.
3. to share my experiences and views on maternal and child health in Thailand

THAILAND
(2)

Country Reportfor JICA training course (2015)
“Countermeasure for Maternal and Child Health and Child Welfare”

～Part (A)　Indicators～

(1) Crude birth rate (per 1000 population)

	Country overall
1990	19
2000	15
2010	11

Source: http://data.worldbank.org/indicator/SP.DYN.CBRT.IN

(2) Crude death rate (per 1000 population)

	Country overall
1990	6
2000	7
2010	7

Source: http://data.worldbank.org/indicator/SP.DYN.CDRT.IN/countries

(3) Leading causes of death (1990) and (2009)

1990: 1.	2.	3.
2006: 1. Cancer 83.1	2. Accident 59.8	3. Heart Disease 28.4
2010: 1. Cancer 91.2	2. Accident 51.6	3. Hypertension 31.4

Leading Cause of Death per 100,000 Population

Source: Public Health Statistics 2010, Thailand

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

	Country overall
1990	30
2000	19
2010	13

Source: http://data.worldbank.org/indicator/SP.DYN.IMRT.IN/countries

(5) Leading causes of infants death (1990) and (2009)

1990: 1) 2) 3)
2010: 1) 2) 3)

Source:

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

	Country overall
1990	37
2000	23
2010	15

Source: http://data.worldbank.org/indicator/SH.DYN.MORT/countries

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

1990:
Diseases: 1) 2) 3)
Morbidity rate: 1) 2) 3)

2010:
Diseases: 1) 2) 3)
Morbidity rate: 1) 2) 3)

Source:

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

	Country overall
1990	42
2000	40
2010	28

Source: http://data.worldbank.org/indicator/SH.STA.MMRT/countries

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

1990: 1) 2) 3)
2010: 1) 2) 3)

Source:

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

If yes, please explain briefly.

There are 7 types of disabilities in Thailand

1. Visual Impairment
2. Hearing Impairment
3. Physical Disabilities
4. Psychiatric Disabilities
5. Intellectual Disabilities
6. Learning Disabilities
7. Autism Disorder

Source: Notification of Ministry of Social Development and Human Security, Subject: Classification and measurement on disabilities (issue 2)

(11) Does your country perform any health check for infants and children?
Yes / No

If 'Yes',

-When (at how many months)? -How many times?

No.	Gestational age
1	12 weeks
2	18 weeks
3	26 weeks
4	32 weeks
5	38 weeks

No.	Baby age
1	1 month (+-7 days)
2	2 months (+-7 days)
3	4 months (+-15 days)
4	6 months (+-15 days)
5	9 months (+-15 days)
6	12 months (+-15 days)
7	18 months (+-1 month)
8	2 years (+-1 month)
9	3 years (+-1 month)
10	4 years (+-1 month)

-What kinds of contents includes in each?

Part 1 a memo for mother.

Part 2 a memo for agent.

Part 3 the knowledge of pregnancy for husband to read and support.

Part 4 the knowledge of baby development for parent and care taker to read and follow the instruction.

Source: Mother and Child Health Book

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

1. National health insurance.
2. Monthly allowance for disabilities 800 Baht/month (2015).
3. Temporary shelter for children and families.
4. Public Health Volunteer System.
5. Social welfare and services within local authority.

Source: Ministry of Public and Ministry of Social Development and Human Security

～Part (B)　Preliminary Analysis～

※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.

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

① Three (3) Strengths in your country / region.
⇒Maternal and Child Welfare：

1. Family and Community Support.

2. Social network and Social media.

3. Re-structure of Welfare Department.

⇒Maternal and Child Health：

1. Public Health Volunteer System.

2. National Health Security Office (NHSO).

3. Mother and Baby Book.

② Three (3) Weaknesses/Challenges in your country / region.
⇒Maternal and Child Welfare：

1. Nuclear family.

2. Single parents.

3. Teenage pregnancy.

⇒Maternal and Child Health：

1. Minimum standard for health insurance (not appropriate).

2. Limitation of health services in rural areas.

3. Inadequate ratio of doctor and nurse.

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?

   1. Mothers and children with HIV.

   2. Terminal patient.

   3. Psychiatric disabilities.

3. What kinds of services are there for the above mentioned groups?

   There are lack of shelter and variety of services for the above mentioned groups.

4. In implementing health/welfare policies and services by your organization:
   ⇒to develop these strengths and improve these weaknesses,
   ⇒to develop the services for the most vulnerable populations,

   ①In your country/province, what are the priority issues/programmes in the area of maternal and child health/welfare? List five issues/programmes in order of priority.

   1. Prevention and protection on teenage pregnancy.
   2. Surrogate mother issue.
   3. Temporary shelter for children and families.
   4. Child protection system.
   5. Maternal and child health insurance.

   ②What are successful areas or programmes? List 3 areas or programmes.

   1. Public Health Volunteer System
   2. National Health Security Office (NHSO).
   3. Re-structure of Welfare Department.

   ②What are these challenges? List 3 challenges.
   1. Teenage pregnancy.
   2. Social worker license.
   3. Educational system.

   ③Regarding the above-mentioned issues/challenges, explain background, current situation and reason why those issues/challenges are difficult to solve.

   According to my own experience, I found that there are limitation of shelter and services for HIV mothers and children. Moreover, the government have not set up the specific shelter or welfare service for this needy group.

④Describe your expectations to the training course.

1. To understand more about Maternal and Child Health (MCH)
2. To share an experience with other participants
3. To improve our work on MCH in temporary shelter

Countermeasure for Maternal and
Child Health and Child Welfare

TIMOR - LESTE

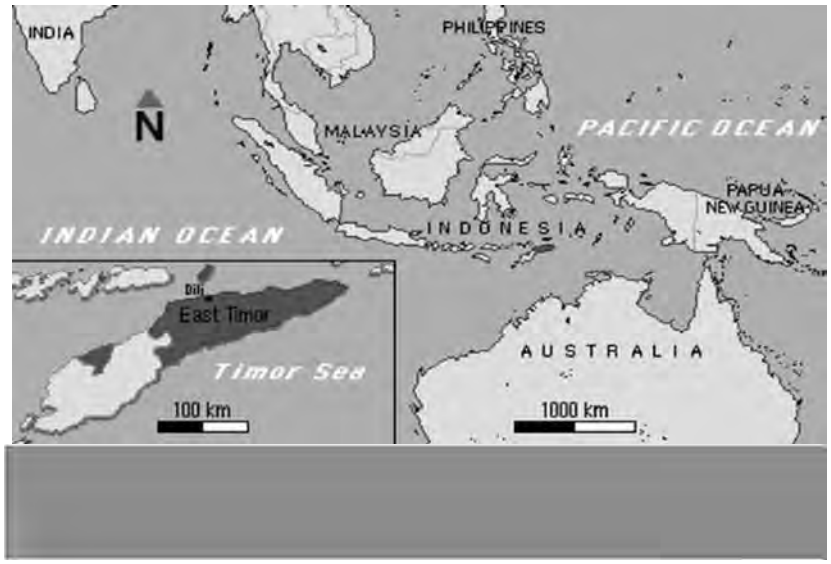
Country Report JICA Training Course on: "Countermeasure for Maternal Child Health and Child Welfare-2015"

(Timor Leste Representative)

COUNTRY PROFILE

A. BACKGROUND

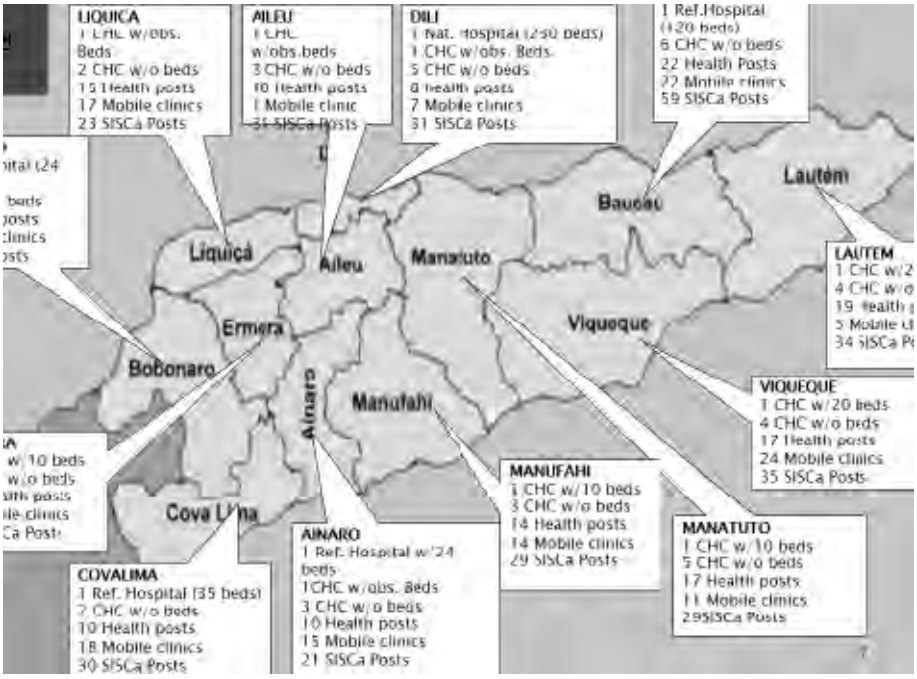
Timor-Leste is a small country in Southeast Asia. It occupies primarily the eastern half of the island of Timor, with West Timor being part of the Republic of Indonesia. Timor-Leste includes the nearby islands of Ataúro and Jaco, and also Oecussi, an exclave in Indonesian West Timor. The first inhabitants are thought to be descended from Australoid and Melanesian people.



Contact between the Portuguese and the island of Timor began in the early 16th century, with trade and eventual colonization occurring in the middle of the century. In 1859, the western portion of the island was ceded to the Dutch. During World War II, Japan occupied Timor-Leste from 1942 to 1945. Portugal resumed colonial authority after the Japanese defeat in 1945. The country declared independence from Portuguese rule on November 28, 1975, but was invaded and occupied by Indonesian forces just nine days later on December 7, 1975. It was incorporated into Indonesia in July 1976 as a province known as Timor-Timur. Between 1974 and 1999, there were an estimated 102,800 conflict-related deaths (approximately 18,600 killings and 84,200 “excess” deaths from hunger and illness), the majority of which occurred during the Indonesian occupation (UNESCO, 2009).

The local climate is tropical and generally hot and humid, characterized by distinct rainy and dry seasons. Timor-Leste is divided into 13 administrative districts (now is known as Municipio), 65 sub-districts, and 442 Sucos and 2,225 aldeias. The 13 districts/municipio are

Ainaro, Alieu, Baucau, Bobonaro, Covalima, Dili, Ermera, Lautem, Liquiçá, Manatuto, Manufahi, Oecussi, and Viqueque. Thirty percent of the population lives in the urban areas, and the rest live in rural areas (NSD, 2010). Dili is the capital. It is the largest city and the main port. The second-largest city is the eastern town of Baucau. Dili has the only functioning international airport, though there is also an airstrip in Baucau that is used for domestic flights. Several languages are spoken in the country. Tetum is the most common language in Timor- Leste and is the first official national language. Portuguese, spoken by fewer people, is the other official language. English and Indonesian are working languages.



Despite having Natural oil and gases, agriculture and fishery are the backbone of the Timorese economy, and coffee plantations have been of major significance. The 2007 Timor-Leste Survey of Living Standards reported that nearly 50 percent of the Timorese lived below the national poverty line, estimated at $0.88 per capita per day. Based on a recent survey-to-survey imputation calculation, the incidence of poverty in the country is predicted to have declined by 9 percentage points between 2007 and 2009 (MOF, 2010). Timor-Leste's Human Development Index for 2010 is 0.502—positioning the country at 120 out of 169 countries and areas (UNDP, 2010). This is an increase of 17 percent from 0.428 in 2005. During the same period, Timor- Leste's life expectancy at birth increased by over 2 years.

According to the 2004 Census, the population of Timor-Leste is 923,198 and the annual growth rate is 5.3 percent (NSD, 2006). The population increased by 24 percent over the last 15 years, growing from 747,547 in 1990 to 923,198 in 2004 (NSD, 2006). The population is currently estimated at 1,066,582 with an annual growth rate of 2.4 percent between the 2004 Census and the 2010 Census (NSD, 2010). According to the 2004 Census, life expectancy was estimated at 59 years, and increased to 62 years according to the 2010 Census.

B. HEALTH SYSTEM PROFILE

1. VISION

The Timor-Leste MOH recognises that health is influenced by a variety of determinants - education, income, housing, food, water and sanitation being among the more significant of these. With this broad understanding of health, the Ministry's vision is for a:

"Healthy East Timorese people in a healthy East Timor"

The MOH envisages a Timorese community enjoying a level of health that allows people to develop to their potential within a healthy environment. The vision is achievable only through multi-sectoral efforts. The vision also reflects a fundamental aim to reduce poverty to a point where all Timorese are sufficiently endowed to cover basic needs. The Ministry believes that only a healthy community is able to achieve poverty alleviation.

2. MISSION

Consistent with its vision statement, the MOH is committed to:

- Ensuring available, accessible and affordable health services for all Timorese people
- Regulating the health sector
- Promoting community and broad-based stakeholder participation

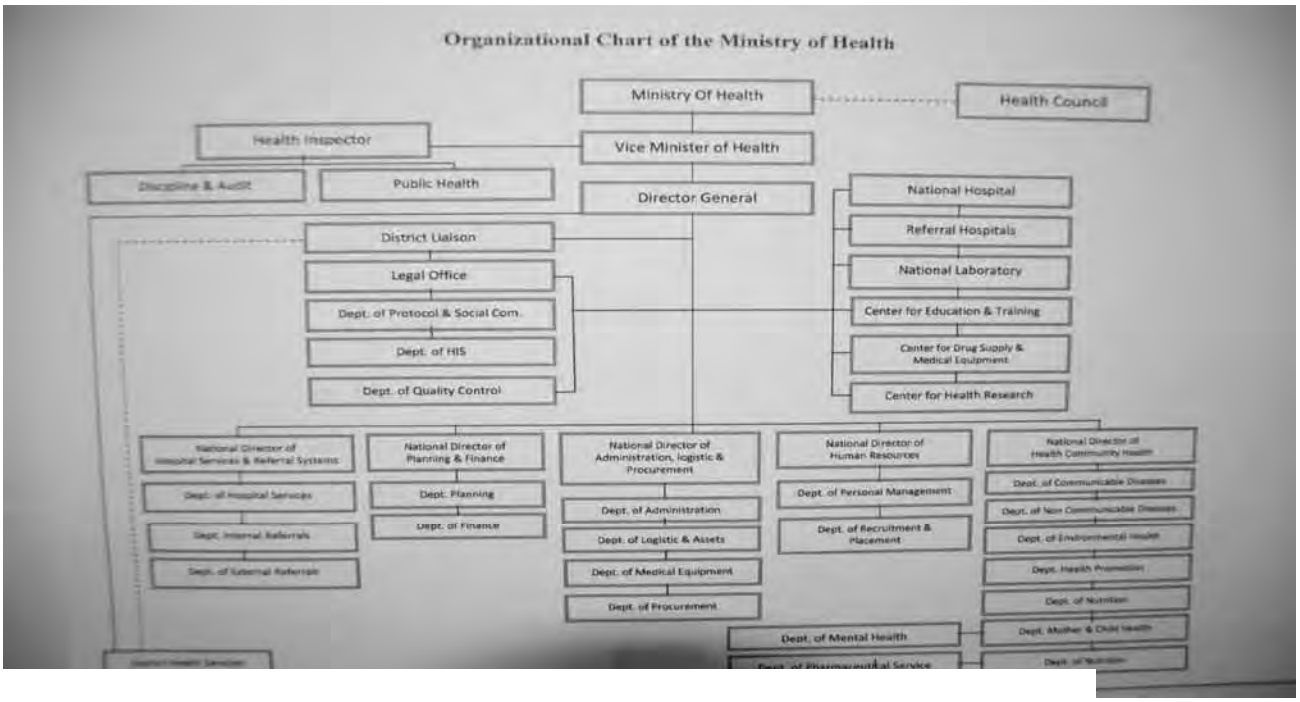
The table below shows recent Timor Leste key Health indicators that was compiled by UNICEF in 2013 as follow:

INDICATORS	VALUE	INDICATORS	VALUE
Population		**Nutrition Indicator**	
Population (thousands) 2011, total	1 154	Low birth weight (%), 2007-2011	12
Population (thousands) 2011, under 18	616	Early initiation of breastfeeding (%), 2007-2011	82
Population (thousands) 2011, under 5	201	Exclusive breastfeeding (%), 2007-2011	52
Population annual growth rate (%), 1990-2011	2	Underweight (%), 2007-2011, moderate	30
Population annual growth rate (%), 2011-2030	3	Underweight (%), 2007-2011, severe	15
Population live below the poverty line (%), 2007	50	Stunting (%), 2007-2011, moderate and severe	58
Human development index, 2011	0.495	Wasting (%), 2007-2011, moderate and severe	19

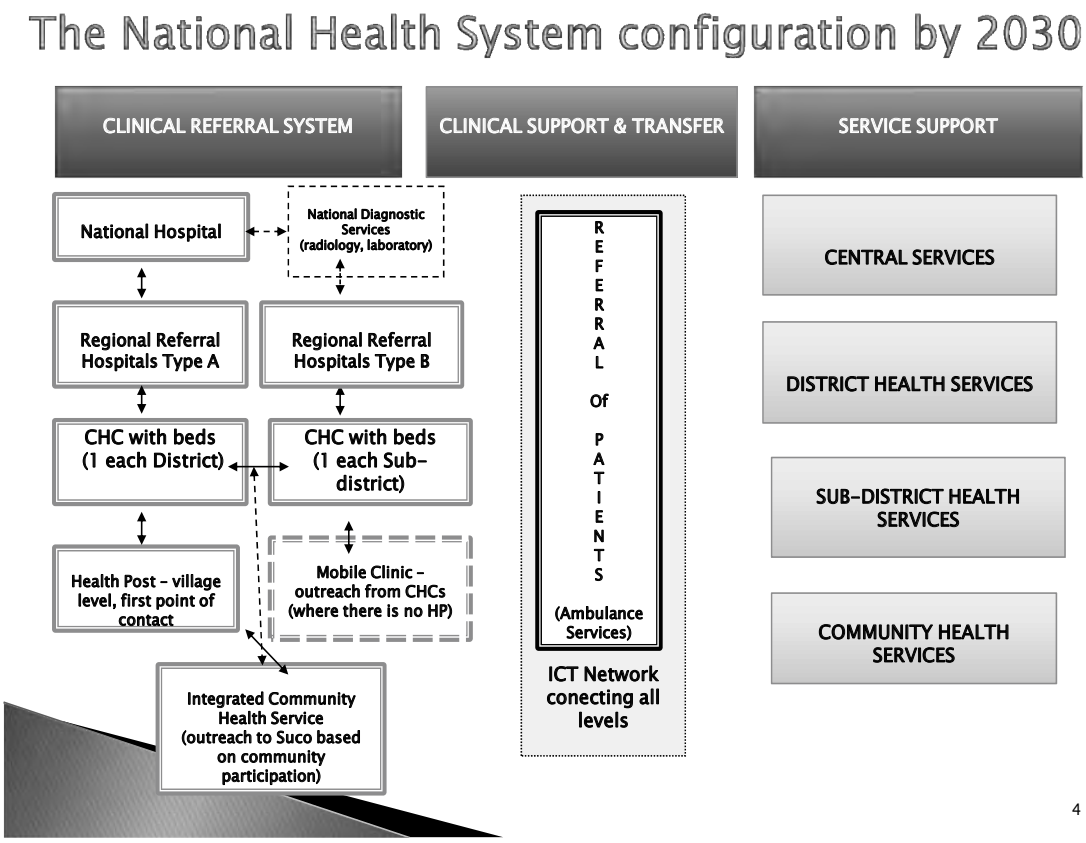
Population live in urban areas (%)	30	Vit A supplementation (%), 2011	59
Number of districts	13	**Immunization**	
Number of sub-districts	66	Immunization coverage (%), 2011, BCG	68
Number of villages (*sucos*)	442	Immunization coverage (%), 2011, DPT1	69
Number of hamlets (*aldeias*)	2225	Immunization coverage (%), 2011, DPT3	67
Basic Indicators		Immunization coverage (%), 2011, Polio3	**66**
Crude death rate, 2011	8	Immunization coverage (%), 2011, HepB3	67
Crude birth rate, 2011	38	Immunization coverage (%), 2011, newborns protected against tetanus	81
Life expectancy, 2011	62	Immunization coverage (%), 2011, MCV	62
Total fertility rate, 2011	6	**Treatment of common childhood illnesses**	
Under-5 mortality rate, 2011(per 1000 live births)	54	Pneumonia (%), 2007-2012, antibiotic treatment	45
Infant mortality rate, 2011(per 1000 live births)	46	Diarrhea (%), 2007-2012, treatment with ORS	71
Neonatal mortality rate, 2011(per 1000 live births)	24	Malaria (%), 2007-2012, anti-malarial treatment among febrile children	6
Annual number of births (thousands), 2011	44	Malaria (%), 2007-2012, children sleeping under ITNs	42
GNI per capita (USD), 2011	2730	Malaria (%), 2007-2012, households with at least 1 ITN	42
Primary school net enrollment (%), 2008-2011	83	**Most populated districts – population projection, 2012, MoH*)**	
CPR (%), 2007-20012	22	Dili	266 236
ANC coverage at least one visit (%), 2007-2012	84	Ermera	124 687
ANC coverage at least four visits (%),	55	Baucau	116 934

2007-2012			
Coverage of skilled care at birth (%), 2007-2012	29	Bobonaro	96 271
Coverage of facility delivery (%), 2007-2012	22	Viqueque	72 797
C-section rate	2	Oecussi	68 655
MMR (per 100 000 live births), DHS 2009-2010	557	Liquica	67 831

Source: UNICEF. At a glance: Timor-Leste, 2013.



Current Health System Organization (2012-2013)



Future Health System by 2030

C. MATERNAL HEALTH

Traditional beliefs and practices around childbearing and child rearing are very strong in Timor-Leste. A high number of maternal deaths have been documented. Furthermore, the absence of a basic health service infrastructure, which was destroyed during the Indonesian withdrawal in 1999, has compromised health services for women and children. Since then, Timor-Leste has set health as its national priority, yet gaps persist in the availability of strong and sustained community- wide health promotion strategies (WHO Timor-Leste, 2004). Due to the above challenges, The National Strategic Development Plan 2011-2030 was then developed and clearly stated that the Government of Timor-Leste's (GoTL) commitment towards improving maternal and child health programs by emphasizing the following: "*To further improve maternal health in Timor-Leste, we will increase access to high quality pre-natal, delivery, post-natal and family planning health services so that by 2015, 70% of pregnant women will receive antenatal care at least four times and 65% of women will have an assisted delivery. We will improve emergency obstetric care through the recognition, early detection and management of obstetric complications at the community and referral level. We will strengthen adolescent reproductive health services and we will empower individuals, families and the community to contribute to the improvement of maternal care and reproductive health services. We will also improve data collection and analysis in relation to maternal health services*." This has further elaborated in the National Health Sector Strategic Plan 2011-2030 and the National Reproductive Health Strategy 2004-2015. The Reproductive Health Strategy promotes a rights-based approach in all reproductive health (RH) services with the following stated objectives.

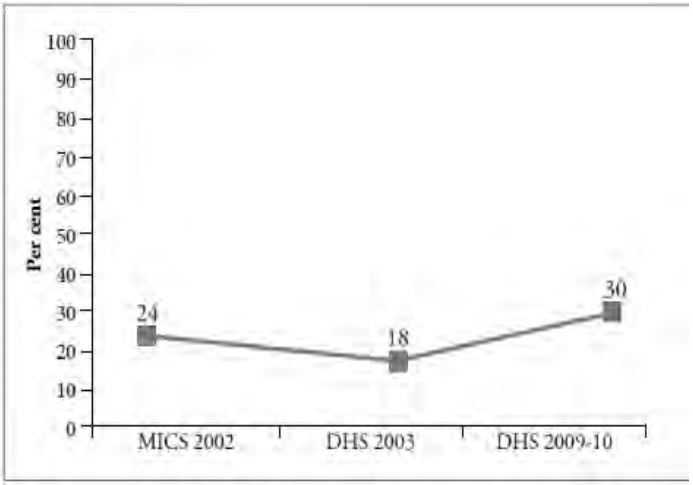
- *To substantially increase the level of knowledge in the general population on issues related to RH.*
- *To promote family planning to stabilize population growth rate and reduce the incidence of unintended, unwanted and mistimed pregnancies.*
- *To ensure that all women and men have access to basic RH services, health promotion and information on issues related to reproduction.*
- *To reduce the level of maternal mortality and morbidity.*
- *To reduce the level of prenatal and neonatal mortality and morbidity.*
- *To reduce the burden of sexually transmitted infections and HIV.*
- *To meet changing RH needs over the life cycle and to improve the health status of reproductive-age people.*

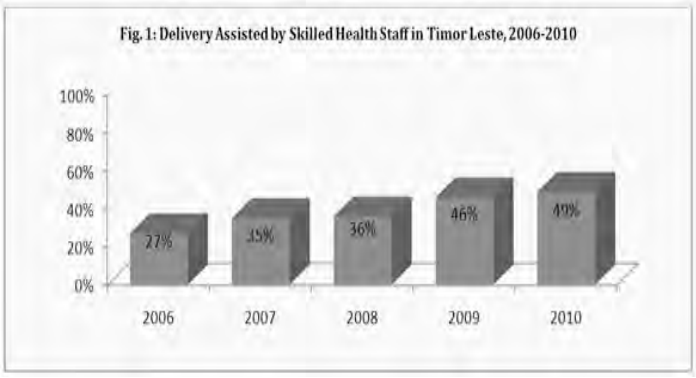
As further elaborated in 2010 a *Declaration for Affirmative Action to Reduce Maternal and Child Death, Birth Rate and Teenage Pregnancy* was adopted to affirm the right to every Timorese to access sexual, maternal and Reproductive Health information and services that are affordable, good quality, culturally sensitive and gender responsive. It pledged the following visions:[1]

- *No Timorese mother will die needlessly from pregnancy and childbirth.*
- *No Timorese baby will die needlessly before, during and after birth.*
- *No Timorese young woman will lose her place in school because of unplanned pregnancy.*
- *All Timorese people – men, women and young people – shall have access to correct and complete information and quality services to ensure their full maternal and SRH rights.*

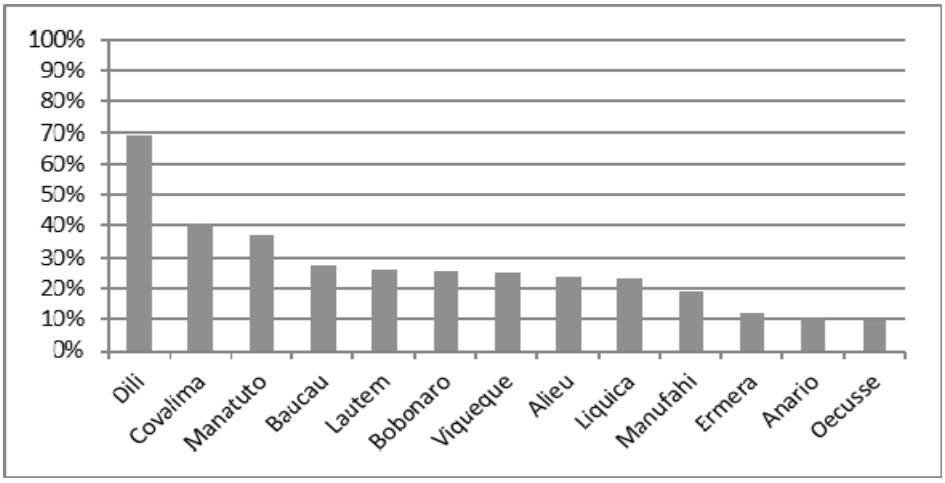
[1] RDTL. *CEDAW Specific Report on Education and Health Sectors – Timor-Leste.* SEPI, Dili, 2011.

- The current Timor Leste Demographic and Health Survey indicates a stable reduction on maternal mortality rate from 660/100.000 reported in 2003 to 557/100.000 in 2010. The major complications of pregnancy reported are haemorrhage, eclampsia, obstructed labour and sepsis. A complication of pregnancy on haemorrhage is reported by 50.2%. There is also an increase proportion of women seeking ANC care from Skilled providers (doctors, midwifes, nurses) of 41% in which, from 61% in 2003 DHS to 86% in 2009-2010 DHS. More than 90% of pregnant mothers were weighed and had their blood pressure taken, while only 55.7% informed on danger signs. Almost 80% received tetanus toxoid injections. The proportion of women who took iron supplements during pregnancy has risen from 43% in 2003 to 61% in 2009; however, only 16% took the recommended dose of iron supplements for at least 90 days. About 13% received deworming during pregnancy, 31% received supplementary food while pregnant with their last birth, and 29% received supplementary food while breastfeeding their last-born child. Just over one in five births are delivered in a health facility, with the vast majority delivered in a public (21%) rather than in a private (1%) facility. The majority of births (78%) are delivered at home. Delivery in a health facility is most common among young mothers (25%), mothers of first-order births (31%), and mothers who have had at least four antenatal visits (31%). The proportion of deliveries assisted by skilled birth attendants has risen from 24% in 2002 to 30% in 2009, which is a slow increase in seven years. About 30% of births are delivered by a skilled provider (doctor, midwife, nurse or assistant nurse), with a midwife or nurse being the most common skilled provider. Moreover, there is a progressive increase in assisted deliveries from 27/ in 2006 to





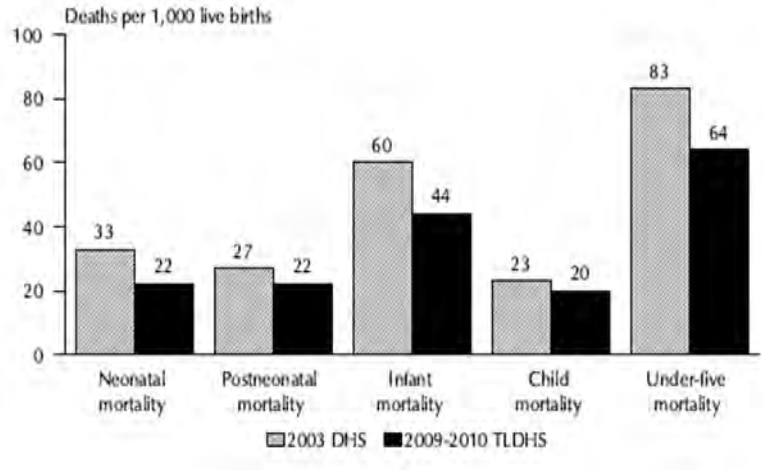
an average of 49.3% reported in 2010. Doctors assisted 3% of deliveries, while nurses assisted less than 1%. The risk of giving birth to a low birth-weight baby is influenced by the mother's nutritional status. About 27% of women were malnourished (BMI less than 18.5 kg/m2), indicating that malnutrition among women is a serious public health concern.



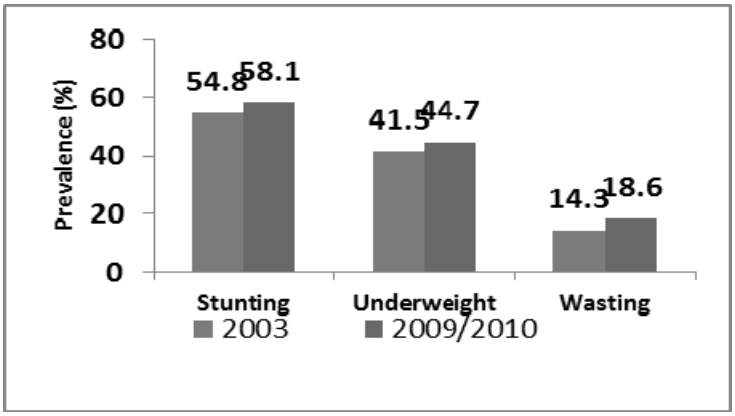
Women age 15-19 are more likely to be under-nourished (33%) and also those who live in rural areas (28%) compared to those in urban areas (24% There are coverage of skilled care at birth by district with the highest coverage in Dili (69%), and the lowest in Ermera (12%), Ainaro (11%) and Oecusse (10%),) as seen in the side figure above.

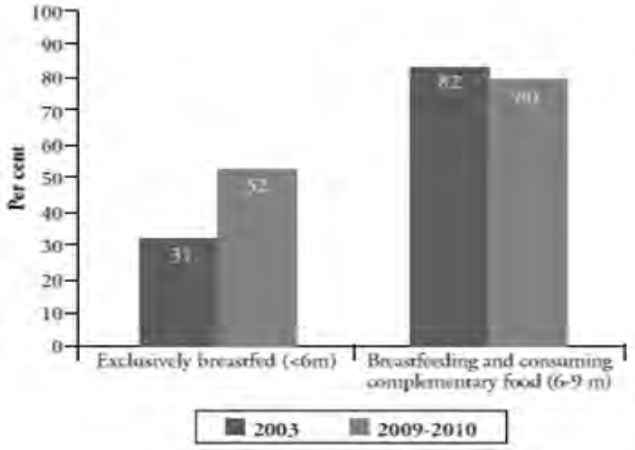
D. CHILD HEALTH

There has been a slight progress on child health care with the recent reduction of indicators showing a reduction of U5 mortality rates from 83/1000 to 45/1000 in 2003 to 64/1000 in 2010 and an improvement in infant mortality rate from 83/1000 to 45/1000 during the same years. DHS 2009-2010 also showed, NMR was 22 per 1000 live births, which decreased from 33 per 1000 live births in 2003. This is mostly due to the decrease in infant mortality rate, from 60 (2003) to 44 per 1000 live births (2009). This decline shows that Timor-Leste is on track to reach the target for the MDG 4, which is, to reduce U-5MR by two-thirds to 60 per 1000 live births by 2015. NMR among small/very small newborns is 34 per 1000 live births. The main causes of neonatal deaths are prematurity, asphyxia, birth trauma and infections. U-5MR in rural areas is consistently higher than in urban areas. According to the 2009 DHS, IMR in rural areas was 61 compared to 42 per 1000 live births in urban areas, while U-5MR was 87 in rural areas and 61 per 1000 live births in urban areas.



This may be because of poor access to health care, a weak communication system and frequent use of harmful indigenous practices in rural areas. The majority of births in Timor-Leste take place at home and, therefore, babies are seldom weighed at birth. The mother's assessment of the size of the baby at birth is used as a proxy for birth weight. The 2009 DHS results indicate that among babies assessed by their mother to be small/very small, their mortality rate is 1.5 times the level observed for babies assessed as average or larger at birth. Under-5 mortality for the most recent period (0-4 years before the survey or, roughly, during the calendar years 2005-2009) is 64 deaths per 1,000 live births. This means that 1 in 16 children born in Timor-Leste dies before the fifth birthday. Seventy percent of deaths among children under age 5 occur during the first year of life: infant mortality is 45 deaths per 1,000 live births. During infancy, the risk of neonatal deaths and post neonatal deaths is 22 and 23 per 1,000 live births, respectively. The proportion of child deaths that occurs in the neonatal period (34%) in Timor-Leste is lower than the global estimation of 38 percent (Lawn et al., 2005). Childhood mortality is higher for males than females for all mortality rates. Under-5 mortality rates for male and female children are 85 and 76 deaths per 1,000 live births, respectively. The excess mortality among male children is mostly due to their higher biological risk during the first month of life. Exclusive breastfeeding up to six months has increased from 31% to 52% between 2003 and2010, while breastfeeding and consumption of complementary food during 6-9 months of age reached around 80% in 2010. Around 82% of children are breastfed within the first hour of birth (from 47% in 2003), while 13% are given prelacteal food (something other than breast milk) during the first three days of life. The poor nutritional status of children has been a serious problem for many years. About 58% of children under five are stunted and 33% are severely stunted, while 19% are wasted and 7% are severely wasted according to DHS 2009-2010. Figure 6.3 shows that the overall nutritional status of children under five was not improved from 2003 to 2009. The proportion of children under five with stunting increased from 54.8% in 2003 to 58.1% in 2009, underweight from 41.5% to 44.7% and wasting from 14.3% to 18.6%. This deserves special and urgent attention. There is a need to understand the contributing factors towards malnutrition in children, such as acute and chronic infections (e.g. malaria and tuberculosis) besides socio-cultural factors.





E. CHILD WELFARE

Significant improvement has been made in reduction of Infant Mortality Rate from 88 in 2002 to 45 in 2009 and U-5MR from 125 in 2002 to 64 in 2009. However, 2010 Timor Leste MDG report indicated that several MDGs (poverty reduction, malnutrition, maternal mortality, school completion and sanitation) are still off-track. Most disadvantaged children in Timor Leste are from poor, large families with less educated parents in disaster prone rural areas. Moreover, they have less access to basic services and participation opportunities and are often left out in policy decisions. They lack also to information and tend to continue harmful practices against child survival, development and protection. These have resulted in lower achievement of MDGs target (UNICEG Timor-Leste Equity Tracker).

PART A – INDICATORS

1. CRUDE BIRTH RATE-CBR (per 1000 population)
   CBR indicates the number of live birth occurring during the year, per 1000 population estimated at midyear. CBR-CDR provides the rate of natural increase, which is equal to rate population change in the absence of migration.

Year	Country overall (according to World Bank)
1990	43.0
2000	43.5
2010-11	38.45

NB: cited from www.tradingeconomics.com

2. CRUDE DEAT RATE-CRD (per 1000 population)
   CDR indicates the number of death occurring in the year, per 1000 population estimated at midyear. CDR-CBR provides the rate of natural increase, which is equal to rate population change in the absence of migration.

Year	Country overall (according to World Bank)
1990	18.0
2000	11.3
2010-11	8.14

NB: cited from www.tradingeconomics.com

3. Leading cause of Death (1990) and (2009)

Year	Leading cause of Death
1990	1. Lower respiratory infection (17%), 2. Diarrheal diseases (12.4%), Measles (7.8%), 4. Preterm Birth Complications (5.1%), 5. Congenital anomalies (5.3%)
2009	1. Lower Respiratory infections (13,5%), 2. Diarrheal diseases (8.2%), 3. Preterm birth complications (7.8%), 4. Congenital anomalies (7.6%), 5. Ischemic Heart Diseases (4,4%)

NB: cited from: *www. healthdata.org* on Global Burden Disease profile in Timor Leste

4. INFANT MORTALITY RATE (IMR) (per 1000 live births)

Year	Country overall
1990	135.00
2000	85.70
2003 DHS survey	60
2010 DHS Survey	46

NB: cited in www.indexmundi.com

5. Leading Causes of Infants Death- 1990 and 2009

Year	Leading cause of Death
1990	2. Lower respiratory infection (17%), 2. Diarrheal diseases (12.4%), Measles (7.8%), 4. Preterm Birth Complications (5.1%), 5. Congenital anomalies (5.3%)
2009	2. Lower Respiratory infections (13,5%), 2. Diarrheal diseases (8.2%), 3. Preterm birth complications (7.8%), 4. Congenital anomalies (7.6%), 5. Ischemic Heart Diseases (4,4%)

6. UNDER 5 MORTALITY RATE (per 1000 live birth)

Year	Country overall
1990	169
2000	100
2003 DHS Survey	83
2010 DHS survey	64

The decline in neonatal, infant and under-5 mortality in the five years preceding the TLDHS 2009-10 indicates that Timor-Leste is on track to reduce infant and under-5 mortality to reach the target for Millennium Development Goal (MDG) 4, that is, to reduce under-5 mortality by two-thirds by 2015. It is notable that the proportion of neonatal deaths to under-5 deaths (34 percent) is relatively lower in Timor-Leste than in the other neighboring countries of Indonesia, Philippines, Bangladesh, India, and Nepal as measured in the latest DHS surveys in these countries. But on the other hand it is to be noted that Neonatal mortality is stagnant, from 21(DHS 2003) to 22 (DHS 2010) in Timor-Leste which is the challenge for the country and urges immediate attention.
Cited in

7. Top 3 diseases and morbidity rate of the under 5 of 1990 and 2010
   In 1990:
   Diseases: Prematurity and low birth weight, Pneumonia (lower respiratory tract infection), and Diarrhoea
   Morbidity rate:

   In 2010:
   Diseases: Prematurity and low birth weight, Pneumonia (lower respiratory tract infection), and Diarrhoea

   Morbidity:

8. Maternal Mortality Rate (per 100. 000 live birth)

Year	Country overall
1990	1200
2000	680
2010	300

9. Leading cause of Maternal deaths in 1990 and 2010

   Mostly related to obstetric complications such as haemorrhage, eclampsia, obstructed labor and sepsis

10. Are there national standards for certifying disabilities in your country?
    Yes there are.

11. Do your country perform any health check for infants and children
    Yes they do. As stated in “Livrinho Saude inan ho oan”

    - Vaccination/immunization

    When: from 0 month-11 months

    How many times: at birth, 6th weeks, 10th weeks, 14h weeks and 9th month

    Contents: mostly related to EPI in Timor leste such as BCG, DPT, HEP B, Polio and Measles, part for Vitamin A and Deworming

    - Child growth and development graph

    When: from birth-5 year of age

    how many times: 3rd-6th months, 9th-12th month, 12th-18th month, 2-3 year old, 3-5 year old and 4-5 year old

    Contents: the graph consists of date by weight, growth and developmentalste

12. In the case of any disabilities are confirmed, is there any support services on them ?

Yes there is.

1. Through collaboration of multi Ministerial approach to assist people with disabilities in Timor Leste as stated by TLDHS 2010 report that out of total population of 1.066.409, approximately, 48.243 of people suffer from some type of disabilities such as 20.593 from motor disability, 29488 from visual impairment, 17.672 from hearing impairment and 13.308 from mental disability. These figures show that there are people who have more than one type of disabilities and thus will have risk of not getting the opportunity to work and access to educational facilities. This report has made such an enormous impact on the IV Constitutional government lead by PM Xanana to finally come up with the approval of National Policy for Inclusion and Promotion of the Rights of People with Disabilities that was approved and signed by PM Xanana on April 2012. The policy stated that multi Ministerial approach to assist and liaise with Disable persons in Timor Leste through subsidized financial assistance.
2. Assistance of Non Governmental Organizations (NGOs) to respective disabilities group
3. There is also group exist so called “ National Association of Disable Persons In Timor Leste”

PART B- Preliminary Analysis

1. Describe the following on surrounding mothers and children:

- Maternal and Child Health

Three strength:

1. Health system follows an integrated approach
2. Nearly 1000 new graduated doctors are in the system now
3. The donor and partner co-ordination and support of MoH

Weakness:

1. Budget constraints/Limited budget (4.5% of total state budget)
2. Low capacity of the human resources (both for managers and clinical staff)
3. Weak health system with less stewardship/leadership
4. Geographical inaccessibility
5. Less demand for health services/low utilisation of health service delivery

- Maternal and Child welfare:

Strength: there is law in place/exist to protect them, state support and

Weakness: limited budget, isolation and discrimination

2. Most vulnerable populations would be:

- Children
- Women
- Elderly
- Disabled persons
    1. Rural areas: mainly isolated in hilly areas and separated by rivers, enclaved population, lack of access to information and facilities
    2. Low income population: although treatment/service is free, but transportation is not available and costly in the rural areas, MoH's referral services is very weak,
    3. Disabilities: unable to perform daily routines, isolation and discrimination

3. Services available are:

1. SISca/ mobile clinic
2. Plan for domiciliary visit by team of health professional (guidelines are on the process of the development)
3. All services are free of cost
4. Free maternity packets
5. Social support/NGOs

4. There are lots of strategies and Standards for improving quality of services. But implementation of the strategies and guideline are not properly done yet, due to lack of capacity of human resources and limited budget which is needed to be addressed. Capacity building should be prioritised for MoH's health staff.

Timor Leste Representatives

1. SMH program to combat high MMR, move towards facility delivery
2. Strengthening PNC by home visits
3. Maternal perinatal death reviews and response
4. Strengthening hospital for treating sick newborn and managing complications in five referral hospital
5. Mobile message for increasing ANC, delivery and postnatal care

Successful program:

1. Establishment of maternity clinic at sub-district level for increasing institutional delivery
2. Strengthening 5 referral hospital including national hospital for comprehensive EmOC services

Challenges:

1. There are new doctors but they are not well skilled for safe and clean delivery
2. Shortage of midwives for 24/7 services
3. Stock out of essential medicine (oxytocin) , equipment (logistic issues)
4. All midwives are not trained on EmOC, not able to manage complications-under skilled

1. There is a training institute (INS), but it itself lacks quality, no trainer, no standardised practise site to train staff
2. Low commitment of health staff to provide quality of care
3. Delayed release of budget to implement activities

To learn:
I would like to learn more about Japan's experience to address challenges

For indicators look at page 94 in NHSSP 2011 document

Countermeasure for Maternal and Child Health and Child Welfare

Viet Nam

Vietnam's Report for JICA training course "Promotion of the Collaboration between Child Welfare and MCH"

～Part (A) Indicators～

(1) Crude birth rate (per 1000 population): The crude birth rate (CBR notation) is one indicator of fertility of the population, and is one of two components of natural increase of population. CBR big or small can affect the size, structure and rate of population growth. Crude birth rate indicates 1,000 people, there are many children born alive in the year.

	Country overall (‰)
1990	27,4
2000	19,2
2010	17,1

Crude death rate (per 1000 population) Crude death rate for every 1,000 residents means how many people died during the period (usually a calendar year). Just as crude birth rate, crude death rate is affected by many characteristics of the population, especially in the age structure of the population. CDR is an indispensable component in calculating the rate of natural increase as well as the growth rate of the general population.

	Country overall (‰)
1990	
2000	5,6
2010	6,8
2012	7,0

(2) Leading causes of death (1990) and (2009)

1990: 1) Infectious diseases

2010: 1) The chronic non-communicable diseases
2) Accidents, injuries
3) Poisonings

(3) Infant mortality rate (per 1000 live birth) [MICS 2010]

	Country overall (‰)
1990	44,4
2000	31
2010	15,8 (rural: 18,2; urban: 9,2)

(4) Leading causes of infants death (1990) and (2009)

1990: 1) Complications of prematurity
2) Pneumonia
3) Complications during labor and birth

2010: 1) Sinh non
2) Nhiễm trùng
3) Ngạt

(5) Under-5 mortality rate (per 1000 live birth) [MICS 2011]

	Country overall
1990	53
2000	24
2010	16

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

2010:

Diseases: 1) pneumonia 2) diarrhea 3) fever

Morbidity rate: 1) 17% 2) 15% 3) 11%

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

	Country overall
1990	233
2009	69

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

1990:1)Haemorrhage 2)Eclampsia 3)Infection

2010:1)34,7-43,4% 2)10,7-18,4% 3) 7,4-14,3%

According to the WHO, UN agencies and the World Bank published 10/2010, the maternal mortality ratio of Vietnam is the 4th in ten Southeast Asian Nations (after Singapore, Malaysia and Thailand)

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

Yes

Explain briefly:

Decree shall detail and guide the implementation of some articles of the Law on Persons with Disabilities by the Government issued April 10, 2012 consists of seven chapters and 35 articles, including Article 2, 3, 4, Chapter I contains provisions on disability type and severity of disability and determine the degree of disability

Article 2. Type of disability

1. Disability is the impaired motor or movement dysfunction head, neck, legs, arms, body leading to restrictions in movement, movement.

2. Hearing disability, said that the impaired or lost function of listening, speaking, or both speaking and listening, pronunciation loud and clear sentences lead to limitations in communication, exchange of information verbally.
3. Disability status view is reduced or lost the ability to see and feel the light, colors, images, objects in low-light conditions and normal environment.
4. neurological disability, mental disorders of perception, memory, emotion, behavior control, thought and expression with the words, act abnormally.
5. Intellectual Disability status is reduced or lost cognitive abilities, thinking manifested by slow or unable to think, analyze the objects, phenomena, to resolve this problem.
6. Other Disability status is reduced or loss of bodily functions for the operation of labor, living, learning difficulty, but not in the cases specified in Clauses 1, 2, 3, 4 and 5 of this Article.
Article 3. The level of disability
1. People with disabilities are particularly severe disability leads to complete loss of function, no self-control or self-realization is the active movement, dressing, personal hygiene, and other things serve the needs of individual daily living that require the monitoring, assistance, care altogether.
2. People with severe disabilities who are disabled due to lead to partial loss or impairment, no self-control or self-realization is a commuter operation, dressing, personal hygiene, and the serve the needs of other personal activities that require the daily monitoring, support and care.
3. Disability mild disability in cases specified in paragraph 1 and paragraph 2 of this Article.
Article 4. Determination of the degree of disability
1. The Board determines the degree of disability based on the provisions of Article 2, Article 3 of this Decree and direct observations of people with disabilities through the implementation of simple operations serve the needs of individual daily living using the questionnaire according to the criteria of health, social and other prescribed method to determine the degree of disability, unless otherwise provided for in paragraph 2 and paragraph 3 of this Article.
2. Medical Examination Council identified disabilities and form conclusions about the degree of disability for cases specified in Clause 2, Article 15 of the Law on Persons with Disabilities.
3. Persons with Disabilities concluded by the Council of Medical Examination of self-serving, the degree of reduction of working capacity before the effective date of this Decree, the Board determines the degree of disability grounds Council conclusions of the medical examination to determine the degree of disability as follows.
a) Persons with disabilities are particularly severe when medical examiners Council conclusions are no longer able to service or labor capacity reduced by 81% or more.

b) People with severe disabilities when medical examiners Council conclusions are able to serve people living if, aids in part or labor capacity decrease from 61% to 80%.
c) Disability Council light when medical examiners concluded with self-service capabilities living or working capacity decline below 61%.
4. If the text of the Council of the medical examination prior to the effective date of this decree is not clear conclusion about the possibility of self-service, the degree of reduction of working capacity, the Board determines the degree of disability made is determining the degree of disability for people with disabilities as defined in Paragraph 1 of this Article.
5. Budget secured funding for implementation of the determination of the degree of disability and disability certificate under decentralized management of the state budget.
6. Ministry of Finance, Ministry of Labour - Invalids and Social Affairs budget guidelines specified in paragraph 5 of this Article.
Ministry of Justice Contact Us Feedback

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

-Yes, it does

- In Vietnam, All children from birthday to 6 years old are free for treating in national hospitals,

-What kinds of contents includes in each?

- Maternal care during pregnancy and postpartum
- Newborn Care
- Breastfeeding and young child feeding
- Micro-nutrients
- Vaccination for mothers and children
- Integrating care for sick children
- Located chemical insecticide treated nets in malaria endemic areas

(11) In the case any diseases or disabilities are confirmed, is there any support services on them? Describe the services, if any

- With normal children, when any diseases are confirmed, they are free in true local hospital. Because they get Medical insurance at the same time getting birth certificate. In the hospital, they get free examination, medicine, sickbed,…ect.
- With disabilities children:

1. Every year, the state budget allocation for the implementation of policies on disability.

2. Prevention, reduce birth defects, defects caused by injury, disease, and other risk of disability.

3. Social protection; assist people with disabilities in health care, education, vocational training, employment, culture, sports, recreation, access to public facilities and information technology, in traffic; implementation of the policy priorities of social protection and support disabled children, the elderly.

4. Integrate policies on disability policy in economic development - social.

5. Create conditions for people with disabilities orthopedic rehabilitation; overcome difficulties, independent living and community integration.

6. Training and retraining of workers counseling, care for people with disabilities.

7. Encourage activities to assist persons with disabilities.

8. To facilitate the organization of persons with disabilities, organized activities for people with disabilities.

9. Reward agencies, organizations and individuals with achievements and contributions in helping people with disabilities.

10. Strictly handle agencies, organizations and individuals that commit acts of violating the provisions of this Act and other provisions of the relevant legislation.

j～Part (B) Preliminary Analysis～

I. Describe the surroundings mothers and children.

Poor maternal, newborn and child health remains a significant problem in developing countries. Health care for mothers and children are always identified as one of the priority tasks of the care for people's health by Vietnam Government. Over the years, the successful implementation of the national strategy on reproductive health care, national strategy on nutrition and a series of national action plans, such as the National Master Plan for motherhood safety, the National Action Plan for the survival of children, the overall national plan of care, protect and improve the health of young adolescents and Vietnam, national guidelines for the care of reproductive health, ... has contributed to the implementation of the Millennium Development Goals (MDG) that Vietnam has committed to the international community in reducing maternal and infant mortality. On 14-11-2011, the Prime Minister signed Decision No. 2013 / QD-TTg approving the Strategy for Population and Reproductive Health Vietnam during the period from 2011 to 2020, marked a new stage in taking reproductive health care with the strategic perspective: "investing in population and reproductive health care is invested in sustainable development, providing direct effects on economy, society and environment ".

Besides the system policy and political commitment, health Vietnam also always interested in strengthening the primary health care, including the field of reproductive health care and the health of mothers and children (RHC / MCH). Currently, the index of reproductive health in general and the indicators of maternal mortality and infant mortality in particular in our country is relatively good compared to other countries with the same level of economic development - society. These indicators, such as antenatal care enough 3 times, giving birth in health facilities, mothers and infants after birth care, maternal mortality and infant mortality, ... are a clear improvement ; network providing reproductive health services from central to local levels have increasingly been expanded, strengthened and developed, including the hospital system, hospital obstetric, pediatric and obstetrics, pediatrics at the hospital level. Most midwives, obstetric care, primary health care workers have the basic skills of RHC national guidelines. In mountainous areas, ethnic minorities, where the proportion of women giving birth at home is high, along with advocacy, encouraging women to give birth in health facilities, the Ministry of Health actual implementation of the type of training village midwives or training of village health workers have the knowledge and skills to manage pregnancy and childbirth clean, safe delivery, including the detection and timely referral high-risk cases, to reduce obstetric complications, maternal mortality and infant mortality.

Goal No. 4 and No. 5

Along with the decline of maternal mortality, infant mortality under 1 year and under 5 years of age decreased rapidly and sustainably. Mortality rate of children under 5 years of age were more than halved from 58 ‰ to 23.2 ‰ in 1990 to 2012. The mortality rate for children under 1 year of age has dropped by nearly two thirds, from 44.4 ‰ in 1990 to 15.4 ‰ in 2012. According to the international community, Vietnam can achieve Goal 4 of reducing deaths of children under 5 years of age (down 19.3 ‰) and less than 1 year old (down 14.8 ‰) in 2015.

This is a result of the implementation of effective mass of the National Target Program, such as expanded immunization; Prevention and acute respiratory infections; Prevention and acute diarrhea; Prevention and malnourished children; Care and treatment of common diseases in children; Reproductive health care ... maternal mortality rate has fallen by more than 3 times from 233 / 100,000 births in 1990 to 69 / 100,000 births in 2009. Compared with the objectives of the Strategy National Health Care reproductive period 2001 - 2010 the maternal mortality ratio is 70 / 100,000 births in 2010, the health sector has completed this indicator before 1 year. According to the international community, Vietnam has the ability to achieve goal number 5 on maternal mortality reduction (down to 58.3 / 100,000 births in 2015) and is one of the countries' progress achieved level "(" on track ") in the implementation of the Millennium Development Goals.

However, there are still large differences in mortality among children under age 1 regions. Highlands is an area with mortality rate of children under 1 year of age the highest in the country. This rate in rural areas is almost two times higher than in urban areas, infant mortality is still quite high, around 70% of deaths of children under 1 year of age and 50% of deaths of children under 5 age.

Strength in Maternal and child Welfare

Firstly, the commitment of the political system.

Maternal and child always been considered a top priority in the care of people's health in Vietnam. The Government of our country's commitment in the implementation of the Millennium Development Goals are important factors contributing to the success of health care for mothers and children. A series of important documents have been issued to bring a positive impact on the health of mothers and children. In 1989, the Law on Protection and Care of People's Health launched, including the protection of women and children, the National Strategy for care and protection of people's health the period 2011-2020, War National Strategy for Population and Reproductive Health period 2011 - 2020, National Strategy on Nutrition period 2011 - 2020, the National Action Plan on infant

feeding ... Congress committee individual responsible for the social problems including health problems of mothers and children.

Second, the economic growth of the country.

After nearly 30 years of implementation of the reform of the country, the economy of Vietnam to develop relatively fast and stable. In the period 2000 - 2008, GDP continued to increase, reaching 7.9% / year. Although affected by the global economic crisis in 2008, but Vietnam has achieved a GDP growth of 6.31% in 2008, 5.89% in 2011, 5.03% in 2012 and 5, 42% in 2013. Per capita income was approximately $ 1,908 in 2013.

Industry and the alleviation of poverty to achieve good results. In two 2011 and 2012, more than 70 trillion has been allocated for poverty reduction. The policy package of health care, education, nutrition, legal services, culture, information, support vocational training, job creation, investment in infrastructure construction has been focused support for the poor and marginalized groups in society, including the 135 program had significant success in efforts to reduce poverty and improve living standards for the poor. The poverty rate in the region was supported by 10%; the income of poor households period 2007 - 2012 increased by 20%.

Third, interventions in the health sector.

Working mothers' health care - children is done through a network of service providers throughout the central and local levels. At the commune level, 99% of commune health stations, nearly 94% of health centers with midwives or obstetric care, 66% of health centers have doctors, 84% of villages with village health workers Version. In these villages are inaccessible to the clinic or ethnic traditions survive birth at home, the health sector has trained village midwives responsible health care for mothers and infants.

Total per capita expenditure on health has increased four-fold from 49 USD to 233 USD 1995 in 2012. The improvement in the provision of health care services for mothers and children through investment upgrading facilities for hospitals and clinics, health centers, training health workers are important contributing factor in improving the health of mothers and children.

The expanding access and improving the quality of health care for mothers and children in all regions, objects, especially in remote, ethnic minority and the number of disadvantaged groups is an important factor to success in reducing malnutrition, mortality among children under 5 and maternal mortality.

Fourth, the active support of international organizations, the participation of civil society and the media.

There are significant achievements as above, not to mention the positive support, both technical and financial organizations of the United Nations, the bilateral donors, multilateral. This support is not large compared to the investment funds, however, support the advisory role is very important, it is essentially oriented, the source of the initiative, the effective intervention in health care for mothers and children. The participation of non-governmental organizations are also important, contributing to implement and demonstrate effective models of health care for mothers and children, depending on local conditions. The contribution of non-governmental organizations are also important in the remote and for special populations such as adolescents, young, migrants, ethnic minorities number. Finally, not to mention the positive role of mass media in the transmission of messages about health care for mothers and children to large masses, mobilizing people to work together with medical Overall economic and social participation of health care for themselves and their families.

Some weakness exist in Vietnam

Vietnam achieved important results in 2/3 of the way done the Millennium Development Goals over and determination towards the completion of this goal in 2015. However, in addition to the already done, the work of health care for mothers and children still face many challenges and difficulties to be addressed, such as:

- Vietnam has been included in the list of countries "middle income", so in the coming years, our country is and will be faced with a huge challenge. It is the reduction of financial aid of the international organizations and donors.

- Investment budget has not met the increasing demands of the people. Although the project has national targets, but only partially meet and also only have to invest mainly in mountainous provinces, provincial difficulties, in recent years, funding projects of national goals Date for the content of reproductive health are being cut.

- Maternal and infant mortality has declined but although the rate of decline in recent years tended to slow down and there are still a large difference between the regions (in the region Mount index to 3 times higher than in the lowlands). Infant mortality is still high, accounting for 70% of deaths of children under 1 year of age and 50% of deaths in children under 5 years of age. Malnutrition underweight has improved markedly, however stunting still pretty high percentage, almost 30% of children under 5 years of age.

- Access and quality of MCH services before, during and after childbirth, infant care is limited, having a baby without medical help is quite common in mountainous areas, ethnic minority areas minorities.

- Network Systems provide reproductive health services was formed to consolidate, but still exists. Facilities and equipment for obstetrics, pediatrics at many district hospitals is poor, failing to meet the care needs emergency treatment of women and children, infants. Due to limited funding, staff working in obstetrics, neonatal and pediatric not been training regularly update their knowledge, leading to limitations in skills, especially her survival skills mother and infant.

-The reporting system is limited and weak, the data collected was inaccurate, not reflect the reality of the situation of maternal mortality, infant mortality, especially in the absence of data on mortality infants, not ensuring the timeliness, failing to meet the requirements of policy formulation and planning interventions.

Policy to promote the achievements and overcome the still exists, difficult problem

Firstly, the consolidation system network organization of reproductive health care / health of mothers and children from the central to local levels. Professional capacity, allocate sufficient staff for obstetric, pediatric hospitals of the provincial, district and ensure the necessary equipment for resuscitation obstetric and neonatal. Striving to all district hospitals which time access to the provincial hospital in time over 60 minutes can perform caesarean sections and blood transfusions.

Secondly, the development of human resources. Enhanced training specialist obstetrics, pediatrics, paying special attention to the form of specialist training for rapid preliminary additional specialist staff force of over two majors currently lack, even in the provincial health facility. This is one of the key recommendations of the World Health Organization (WHO) "guarantee each births are skilled birth attendants help ". The health sector strive to 2015, 80% of the medical staff working in obstetrics at the provincial level, 70% at district level standards "skilled birth attendants", each have at CHS least one midwifery staff qualified "person skilled birth attendants". Training improve emergency obstetric and neonatal care and emergency essential newborn oriented "hands-on" training the crew, address, on demand. For remote areas, remote areas, ethnic minorities need to strengthen training of village midwives or health officials said village manager pregnancy, childbirth clean, safe delivery, detection, treatment -aid and

timely referral of cases of pregnant women at risk.

Thirdly, interventions in the health sector.

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Forthly, increased investment, financial security and logistics. To ensure the necessary budget for the activities of reproductive health / maternal health - children. Recommend Parliament, the Government increased investment for the reproductive health care through the national target program with a minimum of 100 billion / year and gradually increase over the years in order to better meet the needs reproductive health care is increasingly diverse people, especially mothers - children (project objective national reproductive health care from 2008 until now, the project national goals reproductive health care is only the average investment of 35 billion / year. 2014, budget cuts only 20 billion).

Fifthly, strengthen the operational information - communication - health education in order to increase knowledge, change attitudes and behaviors of people, especially people in the mountainous areas, areas distance of prenatal care, the risk of non-routine maternity care and not to give birth in health facilities or self-birth, birth without medical staff trained support as well as the risk of thick tongue, prolific children, preterm birth (less than 20 years old) or late calving (over 35 years old).

Sixthly, replicate the model was evaluated to be effective, as the "Community-based Transit" (1); model "Caring mother - infant continuously from communities and families to health facilities"; promote "the evaluation of maternal

death" experience to draw on expertise, on the basis of consideration and detailed assessment of the diagnostic process, monitoring, emergency women, thereby making judgments about the causes and factors affecting such deaths. This activity will help physicians timely lessons learned expertise to improve the quality of treatment, emergency management in order to avoid the occurrence of similar cases of complications.

Seventhly, strengthen supervision and professional support from higher levels to lower levels; perform well Scheme rotating staff to support streaming on the lower level (Project 1816), Scheme satellite clinics; improve the effectiveness and efficiency of the inspection and examination of the implementation of the provisions of the Law on Examination and Treatment; hospital regulations, technical procedures, technical guidance of the Ministry of Health for public health facilities as well as private. /.

2. In my country / region, the most vulnerable populations (list three groups in order of priority)

- Groups are living in rural areas
- Groups with low-income
- Groups with disabilities

3. What kinds of services are there for the above mentioned groups?

For the groups living in rural areas:

Set up and operate the neonatal care unit separately at the district hospital.

Training of health personnel directly engaged in obstetrics become "skilled birth attendants" to limit and timely management of obstetric complications, ensuring the safety of every birth

Ensure policy regime to attract professional staff, especially qualified staff to work permanently in the mountainous, remote and distant. Promulgate regulations on social obligation for doctors to work in the remote, implement specific policies to support her team to help villages of ethnic minorities such as village health workers Version.

For the group with disabilities

1. A serious problem, such as the Annual State budget allocation for the implementation of policies on disability.

2. Prevention, reduce birth defects, defects caused by injury, disease, and other risk of disability.

3. Social protection; assist people with disabilities in health care, education, vocational training, employment, culture, sports, recreation, access to public facilities and information technology, in traffic; implementation of the policy priorities of social protection and support disabled children, the elderly.

4. Integrate policies on disability policy in economic development - social.

5. Create conditions for people with disabilities orthopedic rehabilitation; overcome difficulties, independent living and community integration.

6. Training and retraining of workers counseling, care for people with disabilities.

7. Encourage activities to assist persons with disabilities.

8. To facilitate the organization of persons with disabilities, organized activities for people with disabilities.

9. Reward agencies, organizations and individuals with achievements and contributions in helping people with disabilities.

10. Strictly handle agencies, organizations and individuals that commit acts of violating the provisions of this Act and other provisions of relevant laws quan.chenh difference, namely the mortality rate of children in the mountains rural areas and in poor families still 3 to 4 times higher than the plains and the more affluent families

4. In implementing health/welfare policies and services by your organization:

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

1. There are large differences in the rates of maternal mortality between regions that we need to address. Maternal mortality rate is still high in the mountainous areas and ethnic minorities. The elements of geography, education level of mothers and customs in the remote mothers often hinder access to health care services reproduction.

2. Ethnic minorities, young people and migrants still face many difficulties in accessing information and services reproductive health care, including services for family planning

3. A large number of Vietnamese children die annually

According UNICEF, Every year there are 28,000 children under the age of 5 have died, in it 16,000 are infants. Percentage of children under 5 years old accounted for 6.5%, estimated 6,000,000 children and babies are born each year where the 1.200.000- 1,500,000

4. The stark difference in the health and nutritional status of children

between cities urban and rural areas, between the wealthy and poorer segments of the population in terms of physical obstacles and economic

obstacles.

5. Perinatal mortality with a huge difference between areas / regions in the country

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

1. Programs to combat child malnutrition
2. The EPI
3. Diarrhea prevention program

What are these challenges? List 3 challenges.

（1. See “some weakness in Vietnam” ）

Describe your expectations to the training course.

Coming to this trainning course, I expect to gain knowledge about Japanese current MCH and child welfare policies. Futhermore, I expect to gain an understanding of the features of Japanese MCH Handbook from the perspective ò coodinnation between health and welfare

The end