International Workshop

（第9会場：神戸ポートピアホテル　偕楽3，16：10～18：10）

Global Partnership to save Mothers, Newborns and Children

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1）Interventions that could reduce Global Perinatal and Maternal Mortality

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Sabaratnam Arulkumaran

2）Partnership for Improvement for Better Maternal and Child Health : JICA's Experiences and Strategy

演者：Japan International Cooperation Agency
Harumi Kitabayashi

3）Situation of Maternal, Newborn and Child Health（MNCH）in Resource-Limited Settings and Progress towards Millennium Development Goals 4 & 5 − Possible Ways in which Human Resources in Japan could Contribute to Improving MNCH around the World

演者：Medical Officer on Reproductive Health, Maternal Child Health and Nutrition Unit, Division of Building Healthy Communities and Populations, WHO Western Pacific Regional Office Hiromi Obara

4）Capacity Building and Partnership, Agents for Improving Maternal and Newborn Health −The Lagos Island Maternity Hospital（LIMH）Experience

演者：Lagos Island Maternity Hospital, Lagos, Nigeria
Greg Aigbe Ohihoin

5）Maternal Health and its Challenge in Cambodia

演者：Chief of Cambodian Ob/Gy Society Koum Kanal

1) Interventions that could reduce Global Perinatal and Maternal Mortality

Sabaratnam Arulkumaran

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Recent estimates of maternal mortality shows a decline from 560,000 to 360,000 per year. However for every mother who dies 20 are injured (Fistula, nerve palsy, sepsis and infertility etc.). There are 2 to 3 million stillbirths and 2 to 3 million newborn mortality due to asphyxia, congenital malformation and sepsis. Although most countries have seen some improvement a few have shown worsening of the situation (e.g. Zimbabwe). Six countries contribute the maximal mortality. Poverty (MDG 1), young age of marriage due to lack of education and empowerment (MDG 2&3), lack of sexual and reproductive health care especially contraception (MDG 5b) and lack of health care facilities and skilled attendance at birth are major contributors (MDG 5a). Poor nutrition, housing, sanitation, lack of vaccination and communicable disease take a toll of infant and child mortality (MDG 4) that urges the women to have more children. Communicable diseases like HIV, TB in addition to Malaria (MDG 6) is the cause of significant maternal mortality in some countries. In some way one could argue that all the MDGs are interlinked and improvement in any of the MDGs would make an impact on the other.

Access to skilled care and functioning health care facilities with availability of medicines and surgical facilities can reduce maternal mortality. The basic emergency obstetric functions should be provided by four healthcare facilities for a population of half a million. The basic emergency obstetric functions are medical interventions of intravenous magnesium sulphate for eclampsia, antibiotics for sepsis, and oxytocics for the management of third stage of labour + three surgical functions that consist of evacuation of the uterus, manual removal of the placenta and vacuum delivery. The four primary healthcare facilities should be supported by a referral centre where comprehensive obstetric functions are available i.e. Caesarean section and facilities for blood transfusion. With such a model many of the maternal deaths due to eclampsia, sepsis, haemorrhage and septic miscarriage can be prevented.

The health care facilities should be available, accessible, affordable and appropriate for the setting. This refers to access time when an emergency arises. There may be delay within the household to make the decision to seek hospital care. In some countries the woman has to seek permission from the husband or mother in law to leave the house (first delay), the transport to hospital may be a problem because of lack of public transport, distance from the hospital facility or difficult terrain (second delay) and finally when woman reaches the hospital the health care providers may not attend to her in time i.e. institutional delay (third delay). This three-delay model is dependent on education and empowerment of the woman and the financial standing in addition to the geography of the health centre. The health centres and the referral centre should have adequate and appropriate personal and medication to provide the care. Countries like Sri Lanka, Malaysia and Tunisia have reduced their MMR by taking these steps.

Countries like Ruwanda has taken steps to provide maternity coupons for free antenatal care and if they make four visits their intrapartum and postnatal acre is free. Several Governments and recently the speakers parliament of 36 African countries have pledged 15% of their budget to be spent on health and a considerable proportion of that for maternal and child health.

Complications of abortion leads to maternal deaths and this could be avoided by the following steps ; Primary prevention of avoiding unwanted pregnancies by contraception. In several countries the unmet needs of contraception is high. Opportunities should be taken to provide women post abortal and post delivery contraception which are long acting and is not dependent on the supply chain or on individuals memory to use them. Emergency contraception is not an aborti facient and proper education and availability would go a long way. Secondary prevention is by providing termination services more accessible and easy to obtain in countries where termination is legal upto a certain gestation. Tertiary prevention of deaths is by treating incomplete or septic miscarriages promptly and effectively without stigma by the use of vacuum aspiration or medical methods and antibiotics and in some cases additional care such as IV fluids and hospitalisation.

In addition to policies in delivery of care, new advances are also making inroads to reduce maternal mortality ; active management of third stage of labour, misoprostol, amino caproic acid, use of anti-shock garment, oxytocin in uniject devices, balloon tamponads using simple devices and simple compression sutures has helped to prevent and treat PPH. The WHO introduced the use of partogram and is currently coming up with safe delivery check list and Odon device to replace vacuum delivery. These innovations and implementing the latest science may help to save many lives. Provision of contraception, abortion services, antenatal and emergency obstetric functions would help reduce maternal mortality.

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2) Partnership for Improvement for Better Maternal and Child Health : JICA's Experiences and Strategy

Harumi Kitabayashi

Japan International Cooperation Agency

Japan's official development assistance (ODA) for health

The net disbursement of Japanese ODA was 9,468.61 million US dollars in 2009, of which 6,001.24 million dollars (63.4%) was channeled bilaterally and the remaining 3,467.37 million dollars (36.6%) was channeled through multilateral organizations. [1] This amount was the 5th largest among the bilateral donor countries of OECD. The bilateral expenditure for health sector in 2009 was 354.37 million dollars, and estimated 402.65 million was spent through multilateral organizations such as UN systems, international development banks and global fund to fight against AIDS, Malaria and tuberculosis (GFATM).[2] Thus, it is estimated that the total amount of ODA for health sector in 2009 was 780.87 million dollars, or 8.2% of net disbursement, which was considerably lower than the average share of health sector expenditure (18%) by the other member countries of development assistance committee of OECD.

The Japan International Cooperation Agency (JICA) is executing most of Japan's bilateral ODA. In 2008 the new JICA was launched by merging existing JICA with the branch of Japan Bank for International Cooperation (JBIC) in charge of ODA loans, and it became the organization responsible for provision of bilateral aid in the forms of technical cooperation, grant aid, and ODA loans. The total expenditure in 2009 was 1,230 billion yen, consisting of 176 billion yen of technical cooperation, 102 billion yen of grant aid, and 745 billion yen of ODA loans. [3] The share of expenditure in health sector differed by aid scheme ; 7.4% of technical cooperation, about 10% of grant aid and only 0.4% of ODA loan was spent for health assistance. Possibility of expansion of loan aid is being discussed in support of health sector investments in the middle income countries.

Brief History of JICA's cooperation for maternal and child health (MCH)

In the 1970s and 1980s maternal and child health care was often integrated with family planning projects. In the late 1980s MCH become a major component of projects aiming at promotion of community and primary health care. In the 1990s the volume of support to child health and survival through the expanded immunization program (EPI) grew rapidly. Vaccine procurement, establishment of cold chain for vaccine storage and distribution, strengthening of surveillance system to monitor disease incidences were supported by technical cooperation and grant aid, often in collaboration with WHO and UNICEF. JICA also assisted domestic production of polio and measles vaccines in Indonesia. These aid activities contributed to the polio eradication in the East Asia and the pacific region in 2000. Compared to increasing support to child survival interventions maternal care support was smaller in its volume and limited

to antenatal care, health and nutrition education and family planning counseling services. Clinical services at the hospitals were considered to be expensive and less accessible option to improve health of mothers in the poor rural areas.

The international conference on population and development (ICPD) held in Cairo in 1994 mainstreamed the concept of sexual and reproductive health and rights. As a result, the focus of population policy shifted from the macro-level to micro-level perspectives. In the same period rapidly increasing incidence and deaths from HIV/AIDS were recognized as a major threat to public health and sustainable economic development. The Japanese government announced the "Global Issues Initiative on population and AIDS (GII) in 1994, in which comprehensive approach was emphasized, which included maternal, and child health care, family planning, primary health care, HIV/AIDS prevention, as well as primary education and empowerment of women. Under the initiative, JICA implemented MCH and family planning projects which integrated non-health sector components such as income generation activities by women's groups. Cooperation with other bilateral and multilateral development partners such as USAID, UNICEF and UNFPA was accelerated to complement each other's input to solve the problems. Since the middle of the 1990s JICA began to pay more attention to maternal health and safe motherhood. One of the examples was the MCH project in Cambodia, which started in 1995. The national MCH center was established to serve as the top referral maternity hospital and the national training center for health professionals engaging obstetrics and midwifery. Later, training activities were expanded to cover health workers of district hospitals and community health centers. Another example was the MCH project in the northeast Brazil, where excessive medical interventions such as high rate of caesarian sections were common. It focused on the "humanized birth", or improvement of evidence-based perinatal care practices that respects women's dignity and autonomy.[4]

Global Health Policy of the Japanese government

Adoption of millennium development goals (MDGs) in 2000 articulated that the reduction of maternal mortality is the global goal to be attained jointly by the UN member countries. More MCH projects supported by JICA included the intervention packages for safe pregnancy, child births and neonatal survival. In 2010 The Ministry of Foreign Affairs (MOFA) issued the "Japan's Global Health Policy 2011-2015", in which a package of interventions called EMBRACE (effective mothers and babies regular access of care) is adopted for assisting the developing countries to save lives of mothers and babies. In its health sector position paper published in 2010, JICA states that it supports developing countries in building and strengthening systems that provide a comprehensive "Continuum of Care for maternal and child health" via improvements in the quality of and access to health services.[5] Specific measures to be taken under this framework include : education and training of health service providers ; upgrading of health facilities, strengthening of referral, sensitization and mobilization of communities, and enhancing managerial capacity of health authorities.

The MCH Project in the Philippines

The technical cooperation project for MCH in the Philippines was implemented for four years from March 2006 in two rural provinces, where the utilization of maternal care services and health indicators

were below the national average. The objective was to increase the deliveries attended by skilled health professionals. For achieving the goal, health centers were renovated to have a delivery room equipped with medical devices, teams of health workers consisting of doctors, nurses and midwives were provided with practical training on basic emergency obstetric care (BEmOC). The BEmOC training was conducted by the Ministry of Health with the cooperation of Philippine Obstetrics and Gynecology Society (POGS). In addition to those measures to improve the maternity care services, community members were organized to form village teams to identify expectant mothers, encourage them to seek care at public health facilities, and provide assistance in transportation to health facilities, especially in emergency. In poor rural villages such community support is essential to overcome socio-economic barriers to maternity care. In addition, subsidized enrollment in the social health insurance was promoted so that women could receive the childbirth care without paying charges. Insurance reimbursement also augmented cash income of the health centers which then could cover the compensation to the staff to attend deliveries at night. By addressing the issues from various aspects of the health system, i.e. personnel, facilities, and finance, the proportion of institutional delivery increased rapidly.

Conclusion

MCH has been one of the priority areas in JICA's health aid, but maternal health has received less attention and resources compared to child health in the past. Recent policy directions of JICA indicate that maternal health is more emphasized then before as a development goal, but the achievement so far requires further efforts and investments. Being a development partner that committed itself to the achievement of human security, JICA should further expand its support to health system strengthening which enables achievement of universal coverage of essential MCH care services.

[1] Ministry of Foreign Affairs. 2011. Japan's ODA white paper 2010 (Japanese).
[2] OECD. 2011. Imputed multilateral contributions to the Health Sector : Secretariat estimations (March 2011).
[3] JICA. 2011. Annual Report 2010.
[4] Umenai. 2001. Conference agreement on the definition of humanization and humanized care. International Journal of Gynecology & Obstetrics. 75, Supplement 1
[5] JICA. 2010. JICA's Operation in Health Sector : Present and Future.

3) Situation of Maternal, Newborn and Child Health (MNCH) in Resource-Limited Settings and Progress towards Millennium Development Goals 4 & 5 – Possible Ways in which Human Resources in Japan could Contribute to Improving MNCH around the World

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1. Maternal Deaths in Resource-Limited Settings

It is estimated that 358,000 women died during and following pregnancy and childbirth in 2008 worldwide, which is equivalent to approximately 1000 women dying every day. Of these deaths, 13,000 are estimated to occur in the Western Pacific Region, which consists of 37 countries and areas. It is well-known that maternal mortality disproportionately affects poor people and poor countries. 99% of all maternal deaths occur in developing countries. The lifetime risk of maternal death is 1 in 4300 in developed regions, but 1 in 120 in developing regions, and 1 in 31 in Sub-Saharan Africa. (Trends in Maternal Mortality 1990 to 2008 Estimated developed by WHO, UNICEF, UNFPA and the World Bank, 2010). In some countries, Estimated Maternal Mortality Ratios (MMR) are at the level of Japan a hundred years ago or more. MMR in developing countries is still unacceptably high.

2. Progress Towards Millennium Development Goals (MDGs) 4 & 5

The MDGs are eight international development goals which 193 United Nations (UN) Member States agreed to achieve by 2015. MDG4 is to improve child health- to reduce Under-Five Mortality rate (U5M) by two-thirds between 1990 and 2015. MDG5 is to improve maternal health- to reduce MMR by three-quarters between 1990 and 2015 and to achieve universal access to reproductive health.

Since 1990, U5M and MMR in developing regions have both declined by a third, U5M-from 89 deaths per 1,000 live births in 1990 to 60 in 2009, MMR- from 440 deaths per 100,000 live births to 290 in 2008. (MDG report, United Nations 2011). Substantial progress has been seen towards both MDG 4 & 5 targets but a lot remains to be done.

3. Accelerating Actions Towards Achieving MDGs 4 and 5 as a Global Agenda

As greater efforts are required to achieve MDGs 4&5, in the High-Level United Nations Meeting in 2010, UN Secretary-General Ban Ki-moon launched the '*Global Strategy for Women's and Children's Health*' (Hereafter Global Strategy). Many organizations – governments both in developed and develop-

ing countries, UN Agencies, professional organizations, academic institutes, NGOs, the private sector and stakeholders – pledged their commitment to it. As of 14 November 2011, 194 organizations declared their commitment, available on the UN website "Every Women Every Child" (http://www.everywomaneverychild.org/commitments/all-commitments). MNCH has become a priority global agenda. Between now and 2015 is a critical time to increase momentum toward achieving MDGs 4&5.

4. Improving Technical Aspects of Clinicians is Necessary, But May Not be Sufficient.

Many obstacles to delivering health services exist in resource-limited settings- shortages of human resources, commodities, and health facilities are common. Access to care is limited due to the burden of financial, geographical, social and cultural reasons, leading to three delays: *Delay in the decision to seek care, Delay in reaching care, Delay in receiving care*. It is still common for newborn and maternal deaths to occur outside health facilities. 37% women in developing regions were estimated not to be attended by skilled birth attendants during birth in 2008. The author believes that if Ob/Gyn doctors and midwives in developing countries were replaced by those from developed countries, the impacts and improvement might still be limited, as other obstacles to access remain. Technical support for existing human resources alone cannot reduce maternal and newborn mortality drastically. To improve MNCH, interventions beyond training & technical assistance are necessary.

5. Necessary Aspects to Improve Maternal, Newborn and Child Health

In order to accelerate MNCH, the Global Consensus for MNCH was set out and launched in 2009.

1). Political leadership, community engagement and mobilization
2). Effective health systems that deliver a package of high-quality interventions
3). Removing barriers to access, with services for women and children
4). Skilled and motivated health workers in the right place at the right time, with the necessary infrastructure, drugs, equipment and regulations
5). Accountability at all levels for credible results

Focused action is urgently needed, with co-ordinated external support.

6. Commitment and Contribution from Japan to the World

In 2010, the Japanese Prime Minister pledged 5 Billion Yen over five years from 2011 with the support of the Global Strategy and launched the Global Health Policy, which emphasizes MNCH, recognized by the global community. Japan has been contributing Official Development Assistance (ODA) to support development through bi-lateral (Grant-Aid, Loan, Technical Cooperation through JICA), and multi-lateral aid (UN Agencies and Fund) – in total $9.5 Billion ODA consisting of $6.1B bi-lateral aid and $3.4B multi-lateral aid in 2009. In financial terms, Japan is the 5th largest ODA provider in the world. (Japan ODA White Paper, 2010).

Besides ODA, several NGOs are working actively in MNCH. Moreover, Japanese health professionals are also working in development agencies and projects abroad. However, under-representation of Japanese staff in UN agencies continues. It is my personal view that the contribution by Japanese professionals related to MNCH as individuals and as professional bodies to the global knowledge base and to development agencies, including UN Agencies, could further improve. With the trend of a declining popula-

tion and ODA, a more strategic commitment and broader stakeholder involvement to enable the leveraging of outcomes are worth considering for Japan's future contributions.

7. Possible Ways in which Human Resources in Japan Could Contribute to Improving MNCH Around the World

Japan has a long history of reducing its maternal and child mortality– down to the lowest level in the world, through many factors– obviously both clinical and administrative human resources contributed to this. Human resources in Japan could contribute to MNCH around the world. Possible and feasible ways to do so are listed at Individual and Organizational levels (professional bodies, academic institution, and health facilities), with the assumption that implementers are primarily Ob/Gyn doctors, though some could also be done by midwives and nurses.

Individual level : some might be interested in volunteer jobs for clinical technical assistance if such clinical post exists. Others might want to be a long-term worker with development agencies such as JICA or UN agencies (This usually requires public health knowledge).

Organizational level : a) In Japan– to register organizations to global networks to receive information ; to advocate and to raise awareness of MNCH in developing countries at local & global levels ; to make linkage between professional societies in Japan and developing countries or between middle– and low–income countries to facilitate professional leaders to take more leadership in their own countries (i.e. funding some activities run by local professional bodies, such as fellowship programs, on-site training/supervision programs) ; to be a sister hospital and to implement exchange programs ; to conduct research to analyze Japanese experiences in improving MNCH to extract applicable issues for resource–limited settings ; to be a WHO Collaboration Center for further collaboration. b) Abroad– some experts could contribute to global technical panels which set standards and guidelines of MNCH ; to implement MNCH projects in collaboration with development agencies ; to conduct surveys in developing countries to find local solutions and to contribute to the global knowledge base.

8. Conclusion

Improving MNCH is a priority global agenda and coordinated actions are urgently requested. MNCH in the world is very challenging but there is definitely of lot of space in which to make improvements, with large populations awaiting assistance. Finally, the author is expecting more individuals and organizations in Japan, particularly professionals in MNCH to increase interest in this area and contribute to the people in need.

Disclaimer : Dr Hiromi Obara is a staff member of the World Health Organization. The views expressed do not necessarily represent the decisions, policy or views of the World Health Organization.

4) Capacity Building and Partnership, Agents for Improving Maternal and Newborn Health –The Lagos Island Maternity Hospital (LIMH) Experience

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OBJECTIVES :

1. To highlight the strategic role and immence potential of Lagos Island Maternity Hospital (LIMH) as regards maternal and newborn health by way of statistical review
2. To identify potential areas for capacity building and partnership.

METHODOLOGY :

The maternal and perinatal indices were calculated from data obtained from the records in the year preceeding definite interventions and the year after these interventions.

RESULTS :

Average birth per annum 3,056. Live births–2804 (91.7%). still births–326 (8.24%). Maternal deaths–175. The unbooked cases–156 (89.14%). The booked cases–19 (10.85%). The maternal mortality ratio was 6241 per 100,000 live births. For booked cases, the maternal mortality ratio was 677 per 100,000 live births. For unbooked cases, it was 5,563 per 100,000 live births.

After interventions in the area of capacity building and audit, preliminary report has shown that the maternal mortality ratio – 3453 per 100,000 live births. For booked patients – 123/100,000 live births.

CONCLUSION :

The trend before and after the commencement of specific interventions has shown a reduction in the maternal mortality ratio.

5) Maternal Health and its Challenge in Cambodia

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It is said that MDG5 is the most difficult to achieve and is underfunded among 8 MDGs. However, the Ministry of Health Cambodia has made great progress, that is, maternal and child mortality has reached MDG goal according to CDHS (Cambodia Demographic and Health Survey) 2010. There are also several process indicators which are well on course to meet CDHS such as antenatal care and assistance at delivery, and those indicators have markedly improved since 2005.

Health policy in Cambodia put priority to accelerate the further progress in the area of reproductive, maternal, new born and child health. 'The Fast Tack Initiative Road Map for reducing maternal and newborn mortality' was developed by the Ministry of Health in order to effectively guide efforts and investments for the sake of rapid, significant and lasting reductions. The Road Map stated that increasing number of midwife who is employed at all health facilities to ensure 24h/7day coverage for all deliveries. Moreover quality of service is required.

Supporting the quality of midwifery care, JICA project for improving Maternal and Newborn Care through Midwifery Capacity Development has launched in 2010. According to the results of baseline survey implemented by the Project, it shows that useful practices were not relatively done, while harmful practices tend to be performed. Besides, disrespect and abuse care by health care providers during labour and delivery were identified. For improving the quality of midwifery care, care providers as a professional should not provide 'manualized care', but they should respect dignity of woman and provide individualized care for each woman with utilization of evidence.