

# **The 15<sup>th</sup> ASEAN & Japan High Level Officials Meeting on Caring Societies**

**- Healthy Development of Children  
for Future Generations -**

## **Overall Summary**

Date: 31 October 2017

Venue: Hotel New Otani Hakata, Fukuoka, Japan

The 15th ASEAN and Japan High Level Officials Meeting on Caring Societies under the theme of “Healthy Development of Children for Future Generations” was held from 31 October to 2 November 2017, in Fukuoka, Japan, hosted by the Ministry of Health, Labour and Welfare, the Government of Japan (MHLW).

The meeting focused on collaboration between health care and social welfare services for the wellbeing of mothers and children.

At the meeting, we shared Japan’s past and recent experiences and their policy implications, and expected participants to actively contribute to policy discussions based on their own expertise and experiences.

Group photo of  
the 15<sup>th</sup> ASEAN & Japan High Level Officials Meeting on Caring Societies



## **1. Background of the meeting**

The ASEAN and Japan High-Level Officials Meeting on Caring Societies has been organized by the Ministry of Health, Labour and Welfare (MHLW) of Japan since 2003. The purpose of the meeting is to enhance human resource development in health and social welfare areas, and to strengthen Japan-ASEAN cooperative relationship.

This Meeting has been recognised as a vital platform to support the ASEAN plus Three (Japan, People's Republic of China, and Republic of Korea) Health Ministers' Meetings as well as the ASEAN Plus Three Ministerial Meetings on Social Welfare and Development. Japan reports the outcome of the Meeting to the ASEAN plus Three Ministers' Meetings.

Since 2011, MHLW has invited officials in charge of employment policies in addition to health and social welfare experts, with a view to promoting cooperation in these three related fields.

## **2. Date and Venue**

31 October (Tue) — 2 November (Thu) 2017, Fukuoka, Japan  
Hotel New Otani Hakata

## **3. Organiser**

Ministry of Health, Labour and Welfare (MHLW), the Government of Japan  
(Logistics: JTB Communication Design INC. (JCD))

## **4. Collaborators**

The ASEAN Secretariat  
World Health Organization (WHO)  
International Labour Organization (ILO) Office for Japan  
Japan International Cooperation Agency (JICA)  
Fukuoka Prefecture  
Fukuoka City  
Shingu Town  
Kitakyu-shu City

## **5. Expected Participants**

(1) ASEAN countries

Health sector, Welfare sector, Labour sector

\* Brunei Darussalam, Kingdom of Cambodia, Republic of Indonesia,

Lao People's Democratic Republic, Malaysia, Republic of the Union of Myanmar, Republic of the Philippines, Republic of Singapore, Kingdom of Thailand, Socialist Republic of Vietnam

(2) Observer Countries

People's Republic of China, Republic of Korea

(3) Collaborators

- The ASEAN Secretariat
- World Health Organization (WHO)
- International Labour Organization (ILO) Office for Japan
- Japan International Cooperation Agency (JICA)
- Fukuoka Prefecture
- Fukuoka City
- Shingu Town
- Kitakyu-shu City

(4) Keynote Speaker and Experts

- Dr. Takashi IGARASHI, C.E.O, National Center for Child Health and Development, Tokyo, Japan
- Dr. Tomoko KODAMA KAWASHIMA, Invited Senior Researcher, Department of International Health & Collaboration, National Institute of Public Health
- Prof. Kencho MATSUURA, Professor, Fukuoka Prefectural University
- Dr. Yoriko YASUKAWA, Senior Advisor to the Rector, University for Peace

## **Day 1: Tuesday, 31 October 2017**

### **Opening Remarks:**

Mr. Toru Kajiwara, Director, Office of Global Health Cooperation, Minister's Secretariat, Ministry of Health, Labour and Welfare, opened the meeting by welcoming all participants and introduced Dr. Yasuhiro Suzuki, Chief Medical & Global Health Officer, Vice-Minister for Health, Ministry of Health, Labour and Welfare (MHLW).



Dr. Suzuki extended a warm welcome to the participants on behalf of MHLW and expressed his gratitude to all the collaborators. He described that this meeting started in 2003 with the purpose of sharing knowledge, discussing and learning common challenges, exchanging good practices, and promoting cooperation among

Japan and ASEAN in the areas of health, labor and welfare. This year's theme is healthy development of children for future generations. Multi-sectoral cooperation on maternal child health and child welfare tailored to parents who need support for childcare is key to promoting the healthy development of all children. It is equally important to establish a firm mechanism to enable all stakeholders in society, such as central and local governments, communities, medical and welfare institutions, schools, and the private sector to collaborate with each other. In 2016, the Government of Japan launched "The Japan's Plan for Dynamic Engagement of All Citizens," which calls for initiatives to create a society where every woman who wants to have children can have children and every child strives towards his/her dream in a secure environment.

He raised three themes: maternal and child health; child welfare; and women's empowerment and childcare support. Firstly, improving maternal and child health is of vital importance as an early entry point for achieving universal health coverage. Japan now has one of the lowest maternal and infant mortality rates in the world. Secondly, it is important to ensure the provision of seamless support from pregnancy to child rearing through closer collaboration between maternal and child health and welfare sectors. Thirdly, Dr. Suzuki stressed the importance of women's empowerment and childcare support. Social advancement in recent years has resulted in dynamic changes in families,

lifestyle, and their environment. A policy framework must create a society where people can have a choice of having children as they wish by enhancing childcare services and promoting good working environments for mothers and fathers. These measures will contribute to developing an enabling environment to achieve the desired birthrate. He hoped that through this meeting the participants will learn from each other towards the betterment of child policies in Japan and ASEAN.

Ms. Akie Omagari, Vice Governor, Fukuoka Prefecture, Japan, welcomed all delegates from ASEAN member states, WHO, other international organizations, the People's Republic of China, and the Republic of Korea. She noted that the declining birthrate is a critical issue in Japan. In addition, mothers are not receiving adequate



help to raise their children, making them feel uneasy about child rearing. Fukuoka Prefecture has a five-year plan from 2015 to create a society where people who want to have children can do so and where the whole community supports child raising. She said it would be an honor if Fukuoka Prefecture's project for mothers and children can contribute to resolving the issues faced by ASEAN member states. Ms. Omagari hoped that this will be a fruitful meeting with many experiences shared, and that the participants will enjoy the delicious food that Fukuoka is famous for.



Dr. Sita Sumrit, Assistant Director, Poverty Eradication and Gender Division, ASEAN Secretariat, expressed her gratitude to MHLW for organizing this meeting. She stated that this year's theme is unique and forward-looking as it concerns children and future generations. By addressing the healthy development of children, it

raises the issues of gender equality of women in the labor market, health and social welfare, and human development in general. Although women and children are often considered as vulnerable groups to be protected and supported, they are in actuality valuable to society. This meeting is an essential platform that promotes a cross-sectoral

and holistic approach to addressing children's issues, which constitutes the core foundation of realizing the ASEAN Vision, the Sustainable Development Goals (SDGs), and human development progress at large. She was confident that this meeting will result in fruitful deliberation and strengthening the collaboration between ASEAN and Japan.

Mr. Kajiwara then introduced the speakers. This was followed by a commemorative photograph session.



Mr. Kajiwara explained that the purpose of this meeting is to compile the issues of social welfare and health, and to conduct policy discussions and share good practices. It is hoped that

ASEAN+3 can strengthen their human resources development in this area and enhance collaboration among the member states. The four sub-themes are: 1) developing infrastructure for secure and safe childbirth; 2) strengthening seamless support for pregnancy, childbirth, and child rearing; 3) actions for workers who need support for childcare; and 4) actions of governments for the healthy development of children. He noted that the intention of the meeting is to report to the ASEAN+3 ministerial meetings of labour, health, and social development.

He then invited Dr. Takashi Igarashi to give the keynote speech.

**Keynote Speech:**

**Health Development of Children for Future Generations**

**Dr. Takashi Igarashi, C.E.O, National Center for Child Health and Development**



Dr. Igarashi began by expressing gratitude for the kind support of countries in the aftermath of the Great East Japan Earthquake, and introducing his institution, the National Center for Child Health and Development (NCCHD) in Tokyo, which consists of the National Medical

Center for Children and Mothers and the National Research Institute for Child Health and Development.

WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of diseases.” Child health is more than about survival and the absence of diseases, and also about achieving the full developmental potential of each child. Preventing and curing diseases is but one of the many tasks for improving child health. Political support and universal implementation of evidence-based cost-effective interventions to improve child health is the key to success at the societal level.

He stated that Japan’s low level of neonatal and infant mortality rates are not good enough for child health. Over 100 years ago, the infant mortality rate was over 170 per 1,000 births, and now it is 1.9. Meanwhile, the neonatal mortality rate has fallen to 0.9. Most of the causes of infant mortality rate are congenital. Japan has succeeded in achieving a very low infant mortality rate for several reasons, including a national health insurance system that covers all people. It is easy for people to access clinics and hospitals in almost all areas in Japan. In addition, Japan uses the Maternal and Child Health (MCH) Handbook. Furthermore, Japan provides a population-based screening system and a health checkup system for all children, and has a high literacy rate. The MCH Handbook contains information about social services in the local area as well as systemic recording forms for the mother and newborn. The concept of the Handbook has spread from Japan to worldwide, including Bhutan, Timor-Leste, India, Indonesia, Cote d’Ivoire, Niger, Lao PDR, and more. Countries such as Afghanistan, Bangladesh, and the United States have partly developed the Handbook. However, its concept is not fully accepted by Western countries, which believe that medical and health records for the child and mother should be independent. In 2017, Japan started a new system for pre and postpartum care support centers called “Japanese Neuvola” in 720 places in the country.

Secondly, he stated that psychosocial evaluation and assistance for youth is insufficient in Japan. It must not be forgotten that children and youth are a biopsychosocial existence. The United States has an effective health supervision system for infants, children, and adolescents called “Bright Futures.” Health supervision visits are provided seven times during infancy, five times between 12 and 30 months old, and once a year between 3 and 21 years old. Children cannot enroll in schools without the visits. Japan does not have such a system, and instead has health examinations at schools. Children cannot discuss their psychosocial issues with a school doctor. Each school has a

counselor, but children do not want to seek advice from the counselor whom they do not know very well.

HEEADSSS psychosocial interview is used in the United States. Pediatricians can use it to evaluate how their teenager patients are coping with the pressures of daily living, especially in the context of electronic and social media. The first priority is to address the concerns of adolescents and their parents. Other priorities for discussion include learning to manage conflict nonviolently, instilling that no means no when dating or in sexual situations, and reinforcing that making and keeping friends is an important life skill. Japan hopes to set up a system to support children and youth bio-psychosocially.

Forty years ago, the five-year survival rate for overall childhood cancer was about 60%, and now it is 80%. Adolescent patients with difficult diseases are increasing and require care in Japan. Recent medical progress can save children with difficult diseases such as congenital heart diseases and malignancies as well as premature babies. However, survivors suffer from complications, and the joint team of the Japan Pediatric Society and MHLW has prepared guidelines to support them.

Children and youth with chronic diseases including asthma, obesity, diabetes, mental disorders, congenital heart anomalies, malignancies, and chronic renal disease are called children and youth with special health care needs, which is a new concept. It accounts for 17% of adolescents in the United States and 13% in Japan. Japan is the only country where the mean birthrate has fallen, probably caused by an increase in late childbearing in Japan. The low birthrate is due to intrauterine growth restriction that leads to various disorders in adults. Care and support for adolescents and youth with difficult diseases are one of the most important issues for pediatricians and related doctors in Japan.

Child poverty is on the rise in Japan, which could result in social exclusion. 13.9% of Japanese children under 17 years of age now live in poverty. Poverty denies children their rights and blights their lives with ill health, malnutrition, and impaired physical and mental development. Poverty also produces child abuse. The poverty rate in fatherless families is extremely high in Japan and is the highest in the world. The Government of Japan enacted the Promotion of Poverty Program for Children Act in 2015 to reduce the poverty rate of children to less than 10% by 2021. However, the Government has limited resources and do not have enough funding for this program. Therefore, a support project has been set up in the Nippon Foundation.

The national campaign plan “Healthy Parents and Children 21” was established, and its first phase of 2001-2014 aimed to create a society where every child can grow up healthy. The achievements of the first phase were evaluated in 2015, and the plan is now in the second phase of 2015-2024. In the first phase, 81% of the goals were achieved or improved, such as decreased prevalence of: abortion among teenagers; sexually transmitted infections among teenagers; emaciation of 15-year-old females; obese children; tobacco consumption among teenagers; and alcohol drinking among teenagers. There was also increased prevalence of keeping knowledge of anticonception among teenagers and having counselors at junior high schools. However, two goals were not improved: prevalence of premature babies; and suicide prevalence in youth. In the second phase, the new major goals are: 1) to ensure that every person born in Japan can equally receive maternal and child health services and life protections; and 2) to extend maternal and child health services to all people regardless of differences among individuals and in the family environment.

The Japanese Government started offering financial support for pediatric chronic specific diseases in 1968. Today, 722 pediatric chronic diseases are specified, and 130,000 children and youth are supported. Data of the patients and disease conditions are collected and statistically analyzed every year. This support is very helpful to the patients and families.

Dr. Kajiwara opened the floor for questions.

Indonesia commented on Dr. Igarashi’s reference to “health development” as opposed to “healthy development,” adding that not only health but also the collaboration of education, labor, welfare, family conditions, and other factors is important. Regarding the high prevalence of suicide in Japan, he suggested that maybe religion can be promoted to families as it is in the ASEAN member states. Dr. Igarashi stated that psychosocial care is unavailable for children at school. Teachers are too busy to provide psychosocial care, and school counselors work at several schools, staying at one school for only two or three hours a day. He noted that children may be able to seek advice from their pediatricians whom they have known since infancy.

Viet Nam commented that she was surprised to learn that 13.9% of Japanese children under 17 years of age are living in poverty. Dr. Igarashi stated that Japan does very well in childhood disease control and prevention but not well on issues of the mind, especially among adolescents.

Myanmar noted that it uses the MCH Handbook and asked how it can be distributed to all people. Dr. Igarashi responded that Japanese people can easily receive the Handbook from their local governments. In response to Myanmar's comment about Japan having a low maternal mortality rate, Dr. Igarashi stated that there are many places in Japan that provide care to babies and pregnant women. The local system covers 14 doctors' visits per pregnancy. The percentage of the fee paid by pregnant women depends on the location. In Okinawa or Fukushima, almost 100% of the fee is paid by the local government. Newborn care is one of the most advanced in Japan, and there are many neonatologists. All fees for the care and treatment of babies are zero throughout Japan, even if the baby stays in a hospital for four or five months.

Malaysia asked how the nine metabolic diseases for the initial screening were decided and whether the screenings were sustainable financially. Dr. Igarashi stated that they are sustainable because only treatable metabolic diseases were selected.

Lao PDR asked what Japan's policy was on nutrition. Dr. Igarashi responded that while the nutrition situation in Japan is good, poor children cannot eat breakfast every day and during the summer or winter holiday cannot eat school lunches. NPOs therefore prepare lunches or breakfasts for poor children.

The Philippines asked what specific interventions are provided under the Promotion of Poverty Program for Children Act. Dr. Igarashi explained that the program does not work very well due to the limited financial resources of the Japanese Government. In addition, in response to the Philippines' question regarding whether any studies have been conducted on the positive and negative impacts of social media on the health and growth of children, Dr. Igarashi commented that children are now advised to limit their social media use to one hour a day.

Indonesia asked for Dr. Igarashi's perspective on the new definition of poor children. Dr. Igarashi responded that poor is defined as having less than half of the average family income.

### **Presentations from Collaborative Organizations**

Prof. Shinjiro Nozaki, External Relations Officer, WHO Centre for Health Development, congratulated the Government of Japan and the ASEAN Secretariat for this meeting. He explained that Dr. Anthony Costello, Director, Department of Maternal, Newborn, Child

and Adolescent Health (MCA), WHO, was unable to attend this meeting due to a scheduling conflict.

Dr. Costello, through a video message, spoke on “global maternal and newborn health: progress and challenges.” He said Viet Nam, a country typical of the region, has seen a dramatic reduction in poverty rate and one of the fastest reductions in the stunting rate. Most countries in the region are below replacement level



(2.0 births per woman), and the poverty headcount ratio has done spectacularly better in the ASEAN region than other regions. Likewise, the infant mortality rate has fallen significantly in the region.

A recent paper showed that although urban-rural differences narrowed in Viet Nam, the gap is still there in some ethnic minorities, as is the case in other places of the world. In all countries, there is rising income inequality but the differences between Europe and Southeast Asia have narrowed. Generally speaking, there has been a dramatic increase in skilled birth attendance, facility delivery, and castration section. However, facility deliveries are still low in countries like Lao PDR and Papua New Guinea.

As the human development index improves, the ecological footprint worsens. Dr. Costello stated that he challenge now in the sustainable era is to be green, practice conservation, and have sustainable development, noting that the wealthy countries are now the problem.

The Global Strategy for Women’s, Children’s and Adolescent Health are centered on: 1) survive; 2) thrive; and 3) transform. Many more women are getting into hospitals but the quality of care they receive at delivery has room for improvement. In India, there is no clear relationship between care and the infant mortality rate. Some countries have a high maternal mortality rate and few caesarian sections. Most countries have too many caesarian sections too soon. In Bangladesh, 50% of pregnant women at hospitals have caesarian sections. There is thus the double problem of a lot of women not getting access to life-saving operations and a lot of women receiving caesarian sections they do

not need. Another issue is antimicrobial resistance, which is becoming a real threat in neonatal units.

WHO launched a network called “Quality, Equity, Dignity,” focusing on ten countries in Africa and Southeast Asia. It aims to halve facility deaths of newborns. The key issues are that it is country-led and ministries are in the leadership role. What are countries doing to provide leadership in quality improvement? What kind of learning networks are set up so that quality is improving continuously and how can hospitals, communities, and districts be made accountable for the care they are providing? In ASEAN this is much more about whether companionship is allowed and mothers are given access to their newborns 24 hours a day in neonatal units.

Attention needs to be paid so that intervention does not cause harm. There are many actions that are low cost, among which are skin-to-skin kangaroo care. Dr. Costello emphasized the importance of building the workforce of newborn nurses and being aware of dignity and respect. In New Delhi, mothers are trained to provide the basic care offered by nurses.

Stunting of children is dangerous because it also reflects stunting of brain. The United States was the only country that saw maternal mortality increase because of hypertension and other cardiovascular causes. The world also faces new and emerging threats such as Zika virus, requiring constant vigilance to see the scale of this virus and how it is mutating.

Breastfeeding is important, yet their rates fall as countries become wealthy. Breastfeeding reduces breast and ovarian cancers, protects against Type 2 diabetes and obesity, and pushes up IQ. It needs to be ensured that commercial interests such as the baby milk industry do not conflict with public health. Much more can be done to promote support for breastfeeding, before and after delivery to ensure that breastfeeding rates increase. Greater focus must also be placed on childhood obesity. Furthermore, there must be more outreach to adolescents in the 21st century to address issues specific to them, such as substance abuse, anxiety, depression, lack of physical activity, and overeating. There is a huge window of opportunity to address long-term problems and cut healthcare costs. In all health facilities, even in wealthy countries, social accountability is needed to hold social facilities accountable to provide respect and dignity.



Prof. Nozaki added that achieving universal health coverage is a focus of WHO. He also stated that with aging often seen as a threat for the future, WHO emphasizes considering a life-course approach that considers not only the aging population but also child supports to create a healthy aging situation.

Ms. Keiko Osaki, Senior Advisor (Health), Japan International Cooperation Agency (JICA), described that health is the main agenda of JICA's cooperation. JICA has three pillars for achieving the SDGs: 1) realizing "human security" and "quality growth" as longtime addressing key issues; 2) playing a



pivotal role in achieving 10 goals of the SDGs, making use of its own experience; and 3) working to secure impact on the SDGs by introducing innovations and collaborating with local and international partners. JICA's programs for maternal, newborn and child health (MNCH) are set in the context of achieving universal healthcare, providing a continuum of care, and implementing a multi-sectoral approach.

As a case study to support achieving universal healthcare through MNCH, Ms. Osaki gave the example of a JICA project in the Philippines, where only 50% of pregnant women were enrolled in the national health insurance program (PhilHealth) in the project sites. Within one year of the project, pregnant women's health insurance coverage increased from 50% to 70%. One of the lessons learned was that if the architecture of universal health insurance exists, the system works with some efforts, such as promoting accreditation of health facilities, and encouraging pregnant women to be enrolled at the antenatal care, to push for its implementation.

To ensure continuum of care in which mothers, children, and adolescents are cared for continuously, five pillars are addressed by the Philippines project. These five pillars are similar to the priority strategic objectives of the WHO's Every Newborn Action Plan

and Ending Preventable Maternal Mortality: 1) care around birth; 2) health system strengthening for quality care; 3) reach every woman and child; 4) harness power of community, family, and individuals; and 5) improve data.

Ms. Osaki also presented on the case of the global promotion of the MCH Handbook. Its expected outcomes include promotion of self-monitoring and self-learning of MNCH, guidance to health workers to ensure provision of national standard services, helping workers monitor clients, facilitating communications on MNCH between health workers, mothers, and families, and getting benefit beyond and above. The Handbook needs to be customized for the local context, and some have observed that the Handbook has potential not only for continuum of care, but also for universal health coverage (e.g., increasing governance, making sure standard contents are provided by local governments) and for empowerment of women and family. In Indonesia, the Handbook serves as a depot for programs such as community activities and mothers' classes. In the Philippines, the Handbook (Family Health Diary) is used to check if the mother is enrolled in insurance or not.

Multi-sectoral approach is still an issue for JICA. For example, as the health sector alone cannot tackle nutrition, Japan's Initiative for Food and Nutrition Security in Africa (IFNA) program is launched. To accelerate and motivate multi-sectoral stakeholders to design joint projects, conducting researches and exploring factors is started. Through a set of systematic reviews, researchers identified that education is a strong indicator for child survival beyond 28 days after birth, as well as for continuum of care and the composite coverage index (CCI), whereas road, electricity, and water were found to be positively correlated with continuum of care and/or CCI. The analysis does not indicate causal inference, but points to the possibility that the maternal and child health service coverage rate is influenced by the development of other sectors.

In realizing the three pillars of universal healthcare, continuum of care, and multi-sectoral approach, JICA and partner countries co-create knowledge. Japan and Thailand both have good practices and share them to other countries. There is also south-to-south cooperation. Indonesia has already hosted south-to-south cooperation for the MCH Handbook, inviting countries from Africa, Central Asia, Middle East, and Southeast Asia. Through south-to-south cooperation workshops, some discussions are held, and they enrich knowledge of implementation, such as how to increase its maturity of implementation, and how to sustain its effective implementation in health system.

They also explore the need of collective support by development partners and let WHO take actions to compile a guide.

JICA has supported MNCH and will continue to support MNCH through facilitating locally customized implementation, co-creation of knowledge of implementation, and its global sharing.

Thailand thanked JICA for introducing the MCH Handbook in his country and updated that Thailand is currently shifting to an electronic book for the new generation. Ms. Osaki appreciated that Thailand is not only adopting electronic devices but is also providing the Handbook in a stable manner through the National Health Security Office (NHSO), and that its lessons learned will be accepted by other countries. She said how to make a good marriage between hardcopy and electric handbooks is one of the current issues in some countries including Japan and as women in the countries tend to keep the Handbook accessible for many years, and thus, hardcopy books are still seen as having a purpose.

Singapore asked how governments can get access to data from the MCH Handbooks kept by mothers for research and policy purposes. Ms. Osaki responded that mothers have the right not to share their handbooks but that an option may be that researchers ask to see the data from the Handbooks upon their consent.

Indonesia commented that ministries in his country work in silo, which in turn limits impacts, and suggested that JICA hold meetings like this ASEAN-Japan High Level Officials Meeting in the capital cities of ASEAN by inviting ministries and promoting inter-ministry implementation.

Ms. Osaki thanked Indonesia for his suggestion and said she would discuss with relevant parties as well. She noted that the multi-sectoral approach is not easy because while JICA needs to respond to the voice of the country, sometimes the country voice comes only from one ministry, and that it would be easier for JICA to respond to a united voice.

### **Panel Session 1:**

#### **Developing Infrastructure for Secure and Safe Childbirth**



Dr. Tomoko Kodama Kawashima, Invited Senior Researcher, Department of International Health and Collaboration, National Institute of Public Health, Japan Board of Directors: Med. Corp. Assoc. “Midori-no-Kai”, acting as moderator for the Panel Discussion, delivered a presentation on people-centered

healthcare for secure and safe birth in Japan. Japan has an aging population combined with a diminishing number of children. The total fertility rate in 2015 was 1.45. The maternal mortality rate was 3.9 and infant mortality rate was 1.9 in 2015. The leading causes of maternal deaths are postpartum hemorrhage, obstetric embolism, and indirect obstetric causes. The mean mother’s age at first childbirth was 30.7 years old in 2016. The mean birthweight was 3,000 g in 2015. The early neonatal mortality rate by birthweight is high for babies weighing less than 500 g. 54% of babies are born in hospitals and 45% at clinics (less than 20 beds). Women choose clinics for their more comfortable accommodation.

A lump-sum allowance for childbirth is provided by health insurance (420,000 yen). Any medical costs are covered by health insurance. In 2009, the Japan Council of Quality Health Care began providing 16,000 yen per birth to cover premiums for the compensation system for a child born with cerebral palsy.

The characteristics of pregnant women and surroundings have changed over 50 years. In 1951, 61% of childbirth was in their mothers’ 20s, but decreased to 36% in 2014 and 58% of childbirth was in mothers’ 30s. The mean mother’s age at her first childbirth is 30.7 years old in 2016. The delay having children has higher risk of complication at childbirth. Also, fertility treatment is increasing. 51,001 babies or 5% of total births were fertilized extracorporeally in 2015.

National Survey reports 67% of mothers are working and decreasing three-generation families with children (14.7% in 2016, compared 27% in 1986), which means mothers receive less support within their families, expecting more support from community.

Williams B. and Grant G. defined in 1998 that a people-centered service must begin with the user’s views on what precisely the problem is within their own unique situation. However, sometime there is a gap between the thinking or priority between healthcare

professionals and mother at childbirth, All the efforts have to be done to achieve secure and safe birth. Current healthcare system for childbirth is people-centred in terms of respecting mother's choice enjoying comfortable accommodation with less medical intervention (such as delivery at clinic, maternity home etc), but once the critical situations happened, prompt medical treatment could be possible using perinatal medical care network system which refers to the facilities providing higher medication and intensive care.

From 1977, health checkups and health guidance for pregnant women, infants, and toddlers and other services were reorganized into municipal services. The Maternity and Child Health Law provides for health guidance, health examination, pregnancy notification to municipalities, MCH Handbook, notification of low birthweight infants to municipalities, and medical and infant care services. Since low birthweight infants have increased, NPO and local governments established the Little Baby Handbook for mothers with low birthweight babies. A nationwide survey shows Japan lacks formal postpartum care. 5-6% of mothers in Japan are in a depressive state within three months after delivery.

The perinatal medical care network system consists of the comprehensive center for perinatal medicine (104), regional center for emergency caesarian section (292) and general maternity unit (711 hospitals and 1,498 clinics).

The health care system in Japan achieved low maternal mortality and infant mortality rates but still needs to improve mother-to-child continuum of care and seamless care in the community.

She invited Lao PDR to give a presentation.

Dr. Panom Phongmany, Deputy Director General, Department of Hygiene and Health Promotion, Ministry of Health, Lao PDR, stated the Lao PDR has high under-five mortality rate of 86 per 1,000 live births and an infant mortality rate of 57 per 1,000 live births. The number of health facilities has increased,



including to 27 type A hospitals, 108 type B hospitals, and 1,055 health centers. The number of health facilities with at least one midwife has increased from 392 in 2014 to 965 in 2016.

Lao PDR has the Five-Year National Socio-economic Development Plan VIII 2016-2020. In the health sector, it has the VIII Health Sector Development Plan 2016-2020, the Health Sector Reform Framework to 2025, and the free MCH Policy. The MCH Policy is new for the country, providing free maternal and child health care for children.

More childcare supports are being offered to workers. Breastfeeding rooms are set up in workplaces. The family law has been revised to increase maternity leave from three months to five months for normal delivery of one child. There is also paternity leave for 15 working days. For the healthy development of children, routine health baby checkups are provided.

The lessons learned include that government leadership and ownership of MNCH and nutrition programming is essential. Coordination between different development partners working in MNCH and nutrition is key to improve the capacity of Ministry of Health staff. It is also important to prioritize high impact interventions for integrated MNCH and nutrition service delivery with a strong referral system and follow up at the community level.



Dr. Atthaphon Kaewsamrit, Deputy-Director General, Department of Health, Ministry of Public Health, Thailand, spoke about Thailand's infrastructure for safe and secure childbirth. Thailand uses the concept of "providing continuum of health care for safe and secure child birth and continue until the child grows up."

Under this concept, the MCH national standard has been established for hospitals, which has undergone a number of revisions to the current routine MCH standard in 2015.

There is at least one hospital for one district. There are almost 1,000 hospitals throughout the country. A universal health coverage scheme provides free of charge care for pregnancy, childbirth, and baby clinic services. 99% of pregnant women receive antenatal care services at least once.

Good practices from Thailand are that well-planned investments are made on building hospitals throughout the country. Universal health coverage provides accessible services for people. There are comprehensive benefit packages for maternal and child health, a prioritized national service plan that includes newborn and perinatal care, and one million community health volunteers who make home visits.

In distant areas, the referral system for emergency cases does not operate smoothly. Furthermore, the health literacy of pregnant women and parents needs to be improved to communicate about basic healthcare. Hard-to-reach groups are still difficult to reach, such as teenagers regarding pregnancy, hill tribes and mountainous people and migrants. Other remaining MCH health problems include low birthweight and teenage pregnancy.

The Government has the Child Support Grant Scheme (CSG) that promotes a child protection system in accordance with UN CRC, providing monthly allowance for poor families for three years and ensure quality care for 1,000 days. For children in difficult circumstances, the Government provides shelters for children and family, rehabilitation centers, and training centers.

The Government develops policy to enhance environment for motherhood. A female employee who is pregnant shall be entitled to maternity leave of not more than 90 days for each pregnancy, and an employer shall not terminate the employment of a female employee on the grounds of her pregnancy. Workplaces are encouraged to set up breastfeeding corners for lactating mothers. Capacity building is also provided to staff. Many intensive measures have been promoted including the establishment of daycare centers.

Ms. Duc Thi Minh Ha, Deputy Director General, International Cooperation Department, Ministry of Labour, Invalids and Social Affairs, Viet Nam, opened her presentation with an overview on the population.



Viet Nam is expected to be one of the fastest aging societies in the world in 10-15 years.

MCH has always been identified by the Vietnamese Government as one of the top priorities in improving people's health. Viet Nam has passed many laws and policies that create a solid infrastructure for safe and secure childbirth. The Constitution passed in 2013 regulated that "Everyone has the right to protection, health care and equality in the use of health services." The Prime Minister also approved the national strategy on nutrition.

Article 157 of the Labor Code regulates that female workers are entitled to leave before or after childbirth for six months. However, employers have complained, and there is currently discussion on whether the maternity leave needs to be reviewed from six months to four months. If mothers adopt a child, the adoption mother is entitled to six months of maternity leave. Male laborers who are paying social insurance are entitled to father leave of five days when their wives give birth. Evidence shows that paternity leave promotes a close relationship between the father and newborn.

By 2020, the Prime Minister targets having more than 90% of villages with health workers. The infant mortality rate has declined from 15.5% in 2011 to 14.7% in 2015 and the under-five mortality rate declined from 23.3% in 2011 to 22.1% in 2015. Stunting under five years dropped from 29.3% in 2010 to 24.6% in 2015. Viet Nam has smaller populations compared to other ASEAN countries and is trying to improve nutrition. 97.2% are immunized within one year. The pre-natal screening rates have increased from 1.5% in 2011 to 15% in 2015. Infant screening has increased from 6% in 2011 to 30% in 2015. By 2015, the model of pre-marital counseling and examinations has been expanded to 63 provinces and cities.

Challenges include high level of disparity in basic health indicators between urban and rural areas, higher maternal and infant mortality rates in some mountainous areas, limited financial investment for MCH, lack of programs and guidelines for mental healthcare and psychological and emotional development, poor data collection, serious pollution of environment, lack of service connection networks, low awareness of parents and caregivers, and gap between rich and poor.

Ms. Ha recommended that Viet Nam needs to enhance the law and speed up preparation and approval of the National Program on Integrated Early Childhood Development, increase investment in infrastructure, promote direct interventions to reduce the

maternal and neonatal mortality rates, organize a network of service supply suitable with culture, customs, and habits, and strengthen inter-sectoral coordination in implementing interventions to ensure safe and secure maternal health and childbirth..

Indonesia commented on ASEAN countries' difficulties with getting access to pregnant women and asked what the policy was for pregnant women who have no access to facilities, as well as for preventing common diseases and preventing the transmission of infectious diseases from mother to child.

Dr. Kaewsamrit stated that every pregnant woman is given medicine for anemia for free. For hospital deliveries, all services are free of charge for mothers. The transmission of HIV from mother to child has decreased. One of the best practices in Thailand is the provision of HIV checkups for all women and their husbands.

Dr. Phongmany said Lao PDR has a law on health promotion and a regulation on MCH. He noted that alternative care is covered but is difficult to access because of lack of staff, midwives, and nurses at health centers. He said almost all deliveries are at home.

Ms. Ha noted that Vietnam has a national strategy that set up indicators. By 2020, it targets to have more than 90% of villages with health workers and more than 95% of commune health station with midwives or pediatric physicians. These are some of the ways pregnant women can have access to health checkups. For preventing HIV/AIDS transmission, pre-marriage counseling is also a good way to raise awareness. Free treatment is also available in Viet Nam for mothers who are found to have HIV/AIDS.

Indonesia commented that it is not yet ready to implement the WHO policy on providing standard antenatal care and asked what the policies of other countries are. Dr. Kaewsamrit stated that Thailand's policy is to offer four antenatal cares because health literacy is a problem.

Myanmar commented that home delivery is still common, which is a major concern. Although it promotes institutional delivery, it still remains at around 40%. She asked what programs Lao PDR offers to promote institutional delivery instead of home delivery.

Dr. Phongmany responded that Lao PDR has an action plan to develop midwives to assist delivery at health centers, but that this is a major challenge and the maternal mortality rate is still high.

Philippines asked how compliance with national laws is enforced to improve health indicators, and if there are penalties if there is non-compliance. She also asked how much the premium for national insurance is to enable benefits to be provided to mothers and children. Dr. Kawashima noted that midwives are also responsible for linking with doctors to reassure the status of delivery. Midwives and obstetricians may deliver babies but if the clinic has a doctor they cooperate with them. The premium of the Japan Obstetric Compensation System for Cerebral Palsy is funded by the 16,000 yen for each birth, and the accumulated money goes towards compensation for cerebral palsy patients and their families.

## **Panel Session 2:**

### **Strengthening Seamless Support for Pregnancy, Childbirth, and Child Rearing**



Ms. Keiko Osaki, Senior Advisor (Health), JICA, acting as moderator, introduced the theme of the second panel session. Seamless support is necessary to be designed when different players are working for the same clients in different dimensions of the needed supports to the clients. As a given condition, many different players

are working in caring for pregnancy, childbirth, and child rearing. In reality in Asia, there are many vertical programs for immunization, nutrition, and maternal health, requiring strategic efforts to integrate the programs or at least move them in the same direction.

The MCH Handbook is people-centered. To fill the gaps to ensure continuum of care, timing is key. Care is accessed and received at different timings. There is also the gap of geographical settings. In rural areas of the Philippines, pregnant women can get antenatal services near their residences but need to go to town for late-term care and child delivery. Thirdly, if people are moving between private and public health facilities, it needs to be ensured that essential services are provided both at private and public

health facilities. Measures have been taken to convince private practitioners to use the MCH Handbook. In Burundi, the Handbook is stipulated in a joint ordinance by the ministry of health and the ministry of home affairs and contains a birth notification that can be filled in by health personnel. The mother or father simply shows the page to register the birth of their child without further efforts such as bring witnesses to the register points. The health sector is the potential to start inclusive service provision for children.

The community plays a role to ensure continuum of care. Kenya has a community unit that motivates people to access facilities. Rather than building more facilities, these people were recruited to encourage people's access to facilities. Community health workers could be an interface between people and facilities. The Kenya case has found that mothers who are either young or from poor households are more likely to find value in owning the MCH Booklet, when community health workers are active. This may imply that the MCH Booklet could serve as an effective and sustainable interface between vulnerable mothers and health services. Thus, the MCH Booklet should be strategically leveraged not only as a self-monitoring tool but also as a communication tool. In Ghana, the gap between the timings needs to be filled. Families are given a star if they visit centers to receive prenatal and postnatal care on time. This system gives families a clear image of their rights to receive these services and help them to take actions to get such services .

To ensure care continuum, gaps need to be designed to fill: care access/receipt at different timings along with the life course; care access/receipt at different geographical settings along with the life course; and care access/receipt at different facilities, both private and public, along with the life course. Care continuum is facilitated or ensured by different players including the health sector, non-health sector, community, and family.

Ms. Osaki welcomed Mr. Khim to give his presentation.

Mr. Sosamrach Khim, Chief of 2nd Overseas Placement Office and Slom Focal Point, Cambodia, discussed good practices and lessons learned on strengthening seamless support for



pregnancy, childbirth, and child rearing.

Article 183 of the Labour Law provides that enterprises with a minimum of 100 female workers establish a nearby nursing room and daycare center at workplaces and entitle female workers a maternity leave of 90 days. From 2018, employers will pay 120% salary to women employees during their maternity leave.

In 2015, the Government adopted a sub-decree on residential care management. The Ministry of Social affairs, Veterans, and Youth Rehabilitation established the 30% Reintegration Plan of Children from RCI to Families from 2016-2018. By implementing this Plan, the Ministry has two targets: care for children in community; and care for children in residential care. For the former there are three types of community care: group home; pagodas and other religious buildings; and boarding school or dormitory. Care for children in residential care has two types: residential care institutions; and transit home and temporary emergency accommodation.

The Ministry of Health established the Health Coverage Plan in 1996, and is currently executing the Health Strategic Plan 3 2016-2020. There are two guidelines, one for further enhancing the quality of health services through strengthening clinical techniques and management capacity of physicians, medical staff, and health officials, and the other to provide a clear direction for developing a dynamic, quality and responsive system which delivers continuously improving health services for all Cambodians.

The maternal mortality ratio is 170 per 100,000 live births, lower than the Cambodia MDG target of 250. Life expectancy at birth was 56 for males in 1990, increasing to 70.8 in 2015, while that for females increased from 51.2 to 66.7.

Malaysia asked whether there was a systematic mechanism that the Government adopted to achieve the payment of 120% salary to female workers on maternity leave from January 2018 and whether there is benchmarking with other countries. Mr. Khim stated that different stakeholders including employers and employees worked together to establish this.

Japan asked whether specific health services were provided at residential care and institutions for children and whether there are requirements for these facilities to collaborate with community workers. In addition, he asked what the percentage is of

children who are taken care of at these facilities versus children being taken care of at home and whether the ratio is rapidly changing.

Mr. Piseth Kang, Ministry of Health, Cambodia, noted that there are many national programs for children's health. If children are staying at facilities, staff perform medical checks to see if there is stunting or other symptoms. As regards facilities, there are children who stay at community homes who come to have breakfast, lunch, or dinner and then go back to school, as well as children who attend capacity building classes and then go back home. On the other hand, institutions provide accommodation. Mr. Kang stated that the Ministry encourages children to stay at home, as children living in institutions lose contact with their families.

Indonesia commented that Indonesia is trying to involve social health care workers, students, midwives, and others to go to communities and give out MCH Handbooks and implement other activities to decrease the under-five mortality rate, increase the number of mothers receiving prenatal care, and increase post-delivery rest.

Ms. Osaki thanked Mr. Khim for his presentation and looked forward to continuing the discussion on Day 3.

Mr. Kajiwara thanked the participants for their active discussion and closed the session.

## **Day 2: Wednesday, 1 November 2017**

### **Study Tour:**

Study visits to various facilities in Kobe city to study good practices proceeding with the construction of a resilient society against disasters. The trip to Disaster Reduction and Human Renovation Institution, Kobe Crisis Management Center and Minato no Mori Park involved studying disaster risk reduction and restoration in order to enhance countries' capabilities to respond to disasters.



Fukuoka City Chiyo Day Care Center



Sea-Ore Shingu



Villa Nozomi Children's Park



Fukuoka City Chuo Ward Health and Welfare Center



Woman Work Café Kitakyushu



## **Day 3: Thursday, 2 November 2017**

### **Overview of Study Tour:**



Mr. Kajiwara welcomed the participants to the final day of the meeting. He introduced the two experts who were not present on the first day and then invited Dr. Kawashima to take the floor.

Dr. Kawashima provided an overview of the study tour on the previous day.

In the morning, the participants went to the Fukuoka City Chiyo Day Care Center and Villa Nozomi Children's Park to observe childcare and supporting mothers. They also visited

Sea – Ore Shingu and the Fukuoka City Chuo Ward Health and Welfare Center to observe health examinations for infants and toddlers. Finally they visited the Women Work Café Kitakyushu. The participants also saw the MCH Handbook. She explained that the Handbook helped increase the percentage of mothers who reported their pregnancies during 12 to 19 weeks of pregnancy from 57% in 1965 to the present 92% within 11 weeks.

The Fukuoka Chuo Ward provides health checkups for children at 4 months, 10 months, 18 months, and 3 years. Health examinations of children are performed by teams of physicians, midwives, public health nurses, and registered nurses. The same health examination record is used for the 4-month and 3-year health examinations to make it easier to track a child's health status. The ward also provides counseling to mothers to address concerns about health and anxiety about childrearing.

Women Work Café Kitakyushu is Japan's first case of national, prefectural, and city collaboration that encourages mothers to work and facilitates childcare. Dr. Kawashima closed by noting that holistic care leads to encouraging women and families to continue to provide childcare in ideal settings.

Mr. Kajiwara added that Fukuoka City Chiyo Day Care Center is a public facility with a history of 60 years. In Chiyo, a city with the fastest growing population in Japan, the participants observed health examinations of 3-year-olds.

Ms. Osaki shared her observations from participating in the first study tour group. She explained that in Japan, health providers know where their pregnant women clients are and home visits have high coverage. She observed that firstly, not only health providers but also local governments have a major role to play in being aware of where their clients are. Secondly, the guidelines are established by the central government but are implemented in a decentralized way, offering opportunities to learn from local governments. Thirdly, she noted that the periodic child health examinations provided in Japan can offer lessons for other countries such as African and some Asian countries, where health examinations may be provided through a child's immunization period but not between immunization and entry into school.

#### **Presentations from Collaborative Organization and Expert:**

Ms. Akiko Taguchi, Director, ILO Office for Japan, presented on the International Labour Organisation (ILO) and its activities for the healthy development of children for future generations. ILO was created in 1919 as part of the Treaty of Versailles that ended World



War I, making it one of the oldest international organizations. The driving forces for ILO creation arose from economic, political, and humanitarian considerations. ILO's membership, unlike other international organizations, consists of not only governments but also representatives of workers and employers.

The 2030 Agenda was adopted at the UN Sustainable Development Summit in September 2015. The Decent Work Agenda became integral elements of the 2030 Agenda for the SDGs. Lack of decent work makes it difficult for parents to raise their own children. The ILO has developed the Decent Work Agenda which contains four strategic objectives: employment creation; social protection; rights at work; and social dialogue.

Although the total number of working poor has been decreasing in South-East Asia, there is still considerable vulnerable employment, making it necessary to improve working conditions.

Around the world, the biggest challenge of women who work at paid jobs is work-family balance, followed by affordable care and unfair treatment. Work-family balance and unfair treatment are major challenges in the South-Eastern Asian and Pacific region.

ILO has adopted the Domestic Workers Convention (C189) in 2011 concerning decent work for domestic workers. Domestic workers, many of whom work in Southeast Asia, support a lot of households with children but have poor working conditions. Making decent work a reality for domestic workers requires each individual to play their part, beginning with treating domestic workers with respect, recognizing their work, paying a decent wage, guaranteeing sufficient rest, and providing decent living conditions.

ILO adopted two conventions for the eradication of child labor: Convention 138 and Convention 182. The latter has been ratified by most member states. Children's involvement in child labor and hazardous work has substantially decreased in the Asia-Pacific. The highest number of children aged 5 to 17 engaged in child labor was found in Africa (72.1 million), followed by Asia-Pacific (62 million).

To achieve good nutrition, education, and health for children, she recommended having One UN policy where all UN organizations collaborate to attain the same goal. Furthermore, she recommended strengthening partnerships, which refer to partnership between governments, partnership between the private and public sectors, and partnership between developed and developing countries. She also proposed that good practices be shared, noting that sharing Japan's experience with many initiatives, some of which were unsuccessful, will help prevent other countries from repeating the same failure.

Mr. Kajiwara asked Ms. Taguchi to elaborate on Japan's failure. Ms. Taguchi gave the example of decent work deficit including long working hours, and lower productivity among the OECD member states. Ms. Taguchi also mentioned the wage gender gap that still remains significant.

Thailand asked about ILO's role in occupational health and safety in relation to the protection of employees. Ms. Taguchi stated that ILO has adopted more than 40 relevant conventions and recommendations. The Global Action for Prevention on Occupational Safety and Health (GAP-OSH programme) is included among the ILO five flagship programmes. In ASEAN member states, occupational health and safety projects are included in ILO/Japan Multi-bilateral Programme such as raising the awareness of employers to improve occupational health and safety standards. Technical assistance is also provided to strengthen capacity of government employees, especially labor inspectors.

With regard to domestic workers and decent work, Malaysia asked if Japan ratified Convention 189 which Malaysia has not. Ms. Taguchi responded that the convention has not been ratified by Japan and only the Philippines has in the region. Malaysia then asked the Philippines to share its experience with the implementation of the convention. Philippines answered that before ratification, an inter-agency taskforce was established to review the laws on domestic work, and domestic legislation was passed to provide benefits to domestic workers, including provision of social welfare benefits such as health insurance and paid leaves. It was noted that more than nine years was taken to amend the law on domestic work.

Malaysia underscored that while domestic workers is often discussed in reference to women, the discussion should be conducted in relation to women and children's health.



Dr. Sumrit delivered a presentation on ASEAN health cooperation relevant to the healthy development of children. Under the ASEAN Post-2015 Health Development Agenda, there is Health Cluster 1 on promoting healthy lifestyle. Health Priority 1 is on non-communicable diseases (NCDs). Health Priority 2 is on reduction of tobacco consumption and harmful use of alcohol. Health Priority 3 is on prevention of injuries, such as from road traffic crashes. Health Priority 5 concerns promotion of mental health. Health Priority 7 focuses on promotion of good nutrition and healthy diet.

The ASEAN Breastfeeding Forum was held in August 2017 in Manila. ASEAN plans to mainstream maternal protection, integrate mother and baby-friendly health standards in health service delivery and facilities, and construct and design national communication strategies for infant and young child feeding.

Health Cluster 2 is about responding to all hazards and emerging threats. Under Health Cluster 3, ASEAN is development recommendations on quality healthcare that cover women, children, and migrants.

She emphasized that healthy development of children should be discussed in the context of the minimal and maximal concepts of being healthy. It is pivotal to understand that children are not a homogenous group and include children with disabilities, children of ethnic minorities, and children with special needs. She highlighted that the work on violence against children is critical to their healthy development as violence includes neglect and lack of care. Malaysia has a plan on child development index, which is important to understanding the development of children across ASEAN. Although maternal and children's health is discussed, it is misleading to talk about children's health as a women's issue. That is why ASEAN promotes gender mainstreaming and inclusive society, and also focuses on gender budgeting in the labor market. It is important to involve men in the discussion on child development, which is not mentioned in this meeting. Furthermore, she underlined that social protection indicators are being developed for ASEAN and that two of the proposed indicators are directly related to maternity leave and safe delivery of children by trained health professionals. The latter touches upon the issue of child poverty, and ASEAN works to have children at the heart of the SDGs.

In conclusion, she urged this meeting to continue the dialogue, using a more cross-sectoral approach and thinking further on the engagement of men and putting less burden on women.

Indonesia asked Ms. Taguchi to explain ILO's policy on migrants. Ms. Taguchi responded that labour migration was on the agenda of the last International Labour Conference, which has adopted resolution concerning fair and effective labour migration governance. Migrant policy must be beneficial for countries of origin, transit and destination as well as the migrants themselves and national populations. In this sense, ILO seeks to develop labour migration governance model, including skills recognition and development, capacity building of migrant recruitment agencies,

facilitating access to social protection. Vulnerable migrants such as women are increasing, but at the same time, are more subject to violence by employers. She said ILO is working hard to protect the human rights and working conditions of migrant workers.

Dr. Sumrit stated that ASEAN sectoral bodies are addressing the issue of migrant women as a collaborative effort. She encouraged participants to take a look at a recent ASEAN publication on women migrant workers in ASEAN, which touches upon social protection policies. By the end of December ASEAN will publish a scoping study on strengthening social protection of women migrants from conflict and disaster.

Philippines shared that at the ASEAN Summit that her country will be hosting in 2017, eight outcome documents will be signed, noted, or adopted by the leaders. She noted that the ASEAN consensus on migrant workers is a collaborative effort that was ten years in the making, and that it will pave the way to create an action plan. She also highlighted that there are outcome documents on topics such as the youth development index and culture of preventing violence against children. Philippines welcomed the signing, noting, and adoption of these documents that will improve the welfare of children.

Viet Nam noted that ASEAN member states do not have sufficient resources to implement all health priorities. He stated that in particular, reducing stunting is important for Viet Nam but that reducing stunting among ethnic minorities is difficult.

Indonesia noted that it conducted a national survey on violence against children in 2013 and another survey will be conducted in 2018, and that the results could contribute to forums such as this meeting.

Prof. Kencho Matsuura, Professor, Fukuoka Prefectural University, opened his presentation by describing the “childrearing salon” held once a year to support childrearing of mothers and promote students’ knowledge on child development in Fukuoka Prefecture. He said at least five official agencies are in charge of child abuse,



which causes inter-agency communication problems. Child abuse as defined in the Child Abuse Prevention Act refers to physical abuse, sexual abuse, psychological abuse, and neglect. The number of child abuse cases to child guidance centers is rising. Every municipality must establish local councils that determine measures for children who need protection including community groups. Secondly, community-based support networks are available nationwide. Fukuoka Prefecture has the worst record in terms of the number of children involved in reported instances of child abuse

In Iizuka City, council meetings review all reported cases of child abuse. Iizuka Hospital, to which many local abused children are taken, runs a community child protection team that reviews cases in order to determine the effectiveness and the speed of its response. A better community network for saving children is the constant objective. A research project to create an information system for all children from prenatal period to 15 years of age has been started at in Kama City.

The number of foster homes was 603 in Japan in 2016. The number of children living in foster homes was 27,288 in Japan in 2016. The main reason for admission is child abuse (37.9% in 2013). In Tagawa, local youth guidance volunteers, police officers, and university students are working together to give children opportunities for sports activities, so as to imbue them with experience and greater emotional control. To combat low academic performance, university students give students after-school study support. To combat their lack of family experience, the social education sector of the Ministry of Education, Culture, Sports, Science and Technology (MEXT) and university students take foster children on a two-day excursion outside of the foster home.

Another issue is the rise of children exhibiting high levels of school absenteeism. 126,000 primary and junior high school students were reported absent from school. School absenteeism is defined as “more than 30 days of absence from school over a year.” Apathy is the most prevalent factor (30.2%). Absenteeism continues into adulthood, resulting in incomplete high school education and an inability to interact with society in adulthood. Health and/or welfare services hardly reach out to them, making prevention of absenteeism critical. 541,000 people were in social withdrawal in Japan in 2015. Fukuoka Prefectural University is a key player in offering community support for children exhibiting absenteeism. The university has a support center for children that gives consultation to parents, teachers, and related persons, and runs an alternative school (free school) for children exhibiting absenteeism. Around 10-14

students from various schools attend the free school every weekday with no long-term vacations, where university students participate as teachers.

16.3% of children were below the poverty line in 2015 and the percentage is steadily increasing. Japan has the world's highest poverty rate for working poor. Working poor families are socially invisible. Community-based "Cafeterias for Children" are becoming popular, numbering more than 400 nationwide. They provide not only meals for children but also help with homework. Kitakyushu City has eight cafeterias in the city, two of which are officially funded and six of which are community-run. A food bank NPO plays a key role in collecting donated surplus food which is safe for consumption. Most of the cafeterias are open once a week at community centers. Senior volunteers cook meals under the supervision of the city. Some of the seniors are living alone and isolated from society, and are thus making community ties in this way. University student volunteers support children with their homework. The three important sectors are schools, companies, and the community. The City of Kitakyushu sends professional staff members to two public cafeterias to ensure hygiene and nutritional management. Many cafeterias in Japan have been closed because of difficulties in providing sustainable management. The most important role for the local administration is to join and connect as many sectors as are required, and to include the official, community, and private levels. This is the key factor in community-based activities for the development and empowerment of a caring society.

Indonesia asked Prof. Matsuura to explain about the creation of community-based cafeterias and about outreach to neglected children to promote their visits to the cafeterias. Prof. Matsuura responded that while the idea of cafeterias originated at the community level, an inter-sectoral effort has begun at the national level with a taskforce being established within the cabinet to bring together multiple ministers. Since cafeterias are difficult to run due to lack of financial resources, their management has been delegated to local governments.

Dr. Yoriko Yasukawa, Senior Advisor to the Rector, University for Peace, asked whether there is a real increase in the incidence of child abuse or whether it is greater reporting of child abuse. Prof. Matsuura answered that regulatory changes that made it mandatory to report child abuse cases about 10 years ago and to report suspected child abuse cases about 6 years ago have indeed resulted in more reported cases.

Myanmar asked why single-mother families are increasing and what actions he would like to see taken to reduce single-mother families in Japan. Prof. Matsuura was unsure whether there are effective government policies to reduce the divorce rate. He believed that it is easier to get divorced in Japan than in Myanmar in the legal context.

Philippines asked whether some children are in more than one foster home and for an explanation of specific interventions regarding young boys or men who suffer from social withdrawal. Prof. Matsuura responded that the number of children in foster homes is decreasing nationwide with the rise in the number of foster parents. He said MHLW has a national project to decrease social withdrawal by giving them short-term jobs and encouraging them to leave their homes.

### **Panel Session 3:**

#### **Actions for Workers Who Need Support for Childcare**



Dr. Yoriko Yasukawa, Senior Advisor to the Rector, University for Peace, acting as moderator for the Panel Discussion, opened by noting that the idea of caring societies is part of the ASEAN Vision and was encouraged by the efforts of government and business leaders. This panel is on childcare needs of workers, which is of special

relevance to women. It relates to SDG5 on the achievement of gender equality and SDG8 on full productive employment and decent work for all men and women. It is an ethical imperative to realize gender quality, which is also key to building caring and cohesive societies and on that foundation building lasting peace. Societies with greater gender equality are less likely to enter into violent conflict. Involving women in conflict resolution increases probability of peace and lasting peace. Women also tend to exercise more inclusive leadership and engage in dialogue. Gender equality will furthermore lead to more equitable distribution of the benefits of economic growth. Access to adequate childcare and ensuring time and freedom for men and women to be with their children are critical. It is also important for the well-being of children and families themselves.

She concluded by mentioning that the World Economic Forum has just published the gender gap index, and that Japan has fallen to the 114th ranking. The Philippines is

among the top 10 performers globally largely because of women's participation in politics. The Philippines has also fully closed the gender gap in education. In general, countries all have difficulties in closing the political and economic gaps. Malaysia has improved on economic participation and ranks 5th in perceptions of wage equality. In Japan, there are few women in technical and professional jobs and in parliament. Aside from objective data, attitudes need to be changed as a large proportion of the population does not believe in gender equality. The World Values Survey published in this year's UNFPA State of the World Population report shows many believe there should be gender equality in university education but not in employment. In this region only Thailand is an exception where 40% believe there should be equal access to employment. The attitudinal shift must start from childhood. She stated that it is important not only to ensure material care for children but also happy families where men and women can participate equally and enjoy each other.

Mrs. Nor Fathiah Raduwan, Assistant Secretary, Policy Division, Ministry of Women, Family and Community Development, Malaysia, presented on childcare in Malaysia. The country has 2.7 million children aged 0-4. The total fertility rate is 2.0% and the infant mortality rate is 6.9%. The total percentage of people aged 65 years and



older is 6.0%. Female participation in the labor force has increased from 49.5% in 2012 to 54.3% in 2016. In Malaysia, there are two laws to monitor and regulate childcare: Childcare Centre Act 1984; and Childcare Centre Regulations 2012. Both were enacted to provide for the registration, inspection, and enforcement of childcare centers and matters related to childcare from birth to four years old.

There are five categories of childcare centers: 1) home based childcare center; 2) institution childcare center; 3) community childcare center; 4) childcare center at workplace; and 5) childcare center for PWD. In order to increase the work participation rates among women and to encourage the public and private sectors to establish their own childcare centers at their workplaces, the Government has introduced an incentive of RM200,000 to any government office to establish childcare centers at workplaces. In the private sector, double deduction is offered on expenditures incurred for the provision and maintenance of childcare centers at workplaces, a double deduction is provided on

childcare allowance given to employees, and industrial building allowance is offered at 10% annually for buildings used as childcare centers. At the individual level, tax release amounting to RM1,000 is available for parents who send children aged 0-6 to a registered childcare center or pre-school.

The Government also provides subsidies. For a government work based center, a subsidy of RM180 per month is provided for each child. For a private childcare center, a subsidy of RM250 per month is provided for each child. These subsidies target low household income families so that mothers can work and increase their household income.



Ms. Khin May Nu, Assistant Secretary, Minister's Office, Ministry of Social Welfare, Relief and Resettlement, Myanmar, shared information on action for workers who need support for childcare in Myanmar. The Ministry of Social Welfare, Relief and Resettlement is the focal ministry for child's rights and women and children.

It runs 7 residential nurseries and 103 pre-primary schools. For each voluntary pre-primary school, 6 lakhs is provided for teacher's salary and 1 lakh for teaching aids. It also provides child development trainings to mothers from mother circles.

Myanmar plans to expand parental education and community based ECD programs. Every child from a residential nursery shall have the right to be adopted in accordance with the Child Law. Assistance of 5 lakhs is provided to mothers who give multiple births (3 or more). All of Myanmar's vulnerable children from birth to five years of age with developmental delays, malnutrition, disabilities and other special needs are able to access high quality ECI services in order to enjoy their rights and achieve their full development potential.

According to the National Social Protection Strategic Plan, eight flagships programs are being implemented. The maternal and child cash transfer program is being implemented based on a two-pronged strategy of cash and allowance. MMK 30,000 is provided for each pregnant woman every two months until her child turns 24 months. At the same time, programs are offered to increase awareness on health, nutrition, hygiene, family

planning, and birth spacing. After implementing the pilot project, the program will be implemented nationwide so that universal cash allowance will be given to all pregnant women until children turn age two.

Present supports for mothers include: proper antenatal care; skilled and institutional delivery and postnatal care; expansion of post-abortion care and quality birth spacing services; emergency obstetric care; essential newborn care; adolescent reproductive health; promoting male involvement in reproductive; cervical cancer screening, early diagnosis and treatment; and promoting referral system and community volunteers.

More than half of women aged 15-19 and about two-thirds of older women in Myanmar are employed. Women with no living children are more likely to be employed (69%) than women with children (62%-66%). According to the law of civil servants, maternity leave of six months with full salary after confinement is provided. Fathers who are insured are entitled to enjoy paternity leave for confinement of his wife of 15 day leaves, receiving 70% of the average wage of the previous year.

Ms. Florita R. Villar, Undersecretary of the Office of the Undersecretary for Policy and Plans Group, Department of Social Welfare and Development, Philippines, delivered a presentation on actions for workers who need support for childcare in her country. According to the 2015 Census, the total population in the Philippines is 100,981,437 persons, with males slightly outnumbering females. 3 in 5 persons aged 15 years old and above are in the labor workforce. Of the 39.3 million employed persons in January 2017, 62.3% were males while 37.7% were females. Philippine women are active in the labor force. Most working women are in the age group of 25-44 years old.



She highlighted that mothers engage in paid work to help their husbands earn a living while conducting household chores. The quality of care during the first eight years of life is critical, which is best done by parents at homes. If both parents are working, the Government provides services to help mothers with their household responsibilities, and at the same time, become active contributors to development.

Ms. Villar then provided an overview of the relevant laws and policies. The Constitution provides for the protection of the life of the mother and the life of the unborn from conception. The Labor Code prohibits stipulation against marriage and acts of discrimination concerning the reproductive function of women. It is unlawful for the employer to require a women employee to not get married, to dismiss a women employee for getting pregnant, or to dismiss a women employee after returning from maternity leave. The Labor Code also establishes standards to ensure the safety and health of women employees, and for private establishments to maintain a clinic or infirmary which shall provide free family planning services. The Labor Code further provides for alternative measures for night work for pregnant and nursing employees, and for the extension of maternity leave where transfer to day work is not possible. A cash entitlement amount is provided for a daily maternity benefit equivalent to 100% of a female employee's average daily salary for 60 days in the case of normal delivery and 78 days in the case of caesarian delivery. The maternity benefit is paid only for the first four deliveries or miscarriages, also as a measure to encourage no more than four children.

The Republic Act 6972 provides for the establishment of day care centers in every village. More recently, laws have been passed to boost early childhood care to provide care for children aged 0-8 years which are considered crucial to a child's life. Most of the laws have been translated into services, one of which is day care service that is provided to 0-5 year old children of parents who find it difficult to fully take care of their children during part of the day because of work or other reasons. In communities that do not have a capability to establish a day care center, Supervised Neighborhood Play is available. Child Minding Centers are also available for children ages 0-3. In addition, the Pantawid Pamilyang Pilipino Program is intended to ensure that children grow up healthy and stay in school. As for center-based services, there are the Reception Study Center for Children (RSCC) and Child Friendly Spaces that enable parents to go about their activities in the aftermath of natural disasters without having to worry about their children.

Mr. Kajiwara asked what role employers have in providing childcare facilities and whether the public sector has a role in providing these services. Ms. Nu stated that private childcare centers are self-funded. In the public sector, caregivers and preschool teachers are subsidized, especially at the ministry level. Ms. Villar commented that pending bills make it mandatory for employers in the private sector to operate facilities. More than 50,000 day care centers are currently run by local governments, and people

working in the public and private sectors can bring their children to the centers. If women are lactating, a law provides that both public and private sectors must provide space for lactation stations. Mrs. Raduwan said that in Malaysia, the Government provides start-up grants for childcare centers, but that in the private sector, many childcare centers are operated by NGOs which are self-funded with fees collected from parents.

Viet Nam asked Mrs. Raduwan about the reduction of child allowance and Ms. Villar about the difference in the number of days of leave between normal and caesarian deliveries. Mrs. Raduwan responded that the Government introduced double-reductions for the private sector that establish a day care center at the workplace, in order to encourage employers to establish such facilities for employees and for more women to participate in the workforce. Mrs. Raduwan's colleague from Malaysia added that flexibility is given to employers. There is no specific regulation that obligates the private sector to offer day care centers. Ms. Villar responded that it gives a longer maternity leave is provided for caesarian deliveries due to the longer recovery time. She believed that once maternity leave is increased to 100 days, paternity leave would also be increased, but that the exact number of days would depend on which bill is passed.

#### **Panel Session 4:**

#### **Actions of Governments for Healthy Development of Children**



Dr. Sumrit, acting as moderator for the Panel Discussion, invited Dr. Nuryana to take the floor.

Dr. Mu'man Nuryana, Senior Researcher for Social Welfare, Senior Advisor to the Ministry for Social Accessibility, Indonesia, presented on the actions of governments for the



healthy development of children. An effective socioeconomic policy can support the healthy development of children. Health in the early years, starting with health of mothers before pregnancy, is critical. A vital and productive society rests on healthy child development. Nutrition is most important in the early stage of life. Indonesia is still in progress to improve the nutrition situation. The most commonly observed growth disorder is speech delay.

Indonesia's national priorities in health development (2015-2019) have four indicators: maternal mortality ratio and infant mortality ratio reduction; nutrition improvement, especially stunting; communicable disease prevention and control; and non-communicable disease prevention and control. The Government has taken actions for the healthy development of children. Specifically, for early child development, the Government is promoting a four-step framework that is comprised of understanding the biology of health of early years of life (e.g., psychological adaptations or disruption), building the foundations of health (e.g., safe and supportive environments, appropriate nutrition), strengthening the capacity of caregivers (e.g., parenting skills), and using policies and programs as levers for innovation.

The family health program with a life cycle approach begins with antenatal care, delivery, postnatal care, and neonatal care. Indonesia has three books adapted from Japan's MCH Handbook. The second component is quality postnatal care, including exclusive breastfeeding counseling and postpartum family planning. The third component is integrated community post, including feeding program for children under five. The cycle then moves on to integrated school health programs, pre-marital counseling, and quality of elderly health.

For the healthy development of children, the Government's strategy is to: provide health coverage and access; support early social, emotional and behavioral health; ensure school readiness by age five; and support parents to ensure children thrive. He concluded that providing healthy children is a priority to ensure quality of long life. The stability, prosperity, and sustainability of a society depend on the development of a healthy population by emphasizing four dimensions associated with high performance: quality, access, efficiency, and fairness. Effective promotion of healthy development of children is more dependent on ensuring the availability and affordability of high quality medical care, further underscoring the need for new creative strategies to improve the health of nations.



Mr. Alex Fun, Director, School Health and Outreach Division, Health Promotion Board, Singapore, shared that Singapore had embarked on initiatives to safeguard the healthy development of children and had interesting insights to share. He explained that in the last decade, the average weight of the Singapore

population's had increased by 3 kg. Studies have also found that the adult population is eating more and consuming as much as 600 calories above the daily recommended level, putting the population at risk for obesity. 10% of five-year-olds are already overweight. Longitudinal studies have also found that 70% of children who were overweight at age seven will continue to be overweight as adults. Data demonstrates that young people are consuming more sweetened beverages and less fruits and vegetables. Although physical activity levels have increased, many factors are contributing to obesity, such as people consuming more calorie dense and nutrient-poor foods and drinks, consuming more frequently, having foods delivered to them, and perceiving that healthy food is not tasty.

Singapore has invested in a national food strategy designed to shape citizens' eating habits by reducing diet quantity and improving diet quality, focusing on: eating balanced and healthy meals; drinking water or lower sugar drinks; and eating less calories, sugar, saturated fat, and more wholegrain. The Healthier Choice Symbol promotes people to purchase healthier choice food products, of which more than 2,500 products are already available. The Government also encourages food establishments to serve meals that are lower in calories and higher in wholegrain, cook food with healthier oil. Public Service Agencies are early adopters for healthier catering services which serve healthier choice food and water as first choice. Schools also must follow guidelines that encourage them to serve meals higher in wholegrain, fruits and vegetables and beverages with lower sugar.

Knowledge can only work so far. It is difficult to change eating habits at population level if the environment is not supportive towards healthy eating. Therefore, an eco-systemic approach is promoted to make the healthier choice default, change the environment and context to nudge consumers, and generate demand for healthier options. Two months ago, the Government has also started the Eat, Drink and Shop

Healthy campaign to encourage population purchase and consume healthier choice foods and drinks. The campaign will be on going throughout the year in order to cultivate the healthy eating habits among citizens.

The Healthy Meals in School Programme (HMSP) was used as an example to illustrate how government policies were implemented, enforced and evaluated to drive health promotion in Singapore. In the early stage of HMSP, guidelines to improve the quality and taste of food served in childcare and educational institutions was developed and recommended to schools. It immediately faced with challenges, such as poorly trained vendors, storage issues, inadequate healthy supply options, and students discarding fruits and vegetables. Since the adoption rate of the guidelines was low, it was necessary to gain support from multiple stakeholders to create a supportive and sustainable environment, including other government agencies, schools, cooks/canteen vendors, students, and parents. With time, compliance with the guidelines increased, sales and consumption of healthier foods and drinks in schools improved. Today, 100% of schools and more than 70% of childcare centres serve healthier meals. It was found that with default healthy meals and the use of repeated cues, behavior has changed, including greater acceptance of fruits/vegetables and preschoolers encouraging their parents to purchase healthier options.

In three years the situation has improved. It was learned that all key stakeholders had to be engaged and kept updated proactively. It had to be ensured that there is market availability of healthier products to meet requirements. A phased approach must be implemented as schools have different readiness and needs. It is also necessary to put in place a compliance audit process to ensure that schools continue to abide with the requirements, and provide value-added products and services to make it easy for stakeholders to implement the guidelines.

Dr. Sumrit thanked the presenters and closed the session by looking forward to continued discussions.

#### **Adoption of Recommendations:**

Mr. Kajiwara opened the discussion of the draft recommendations. He read out the preamble and asked whether the participants had any comments. There were none.

Mr. Kajiwara read out the text, paragraph by paragraph. There were no comments about paragraphs 1-3.

Thailand proposed deleting “without” from “without leaving no one behind.” Paragraph 4 was adopted with no further changes.

Viet Nam opined that paragraphs 1-4 were more a preamble than recommendations. Mr. Kajiwara suggested keeping the paragraph numbers and modifying “Reaffirm” to “Reaffirming” in paragraph 1, “Stress” to “Stressing” in paragraph 2, “Reaffirm” to “Reaffirming” in paragraph 3, and “Emphasise” to “Emphasising” in paragraph 4.

There were no comments on paragraphs 5-6.

Regarding paragraph 7, Indonesia proposed changing “health facilities” to “health and welfare facilities.” The paragraph was adopted with no further changes.

For paragraph 8, Mr. Kajiwara proposed revising “their family” to “their families.” The paragraph was adopted with no further changes.

There were no comments on paragraphs 9-10.

For paragraph 11, Mr. Kajiwara proposed amending “ASEAN Member States” to “ASEAN Member States and plus three countries.” The paragraph was adopted with no further changes.

Indonesia wished to include other points based on the field visit, such as a statement on avoiding the possibility of sexual exploitation of children when living alone at home. He noted that Genki-no-mori in Kitakyushu was a good example of initiatives to address this issue. Mr. Kajiwara proposed adding a new paragraph after paragraph 8, and the following paragraph was added: “Promote a safe and secure environment for children and parents which enables them to play, bond and build resilient closer relationship for healthy development of children.”

Myanmar proposed adding “Recommendation” before paragraph 5. Viet Nam suggested that text to the effect of “Have agreed on the following recommendations” be added after paragraph 4 and that Secretariat can then refine the text.

With no further comments, the recommendations were adopted.



**Closing Ceremony:**

Mr. Kajiwara invited the closing speaker to take the stage.



Mr. Kazuhisa Takahashi, Deputy Assistant Minister for International Policy Planning, International Affairs Division, Minister's Secretariat, MHLW, thanked the moderators and presenters for sharing their experience. The exchanges have deepened the knowledge and mutual understanding of Japan and ASEAN. He

congratulated the participants on the fruitful discussions, especially the recommendations that were just adopted. He stated that Japan has a low birthrate, leading to a situation which some experts call a “silent crisis.” About half of the ASEAN member states present also have low fertility rates and may face similar situations in the future. He hoped that Japan’s experience will be useful for these countries. On behalf of MHLW, he expressed Japan’s firm commitment to promoting multi-sectoral discussion that is highly important to ASEAN+3 countries.

Mr. Kajiwara declared the conclusion of the 15th ASEAN & Japan High Level Officials Meeting on Caring Societies, thanking the participants once again and looking forward to seeing each other in the near future.