(Cabinet Order
No. 269
19 June 2012)

Maternal and Child Health Improvement Plan 2012-2014
(Informative Part)

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Contents

Abbreviations used 3

Introduction 4

1. Situation characterisation and problem formulation 5
    1.1. Child health 5
        1.1.1. Perinatal mortality 7
        1.1.2. Infant mortality 10
    1.2. Maternal health 11
        1.2.1. Antenatal care 12
        1.2.2. Maternal mortality 19
    1.3. Infertility treatment 21
    1.4. Role of intersectoral co-operation in maternal and child health improvement 22
    1.5. Main problems identified 24

2. Hierarchy of objectives, results and performance indicators thereof 25

3. Connection of the plan with other development programming documents and legal acts binding on Latvia 27

4. Financing necessary for introduction of the plan 31

5. Institutions responsible for the implementation of measures 33

6. Procedures for assessment of the plan and reporting 34

7. Measures intended in the Plan 35

Abbreviations used

UN	United Nations
CSB	Central Statistical Bureau
EC	European Commission
EU	European Union
MoES	Ministry of Education and Science
MoW	Ministry of Welfare
Cabinet	Cabinet
NHS	National Health Service
NGO	Non-governmental organisations
Plan	Maternal and Child Health Improvement Plan 2012-2014
WHO	World Health Organisation
CDPC	Centre for Disease Prevention and Control
STI	Sexually transmitted infections
HI	Health Inspectorate
MoH	Ministry of Health

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Introduction

The Maternal and Child Health Improvement Plan 2012-2014 is a short-term policy planning document that is developed in conformity with the sub-objective of the Public Health Strategy 2011-2017 – to improve maternal and child health, to reduce infant mortality, and, in conformity with the UN Millennium Development Goals, to reduce child mortality and to improve maternal health. The Millennium Declaration[1] was adopted in the UN Millennium Summit in September 2000 by 189 states and signed by leaders of 147 states and governments.

In global and European scale maternal and child health is set as one of priority indicators of the public health and welfare, and several strategy documents and guidelines of global and European level have been drawn up (for example, Global Strategy for Women's and Children's Health[2]; European strategy for child and adolescent health development[3], etc.).

Maternal and child health is one of the most essential fields of the public health. Healthy child is a precondition of healthy society. Promoting of maternal and child health fosters not only reproductive and child health but also improves the entire public health in general.

Each UN Member State shall select the Millennium Development Goals in conformity with the local conditions by developing the goals, tasks and indicators appropriate for its country and keeping track of the progress of its country in achievements of results.

State administrative authorities, professional associations and representatives of non-governmental organisations took part in the development of the draft Plan.

In 2012 the MoH proposes the improvement of maternal and child health care as a priority by reducing child and maternal mortality, treating infertility and developing solving of the issue of intersectoral co-operation in the national level.

[1] Millennium Declaration. Millennium Summit of world leaders in New York, 6-8 September 2000.
[2] Global Strategy for Women's and Children's Health. United Nations Secretary-General, 2010.
[3] European strategy for child and adolescent health development. WHO, 2005.

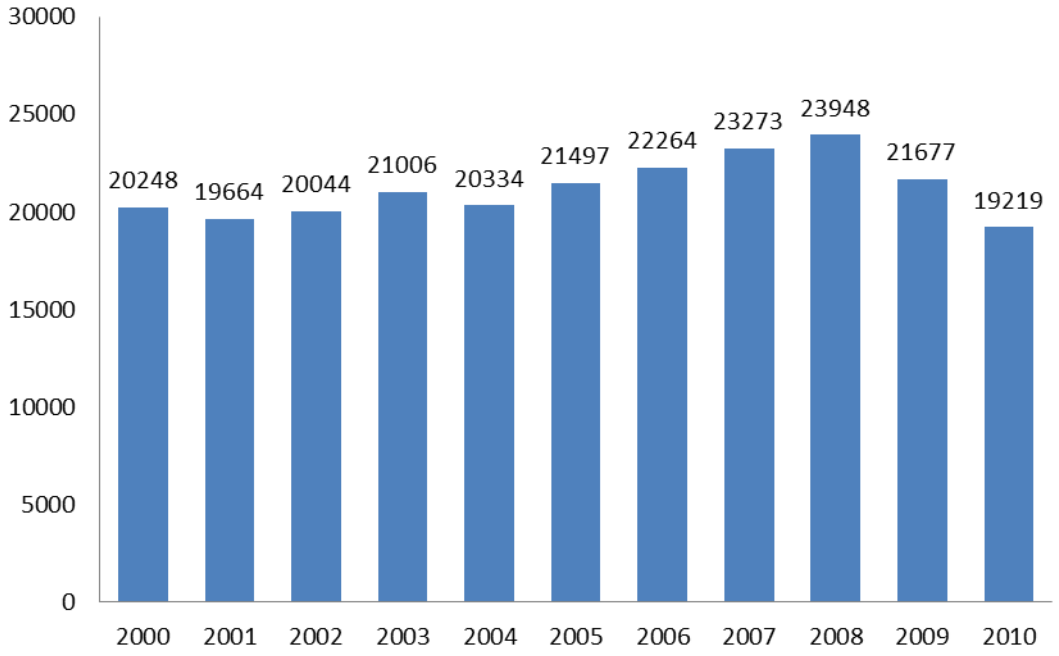
1. Situation characterisation and problem formulation

1.1. Child health

The health and welfare of Latvian newborn children, infants and children of pre-school age are still lower when compared to other EU states. Improvement of health indicators of infants and children of pre-school age may ensure healthy start of life and development of healthier society in the future. Many health indicators of children improve, however, comparing to the average indicators of EU Member States, the indicators in Latvia still fall behind significantly and have not reached the preferable level.

State welfare, public development and health in general are characterised by birthrate indicators. In 2008 in Latvia birthrate reached the highest level in the last 10 years – more than 23 thousand live births per year (10.6 live births per 1000 inhabitants). As shown in Figure 1, since 2009 the number of live births is reducing, respectively the total number of live births in 2009 was 21 677 (9.6 live births per 1000 inhabitants), in 2010 – 19 219 (9.6 live births per 1000 inhabitants).

Figure 1. **Number of live births in 2000-2010 in Latvia**

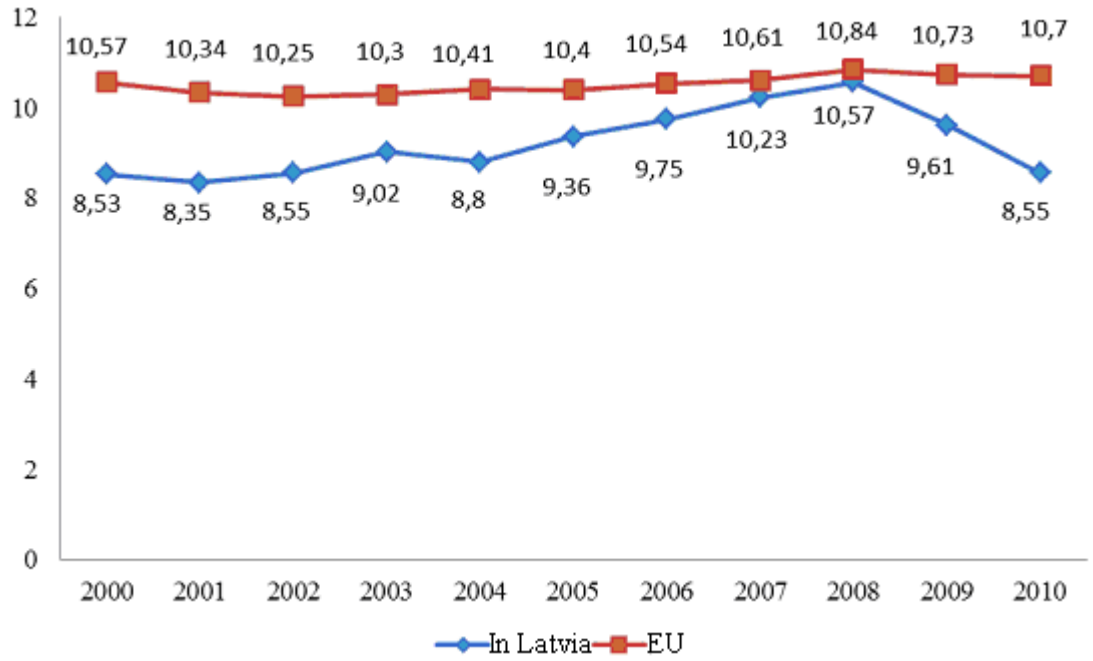


Source: CSB

In 2007 and 2008 the birthrate indicator in Latvia came close to the EU average birthrate indicator[4], however, it is still one of the lowest in EU. In Latvia during the time period from 2008 until 2010 the economic situation and increased sense of insecurity regarding income and retaining of work in the future have left a significant impact on the birthrate indicators.

[4] WHO, data of the European Health for All database.

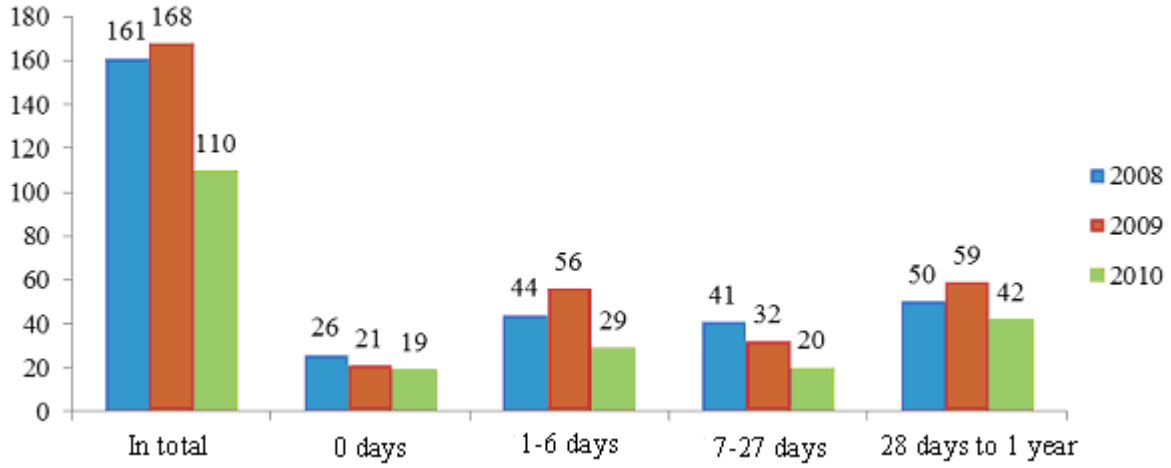
Figure 2. **Birthrate per 1000 inhabitants in Latvia and EU**



Source: WHO European Health for All

Taking into account the tendency of reduction in birthrate indicators, the natural growth in Latvia still remains negative, also infant mortality indicators in Latvia are higher than on average in EU. As it is shown in Figure 3, in 2009 in Latvia 168 children died not reaching the age of one year (7.75 per 1000 live births). In 2010 this indicator reduced in Latvia – 110 children died (5.72 per 1000 live births). A positive tendency is observed and in 2010 infant mortality has reduced, as well as infant mortality in neonatal period (in the age up to 27 days) has rapidly reduced. Concurrently the data of *WHO European Health for All* database specify that in 2009 the EU average infant mortality indicator was 4.23 per 1000 live births and in 2010 – 4.18.

Figure 3. **Infant mortality according to age (in absolute figures)**



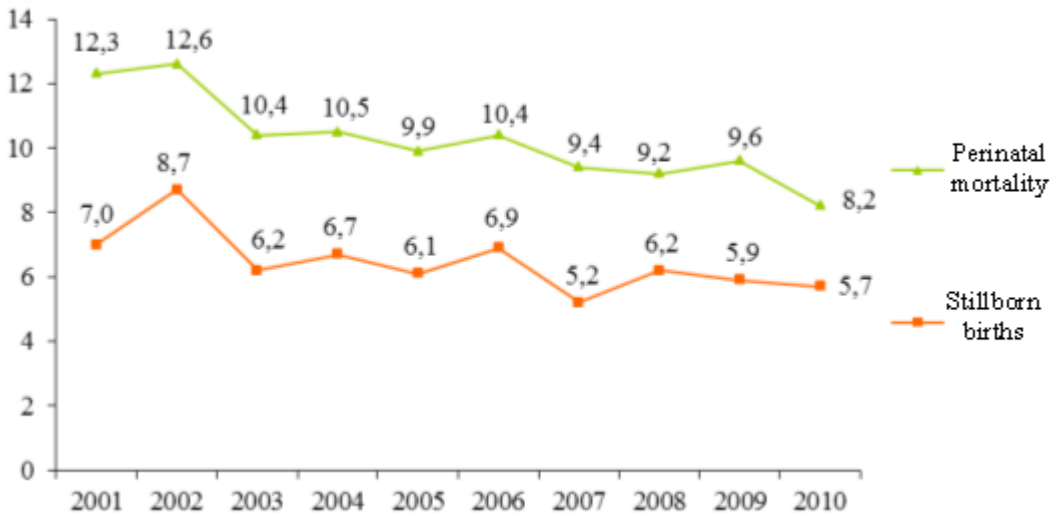
Source: CSB

1.1.1. Perinatal mortality

Perinatal mortality is one of the indicators characterising the quality of the perinatal health care system in the State.

Perinatal, neonatal and post-neonatal mortality indicators, as well as other reproductive health indicators, may be influenced by the attitude towards pregnancy of both the mother and father, the lifestyle and health status of both parents, and the parents' knowledge regarding childcare and injury prevention, as well as the quality of work performed by the relevant health care service providers and by the availability of health care services during pregnancy and delivery.

Figure 4. **Perinatal mortality and number of stillborn children per 1 000 live and stillborn births**



Source: CDPC

Since 2004 the tendency of slow reduction in perinatal mortality indicators is observed, a similar tendency is observed in the indicator of stillborn births (see Figure 4).Concurrently the data of the WHO European Health for All database specify that the perinatal mortality indicator in Latvia in comparison to other EU Member States and the EU average indicator still remains relatively high. In 2009 in Latvia this indicator was 7.04 per 1000 live births, but in the EU on average – 5.58 per 1000 live births. In Latvia this indicator was significantly higher in 2009 than in Lithuania (4.4 per 1000 live births) and Estonia (4.51 per 1000 live births).Proportion of stillborn births in Latvia is higher than in the EU states on average. In 2009 in Latvia this indicator was 5.87 per 1000 stillborn births while in the EU on average – 4.06.

In Lithuania and Estonia this indicator was accordingly 4.1 per 1000 live births and 4.99 per 1000 live births[5].

The definitions of perinatal period and the principles of statistical registration differ in different European states; it should be taken into account when mutually comparing statistical indicators characterising maternal and child health care. According to WHO data perinatal period starts from 22 complete pregnancy weeks (154 days) up to 7 complete days after the birth. In EU states, as well as in Norway, registration of perinatal mortality indicators differ.

[5] WHO, the data of the European Health for All database.

Majority of states registers perinatal mortality from the 22nd week of pregnancy, including the Baltic States, Denmark, the Netherlands, France, the Czech Republic, Finland and others. In turn, Greece, Sweden – from 28th week of pregnancy. Hungary, Portugal – from 24th week of pregnancy and Norway – already from 12th week of pregnancy[6].

The main causes of perinatal mortality are congenital foetus/child anomalies, premature birth, placenta and umbilical-cord pathology, complications of multifetal pregnancy, as well as age of the mother and health problems – illness with gestational diabetes, syphilis and tuberculosis and harmful habits (smoking).

During the last years a tendency of increase in the age of primiparae and women giving birth repeatedly may be observed. More and more pregnant women become under the care of a gynaecologist who are included in a high-risk group even before commencing the examination of the mother and foetus[7]. Although the prevailing age of pregnant women is 25-29 years, approximately 15-20% of pregnant women are over 35 years and in this age group 50% of pregnancies include the Down's syndrome risk (chromosome trisomy 21)[8].

Trisomy is one of the main reasons of perinatal mortality and disability. Early detection of chromosomal pathologies is one of the most significant reasons why invasive diagnostic techniques related to the risk of spontaneous end of a pregnancy after a procedure are used. From 1970 the main reason for trisomy screening was the age of mother, but from 1980 – the blood plasma biochemical analysis of the mother and a detailed fetal ultrasound in the II trimester. Since 1990 it is considered that it is possible to identify the majority part of foetuses with trisomy in 85-95% of cases, combining the data regarding the mother's age, the thickness of fetal neck at 11-13 weeks of pregnancy (NT – *nuchal translucency*), the blood plasma biochemical indicators of the mother: free chorionic gonadotropin beta (βHGT) and pregnancy-associated plasma protein A (PAPP-A). It is possible to reduce the number of false positive results (5%) by carrying out detailed fetal ultrasound measurements at 11-13 weeks.

During the last ten years more significance is assigned to biochemical screening of I trimester, combining it with fetal ultrasound markers – thickness of nuchal fold[9]. Using only PAPP-A, free (βHGT) and the mother's age for screening, 65% of chromosome trisomy 21 cases are detected (false positive 5%). This technique is more sensitive in 9-10 gestation week than in week 13 due to more significant difference of PAPP-A level between normal and pathologic foetuses in terms of chromosomes[10].

Thickened nuchal fold of chromosome trisomy 21 is formed by the collecting of fluid in the nape area which may be detected for foetus in week 12 by ultrasound technique and to interpret it as increased nape fold (NT)[11]. Researches carried out for 20 years prove the efficiency of early performed NT measurements in the diagnostics of chromosome pathologies, heart diseases and other fetal pathologies[12].

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[6] European Perinatal Health Report by the Euro-Peristat project in collaboration with SCPE, EUROCAT & EURONEOSTAT. European Perinatal Health Report, 2008.
[7] http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home.
[8] Nicolaides KH. Screening for fetal aneuploidies at 11 to 13 weeks. Prenat Diagn, 2011, 31, 3-6.
[9] Nicolaides KH. Screening for fetal aneuploidies at 11 to 13 weeks. Prenat Diagn, 2011, 31, 3 – 6.
[10] Wright D, Spencer K, Kagan KO, et al. First trimester combinated screening for trisomy 21 at 7 – 14 weeks gestation. Ultrasound Obstet Gynecol, 2010, 36, 404 – 411.
[11] Nicolaides KH, Azar G, Byrne D, Mansur C, Marks K. Fetal nuchal translucency: ultrasound screening for chromosomal defects in the first trimester of pregnancy. Br Med J, 1992, 304, 867 – 869.
[12] Souka AP, Von Kaisenberg CS, Hett JA, Sonek JD, Nikolaides KH. Increased NT with normal karyotype. Am J Obstet Gynecol, 2005, 192, 1005 – 1021.

Structural diagnostics of fetal development anomalies may be divided into three large groups in conformity with I, II and III trimester in which it is possible to recognise early demonstration of the relevant pathologies. The first group includes structural fetal pathology which may be diagnosed early in week 11-13 of pregnancy: *anencephalia, holoprosencephalia alobaris, omphalocele, gastroschisis, megacystis*. The second group includes fetal pathologies which cannot be detected early because they demonstrate themselves only in II or III trimester (for example, *microcephalia, agenesis corpus collosum, holoprosencephalia semilobaris, hypoplasia cerebelli/vermis cerebelli*). In turn the third group includes fetal pathologies which may be predicted, for example, in I trimester thickened nuchal fold as marker not only for Down's syndrome, but also for congenital fetal heart disease, diaphragmatic hernia or skeletal dysplasia[13].

In performing combined screening of I trimester, it is possible to differentiate a high risk group not only in relation to chromosomal pathologies, but also to stillborn births (45%) and foetuses perished during a pregnancy 35%) – a thickened nape fold, *ductus venosus* reverse flow and reduced PAPP-A[14] indicate to risk.

In performing combined screening of I trimester, it is also possible to predict 90% of early preeclampsia (until 34th gestation week), 80% of demonstration of preeclampsia at gestation week 34-37 and 60% of late development of preeclampsia after 37th week (fraudulent positive 5%)[15].

Taking into account the role of PAPP-A as a biochemical marker in the early period of pregnancy (Down's syndrome screening, preeclampsia screening), the necessity for this examination is justified in order to predict different perinatal conditions during the pregnancy for all pregnant women.

Currently antenatal programme in Latvia does not provide for such examination for all pregnant women. Gestation week 11-13 is the most significant period in care of a pregnant woman and foetus in order to assess the risks of foetus and mother and predict further strategy for the model of antenatal care.

In order to improve efficiently the indicators of maternal and child health, it is necessary to identify and purposefully influence causes that deteriorate these indicators. As well as immediately after a child's birth it is necessary to provide timely treatment of congenital pathologies for a newborn child and to improve care of newborn children in regional perinatal centres.

In order to reduce perinatal mortality, it is necessary to improve prenatal diagnostics of congenital anomalies and maternal health because it affects perishing of foetus, as well as maternal care, newborn care and residing environment of a newborn are important. By improving the availability and quality of health care services during pregnancy and delivery, as well as by promoting the sense of responsibility of parents-to-be regarding their health and that of their child, perinatal mortality could be reduced in the future. In order to improve perinatal care quality in the state, it is necessary to establish a perinatal mortality audit system

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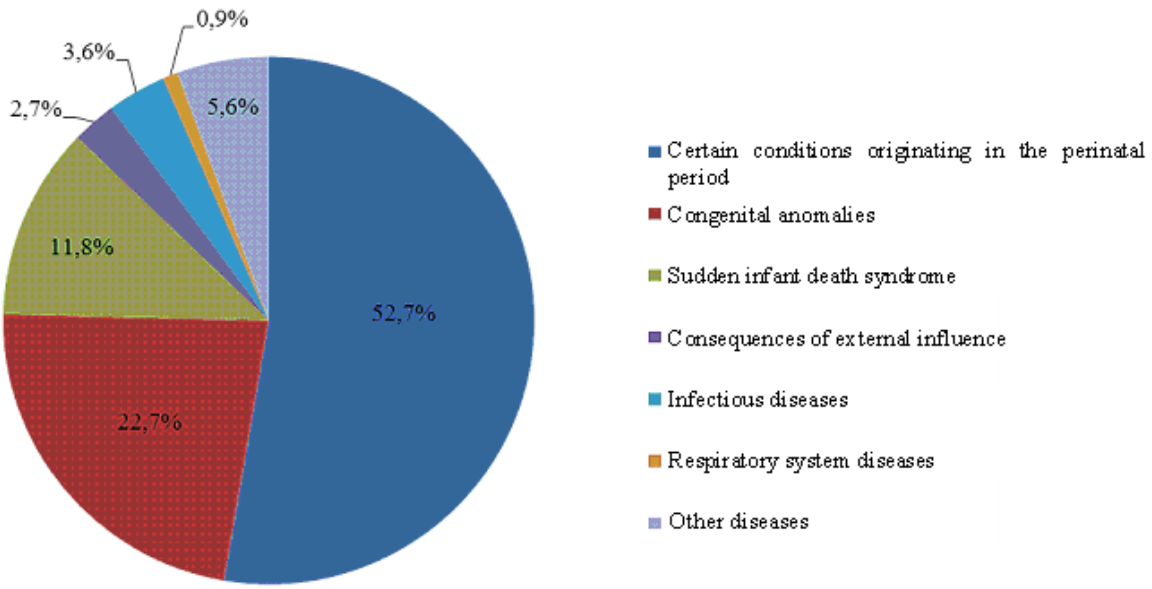
[13] Syngelaki A, Chelemen T, Dagklis T, Allan L, Nicolaides KH. Challenges in the diagnosis of fetal non-chromosomal abnormalities at 11–13 weeks. Prenat Diagn 2011, 31, 90–102.
[14] Akolekar R, Bower S, Flack N, Bilardo CM, Nicolaides KH. Prediction of miscarriage and stillbirth at 11–13 weeks and the contribution of chorionic villus sampling. Prenatal Diagn, 2011, 31, 38–45.
[15] Akolekar R, Syngelaki A, Sarquis R, Wright D, Nicolaides KH. Prediction of preeclampsia from biophysical and biochemical markers at 11–13 weeks. Prenat Diagn 2011, 31, 66–74.

in Latvia where, as a result of analysis, it would be possible to introduce changes operatively in the perinatal care system in the state.

1.1.2. Infant mortality

Infant mortality is one of indicators which characterises both general health status and also health care before and after delivery, as well as indirectly characterises socio-economic conditions in the country in general.

Figure 5. **Main causes for infant mortality in Latvia in 2010 (proportion from all causes %)**



Source: CDPC

The main cause of infant mortality is certain perinatal period conditions (for example, delivery trauma, intrauterine hypoxia, hereditary and aspiration pneumonia, etc.). Conditions of the perinatal period are the cause of death for approximately 52.7% of all children who die during the first year of life (see Figure 5). During the last years mortality due to such causes has reduced slightly.

Congenital anomalies are the cause of death for approximately one fourth of children who die during the first year of life. This indicator has the tendency to reduce in the last years. It may be explained by timely performance of genetic examinations, as a result of which it has been possible to diagnose congenital pathologies and to terminate pregnancy thus reducing the risk of birth of severely ill children, however, in several cases pathology was diagnosed belatedly, pregnancy was terminated after week 22, and these cases were included in the perinatal mortality. The number of congenital anomalies is still high and it indicates that it is significant to introduce an additional ultrasound examination and to improve diagnostics of perinatal congenital anomalies that would allow detecting of congenital pathologies more accurately, to prepare for them or to terminate pregnancy in cases of such pathologies where severe remaining consequences after elimination of the pathology are predicted.

Another reason of infant mortality is still external causes regardless of the fact that they can be restricted or even eliminated. In 2008 due to external causes of death 6 infants died (2.5

infants per 10 000 live births), in 2009 – 4 infants (1.8 infants per 10 000 live births), but in 2010 – 3 infants (1.6 per 10 000 live births)[16].

Educating of the society regarding infant mortality risk factors and measures for elimination thereof has a significant role in improving the quality of life of infants, especially in families with a child up to 1 year of age.

1.2. Maternal health

Health and development of a child until his or her birth and during the first year of his or her life mainly depends on the health of his or her mother and father, lifestyle habits, parents' knowledge regarding the health of a child and care for a child.

Also the issue regarding family planning and promotion of reproductive health is significant, therefore, educating and training of new parents in the field of sexual and reproductive health is especially significant. Medical personnel is of great significance, thus it is important to train the team of a family doctor which will lead (supervise) a pregnancy in respect of family planning, sexual and reproductive health (leading of physiological pregnancy, prevention of abortions, educating of pregnant women regarding risk factors that may influence the course of the pregnancy).

Before the child is born it is essential for parents-to-be to acquire the basic skills regarding child care and safety, including, breast-feeding. As well as after the child is born a family doctor and/or the team of a family doctor should ensure training of the parents of a newborn child regarding child care and safety during postnatal care. The WHO recommends that the most suitable nourishment for newborn children is mother's milk which ensures a child with nutrients necessary for growth and development. It is recommended to feed babies with mother's milk only up to the age of 6 months (exclusive breast-feeding).[17] The positive tendency in breast-feeding indicators of children is influenced by education and informing of the public in the development and implementation of the measures for promoting breast-feeding.

A significant contribution to promoting breast-feeding and improvement of health in the initial stage of life has been provided by the Baby-Friendly Hospital Initiative[18], the purpose of which is to promote maternal and child health in both Latvia and the world and to achieve that an infant is exclusively breastfed up to the age of six months, but later breast-feeding is combined with age-appropriate nourishment. In order to become a Baby-Friendly Hospital, the hospital must meet certain criteria. They apply to help guaranteed by the personnel at the beginning of breast-feeding, for example: helping mother to start breast-feeding her child within half an hour after the child is born; medical personnel shows the mother how to breast-feed and how to maintain lactation in cases when the child is not together with his or her mother; babies are not given another type of nutrition or liquid other than mother's milk unless an exception must be made due to treatment considerations. In order to ascertain the conformity of the hospital with these criteria, a regular assessment is carried out. Participation of hospitals in this initiative is voluntary. Assessment of hospitals with regard to conformity with the criteria for Baby-Friendly Hospital in Latvia took place until 2009.

Smoking, use of alcohol, drugs and other substances causing addiction have adverse effect on both the health of a pregnant woman and the development of the foetus. Approximately 10%

[16] Data of the CSB.
[17] Baby-Friendly Hospital Initiative. WHO, UNICEF, 2009.
[18] Baby-Friendly Hospital Initiative. WHO, UNICEF, 2009.

of women in labour have been smoking during pregnancy, 0.5% have been using alcohol, but 0.1% – drugs[19]. Use of psychoactive substances is often related to unfavourable socio-economic circumstances, antisocial behaviour, insufficient health care. The statistical data of Latvia clearly demonstrates harmful influence of smoking by both mother and father on the health of the foetus and increased perinatal mortality risk. These harmful habits often are the cause for miscarriage, organ system development disorders, premature birth, birth of miscarried children, stillborn births and infant mortality during the first week of their life.

Maternal and child health is also influenced by morbidity of mother with infectious diseases, especially with reproductive tract infections (syphilis, chlamidiosis, gonorrhea, bacterial vaginosis), carrying of group B β hemolytic streptococci, HIV, acute respiratory viral infections. However, a woman cannot always protect herself from different infectious diseases such as influenza, therefore pregnant women shall be included in a high-risk group for voluntary vaccination against influenza, as well as significant role should be assigned to educating pregnant women in the field of reproductive tract infection prevention.

Reproductive tract, urinary tract and other untreated infections are the main etiological factor of premature delivery. If the mother registers in the register of pregnant women in a timely manner and takes care of her health during pregnancy, a healthier child is born. The quality of and access to health care, as well as the woman's knowledge regarding her body, healthy lifestyle, child care, would reduce perinatal mortality, the number of injuries obtained, the possibility of falling ill with any infectious and respiratory system disease.

The Cabinet Regulation[20] currently in force already determines additional applicable reimbursement for children up to 3 years of age in diagnoses, in case of which expenses for the purchase of medicinal products are not reimbursed for adults. One of the tasks of this plan is to expand the range of patients (pregnant women and women in postnatal period, as well children up to 2 years of age) with diagnosis of acute diseases who will be able to receive additional State aid in purchasing specific prescription medicinal products in case of illness, but the existing reimbursement system for medicinal products will not be reduced.

1.2.1. Antenatal care

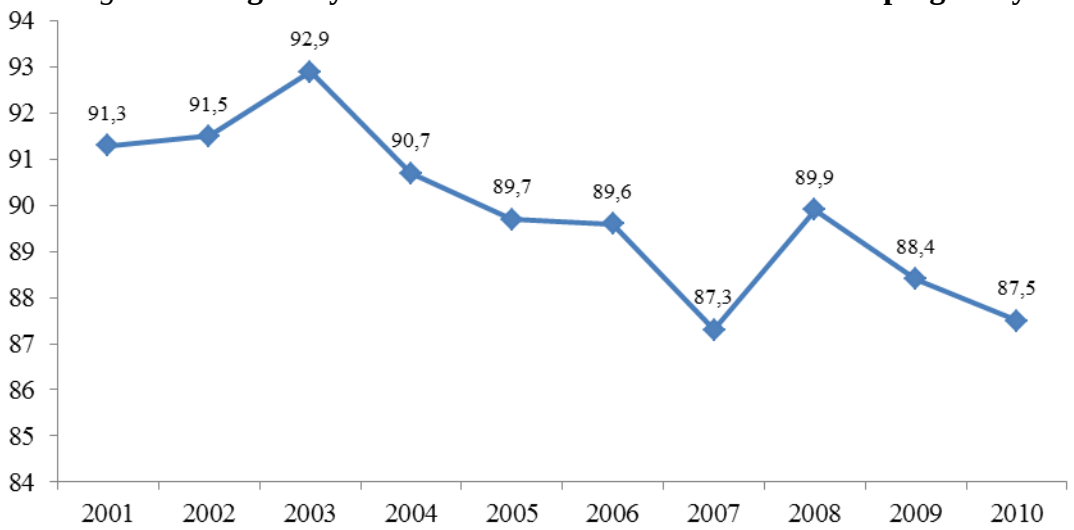
In order for the course of pregnancy to be successful, it is very important to monitor it and for the pregnant woman to register in the register in a timely manner. Early registering in the register reduces the risk of the birth of a child with health problems because the potential risk factors for the health of both, the child and the mother, are detected and eliminated in due time.

The fact that since 2004 the proportion of those pregnant women in Latvia who have registered in the register of pregnant women by 12th week of pregnancy has reduced should be perceived as negative (see Figure 6). Until 2004 timely registering of pregnancy was financially stimulated by greater (double) childbirth allowance, but it was changed by amendments to the laws and regulations – the benefit in all cases is equal, but a woman for whom the medical care in relation to pregnancy has been commenced in a medical treatment institution until the 12th week of pregnancy and continued for the whole period of the pregnancy, has the right to receive a maternity benefit for a supplementary leave of 14 days. In 2008 a small increase of this indicator was observed when socially insured persons could receive a parenting benefit in the amount of 70% of wage subject to social contributions. This

[19] Cabinet Order No. 504 of 5 October 2011, On Public Health Guidelines 2011 – 2017.
[20] Cabinet Regulation No. 899 of 31 October 2006, Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment.

benefit was disbursed from the social insurance budget, taking into account social contributions of each individual. The maximum limit was not determined for this benefit – it was similar to the wage which a person received after payment of taxes. As a result of the decisions of the crises period the amounts of disbursable benefits changed starting from 2009.

Figure 6. **Pregnancy care commenced until the 12th week of pregnancy**



Source: NHS

If pregnancy care is commenced after the 12th week of pregnancy, the risk of perinatal mortality increases for those newborn children for whose mothers pregnancy care was not commenced by the 12th week of pregnancy (in 2008 – 26.2 per 1000 live births and stillbirths, in 2009 – 18.1 per 1000 live births and stillbirths, in 2010 – 18.0 per 1000 live births and stillbirths).[21]

Researches performed over twenty years have proven that a detailed examination of a pregnant woman during her first visit in the 11th-13th week of pregnancy allows to anticipate different perinatal conditions for the mother and the child, taking into account the general condition of the mother, anamnesis, biochemical examinations, as well as carrying out a detailed fetal ultrasound. There is a great possibility to calculate specific risks for a pregnant woman: the risk of congenital anomalies of fetal development, the risk of intrauterine perishing of foetus, the risk of preeclampsia, the risk of premature delivery, the risk of gestational diabetes, the risk of intrauterine growth retardation, the risk of macrosomia. The 11th-13th week of pregnancy is the most important time in prenatal period when it is possible to acquire the most information regarding maternal and child health in order to include the pregnant woman in high-risk or low-risk group, taking into account the data obtained and results of examinations. Upon studying the risk of dangerous perinatal conditions, it would be possible to reduce maternal and child mortality in Latvia by carrying out purposeful diagnostics of the existing pathology and individual antenatal care specific to disease.

Now the Cabinet Regulation determines that ultrasound for pregnant women who are not in a risk group shall be carried out in the 16th-18th week of pregnancy and in 34th-36th week of pregnancy[22]. However, the performance of diagnostics of congenital anomalies is most efficient in the first trimester of pregnancy. The ultrasound examination performed during this period helps to determine more precise age of the foetus, as well as the time of delivery. Also

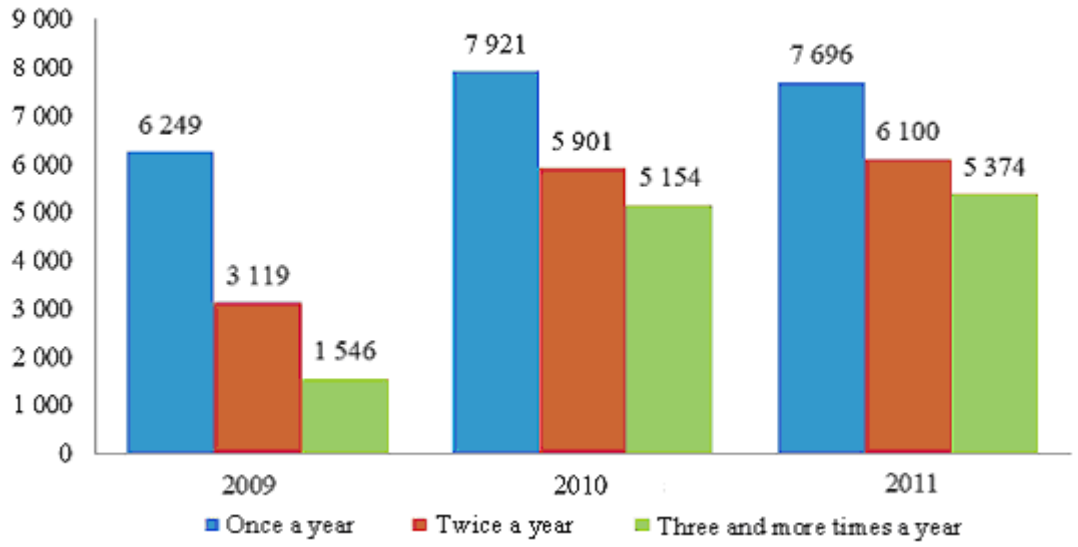
[21] Data of the CDPC.
[22] Regulation No. 611 of 25 July 2006, Procedures for Ensuring of Assistance with Deliveries

information regarding placement of the foetus in the uterine cavity, as well as the development processes of the foetus is obtained.

Complications during pregnancy may arise also without obvious risk factors, therefore regular performance of ultrasound examination in all trimesters of pregnancy would be necessary. In respect of child mortality indicators, the ultrasound helps to discover anomalies of mild or medium severity by helping to eliminate them immediately after birth or in separate cases already during pregnancy.

According to the NHS data (the number of ultrasound examinations performed which are performed by specialists who are in contractual relations with the State), the number of ultrasound examinations performed twice a year in 2009 was 3 119, in 2010 – 5 901, in 2011 – 6 100. If necessary, three or more ultrasound examinations are carried out for pregnant women, and the number of such examinations in 2009 was 1 546, in 2010 – 5 154, in 2011 – 5 374 (Figure 7). Data regarding ultrasound examinations performed for pregnant women by specialists practicing in private practices are not available to the NHS. As pregnancy may commence in one year and end in another year, the number of ultrasound examinations do not always demonstrate the number of the ultrasounds performed during pregnancy and it is not possible to acquire objective data regarding the number of ultrasound examinations performed during each pregnancy.

Figure 7. **Number of ultrasound examinations for pregnant women**



Source: NHS

The ultrasound is considered a safe procedure with minimal known adverse effect and no radiation exposure. Thus it has been made a widely used antenatal care examination[23].

The laws and regulations[24] currently in force provide for seven visits to the medical practitioner (gynaecologist (obstetrician), midwife or family doctor) before delivery and two visits after delivery. In accordance with that provided for in the Consumer Rights Protection Law, a pregnant woman has the right to choose a medical practitioner (a gynaecologist, a midwife or a family doctor) with which to register in the register of pregnant women and to establish a mutual co-operation with the specialist selected by her. Depending on the selected specialist (a specialist who ensures State-paid pregnancy care or a private specialist who

[23] http://www.who.int/diagnostic_imaging/imaging_modalities/dim_ultrasound/en/index.html.
[24] Cabinet Regulation No. 611 of 25 July 2006, Procedures for Ensuring Assistance with Deliveries.

ensures such care for a fee) pregnancy expenditures also differ, they are also affected by the fact whether the pregnant women has or has not a contract with an insurance company. When selecting the State-paid pregnancy care, expenditures for pregnancy care services are covered by the State, however, each year State-paid services are limited, determining a particular amount of the financing.

The Cabinet Regulation[25] currently already in force determines the procedures for the health care of a woman during pregnancy, delivery and postnatal period, as well as the procedures for the health care of a newborn child. One of the tasks of this plan is to supplement the referred-to regulation with a more extensive description in which the information for the performance of training of parents-to-be will be indicated that will improve the knowledge of parents regarding child care and safety. Concurrently the plan will be also promote greater participation and responsibility of parents-to-be in child care and ensuring of safety.

In order to improve the availability of health care services to pregnant women, the quality of performance of services (to reduce the waiting queues to the State paid specialists and thus to achieve examinations carried out in due time and in good quality because queues are not permissible), the amount of payment for a service, it is necessary to involve gynaecologists practicing in private practice and other specialists in the care of pregnant women implementing the principle "money follows a pregnant woman". Mothers-to-be will have a possibility to receive State-paid services during pregnancy also at the private gynaecologists or other specialists who will have entered into a separate agreement with the NHS regarding care of pregnant women.

Availability (both financial and territorial, and availability of specialists) of health care services characterises the quality and efficiency of the health care system. In Latvia part of inhabitants do not have access to health care when it is necessary due to financial circumstances[26].

During the last years the number of pregnant women with diabetes mellitus has been increasing rapidly in Latvia, which has commenced during pregnancy (in 2006 – 45, in 2007 – 75, in 2008 – 105, in 2009 – 140 and in 2010 – 179)[27]. Gestational diabetes mellitus is one of most frequent pregnancy complications. It concerns 1.5-10% of pregnant women, however, many cases remain undiscovered. Gestational diabetes mellitus causes serious complications for both, the mother and the foetus. For the mother – high risk for the development of type 2 diabetes mellitus in the future, as well as possible preeclampsia, premature detachment of placenta, premature delivery, weakness at delivery, urinary tract infection. The number of caesarean sections and operative vaginal deliveries has increased. For the foetus – macrosomia, chronic fetal hypoxia, intrauterine perishing of foetus. Probability of hypoglicemia, hyperbilirubinemia, hypocalcaemia, chronic fetal hypoxia for a newborn child exists. The frequency of congenital anomalies of cardiac and other organs increases. In the future children are more prone to be ailing with diabetes and obesity.

Clinical Practice Guidelines for the Prevention and Management of Diabetes of the Canadian Diabetes Association recommend to perform gestational diabetes screening for all pregnant women in the period between 24th and 28th gestational week. For women with several gestational diabetes risk factors screening should be performed in the first trimester of

[25] *Ibid*.
[26] Access to health care and the financial burdes of out-of-pocket health payments in Latvia. WHO, 2009.
[27] Data of the CDPC.

pregnancy[28]. It is proven that universal screening is more efficient than approach based on risk factors. Researches show that screening based on risk factors demonstrates only approximately half of the cases of gestational diabetes[29].

By expanding the possibilities for the performance of gestational diabetes screening for pregnant women it is possible to detect and treat pregnant women affected by gestational diabetes, thus reducing the number of complications during pregnancy and delivery (including the quantity of manipulations). Moreover, there are also long-term benefits – limiting of the spread of type 2 diabetes and obesity in the future.

Taking into account the fact that gestational diabetes screening is neither expensive nor complicated, moreover successful treatment of the disease is possible, it would be optimal to introduce it in Latvia.

In relation to infectious diseases group B β hemolytic streptococci is the main cause of perinatal morbidity and mortality among the European states, the USA and Canada because it is the main pathogen of sepsis and meningitis during the period of newborn children. Group B β hemolytic streptococci is the cause of neonatal death for 1 per 10 000 newborn children[30].

Colonisation of group B β hemolytic streptococci in gastrointestial tract in European regions is as follows: in Eastern Europe 19.7-29.3%, Western Europe 1-21%, Scandinavia 24-36%, Southern Europe 6.5-32%[31]. In Latvia carrying of group B β hemolytic streptococci is detected for 17% of pregnant women[32].

For a woman colonisation of group B β hemolytic streptococci is usually asymptomatic, however, a micro-organism may be the cause for urinary infection, chorioamnionitis, postpartum endometritis, bacteremia, as well as intrauterine perishing of foetus.[33]

40-75% of newborn children have a vertical transmission risk during vaginal delivery of carriers of group B beta-hemolytic streptococci, for 1-2% of them infection caused by group B beta-hemolytic streptococci develops during neonatal period.

Since 2007 the number of infants with newborn bacterial sepsis has increased in Latvia (in 2007 – 14, in 2008 – 24, in 2009 – 24, in 2010 – 23), also the number of deceased infants has

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[28] Canadian Diabetes Association 2008 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada.

[29] Pöyhönen-Alho MK,Teramo KA, Kaaja RJ, et al. 50gram oral glucose challenge test combined with risk factor-based screening for gestational diabetes. European Journal Obstetrics Gynecology and Reproductive Biology 2005, 121:34-37.

[30] Cunningham FG, Leveno JK, Bloom LS, Hauth CJ, Gilstrap III C L, Wenstrom DK. Williams Obstetrics, 22nd Edition, New York: McGrow-Hill Companies, 2005. p.1306-1307,1284-1287 and Berghella V.Maternal-Fetal Evidence Based Guidelines, London: Informa UK Ltd; 2007.p.239-243, 256-264. Centers for Disease Control and Prevention (CDC).

[31] Barcaite E, Bartusevicius A, Tameliene R, Kliucinskas M, Maleckiene L, Nadisauskiene R, Prevalence of maternal group B streptococcal colonisation in European countries, Acta Obstetricia and Gynecologica 2008, 87:260-271.

[32] Veisa V, Eihenberga S, Beļevičs J, Afanasjeva A, Rezeberga D. Incidence of C.trachomatis and BGS among Pregnant Women in Latvia: Potential Recommendations for Amendments to Antenatal Care Programme. Theses of the 6th Congress of Gynaecologists and Obstetricians of Latvia.

[33] Cunningham FG, Leveno JK, Bloom LS, Hauth CJ, Gilstrap III C L, Wenstrom DK. Williams Obstetrics, 22nd Edition, New York: McGrow-Hill Companies; 2005. p.1306-1307,1284-1287and Berghella V.Maternal-Fetal Evidence Based Guidelines, London: Informa UK Ltd; 2007.p.239-243, 256-264. Centers for Disease Control and Prevention (CDC).

increased (in 2007 – 2, in 2008 – 7, in 2009 – 5, in 2010 – 8). Currently prophylaxis of group B beta-hemolytic streptococci based on risk factors is used in Latvia.

It means that patients who have risk factors receive intrapartum antibiotic therapy. Introduction of screening for all pregnant women with subsequent antibiotic prophylaxis for the carriers of the referred-to micro-organism is scientifically substantiated and reduces mortality of newborn children from severe newborn infections.

Universal screening of group B beta-hemolytic streptococci for pregnant women in 35th to 37th week of pregnancy with subsequent intrapartum antibiotic prophylaxis is more than 50% efficient than strategy based on risk factors.

After introduction of universal screening of pregnant women and intrapartum antibiotic prophylaxis, the frequency of early neonatal sepsis has reduced in the USA from 1.7/1000 newborn children in 1990 up to 0.34-0.37/1000 newborn children in 2008[34].

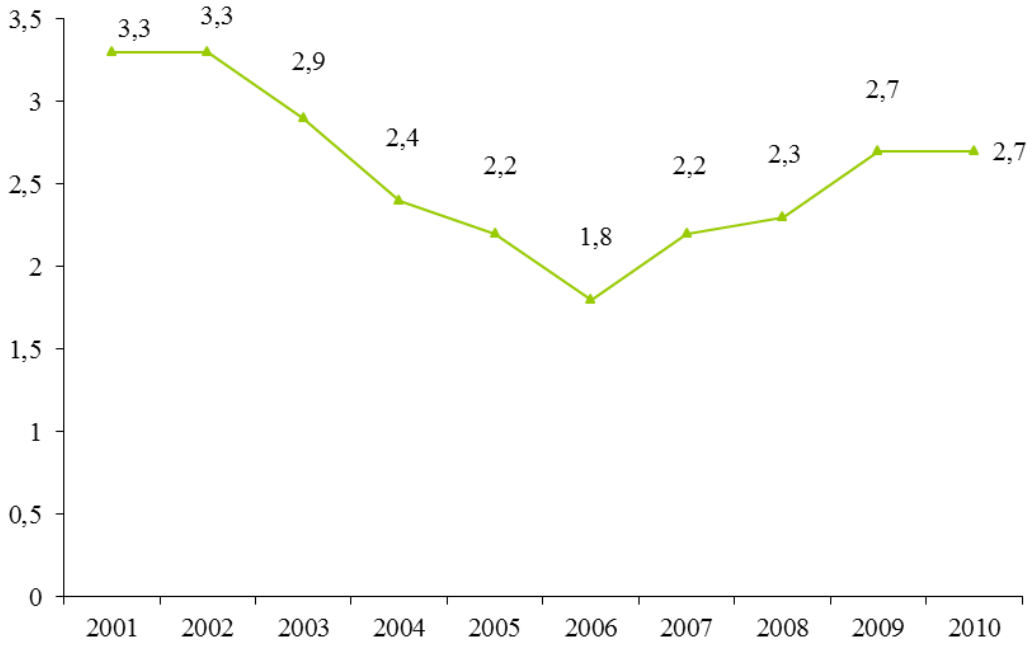
Centre for Disease Control and Prevention of the USA recommends to carry out screening of group B beta-hemolytic streptococci for pregnant women in the period between 35th and 37th gestational week in order to avoid increased risk for newborn sepsis and mortality from it[35].

Since 2007 the proportion of parturient women without antenatal care to increase in Latvia has the tendency to increase. The possible reason may be the lack of informing of inhabitants regarding the necessity to be in the register with the specialist during pregnancy, deterioration of economic situation of the inhabitants and insufficiency of availability of State-paid services for pregnant women (culture of group B beta-hemolytic streptococci, gestational diabetes screening, etc.), resulting in complications which may be the reason for death of the mother, unborn child or newborn child.

In 2010 the proportion indicator of parturient women without antenatal care remained in the level of 2009 – 2.7%[36].

[34] Berghella V.Maternal-Fetal Evidence Based Guidelines, London: Informa UK Ltd, 2007.p.239-243, 256-264. Centers for Disease Control and Prevention (CDC) and Prevention of perinatal group B streptococcal disease: revised guidelines from CDC. MMWR Morb Mortal Wkly Rep 2010, 54:1205-8.
[35] http://www.cdc.gov/mmwr/pdf/rr/rr5910.pdf.
[36] CDPC, Latvian Database of Health and Health Care Indicators 2000-2010

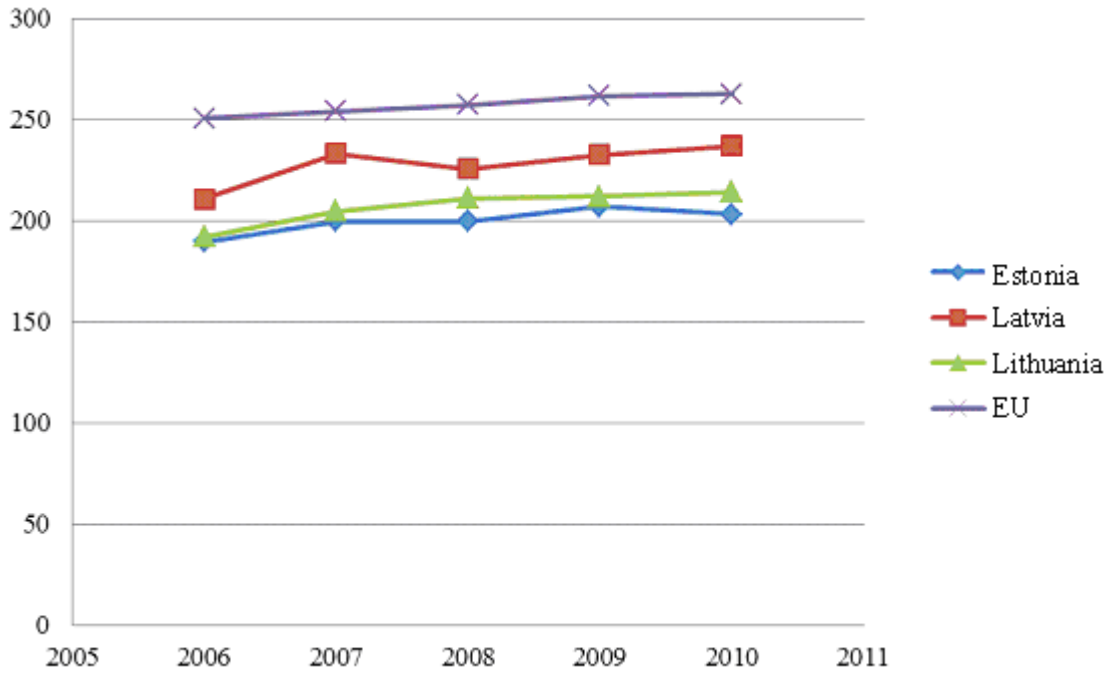
Figure 8. **Proportion of parturient women without antenatal care (%)**



Source: CDPC

Upon development of the guidelines for antenatal care and the criteria for determining the competence of medical practitioners, the care of pregnant women would improve, thus the proportion of parturient women without antenatal care would reduce and the possible risk factors for the health of both, the child and the mother, would be detected in due time.

Figure 9. **Number of caesarean sections in Latvia and other EU states, per 1000 live births**



Source: WHO European Health for All

The number of caesarean sections (per 1000 live births) in Latvia like in other EU states has an increasing tendency during the last five years. In Latvia it is the highest in the Baltic states. In 2010 in Latvia this indicator was 237.27 per 1000 live births, in Lithuania – 214.23 per

1000 live births, in Estonia – 203.35 per 1000 live births. One of the reasons for increase in the proportion of caesarean sections is more frequent chronic diseases which increase along with the age of the parturient woman, as well as the fact that the indications for the performance of caesarean section determined in the guidelines, probably, should be reviewed.

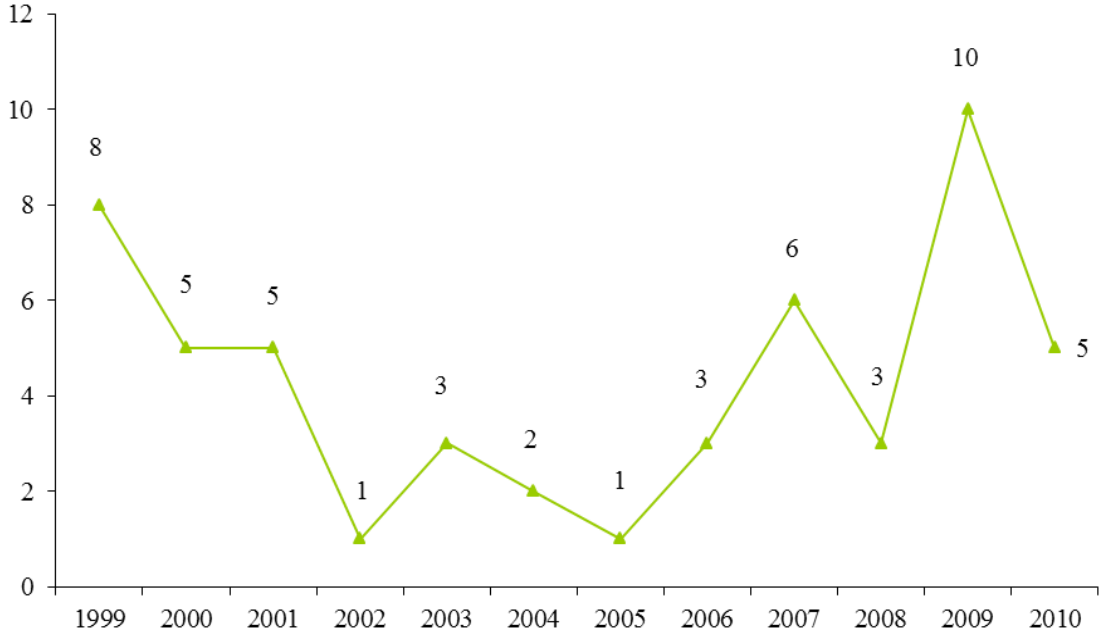
The number of caesarean sections cannot be reduced mechanically, therefore preventive measures are necessary which would improve care of pregnant women – to ensure access to health care services and the possibility to receive State-paid services from gynaecologists and other specialists practicing in private practice, as well as to draw up antenatal guidelines and the criteria for determining the competence of medical practitioners. By improving care of pregnant women, the necessity for the performance of caesarean sections would reduce and the proportion of complications during delivery would reduce.

1.2.2. Maternal mortality

Maternal mortality is one of the indicators which describes the quality of antenatal and perinatal care in the state.

Maternal mortality in Latvia comparing to the average indicator of the EU states is high. In 2008 3 women died during pregnancy, delivery and postnatal period, in 2009 – 10 women, but in 2010 – 5 (see Figure 10). When expressed per 100 000 live births, this indicator in 2010 was 26 (in 2009 – 46 per 100 000 live births). Such indicator is usually used for international comparisons where the indicator of Latvia is alarmingly high because, for example, the average EU indicator is 6 per 100 000 live births. However, it should be taken into account in international comparisons that this indicator is explicitly labile (sensitive) in Latvia – it is affected by each case of maternal death because approximately 20 000 children are born per year in Latvia, but the indicator is calculated per 100 000 live births, which accordingly explains the comparatively high values of this indicator.

Figure 10. **Maternal mortality, number of deaths (in absolute figures)**

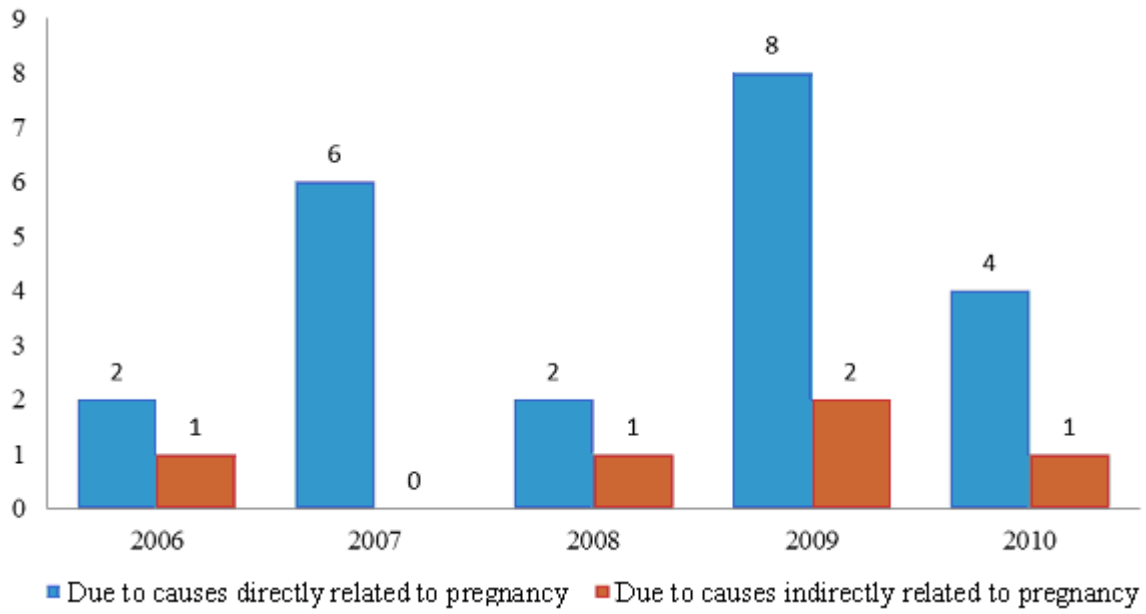


Source: CDPC

The ratio of causes for maternal mortality which are directly and indirectly related to pregnancy are different each year.

Since 2006 causes for maternal mortality which are directly related to pregnancy have been different, including abortions – 3 (including criminal), ectopic pregnancy – 2, amniotic fluid embolism – 1 (in 2009), phlebothrombosis – 2, haemorrhage – 9, toxicosis, eclampsia – 2, uterine rupture – 1 (in 2007), placental abruption – 1 (in 2007), sepsis –1 (in 2009).

Figure 11. **Causes for maternal mortality (in absolute figures)**



Source: CDPC

It should be taken into account that in certain cases maternal mortality is not directly related to pregnancy, for example, breast cancer – 1 (in 2008). During the last years maternal mortality from influenza has been detected in Latvia, for example, 2 cases were registered in 2009 when two pregnant women died from influenza AH_1N_1. There were in total 10 cases of maternal mortality (due to causes directly and indirectly related to pregnancy) in 2009 in Latvia. Accordingly 20% of causes of maternal mortality were influenza, which is an alarmingly high indicator comparing to indicators of the EU states. In a state with a small number of parturient women, it is relatively important to prevent the death of each pregnant woman due to causes directly and indirectly related to pregnancy. A pregnant woman with influenza is more exposed to serious diseases with complications caused by influenza, as well as to serious problems for her unborn child, which is related to physiological changes during pregnancy. Due to increased risk during pregnancy, inactivated influenza vaccine should be considered as the best and most safe means of prophylaxis regardless of the pregnancy trimester. WHO recommends vaccination for those women who are or will be pregnant during influenza season. Influenza vaccine provides protection against influenza for pregnant women, newborn children and protects infants up to 6 months after their birth, if the woman has been vaccinated against influenza during pregnancy[37]. There is an increased risk to became ill with influenza and complications caused thereby for infants up to the age of 6 months, as well as it is not recommended to vaccinate infants because they do not develop sufficient immune response to influenza[38]. Therefore, vaccination during pregnancy is

[37] Poehling KA, Szilagyi PG, Staat MA, et al. Impact of maternal immunization on influenza hospitalizations in infants. Am J Obstet Gynecol 2011, 204:S141.
[38] Halasa NB, Gerber MA, Chen Q, et al. Safety and immunogenicity of trivalent inactivated influenza vaccine in infants. J Infect Dis 2008, 197:1448

important in order to reduce morbidity and mortality of infants up to the age of 6 months[39]. Some researches show that influenza during pregnancy increases the risk of congenital pathologies, for example, lip, neural tube defects and heart diseases[40]. There is also indirect proof that influenza infection of the mother during pregnancy is related to increased risk for miscarriage, premature delivery, low birth weight for a newborn child.[41]

In order to prevent mortality of pregnant women from influenza, it is very important to vaccinate pregnant women in due time who suffer from diseases with immune deficiency symptomatic, for whom surgeries or manipulations are planned in a hospital during an influenza epidemic. It is necessary to include such pregnant women in a high-risk group for voluntary vaccination against influenza.

Currently studies of the causes of maternal mortality are vague in Latvia and not all cases of maternal mortality are registered, therefore thorough analysis of each case is required and it is necessary to introduce a confidential analysis system of maternal mortality so that in analysing each case of maternal mortality it would be possible to understand its reasons, thus preventing other similar cases.

1.3. Infertility treatment

One of the most significant problems in the field of sexual and reproductive health is infertility. This problem is promoted by delaying pregnancy, excessive weight gain, sexually transmitted diseases, etc. Due to adverse demographic situation, infertility is a very serious medical and social problem. A statistical database has not been created in Latvia for solving of infertility problems. The experience of developed states shows that on average 6-10% of spouses are infertile, in Europe on average 8-10% of spouses. On average 1100 *in vitro* fertilisation procedures per year are performed in Latvia, and for the time being they are provided as a paid service. In Latvia approximately 200-300 children are born each year as a result of artificial insemination.

The most frequent causes of female infertility are oviduct impermeability which appears after inflammation (often after suffering from gonorrhea), consequences of surgical interference in sexual organs, as well as disorders of ovarian function, uterine, ovarian cancers, metabolic disturbance, stress, unhealthy lifestyle, etc. Male infertility may be caused by reduced quantity of spermatozoons, or complete lack thereof, as well as when the quantity of spermatozoons is sufficient, but they are motionless or lifeless, and other causes. The problem of infertility in the context of demography is solved by the State Family Policy Guidelines 2011-2017[42] by anticipating the task – to assess the possibility of implementing State aid measures for treatment of infertility, as well as to inform the society regarding threats and risks to reproductive health which increase infertility. In order to assess the possibility of introducing State aid measures, it is necessary to study the occurrence of infertility problem in Latvia. Informative and educating work of inhabitants in sexual and reproductive health issues, family planning and ensuring of correct development of a child should be improved.

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[39] Fiore, AE, Uyeki, TM, Broder, K, Finelli, L, Euler, GL, Singleton, JA, et al. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR Recomm Rep 2010, 59:1.

[40] Acs N, Bánhidy F, Puhó E, Czeizel AE. Maternal influenza during pregnancy and risk of congenital abnormalities in offspring. Birth Defects Res A Clin Mol Teratol 2005 and Rasmussen SA, Jamieson DJ, Bresee JS. Pandemic influenza and pregnant women. Emerg Infect Dis 2008.

[41] Mosby LG, Rasmussen SA, Jamieson DJ. 2009 pandemic influenza A (H1N1) in pregnancy: a systematic review of the literature. Am J Obstet Gynecol 2011,205:10.

[42] Cabinet Order No. 65 of 18 February 2011, On State Family Policy Guidelines 2011-2017

More attention should be paid to timely recognition and treatment of reproductive organ illnesses and pathologies even in childhood.

Efficient and qualitative reproductive health care of inhabitants is one of the main preconditions for the increase of birthrate and creation of a healthy new generation. The most significant role should be assigned to disease prophylaxis – educating of the youth in sexual and reproductive health issues. Reproductive health care is an aggregate of measures of prophylaxis, diagnostics, treatment and monitoring of reproductive organ diseases, uterine tract infections, human immunodeficiency virus infection (HIV) and AIDS, as well as infertility, birth control, pregnancy termination and medically performed fertilisation to be carried out by medical practitioners.

The non-existence of a unified infertility register in the state is a significant problem. Now each medical fertilisation clinic keeps a separate register, therefore common statistics regarding infertility and medical fertilisation is not available in Latvia. Such statistical data would be significant both for scientific researches and for the development of State policy and financing system of medical fertilisation[43]. In implementing the plan in accordance with the laws and regulations in force, as well as taking into account the exception determined in respect of processing of sensitive personal data[44], the persons whom need the State aid programme for treatment of infertility will be noted, and record-keeping of medically assisted reproduction manipulations performed for such persons, as well as the register of children born as a result of artificial insemination will be kept. It is necessary to establish a centralised semen data bank in Latvia, including examination of generative cell donors. Age is one of the determining factors in selecting infertility treatment methods. Medically assisted reproduction is recommended for women with impermeable oviducts and men with azoospermia which cannot be corrected by medicinal products or surgery. It is very important to make infertility treatment more accessible to as great number of infertile spouses and persons as possible, as well as it is also necessary to include infertility treatment (medicinal products, diagnostics, also medically assisted reproduction) in State-paid services.

1.4. Role of intersectoral co-operation in maternal and child health improvement

In order to ensure more successful implementation of the objectives and tasks defined in the Plan, it is necessary to involve representatives of other sectors as much as possible and to co-operate with them. The State should actively co-operate and support the activity of NGOs in the field of health. NGOs have developed a broad network of co-operation partners, as well as they cover wider part of the society and successfully develop and strengthen informal education of adolescents and youth. Support of ministries, local governments is significant because the objective may be reached much quicker by joint co-operation.

Currently demography issues, including sexual and reproductive health, are defined as one of the government priorities. Due to this reason special attention should be paid to educating the youth already at schools because insufficiency of information is direct reason for the increase in the number of unplanned pregnancies and artificial abortions among the youth. It is important for adolescents and youth who are the creators of the new generation of Latvia to be educated in health issues, family planning, therefore it is necessary to acquire these very significant issues already at school, to improve sample curricula by promoting integrated successive acquisition of health, sports education and human safety issues in pre-school education, basic education and secondary education.

[43] Reproductive Health of Inhabitants of Latvia. Report on the situation in Latvia (2003 – 2011), published in 2011, available on www.papardeszieds.lv.
[44] Section 11, Clause 5 of the Personal Data Protection Law of 23 March 2000.

Only upon mutual co-operation of State institutions, local governments and NGOs it is possible to develop successfully and to strengthen informal education of adolescents and youth regarding sexual and reproductive health issues. In co-operation with NGOs it is necessary to organise informative and educating measures for youth and adolescents, covering issues regarding hygiene, relationship forming and safe sexual relations. In 2011 the guidelines for local governments for health promotion were approved (MoH Order No. 243 of 29 December 2011), and their purpose is to provide a methodological aid to local governments for the implementation of health promoting activities for inhabitants, including for youth regarding sexual and reproductive health issues, by providing recommendations for reduction of STD, HIV infections, improvement of education and carrying out of different support measures. In order to ensure introduction of the guidelines in local governments, from 2012 it is planned to establish a network of local government co-ordinators who will be responsible for organising health promoting activities in their local government. Training courses will be organised for the delegated contact persons in health promotion and public health issues, including regarding sexual and reproductive health issues.

The child safety issue becomes increasingly current in Latvia. Especially it is current in solving demographic problems of Latvia. In conformity with WHO findings[45] children in the age from 0-4 years are subject to the highest risk of violence in the family because children of this group completely depend on their carer and they have less possibilities of protecting themselves. Violence against a little child is not always intentional (physical violence), it is also insufficient or incorrect child care and failure to provide for the child's needs, as a result of which the child suffers from casual accidents or health disorders. The cause for such behaviour is lack of information and skills for new parents or emotional problems in the family. In 2010 2 children at the age up to 4 years died as a result of physical violence. In turn, 766 children at the age up to 4 years underwent treatment in a hospital from injuries suffered at home.[46]

Several local governments (Riga, Rēzekne, Talsi, etc.) organise work groups of specialists for exchange of information regarding cases of violence or leaving a child unattended, as well as ensure family assistants or voluntary support groups for families.

In 2011 specialists of the Health Economics Centre with the support of the WHO Regional Office for Europe carried out a research on Adverse Childhood Experiences of Young Adults in Latvia. According to the results of the research, 65.9% of respondents admitted that they have been punished physically in childhood, in turn 35.9% of respondents admitted emotional leaving unattended, but 27% – physical leaving unattended. Amendments to the Medical Treatment Law have been made for solving the issue, and they determine that medical treatment institutions, upon providing aid to a minor patient and when there is a basis to assume that the patient has suffered from lack of due care and attendance or other infringement of the child's rights, the medical treatment institution shall immediately, however not later than within 12 hours, notify the State Police thereof.

In addition to that, *Recommendations for reproductive health specialists regarding examination of a patient and provision of aid*, as well as a training programme for specialists for prophylaxis of violence and injuries were developed within the framework of a biennial collaborative agreement in 2010 with the support of the WHO.

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[45] WHO report "Violence and Health" (2003) and report "Preventing child maltreatment: a guide to taking action and generating evidence" (2006).
[46] CDPC database.

Regardless of the measures taken, the understanding of the society and different institutions regarding domestic violence, including emotional violence, is not complete, therefore it is important to promote the recognition of domestic violence and violence prophylaxis, by involving experts of the public health and of other fields. Educating of young parents regarding child care and significance of attendance is important in order to guarantee safety of children, as well as regarding prevention of domestic violence and possibilities of support. It is necessary to promote the understanding of the society regarding the role of the society in reduction of violence and the possibilities for preventing violence and regarding promoting safety of children, as well as involvement of mass media in educating the society regarding issues of upbringing of children and relationship forming in a family. More active participation of primary care specialists in informing parents regarding safety issues of children is necessary.

In order to develop and implement maternal and child policy in Latvia more efficiently, aspects of education, welfare and other sectors must be included in common intersectoral policy, co-operating with other ministries, local governments and non-governmental sector, as well as the WHO and EU institutions. Maternal and child health issues should be solved strategically and in an integrated manner in order to implement the principle 'health in all policies', because these issues are directly related to improving the demographic situation and healthy development of the State.

1.5. Main problems identified:

1. High perinatal, infant and maternal mortality in Latvia.

2. Insufficient involvement of the primary care stage in the provision of reproductive services (antenatal care, cervical cancer screening, family planning services) which limits access to services, particularly for social exclusion risk groups.

3. Insufficient knowledge of new parents regarding sexual and reproductive health, health retaining during pregnancy, care and safety of a newborn child.

4. There is no unified infertility register and centralised semen data bank in the country, as well as infertility diagnostical examinations and medically assisted reproduction procedures are not included in State-paid services.

5. Confidential analysis of maternal mortality and audit system of perinatal mortality have not been established for the identification and elimination of problems.

6. Insufficient intersectoral co-operation in the field of reproductive health, improvement of maternal and child health, insufficient information for youth and adolescents regarding sexual and reproductive health issues.

2. Hierarchy of objectives, results and performance indicators thereof

Objective of the plan is to improve the health of the mother and child (including to reduce perinatal mortality and maternal mortality) by ensuring that planned, agreed and co-ordinated measures are carried out.

Objective of the plan may be reached by implementing three points of progress:

1. Measures for improving health care of the mother and the child.

2. Inclusion of infertility treatment (including medically assisted reproduction) in State-paid services.

3. Involvement of other sectors (intersectoral co-operation) for integrated and national solving of the issue.

In order to achieve the objective defined in the Plan the following tasks are determined:

1. To introduce additional examination methods for pregnant women in order to reduce the development of congenital anomalies for newborn children.

2. To implement the principle ‘money follows a pregnant woman’ in the State-financed care of pregnant women.

3. To involve a team of family doctors (a nurse or midwife) in family planning and promoting of reproductive health.

4. To develop and register the antenatal care guidelines and the criteria for determining the competence of medical practitioners.

5. To create a confidential analysis system of maternal mortality, as well as an analysis system of perinatal mortality for improvement of health care.

6. To include pregnant women in a high-risk group for voluntary vaccination against influenza and to ensure reimbursement of the vaccine price in the amount of 100% from the funds from the State budget. Pregnant women who suffer from diseases with immune deficiency symptomatic or for whom surgeries or manipulations in a hospital are planned during influenza epidemic are vaccinated.

7. To ensure informing of parents and free training process of parents-to-be with during prenatal and postnatal care, to promote breast-feeding.

8. To reimburse prescription medicinal products in the amount of 25% for pregnant women and women in postnatal period, to reimburse prescription medicinal products in the amount of 50% for children up to 2 years of age (not including), if diagnosis with another amount of reimbursement is not determined.

9. To establish an infertility register and a centralised semen data bank in the state.

10. To include medicinal products for treatment of infertility in the list of State compensated medicinal products.

11. To include additional diagnostic examinations for determination of infertility and medically assisted reproduction procedures in State-paid services.

12. To perform intersectoral co-operation by ensuring education of youth and adolescents and prevention of violence against children.

Policy outcome	Performance indicators	Reference level		year 2012	year 2014
		Indicator	Year		
1. Health status of the child and the mother improves	Performance indicator: perinatal mortality (per 1000 live births and stillbirths)	8.12[47]	2010	8.2	7.5
	Performance indicator: infant mortality (per 1000 live births)	5.7[48]	2010	5.5	5
	Performance indicator: infant mortality from certain conditions of perinatal period (per 1000 live births and stillbirths)	3.0[49]	2010	2.9	2.7
2. Informing of parents regarding effect of substances causing addiction on health of a pregnant woman and foetus and the significance of the mother's milk for ensuring the health of the child is ensured	Performance indicator: proportion of smoking parturient women (%)	10.2%[50]	2010	10%	7%
	Performance indicator: proportion of infants who have received breast-feeding until the age of 6 months	52.5[51]	2010	53.7	56.7
3. Reduced maternal mortality	Performance indicator: maternal mortality (per 100 000 live births)	26.1[52]	2010	20	15
4. Ensured infertility treatment	Performance indicator: the register of infertile patients has been established in the country	-	2010	X	X
	Performance indicator: a centralised semen data bank has been established in the country	-	2010	X	X

[47] Data of the CDPC.
[48] *Ibid*.
[49] *Ibid*.
[50] *Ibid*.
[51] *Ibid*.
[52] WHO, data of the European Health for All database.

3. Linking of the plan with other development programming documents and international legal acts binding on Latvia

The plan was drawn up on the basis of the following documents:

1. *Public Health Strategy 2011-2017*[53], sub-objective – to improve the health of a mother and a child, to reduce infant mortality.

2. Strategy for sustainable development of Latvia "Latvia 2030"[54], long-term action laid down in Section 2 "Long-term Investments in Human Capital" – quality of and access to health and social services.

3. National Development Plan of Latvia 2007-2013[55], which provides for establishment of balanced responsibility of the State and individual for maintaining and improving health, forming of understanding by the society of healthy lifestyle and nutrition, and involvement of the society in the battle against addiction diseases.

4. Strategic Development Plan of Latvia 2010-2013[56], in which a healthy human in sustainable society is defined as a precondition for safe and stable development.

Other policy programming documents with which the plan is related to:

In the field of employment and social policy:

• State Family Policy Guidelines 2011-2017[57] (overarching objective – to promote establishment, stability, welfare of families, to promote birthrate, as well as to strengthen the institution of marriage and its value in the society).

• Plan "Suitable Latvia for Children 2010-2012"[58] (overarching objective – to create such a world which would meet all the needs and interests of children).

In the field of education and science:

• Youth Policy State Programme 2009-2013[59] (overarching objective – to improve the quality of life of youth by promoting their initiatives, participation in decision-making and social life, by supporting work with youth and ensuring smoother transition from child status to adult status for the youth).

In the field of transport and communications policy:

• Road Traffic Safety Programme 2007-2013[60] (objective – to achieve reduction in the number of persons deceased in road traffic accidents. Especially, in solving the following tasks – guaranteeing of the safety of less protected road traffic participants, increasing of the

[53] Cabinet Order No. 504 of 5 October 2011, On Public Health Guidelines 2011 – 2017.
[54] Approved during the *Saeima* meeting of 10 June 2010 (*Latvijas Vēstnesis*, No.101, 29 June 2010.).
[55] Cabinet Regulation No. 564 of 4 July 2006, Regulations Regarding the National Development Plan of Latvia 2007-2013.
[56] Cabinet Order No. 203 of 9 April 2010, Strategic Development Plan of Latvia 2010-2013.
[57] Cabinet Order No. 65 of 18 February 2011, On State Family Policy Guidelines for 2011-2017.
[58] Cabinet Order No. 324, On Plan "Suitable Latvia for Children 2010-2012".
[59] Cabinet Order No. 589 of 27 August 2009, On Youth Policy State Programme 2009-2013.
[60] Cabinet Order No. 209 of 13 April 2007, On the Road Traffic Safety Programme 2007-2013.

safety level of children in road traffic, eradication of driving of vehicles under the influence of alcohol).

In the field of foreign policy:

• Report on Millennium Development Goals in Latvia 2005[61], (objective – improvement of maternal health and reduction of child mortality).

EU documents:

1. Council of the European Union Resolution on action on health determinants[62], where the necessity to develop knowledge in order to assess the influence of other fields of policy and determining factors thereof on health is emphasised. The Member States are invited to promote introduction of such policies which ensure a high level of health protection. (OV C 218, 31.07.2000)

2. White Paper. Together for Health: A Strategic Approach for EU 2008-2013[63], especially the strategic objective thereof which determines that health policy at the Community level should foster good health, protect citizens from threats, and support sustainability (COM(2007)630).

3. Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-13).[64] The decision determines to improve citizens' health security, to promote health, including the reduction of health inequalities, and to generate and disseminate health protection information.

4. European Parliament resolution of 5 September 2007 on an European Union strategy to support Member States in reducing alcohol-related harm (2007/2005(INI))[65], which invites the Member States to pay attention to such non-protected social groups as children, youth and pregnant women, and to solve the problems caused by use of alcohol dangerous and harmful to health among youth, workers and drivers via help of informative and awareness-raising campaigns.

5. Communication for the European Commission of 24 October 2006, An EU strategy to support Member States in reducing alcohol related harm (COM(2006)0625)[66], where the EC has determined five especially important fields: protect young people, children and the unborn child; reduce injuries and deaths from alcohol-related road traffic accidents; prevent alcohol-related harm among adults and reduce the negative impact on the workplace; inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns, as well as develop, support and maintain a common evidence base in EU level.

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[61] Report on Millennium Development Goals in Latvia, the Ministry of Foreign Affairs of the Republic of Latvia and the UN in Latvia, 2005.
[62] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2000:218:0008:0009:EN:PDF.
[63] White Paper. Together for Health: A Strategic Approach for EU 2008-2013. Brussels.
[64] Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-13).
[65] European Parliament resolution of 5 September 2007 on an European Union strategy to support Member States in reducing alcohol-related harm (2007/2005(INI)).
[66] http://www.europarl.europa.eu/meetdocs/2004_2009/documents/com/com_com(2006)0625/com_com.

WHO documents:

1. WHO Guidelines for the European region Health for All in the 21st century[67], where the objective to foster and protect human health throughout life and to reduce frequency of diseases and injuries, and to mitigate suffer caused by them, is brought forward (May 1998, World Health Assembly).

2. WHO Global Strategy for the Prevention and Control of Noncommunicable Diseases[68], which provides for implementation of appropriate measures in order to prevent risk factors of noncommunicable diseases – unhealthy nutrition, insufficient physical activity, use of alcohol and tobacco products (20 May 2000, 53rd World Health Assembly).

3. WHO 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (18 April 2008, World Health Assembly)[69].

4. WHO 2012-2016 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (12-15 September 2011, Azerbaijan)[70].

5. WHO European Region Resolution on prevention of injuries in the WHO European Region[71], which encourages the Member States to give priority to the prevention of violence and unintentional injury by developing national action plans, developing injury surveillance, strengthening technical and institutional capacity to address the issue of injuries (September 2005. Bucharest, session of WHO Regional Committee for Europe).

6. Global Strategy for Women's and Children's Health[72] mentioning the significant role of women and children in development of the society, as well as indicating that upon investing more resources in improvement and maintaining of women's and children's health a healthier society will be created.

7. European strategy for child and adolescent health development[73], particularly emphasising that children and adolescents are investment in the creation of tomorrow's society and that their health and the way in which parents nurture them will determine the prosperity and stability of the European states over the next decades.

8. Children's Environment and Health Action Plan for Europe[74], by which the states undertake to develop national children's environmental and health action plans in order to ensure the achievement of the priority goals defined on regional level (for example, to prevent and substantially reduce health consequences from accidents and injuries, pursue a decrease in morbidity from lack of physical activity, reduce the risk of disease arising from exposure to

[67] Health For All in the 21st century. World Health Organization 1998.
[68] Global Strategy for the Prevention and Control of Noncommunicable Diseases. Fifty-third World Health Assembly, 2000.
[69] 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. World Health Organization 2008.
[70] Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012-2016. Regional Committee for Europe. Baku, Azerbaijan, 12–15 September 2011.
[71] Resolution. Prevention of injuries in the WHO European Region. Regional Committee for Europe. Bucharest, Romania, 12–15 September 2005.
[72] Global Strategy for Women's and Children's Health. United Nations Secretary-General, 2010.
[73] European strategy for child and adolescent health development. WHO, 2005.
[74] Children's Environment and Health Action Plan for Europe. Fourth Ministerial Conference on Environment and Health. Budapest, Hungary, 23-25 June 2004.

hazardous chemicals, physical and biological agents), June 2004, Fourth Ministerial Conference on Environment and Health of WHO.

UN documents:

1. United Nations Millennium Declaration, adopted by the Millennium Summit in New York which took place 6-8 September 2000[75], where the commitment to take measures for the implementation of eight Millennium Development goals is mentioned. They concern different issues related to improvement of life level in such fields as education, health, environmental sustainability, etc.

2. UN Declaration of the Rights of the Child of 20 November 1959[76], in accordance with which a child and his mother shall be provided with special care and protection, including adequate pre-natal and post-natal care.

3. UN Convention on the Rights of the Child of 20 November 1989[77], in accordance with which the States Parties shall ensure "appropriate pre-natal and post-natal health care for mothers".

[75] United Nations Millennium Declaration.
[76] Declaration of the Rights of the Child. General Assembly. 20 November 1959.
[77] Convention on the Rights of the Child. General Assembly. 20 November 1989.

4. Financing necessary for introduction of the plan

In order to improve maternal and child health care, additional financing in the amount of **1 266 300** lats is needed which includes introduction of additional examination methods for *pregnant women*, including to perform culture of group B beta-hemolytic streptococci for all pregnant women in 37th week, to introduce additional ultrasound screening, to broaden the possibilities for performance of *gestational diabetes screening* and *to broaden prenatal diagnostics.*

In order to promote improvement of health care of pregnant women, new mothers and newborn children, additional financing in the amount of **3 750 750** lats is needed, it is necessary to involve gynaecologists and other specialists practicing in private practice in the State-financed care of pregnant women by implementing the principle 'money follows a pregnant woman' (by entering in an agreement with the State regarding the care of pregnant women it is planned to increase payment for care from LVL 4.56 to LVL 12.00, concurrently reimbursing the patient's fee LVL 3.00 and the tariff for ultrasound from LVL 15.00 to LVL 13.21 (concurrently financing the patient's fee LVL 3.00).

In order to improve care of newborn children with congenital pathologies in regions, additional financing in the amount of **501 000** lats is needed, which is intended for the renewal of reanimation technologies for newborn children, equipment and ensuring of perinatal period care.

Additional financing in the amount of **17 496** lats is needed in order to provide voluntary vaccination by intending inclusion of pregnant women in high-risk group for voluntary vaccination against influenza and ensuring reimbursement in the amount of 100% from the State budget resources.

Additional financing in the amount of **359 711** lats is needed in order to ensure access to medicinal products by reimbursing the necessary prescription medicinal products in the amount of 25% for pregnant women and women in post-natal period up to 42 days, by reimbursing the necessary prescription medicinal products in the amount of 50% for children up to 2 years of age (not including), if other diagnosis with another amount of reimbursement has not been determined.

Additional financing in the amount of **1 536 082** lats is needed in order to solve infertility problems, which include registration of infertile persons and registration of manipulations performed for such persons, reimbursement of medicinal products (for the provision of treatment of infertility), payment for infertility diagnostic examinations and medically assisted reproduction procedures/manipulations.

In implementing the referred-to measures for improvement of maternal and child health care which include additional informative, support, diagnostic and therapeutic measures, including inclusion of medically assisted reproduction in State-paid services, the total additional financing needed in the health sector for the three-year period (in 2012 – in the amount of 1 112 855 lats, in 2013 – in the amount of 2 871 492 lats, in 2014 – in the amount of 3 446 992 lats) is 7 431 339 lats.

The issue regarding allocation of additional State budget resources for implementation of the tasks 1.1.1, 1.2.1, 1.2.4, 1.6.1, 1.9.1, 1.9.2, 2.2.2 and 2.2.4 of the plan to the Ministry of Health in 2012 – in the amount of 1 112 855 lats will be reviewed by the Cabinet during

drafting and review procedure of the draft law “Amendments to the Law On the State Budget for 2012”.

The issue regarding allocation of additional State budget resources for implementation of the tasks 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.2.1, 1.2.4, 1.6.1, 1.9.1, 1.9.2, 2.1.1, 2.2.2, 2.2.3 and 2.2.4 of the plan to the Ministry of Health in 2013 – in the amount of 2 871 492 lats and for implementation of the tasks 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.2.1, 1.2.4, 1.6.1, 1.9.1, 1.9.2, 2.1.1, 2.2.2, 2.2.3 and 2.2.4 of the plan in 2014 – in the amount of 3 446 992 lats will be examined by the Cabinet during drafting and review procedure of the draft law on the State budget for the current year.

Certain measures will be implemented within the framework of the State budget resources allocated to the involved institutions for implementation of the measures (tasks) within the competence thereof, within the scope of the funding of Activity 1.3.2.3 of the European Social Fund “Enhancement of competencies, qualification and skills of health care and health promotion personnel”.

5. Institutions responsible for the implementation of measures

The authority responsible for supervising the results of implementation of the plan is the MoH. Three ministries and four State authorities, the Latvian Association of Gynaecologists and Obstetricians, the Association of Midwives of Latvia, family doctors, medical treatment institutions, representatives of local governments, NGOs and WHO are involved in the introduction of the plan. The institutions responsible for the performance of measures are determined in the plan.

6. Procedures for assessment of the plan and reporting

The MoH shall, until 1 June 2015, submit information to the Cabinet regarding implementation of the plan during the period of operation thereof.

7. Measures intended in the plan

Linking with the policy objectives, actions or tasks put forward in the strategy (if the plan has been developed for the implementation of the strategy)	Sub-objective of the Public Health Strategy 2011-2017 – to improve the health of the mother and the child, to reduce infant mortality.				
Objective put forward in the plan	**Objective of the plan – to improve** the health of the mother and the child (including to reduce perinatal mortality and maternal mortality), **ensuring planned, agreed and co-ordinated performance of measures.**				
Action for the achievement of the objective	**1. Action** – Measures for improving the health care of mother and child				
Task for achieving the objective	**1.1. To implement additional examination methods for pregnant women in order to reduce the development of congenital anomalies for newborn children**				
Measures for achieving the objective put foward	**Term of execution**	**Responsible institution**	**Institutions involved**	**Direct action results**	**Anticipated funding and its sources (LVL)**
1.1.1. To perform culture of group B beta-hemolytic streptococci for all pregnant women in the 37th week	30 December 2012, 30 December 2013, 30 December 2014	MoH	NHS	Reduced risk for sepsis of newborn children and mortality therefrom (amendments are made to Cabinet Regulation No. 611 of 25 July 2006, Procedures for Ensuring Assistance with Deliveries)	Additional funding from the State budget resources is needed, in total LVL 321 000 in the sub-programme 33.01.00. In 2012 – LVL 64 200 In 2013 –LVL 128 400 In 2014 –LVL 128 400 Forecasted number of pregnant women per year – 20 000. Price for one examination – LVL 6.42 (tariff approved by Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care – the tariff used in the

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					calculation is obtained in conformity with the proportion of manipulations 44507 and 44508 applied). Additional resources for a complete year: LVL 6.42 × 20 000 = LVL 128 400. In 2012: LVL 128 400 / 2 = LVL 64 200 (amount for the second half-year).
1.1.2. To introduce additional ultrasound screening, performing informative and explanatory work regarding the methodology for those gynaecologists who perform such examinations and for other specialists who are performing care of pregnant women	30 December 2013, 30 December 2014	MoH	NHS CDPC Latvian Association of Gynaecologists and Obstetricians	Foetuses with timely identified congenital pathologies (amendments are made to Cabinet Regulation No. 611 of 25 July 2006, Procedures for Ensuring Assistance with Deliveries, and to Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care	Additional funding from the Sate budget resources is needed, in total in the amount of 396 300 LVL including: in 2013 –198 150 LVL,. in 2014 –198 150 LVL. 1. Every year 9000 pregnant women x 13,21 LVL = 118 890 LVL (according to the present ultrasound examination data the forecasted number of pregnant women per year who will perform the third ultrasound examination – 9000). Price for one ultrasound examination – LVL 13.21 (tariff approved by Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care – the tariff used in the calculation is obtained according to manipulations – 50697 (LVL 4.81), 50742 (LVL 5.40) and

					reimbursement of a patient's fee (LVL 3), in total LVL 4.81 + LVL 5.40 + LVL 3 = LVL 13.21)). Resources are needed in the sub-programme 33.01.00. 2. For mehtodological work: 2.1. in 2013 – to carry out informative and explanatory work concerning methodology for those gynaecologists who are performing such examinations – LVL 79 260; 2.2. in 2014 – to carry out informative and explanatory work for other specialists who are performing care of pregnant women – LVL 79 260. Resources will be necessary for the Centre for Disease Prevention and Control which from 2013 will be financed in the sub-programme 46.03.00 "Ensuring of Disease Prevention" of the new budget
1.1.3. To expand the possibilities for the performance of gestational diabetes screening	30 December 2013 30 December 2014	MoH	NHS	Pregnant women with diabetes risk identified (guidelines developed)	Additional funding from the State budget resources is needed, in total LVL 37 800 in the sub-programme 33.01.00. In 2013 –LVL 18 900. In 2014 –LVL 18 900. Forecasted number of pregnant women per year – 20 000. Price for one examination – LVL 1.89 (tariff approved by Cabinet Regulation No.

					1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care – the tariff used in the calculation is obtained according to the proportion of manipulation 41096 applied). It is planned to carry out screening for 50% or 10 000 pregnant women each year. Additional resources per year: LVL 1.89 × 10 000 = LVL 18 900.
1.1.4. To improve prenatal diagnostics of congenital anomalies	30 December 2013 30 December 2014	MoH	NHS	The possibility to identify foetuses with congenital pathologies earlier (amendments are made to Cabinet Regulation No. 611 of 25 July 2006, Procedures for Ensuring Assistance with Deliveries, and to Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care	Additional funding from the State budget resources is needed, in total LVL 511 200 in the sub-programme 33.01.00. In 2013 –LVL 255 600. In 2014 –LVL 255 600. Forecasted number of pregnant women per year – 20 000. Prices for examinations: 49008* Detection of PAPP-A in blood serum of pregnant women in the 1st trimester – LVL 6.77 49009* Detection of free β-human chorionic gonadotropin in blood serum of pregnant women in the 1st or 2nd trimester – LVL 6.01

					Additional resources necessary per year: LVL 6.77 x 20 000 x + LVL 6.01 x 20 000 = LVL 255 600
1.1.5. Adjust procedures for the care of pregnant women, including providing for additional examinations (fetal echocardiography, repeat detection of blood type) for pregnant women of risk group	1 May 2013			Amendments are made to Cabinet Regulation No. 611 of 25 July 2006, Procedures for Ensuring Assistance with Deliveries, by specifying the procedures for the care of pregnant women and determining additional examinations (fetal echocardiography, repeat detection of blood type) for pregnant women of risk group.	Within the scope of the present State funding in the sub-programme 33.01.00.
Task for achieving the objective	**1.2. To involve gynaecologists practicing and other specialists in private practice in State-financed care of pregnant women**				
1.2.1. To implement the principle 'money follows a pregnant woman' which is binding on those medical practitioners (gynaecologist (obstetrician), family doctor or midwife) which ensure the care of pregnant women	30 December 2012, 30 December 2013, 30 December 2014	MoH	NHS	The number of pregnant women without antenatal care decreases (amendments are made to Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care, and to Cabinet Regulation No. 611 of 25 July 2006, Procedures for Ensuring Assistance with	Additional funding from the State budget resources is needed, in total in the amount of LVL 3 750 750 including: in 2012 –LVL 750 150; in 2013 – LVL 1 500 300; in 2014 – LVL 1 500 300. Forecasted number of pregnant women per year – 20 000. By entering into an agreement with the State it is planned to increase payment

				Deliveries)	for care from LVL 4.56 to LVL 12.00, concurrently reimbursing the patient's fee LVL 3.00, thus the difference to be covered from the State budget is LVL 7.44 (it forms as the difference between the average tariff of the paid service for a consultation of a pregnant woman at the gynaecologist (LVL 12) and the tariff which is paid by the State for a consultation of a pregnant woman (LVL 4.56): LVL 12 – LVL 4.56 = LVL 7.44). 9 care episodes are intended. Additionally 3 ultrasound examinations for 9000 pregnant women and 6 examinations for 9000 pregnant women are intended, covering the difference between the paid service of LVL 15 and expenses for service LVL 13.21 (= LVL 1.79). Additionally in total per year: ((LVL 7.44 × 20 000 × 9) + (LVL 1.79 × 9000 × 3) + (LVL 1.79 × 9000 × 6)) = LVL 1 339 200 + LVL 48 330 + LVL 96 660 = LVL 1 484 190. In 2012 the resources are planned for the second half-year: LVL 1 484 190/2 = LVL 742 095. Resources are needed in the sub-

					programme 33.01.00 “Treatment”. Moreover, each year the National Health Service needs additional resources in the amount of LVL 16 110 (in 2012 – the sum for the second half-year LVL 8 055) in order to implement informative campaigns regarding improvement of access to health care services for pregnant women. Resources needed in the budget programme 45.00.00. Total funding for the measure for 2013-2014: LVL 1 484 190 + LVL 16 110 = LVL 1 500 300 For the second half-year of 2012: LVL 742 095 + LVL 8 055 = LVL 750 150.
1.2.2. To prepare an informative report on availability of the ultrasound for pregnant women in Latvia, studying the present situation and providing proposals for further action	30 December 2012	MoH	NHS	Informative report is prepared.	Within the scope of the existing State funding in the sub-programme 01.01.00.
1.2.3. To ensure training regarding performance of ultrasound screening and completing of medical	30 December 2014	MoH	Latvian Association of Gynaecologists and	Trained medical practitioners who are performing ultrasound screening for pregnant	Within the scope of the funding of Activity 1.3.2.3 “Enhancement of competencies, qualification and skills of health care and health promotion

documentation for those medical practitioners who are performing ultrasound screening for pregnant women			Obstetricians	women	personnel" of the European Social Fund. In 2014 –LVL 15 000.
1.2.4. Strengthening of regional perinatal centres	30 December 2012, 30 December 2013, 30 December 2014	MoH	Latvian Association of Gynaecologists and Obstetricians	Qualitative care of newborn children with congenital pathologies in regions	Additional funding from the State budget resources is needed, in total LVL 501 000 in the sub-programme 33.01.00. In 2012 –LVL 167 000. In 2013 –LVL 167 000. In 2014 –LVL 167 000. The additionally needed funding is intended for the renewal of reanimation technologies, equipment for newborn children and ensuring of perinatal period care in regions (for example, Liepāja, Rēzekne).
1.2.5. Establishment of a consultation system for specification of prenatal congenital pathologies, involving regional perinatal centres	30 December 2013, 30 December 2014	MoH	Latvian Association of Gynaecologists and Obstetricians Regional perinatal care centres	A consultation system for specification of diagnosis is established	Within the scope of the existing State funding in the sub-programme 01.01.00.
Task for achieving the objective	**To involve a team of family doctors (a nurse or midwife) in family planning and promoting of reproductive health**				
1.3.1. To introduce a family planning, sexual and reproductive health course	30 December 2014	MoH	Latvian Association of Gynaecologists	Trained team of a family doctor which ensures care of pregnant women	Within the scope of the funding of Activity 1.3.2.3 "Enhancement of competencies, qualification and skills of

in further education programmes for a team of a family doctor: management of physiological pregnancy, abortion prevention, educating of pregnant women regarding risk factors which may influence the course of pregnancy, fostering of breast-feeding and support to breast-feeding mothers			and Obstetricians Association of Midwives of Latvia HI	regarding family planning, sexual and reproductive health	health care and health promotion personnel" of the European Social Fund. In 2014 – LVL 40 000.
1.3.2. Improvement of access to posts of paramedics – posts of midwives in the provision of primary health care services (increase of load for a paramedic or midwife working at the post of paramedics)	30 December 2012	MoH	NHS	Access to posts of paramedics is ensured for patients (including pregnant women and new parents) in regions of low population density (amendments are made to Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care.	Within the scope of the existing State funding in the sub-programme 33.01.00.
Task for achieving the objective	**1.4. To develop and register the guidelines for antenatal care and the criteria for determining the competence of medical practitioners**				
1.4.1. To develop and register guidelines and criteria for antenatal care	30 December 2013	NHS	Latvian Association of Gynaecologists and Obstetricians	Guidelines for antenatal care and criteria for determining the competence of medical practitioners are	Within the scope of the NHS budget in the programme 45.00.00.

			Association of Midwives of Latvia HI	developed and registered	
1.4.2. To prepare an informative report on the proportion of caesarean sections and complications during delivery in Latvia, studying the present situation and providing proposals for further action	30 December 2013	MoH	NHS Latvian Association of Gynaecologists and Obstetricians	The informative report is prepared.	Within the scope of the existing State funding in the sub-programme 01.01.00.
Task for achieving the objective	**1.5. To establish perinatal and maternal mortality audit systems**				
1.5.1. To perform analysis of perinatal mortality and, on the basis of the results of the analysis, to assess the possibility to introduce changes in the State perinatal care system	30 December 2012, 30 December 2013, 30 December 2014	MoH	Latvian Association of Gynaecologists and Obstetricians Association of Midwives of Latvia HI WHO	Changes in the issues of perinatal care system – a perinatal audit system is established	Within the scope of the existing State funding in the sub-programme 01.01.00.
1.5.2. To perform confidential audit of maternal mortality, introducing changes in the guidelines for the management of delivery and pregnancy	30 December 2012, 30 December 2013, 30 December 2014	MoH	Latvian Association of Gynaecologists and Obstetricians Association of Midwives of Latvia	Changes in the issues of the management of delivery and pregnancy – a confidential audit system of maternal mortality is established.	Within the scope of the existing State funding in the sub-programme 01.01.00.

			HI WHO		
Task for achieving the objective	**1.6. Vaccination of pregnant women against influenza**				
1.6.1. To include all pregnant women in a high-risk group for voluntary vaccination against influenza and to ensure reimbursement of vaccine price in the amount of 50% from the State budget resources	30 December 2012, 30 December 2013, 30 December 2014	MoH	NHS CDPC	Morbidity with influenza reduces. The indicator of morbidity of pregnant women from influenza is 0 (amendments are made to Cabinet Regulation No. 899 of 31 October 2006, Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment, by including in Annex 1 a new group of patients for diagnosis Z25.1, determining that in this case both codes Z25.1 and Z33 *Present pregnancy* shall be specified on the special prescription	Additional funding from the State budget resources is needed, in total LVL 17 496 in the sub-programme 33.03.00.: in 2012 – LVL 5 832; in 2013 – LVL 5 832; in 2014 – LVL 5 832. The forecasted number of pregnant women per year – 2 400 (12% of the total number). The price of one vaccine – LVL 4.86 (price is obtained from the list of reimbursable medicinal products (LVL 4.75), supplementing it with vaccination (administration of vaccine into skin, subcutaneous tissue and muscle) tariff which is approved by Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care). Additional resources per year: LVL 2.43 × 2 400 = LVL 5 832. As vaccination is performed in in the second half-year, resources are needed in full amount also for 2012.

Task for achieving the objective	1.7. Informing of parents				
1.7.1. To ensure training of parents-to-be during pre-natal care, including to ensure information regarding availability of ultrasound in regions of Latvia	30 December 2012, 30 December 2013, 30 December 2014	MoH	Latvian Association of Gynaecologists and Obstetricians Association of Midwives of Latvia	Amendments are made to Cabinet Regulation No. 611 of 25 July 2006, Procedures for Ensuring Assistance with Deliveries, intending to ensure training for parents regarding child care and safety	Within the scope of the existing State funding in the sub-programme 33.01.00 (see section 7, task 1.2.1).
1.7.2. To ensure training of new parents regarding child care and safety at practices of family doctors	1 January 2013	MoH	NHS	Amendments are made to Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care, determining that training of parents regarding child care and safety in family should be ensured at a practice of a family doctor	Within the scope of the existing State funding in the sub-programme 33.01.00.
1.7.3. To establish an inter-institutional working group in order to improve the functioning of an early notification system regarding violence against a child and injury at his or her place of residence, including preventive home visits of a	30 December 2014	MoH	NHS HI MoW	Proposals for amendments to legal acts are prepared in order to improve the functioning of the early notification system regarding violence against a child and injury at his or her place of residence,	Within the scope of the existing State funding in the sub-programme 01.01.00.

team of the family doctor for children up to the age of one and a half years.				including preventive home visits of a team of the family doctor for children up to the age of one and a half years.	
Task for achieving the objective	**1.8. Promotion of breast-feeding**				
1.8.1. To renew the Baby-Friendly Hospital Initiative in Latvia	30 December 2014	MoH	MoH HI RSU regional hospitals	Baby-Friendly Hospital Initiative is renewed	Within the scope of the existing State funding in the sub-programme 01.01.00.
1.8.2. To publish informative material "Breast-feeding ABC" repeatedly for free distribution to new mothers in maternity wards	30 December 2012, 30 December 2013, 30 December 2014	MoH	CDPC	Informative materials are published and distributed	Within the scope of the existing State funding in the sub-programme 01.05.00.
1.8.3. To organise informative measures for pregnant women and new parents regarding breast-feeding and child safety (including regarding prevention of domestic violence and prevention of sudden infant death syndrome) and for youth regarding healthy lifestyle, sexual and reproductive health issues	30 December 2012, 30 December 2013, 30 December 2014	MoH	CDPC local governments, NGOs	Informative measures are organised	Within the scope of the existing State funding in the sub-programme 01.05.00.

Task for achieving the objective	1.9. Ensuring of access to medicinal products				
1.9.1. To reimburse expenses for the acquisition of prescription medicinal products in the amount of 25% for pregnant women and women in post-natal period up to 42 days, if other diagnosis with another amount of reimbursement has not been determined for them	30 December 2012, 30 December 2013, 30 December 2014	MoH	NHS	The necessary prescription medicinal products are reimbursed in the amount of 25% (amendments are made to Cabinet Regulation No. 899 of 31 October 2006, Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment, changing Paragraph 4 in respect of reimbursement categories, where it should be mentioned that in such case a diagnose code Z33 *Present pregnancy* or Z39.2 *Standard post-natal monitoring* should be specified on the special prescription, as well as such new payment mechanism must be explained)	Additional funding from the State budget resources is needed, in total LVL 75 000 in the sub-programme 33.03.00. In 2012 –LVL 15 000. In 2013 –LVL 30 000. In 2014 –LVL 30 000. Forecasted number of pregnant women per year – 20 000, forecasted number of pregnant women who need prescription medicinal products – 3000 (15%). Price for medicinal products per year on average is LVL 40, reimbursement of 25% – LVL 10. Needed additionally for the year: LVL 10 × 3 000 = LVL 30 000. Resources planned for the second half-year of 2012 (from 1 September 2012): LVL 30 000/2 = LVL 15 000.

1.9.2. To reimburse expenses for the purchase of prescription medicinal products in the amount of 50% for children up to 2 years of age (not including), if the diagnosis with another amount of reimbursement is not determined for them	30 December 2012, 30 December 2013, 30 December 2014	MoH	NHS	The necessary prescription medicinal products are reimbursed in the amount of 50% (amendments are made to Cabinet Regulation No. 899 of 31 October 2006, Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment, changing Paragraph 4 in respect of reimbursement categories, as well as such new payment mechanism must be explained)	Additional funding from the State budget resources is needed, in total LVL 284 711 in the sub-programme 33.03.00. In 2012 – LVL 40 673. In 2013 – LVL 122 019. In 2014 –LVL 122 019. Number of newborn children from 0-2 years of age (not including) – 40 673 (data of 2011), the forecasted number of children who will need prescription medicinal products – (15%). The price for medicinal products per year on average is LVL 40, reimbursement of 50% – LVL 20. Needed additionally for the year: (40 673 x 15%) x (LVL 40 x 50%) = LVL 122 019 for 2012 it is planned from 1 September 2012 (4 months): LVL 122 019/ 3 = LVL 40 673.
Action for achieving the objective	**Action** – inclusion of infertility treatment (including medically assisted reproduction) in State-paid services				
Task for achieving the objective	**2.1. Establishment of infertility register and centralised semen data bank**				
2.1.1. To ensure registration of infertile persons and registration of manipulations performed for them	30 December 2012, 30 December	NHS	MoH	Data acquisition mechanism, including data acquisition from private medical treatment	Additional funding from the State budget resources is needed, in total LVL 21 782 in the sub-programme 45.00.00.

(ensuring of compatibility of existing registers)	2013, 30 December 2014			institutions, is improved. Data analysis and data compilation are performed regarding infertile patients included in the NHS register, manipulations performed for them, as well as children born as a result of artificial insemination are registered.	In 2013 –LVL 11 891. In 2014 –LVL 9 891. Additional funding is needed for implementation expenses of the measure for the system of settlement of payments for reimbursable medicinal products of the management information system (VIS KMANS) (classifier of prescription medicinal products, changes are entered in forms and calculation mechanism to the extent determined for the compensation of prescription for pregnant women and children, new type of invoice (sums for pregnant women and children), one report on sums of medicinal products counter sold to pregnant women and children).
2.1.2. To establish a unified semen bank data registration in Latvia (including examination of generative cell donors)	30 December 2014	NHS	Medical treatment institutions MoH CDPC HI	Medical treatment institutions, when entering into agreements with the NHS regarding performance of medically assisted reproduction, intend within the framework of the agreement that they provide data to the NHS regarding semen donors. The NHS shall establish a unified data base. A	Within the scope of the existing State funding in the sub-programme 45.00.00.

				unified semen data bank is established in Latvia (including examination of generative cell donors) in conformity with the requirements of Cabinet Regulation No. 716 of 16 December 2003, Organisational Procedures for Medically Assisted Reproduction and Procedures for the Establishment of Infertile Family Register, Medically Assisted Reproduction Register, Generative Cell Donor Register and Donor Generative Cell Bank	
Task for achieving the objective	**2.2. Infertility treatment**				
2.2.1. To develop guidelines for infertility diagnostics and treatment	30 August 2012	NHS	Latvian Association of Gynaecologists and Obstetricians	The guidelines for infertility diagnostics and treatment are developed and registered in the NHS data base.	Within the scope of the NHS budget in the programme 45.00.00.
2.2.2. Reimbursement of medicinal products for ensuring infertility treatment	30 December 2012, 30 December 2013,	MoH	NHS	Medicinal products intended for infertility treatment are included in the list of medicinal products to be reimbursed by the State	Additional funding from the State budget resources is needed, in total LVL 805 000 in the sub-programme 33.03.00. In 2012 –LVL 35 000. In 2013 –LVL 231 000.

	30 December 2014			(amendments are made to Cabinet Regulation No. 899 of 31 October 2006, Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment, including the relevant diagnoses in Annex 1–N97 *Female infertility*, N46 *Male infertility* (Azoospermia, oligospermia), Z31.1 *Artificial insemination*, Z31.2 *In vitro insemination*, as well as changing Chapter 10 regarding the methodology for calculation of quotas.)	In 2014 –LVL 539 000.
					
					Number of infertile spouses on average 1100 per year.
					
					Expenses for medicinal products intended for infertility treatment for one case on average – LVL 700.
					
					Planned extent:
					2012 – 50 couples (patients), in 2013 – 30% or 330 patients, in 2014 – 70% or 770 patients.
					
					Expenses for medicinal products:
					
					in 2012: LVL 700 x 50 = LVL 35 000;
					in 2013: LVL 700 x 330 = LVL 231 000;
					in 2014: LVL 700 x 770 = LVL 539 000.
					
					One medical treatment course and one medically assisted reproduction manipulation for each spouse (patient).

2.2.3. Payment for infertility diagnostic examinations	30 December 2012, 30 December 2013, 30 December	MoH	NHS	Diagnostic examinations of infertility treatment are included in State-paid services. From 2013 spermiogram examinations are	Additional funding from the State budget resources is needed, in total LVL 19 800 in the sub-programme 33.01.00. In 2012 – within the framework of the existing funding in 2013 –LVL 9 900

	2014			included additionally in order to determine more accurate reasons for male infertility.	in 2014 – LVL 9 900 Number of infertile spouses on average 1100 per year. Expenses for infertility diagnostic examinations on average LVL 4.50, the planned extent 100%, two examinations are planned. Total expenses for examinations per year: LVL 4.50 x 1100 x 2 = LVL 9 900.
2.2.4. Payment for medically assisted reproduction procedures/manipulations	30 December 2012, 30 December 2013, 30 December 2014	MoH	NHS	Medically assisted reproduction procedures/manipulations intended for infertility treatment are included in State-paid services (amendments are made to Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care)	Additional funding from the State budget resources is needed, in total LVL 689 500 in the sub-programme 33.01.00. In 2012 –LVL 35 000. In 2013 –LVL 192 500. In 2014 –LVL 462 000. Number of infertile spouses on average 1100 per year. Expenses for medically assisted reproduction/manipulations intended for infertility treatment for one case – on average LVL 700. Planned extent: in 2012 50 couples (patients), in 2013 – 25% or 275 patients, in 2014 – 60% or 660

					patients. Costs for manipulations: In 2012: LVL 700 x 50 = LVL 35 000; in 2013: LVL 700 x 275 = LVL 192 500; in 2014: LVL 700 x 660 = LVL 462 000.
2.2.4.1. Establishment of a tariff for medically assisted reproduction procedures/manipulations	1 September 2012	NHS	Latvian Association of Gynaecologists and Obstetricians	Tariffs for medically assisted reproduction procedures/manipulations are established	Within the scope of the NHS budget in the programme 45.00.00.
2.2.4.2. Amending of Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care	1 October 2012	MoH	NHS	Amendments are made to Cabinet Regulation No. 1046 of 19 December 2006, Procedures for the Organisation and Financing of Health Care	Within the scope of the existing State funding in the sub-programme 01.01.00.
2.2.4.3. Entering into agreements by the NHS with service providers	1 November 2012	NHS	MoH	Agreements are entered into with service providers for the performance of medically assisted reproduction procedures	Within the scope of the NHS budget in the programme 45.00.00.
2.2.4.4. Performance of medically assisted reproduction procedures/manipulations	1 December 2012	Medical treatment institutions	MoH	Medically assisted reproduction procedures/manipulations are performed	Additional funding from the State budget resources is needed in the sub-programme 33.01.00.

2.2.5. To prepare informative report on activities performed in relation to inclusion of infertility treatment (including medically assisted reproduction) in State-paid services	30 December 2014	MoH	NHS	The informative report is prepared.	Within the scope of the existing State funding in the sub-programme 01.01.00.
Action for achieving the objective	**3. Action** – Involvement of other sectors (intersectoral co-operation) for integrated and national solving of the issue				
Task for achieving the objective	**Educating of children and youth**				
3.1.1. To improve sample curricula by promoting integrated successive acquisition of health, sports education and human safety issues in pre-school education, basic education and secondary education	1 December 2013	MoES	MoH NGO Latvia‘s Association for Family and Sexual Health Association of Midwives of Latvia „Papardes zieds”	The number of educatees of general secondary and vocational education institutions who have acquired more extensive knowledge regarding human health has increased	Within the scope of the existing State funding of the MoES.
3.1.2. In co-operation with NGOs and local governments, to improve the knowledge of youth regarding healthy lifestyle, sexual and reproductive health issues within the scope of informal education programmes	30 December 2013, 30 December 2014	MoH	NGO local governments	The number of young persons who are attending institutions offering informal education programmes has increased	Within the scope of the existing State funding in the sub-programme 01.05.00.

3.1.3. To educate new parents regarding prevention of domestic violence and possibilities of support, as well as to foster the understanding of the society regarding the possibilities of prevention of domestic violence	30 December 2012	MoH	MoW NGO Local governments	The number of new parents who are able to identify cases of domestic violence and who are informed where to find support and help has increased	Within the scope of the existing State funding in the sub-programme 01.05.00.
3.1.4. To publish an informative material for new parents regarding child's health (including regarding prevention of domestic violence and possibilities of support)	30 December 2013 30 December 2014	MoH	MoW CDPC NGO	Informative materials are published and distributed	Within the scope of the existing funding in the sub-programme 01.05.00.

Acting for the Minister for Health – Minister for Agriculture L. Straujuma

(Cabinet Order
No. 269
19 June 2012)

Summary of Maternal and Child Health Improvement Plan 2012-2014

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Nature of the issue to be resolved

Maternal and child health has been brought forward as one of priority indicators of the public health and welfare in global and European scale. State welfare, public development and health in general are characterised by birthrate indicators. Upon evaluating these indicators it may be concluded that since 2009 the birthrate has decreased in Latvia. Taking into account the negative tendencies of birthrate, the natural growth in Latvia still remains negative, also infant mortality indicators in Latvia are higher than on average in EU. Infant mortality is one of the indicators which characterises general health status of the mother and the child and prenatal and postnatal health care. In comparison to the average indicator of the EU states maternal mortality in Latvia is comparatively high.

Health and development of a child until his or her birth and during the first year of his or her life mainly depends on the health, lifestyle, habits of his or her mother and father, parents' knowledge regarding the health of the child and care for the child. Educating and training of parents-to-be parents in the field of sexual and reproductive health has a significant role, and it is one of the main preconditions for raising of birthrate and creation of healthy new generation.

One of the most significant problems in the field of sexually reproductive health is infertility. A statistical data base for solving of infertility problems has not been established yet, but the experience of the developed states shows that approximately 6-10% of spouses are infertile.

Sufficient intersectoral co-operation in the field of reproductive health has not been established In Latvia, youth and adolescents are insufficiently informed regarding sexual and reproductive health issues. Understanding of the society regarding domestic violence (including emotional violence) is insufficient, therefore it is important to foster recognition of violence in a family by involving public health experts, as well as experts of other fields.

The Ministry of Health has developed the Maternal and Child Health Improvement Plan 2012-2014 (hereinafter – Plant). It has been drawn up in conformity with the sub-objective of the Public Health Strategy 2011-2017 – to improve the health of the mother and the child, as well as to reduce infant mortality, and in conformity with the Millennium Development Goals of the United Nations reduce of child mortality and to improve maternal health. The Plan is a short-term programming document.

Objective of the Plan is to ensure agreed and co-ordinated performance of measures in order to improve the health of the mother and the child (including to reduce perinatal mortality and maternal mortality).

Solution offered

Solution offered for the implementation of the Plan is incorporated in three main actions:

1. Measures for improvement of the health care of the mother and the child.

2. Inclusion of infertility treatment (including medically assisted reproduction) in State-paid services.

3. Involvement of other sectors (intersectoral co-operation) for integrated and national solving of the issue.

Funding needed for the implementation of the plan and intended source of funding

In implementing measures for improvement of maternal and child health and health care (they include additional informative, support, diagnostic and medical treatment measures, including inclusion of medically assisted reproduction in State-paid services), the Ministry of Health needs additional funding in the amount of 7 431 339 lats (including in 2012 – in the amount of 1 112 855 lats, in 2013 – in the amount of 2 871 492 lats, in 2014 – in the amount of 3 446 992).

An issue regarding allocation of additional State budget resources for implementation of the tasks 1.1.1, 1.2.1, 1.2.4, 1.6.1, 1.9.1, 1.9.2, 2.2.2 and 2.2.4 of the Plan to the Ministry of Health in 2012 in the amount of 1 112 855 lats will be reviewed by the Cabinet during drafting of the draft law on amendments to the Law On the State Budget for 2012.

An issue regarding allocation of additional State budget resources for implementation of the tasks 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.2.1, 1.2.4, 1.6.1, 1.9.1, 1.9.2, 2.1.1, 2.2.2, 2.2.3 and 2.2.4 of the Plan to the Ministry of Health in 2013 – in the amount of 2 871 492 lats and for implementation of the tasks 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.2.1, 1.2.4, 1.6.1, 1.9.1, 1.9.2, 2.1.1, 2.2.2, 2.2.3 and 2.2.4 of the Plan in 2014 – in the amount of 3 446 992 lats will be reviewed by the Cabinet during drafting of the draft law on the State budget for the current year.

The Ministry of Health will ensure the task 2.2.3 of the Plan in 2012, the tasks 1.2.2, 1.2.5, 1.3.2, 1.4.1, 1.4.2, 1.5.1, 1.5.2, 1.7.1, 1.7.2, 1.7.3, 1.8.1, 1.8.2, 1.8.3, 2.1.2, 2.2.1, 2.2.4.1, 2.2.4.2, 2.2.4.3, 2.2.4.4, 2.2.5, 3.1.2, 3.1.3 and 3.1.4 of the Plan in 2012 and the following years, the Ministry of Education and Science will ensure the task 3.1.1 of the Plan in 2012 and the following years from the existing State budget resources.

Certain measures will be implemented within the scope of the funding of Activity 1.3.2.3 of the European Social Fund “Enhancement of competencies, qualification and skills of health care and health promotion personnel”.

Acting for the Minister for Health –
Minister for Agriculture L.Straujuma