

Looking beyond Maternal Mortality Rates in maternal health interventions: Lessons from Nepal

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*Nepal has long been hailed as a global success in reducing maternal mortality, but recent census data suggests there has been less progress than the international development agencies had estimated. This raises several questions: are Maternal Mortality Rates (MMRs) the best way to measure progress on maternal health? What are the consequences of the political pressure to demonstrate the impact of programmatic and technical interventions? In this brief **Jeevan R. Sharma** seeks to offer some preliminary answers.*

The Maternal Mortality Rate (MMR) is seen as the single most important indicator of maternal health. While exact figures are not available, global health institutions spend considerable resources to calculate and measure MMR. The growing significance of indicators like MMR and their use in programmatic interventions in global development is directly linked to new norms of 'evidence based development', 'value for money' and pressure to 'demonstrate/produce impact', and do it in such a way that the results can be attributed to specific interventions.

Nepal's progress on maternal mortality since 1990 has been hailed as a global success story. According to UN estimates, MMR declined from 790 per 100,000 live births in 1996 to 190 in 2013. Explanations for the decline have ranged from specific interventions in the health sector such as maternity incentives initiatives (known as the [Aama Programme](#) in Nepal) or other technical and financial support from donors and other global health institutions.

In 2014, the Government of Nepal published its [Population Monograph](#), which is based on its decennial census. The data showed Nepal's MMR at 480, considerably higher than the estimates of 190 used by a consortium of UN, WHO, UNICEF and the World Bank. Nepal's census data on MMR raises awkward questions for policy makers who have been hailing Nepal's success and attributing it to INGO/donor interventions. The discrepancy in data challenges existing narratives on the contribution of the interventions to the rapid reduction of MMR in Nepal, whilst its neighbors have been struggling to meet targets.

Key issues

1. MMR has a narrow frame

While Nepal has made impressive progress on MMR over the last 25 years, it is often conflated with maternal health – a much broader category – in maternal health policy. Taking MMR targets as the focus of interventions can disrupt more holistic approaches to maternal health. Programmes become shaped by what can be measured, and not necessarily by what might bring the greatest and most sustainable changes in women's health.

Target-focused development results in interventions that have quick and obvious impacts, while less attention is given to those which contribute to strengthening efforts in the wider health system, broader gender inequalities or structural issues. Further, while MMR helps give an aggregate longitudinal and global comparative picture, and helps in mobilising global policy responses and resources, it is not necessarily the best way to understand maternal health. In particular, MMR hides gender politics, which is the key determinant of maternal health.

2. The measurement of MMR data is political, and therefore has political consequences

The global success story has been based on data from a consortium of international agencies, while Nepali estimates, based on census data, give a very different picture. Although the latter shows that the progress has not

been as impressive as claimed, there is very little debate on this discrepancy beyond an implicit recognition that there exists different metrics and computing methods that produce different results. However, this explanation is simplistic and uncritical, because data have powerful consequences on resource distribution, and more importantly in saving lives.

3. Global development indicators invariably take country as the unit of analysis, which hides regional and other forms of internal inequalities

Estimates suggest that MMRs in some geographic locations of Nepal are very high and comparable to those in Afghanistan.[1] Data disaggregation and acknowledging those who have been left out of the 'impressive gain narrative' remains a major challenge. Looking at MMR data at the sub-national level demands a different narrative based on persistent inequalities, rather than as a success.

4. Can changes in MMR and other health indicators be attributed to non-health socio-economic changes in Nepali society?

Despite their decreasing share in the national budget, development donors command considerable policy leverage in countries like Nepal. They are often at the forefront in attributing progress in MMR to the programmatic and technical interventions that they fund. USAID funded the Nepal Family Health Program (NFHP), which, for example has been credited to improving maternal and child health services in Nepal through interventions such as promotion of [family planning and distribution of misoprostol](#), among others. Likewise, the DFID-funded Nepal Safe Motherhood Project (NSMP) and Support for Safer Motherhood Programme (SSMP) are [cited as key contributors](#) to increasing access to quality maternal health services, thereby impacting reduction in MMR. Whatever the statistics say on MMR in Nepal in the last 25 years, Nepali society has gone through profound changes, including rising income levels, increasing school enrollment and education levels, expanding road networks and private sector health care providers, growing access to contraceptives and changing gender dynamics.

Surely these wider changes have had an impact on maternal health. It may be that INGOs and others have contributed to these developments in other ways, but it does raise questions about the actual contribution of MMR-focused donors who often claim credit for significant changes in health indicators. The political pressure on donors, governments, NGOs and other organisations to demonstrate impact, therefore has significant limitations.

5. The focus on targets and results have made it easier to sideline pressing discussions around gender inequalities and women's health in Nepal

The MMR story can be situated in the context of new norms and forms of development, outsourcing and results-based/value for money frameworks. Technical solutions to gender imbalances can only get us so far; a deeper socio-political mobilisation and push for more fundamental changes is required.

Implications

While data is certainly important for giving an aggregate longitudinal and comparative picture for policy and planning, investing large amounts of resources to get precise numbers may not be the best use of resources. The focus on targets and results leaves very little room for more innovative and grounded approaches to improve women's health and influence positive changes.

For example, Nepal has an impressive cadre of over 50,000 Female Community Health Volunteers (FCHVs) and mothers' groups. These volunteers are not there as agents to support various donor funded programmatic interventions, but more importantly to broker relationship between the community and health care providers. To achieve a more genuine engagement, the Government of Nepal and the external donors, who have significant

leverage in Nepal's health sector policy, need to view FCHVs as representatives of the community, not just as vehicles for delivery of programmatic interventions.



Female Community Health Volunteer during a visit. Credit: Bread for the World CC BY-ND 2.0

Beyond the narrow focus on programmatic and technical interventions, institutional space for improvement in maternal health must be sought in the wider social movements. Unfortunately, as in other sectors, women's movements have been limited to carrying out time-bound projects outsourced by INGOs and donors, and as a result have not really engaged in the critical issues on the ground that affect women's health. If sustainable change is to be achieved, this activism needs to be encouraged and supported.

Improving the health infrastructure requires political engagement and partnerships with a broader set of stakeholders. Meaningful development practice on maternal health must be based on the explicit acknowledgement of gender politics. This requires challenging the structures of power of institutions that often stand in the way of women's empowerment. For example, a large part of the health budget is borne by 'out of pocket' expenses. This creates an unfair burden on women from poor households who are most likely to be denied essential health services because they cannot afford it. Global health technical innovations are important in their own right, but they cannot substitute for a struggling public health system. Both governments and donors must consider this when designing health policy and interventions.

[1] An article in *Lancet* writes that although estimates by UN group indicated a 64% decrease in MMR from 1100 in 2000 to 396 in 2015, this figure is disputed. Institute for Health Metrics and Evaluation reports maternal mortality of 716.3 deaths in 2003 and 885.0 deaths in 2013, implying a 24% increase over the last decade.

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