The Other Side of the Coin: Disparities in Achievement of Health Related Millennium Development Goals (MDGs) in Nepal

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Abstract

Over the last one decade Nepal has significantly reduced child mortality and is on track to achieve two major health related Millennium Development Goals. However, Nepal has failed to distribute the benefits equally across different socio-economic groups and geographical regions. Indicators of progress are critically below national average for Dalit/minority groups, poor, rural setting, mountain area and Far western region.

Keywords: *Millennium Development Goals, Health, Socio-economic groups, Disparity*

1. Introduction

At the millennium summit in September 2000, world leaders adopted a new global partnership for development setting out a series of time bound and quantified targets with a deadline of 2015. These targets are known as millennium goals (MDGs). There are eight MDGs and 21 quantifiable targets which are measured by 60 indicators. The eight goals are: 1.eradicating extreme poverty and hunger, 2.achieving universal primary education, 3.reducing child mortality, 4.improving maternal health, 5.combating HIV/AIDS, 5.malaria and other diseases, 7.ensuring environmental sustainability and 8.developing global partnership for development (NPC 2010). Of the 8 goals, three relate to health: Goal 4 Reducing Child Mortality, Goal 5 Improve Maternal Health and Goal 6 Combat HIV AIDS, Malaria and other diseases.

As a member state of the United Nations, Nepal is committed to the achievement of MDGs. Nepal's progress toward achievement of MDGs, especially those related to child and maternal health, has been hailed nationally and internationally. Nepal has received MDG award for reducing maternal mortality. National aggregate shows significant improvements in child and maternal health indicators over time and Nepal is set to achieve the targets of reducing child and maternal mortality by 2015. But there is another side of the coin. If we look at the disaggregated data, the picture is quite different. National aggregates mask serious disparities across socio-

economic groups and ecological regions of Nepal.

The relationship between social inequality and health has long been an area of Anthropological inquiry. Anthropological approaches broaden and deepen our understanding of the finding that high levels of socioeconomic inequality are closely linked with worsened health outcomes in a society (Nguyen and Peschard 2003). Though this study doesn't employ any explicit theoretical approach, it uses Anthropological insights while analyzing the health inequality in Nepal. In this connection, the main objective of this paper is to analyse disparities in the achievements of health related MDGs of Nepal particularly focusing on MDG-4 and 5. The paper is based on existing literature and secondary data. Though recent data are not available for some major background variables such as caste/ethnicity, there are other useful disaggregated data from national level studies such as National Demographic Health Surveys (NDHS).

2. Progress in Child Health (Goal-4)

In the area of reducing child mortality, Nepal is one of the highest achievers globally. Both infant mortality and under five mortality have declined remarkably over the last one decade. Recent survey (NDHS 2012) shows that infant and under-five mortality rates continued to decline remarkably from 64 (per 1,000 live births) in 2005 to 46 in 2010 and 91 in 2005 to 54 in 2010 respectively. It means one in every 19 children still does not survive to his or her fifth birthday. Nevertheless, the rate of decline is impressive. Similarly, there is steady increment in the proportion of children immunized against measles. The data indicates that Nepal is on track to achieve the targets by 2015.

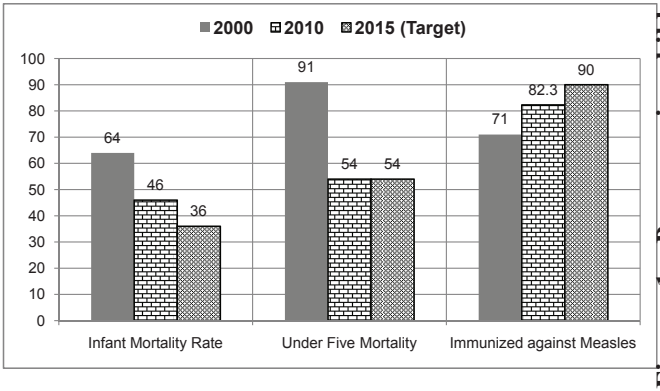

Figure 1: Progress in child mortality across years

Source: MOHP, 2012 and NPC and UN Country Team of Nepal, 2010

3. Disparity in Child Health

Though the figure 1 showed remarkable progress in the situation of child survival, this is only half of the story. Table 1 clearly shows that the aggregate figure of achievement mystify the significant disparities across ecological/geographical regions and socioeconomic groups. For example, under-five mortality rate is 45 (per 1,000 live births) for the urban area whereas it is remarkably higher (64) for the rural area. In the same vein, mountain area has the highest mortality rate (87) whereas it is much lower (58) for the hill region. In relation to economic group, the inequality is more evident because under-five mortality rate is two times greater (75) in the lowest wealth quintile compared highest wealth quintile (36). Though NDHS 2012 did not provide the data about inequality across caste/ethnic groups, it is not difficult to presume that *Dalits* and other minority groups have the higher under-five mortality rate in the country. This is supported by the evidence that under-five mortality rate was 90 among the *Dalits* compared with national aggregate 68 in 2006 (MOHP 2007, cited in UNDP, 2009). Unsurprisingly, Far-western region has the highest mortality rate (82) whereas Eastern region has the lowest rate (55). The data clearly shows huge disparity in child health in terms of reduction in child mortality rate in Nepal.

Table 1: Disparities in child mortality

Residence	**Under-five Mortality Rate**
Urban	45
Rural	64
Political Division	
Eastern	55
Central	60
Western	57
Middle-west	73
Far-western	82
Ecology	
Mountain	87
Terai	62
Hill	58
Wealth Quintile	
Lowest	75
Highest	36

Source: MOHP, 2012

4. Progress in Maternal Health (Goal-5)

Similar to progress in child mortality, Nepal's achievement is remarkable in reducing maternal mortality rate (MMR). Over the last one decade, MMR declined from 415 (per 100,000 live births) in 2000 to 229 in 2010. The data shows that Nepal will meet maternal mortality related target easily. There is increase in the percentage of birth attended by skilled providers which also indicates some improvements in maternal health services. In 2000, only few births were assisted by skilled providers whereas one-third of the deliveries were attended by skilled providers by 2010. However, the situation of maternal health services is still not satisfactory as the services are still not accessible for the vast majority of women. Contraceptive prevalence rate has increased at slower pace. There is remarkable increase in the percentage of women who accessed antenatal care services at least once in their last pregnancy.

Table 2: Maternal Health Indicators

Indicators	2000	2010	2015 (target)
Maternal mortality ratio (MMR)	415	229	213
Percentage of births attended by skilled birth attendant	11	36.0	60
Antenatal Care (at least one visit)	48.5	89.9	100
Contraceptive prevalence rate	39	49.7	67

Source: MOHP, 2012 and GON and UN Country Team of Nepal, 2010

5. Disparity in Maternal Health

Though there is no clear and recent disaggregated data for MMR, it is obvious that MMR is not immune to disparities that existed in child mortality. Some studies such as Nepal Mortality and Morbidity Study 2009 shows that MMR varies across caste/ethnic groups. For example, Muslim, Terai/*Madhesi* and Dalit groups have high MMR ranging between 273 and 318. *Newar* has the lowest MMR rate-105 (MOHP 2010).

There is unequal access to maternal health care services across different groups. Table 3 shows that more than two third deliveries were assisted by skilled attendants in urban area whereas it is only one-third in the case of rural area. Middle-west Region and Eastern Region has the lowest and the highest percentage of deliveries attended by skilled providers respectively. Similarly Mountain area has the lowest percentage (18.9) whereas it is significantly high in hill area (42.8). The percentage is extremely low

(10.7) in the lowest wealth quintile compared to the highest wealth quintile (81.5). If we compare all four categories, the inequality is more intense in rural-urban and economic/wealth categories.

Table 3: Birth Attended by Skilled Attendant-disparity in access to maternal health services

Residence	**Percentage**
Urban	72.7
Rural	32.3
Development Region	
Eastern	42.0
Central	35.9
Western	37.8
Middle-west	28.7
Far-western	30.7
Ecology	
Mountain	18.9
Terai	30.4
Hill	42.8
Wealth Quintile	
Lowest	10.7
Highest	81.5

Source: MOHP, 2012

The access to services is also linked with availability of health service providers. WHO has recommended 'threshold' density of 23 health workers per 10,000 population to achieve the MDG goals. It is 2.9 health workers per 10,000 population in Nepal. Furthermore there is a huge inequality in distribution of health workers across ecological and development regions (MOHP 2012, cited in Solid Nepal and Merlin Nepal 2012). It also severely limits the access of disadvantaged people to access to services.

6. Final Remarks

Disparities in achievement of health related MDGs suggest unequal distribution of fruits of health development in Nepal. Health inequalities are inextricably linked with the social inequality in the Nepalese society. Unless the structural determinants of health are addressed, the progress Nepal has made in the area of child and maternal health is not complete and sustainable. The poor, *Dalits* and minority groups, rural population and

people residing in Far-western and Mountain regions still have poor access to basic health care services. There is a need of integrated effort to address pervasive social, economic and spatial inequalities and deprivation. It is also important to understand the political-economy of health in Nepal. Acute commercialization of health services and unequal distribution of health resources are severely limiting access of poor and disadvantaged groups to health care services in Nepal. There is a need of targeted health intervention to address the disparities. But it is equally important to neutralise the repercussions of neoliberal 'reforms'. Increasing allocation of resources in social sectors and its efficient use are prerequisites for sustainable and equitable change in health status of Nepal. It will help to tackle poverty-health nexus. Nepal relied heavily on external financial and technical supports for achieving the MDGs. It may pose a challenge to future progress and sustainability of the current outcomes. There is no shortcut to self-reliance but it is necessary to decrease the external dependency gradually for a more sustainable change in maternal and child health in Nepal.

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