■ *Guest editorial*

A Commentary on Declining Maternal Mortality in Nepal

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The 2006 report of the Nepal Demographic and Health Survey broke the news of declining maternal mortality ratio (MMR) in the country, for the first time. Indeed a good news after 45 years of the national policy of maternal and child health and family planning (MCH/FP) in continuum since 1965[1]. It has finally started paying off in savingthe lives of young women and their babies from the complications of pregnancy and childbirth. MMR as an important variable of measuring human development index (HDI), its decline also mirrors the improvingtrend in the overall health condition of Nepali people at large.

Looking back, except the newly established Maternity Hospital in Kathmandu, no health care services existed for mothers and children in the early '60s. Maternal death used to be viewed then as a natural outcome of being a woman. The data on health situation of that time are uniformly scarce and weak. However, by extrapolating the data of the 1961 Censusand that of the first National Health Survey 1965-66(FNHS), one can only drawinferencesabout Nepal's MMR level of that period. The FNHS had concluded that 37 % of all deaths occurred among infants and 56 % of all deaths occurred before the age of 15[2]. The estimated total population of Nepal was 9,413,000 with an average life span of 40 years[3]. Against this backdrop, one can safely infer Nepal's MMR to be at a natural level of 1500 or more per 100 000 live births during the 1960s.

A quick glance at table 1 shows the impressive stride the country has made in lowering its MMR from 1500 or more in the '60s to 281 in 2006.This is no small gain for a country marred with the centuries of feudalistic societal legacy, poverty, illiteracy, poor transport communication, gender and ethnic discrimination, internal conflict and the never ending political transition.The United Nations has duly recognized Nepal for earning the prestigious ranking as one the countries that is likely to achieve the Millennium Development Goals on maternal mortality by 2015.

However, what is paradoxically interesting isthat Nepalcould lower the MMR to 281 per 100 000 lives births with only 20% of total births attended by skilled birth attendants (SBA)[44] Nepal Demographic and Health Survey, 2006.

This seems to defythe existing epidemiological norms ofthe inverse relationship existing between the MMR and the proportion of births attended by SBA. A 20% SBA attended births is usually associated with MMR ranging from 400 to 1500 per 100 000 live births.

Nevertheless, this apparent paradox fades away as one takes a deeper look at the construct of maternal mortality.Maternal death is the function of the two primary components i.e. thefertility and maternity. Fertility component relates to woman's exposure to the risk of becoming pregnant, while the maternity component relates to the risk of dying of complications of pregnancy & childbirth after becoming pregnant. A reduction in either component or both can effect a reduction of maternal deaths. A host of social, education, economic, cultural and health system factors in turn will influence these two components.

In Nepal's case, the evidence suggests that the fertility component has a dominant influence in the reduction of MMR. The total fertility rate of 6 in the mid'70s has halved and the contraceptive use rate has increased from a zero level in the '60s to 44% in 2006.

The above progress in the reduction of MMR is good, but much remains to be done. Maternal mortality still continues as the leading cause of death among young women. Most women give births at home with no assistance of a skilled health worker at the riskiest moment of their lives. This indicates that the health care services related to maternity component are

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not within the reach of most women, especially at the riskiest time of birthing.

Besides, the decline in the national average of MMR masks the wide MMR disparity between the regions, districts, urban-rural, rich-poor and between ethnic groups. The national average of MMR of 281 variesfrom 153 in Sunsari (Eastern Region) to 301 in Jumala(Mid-Western Region). Muslim women suffer the highest maternal mortality[5].

At the face of these glaring challenges, Nepal's achieving the MDG 5 on maternal mortality reduction is still far off. The constitutional promise to ensure every woman's right to be able to go safely through wanted pregnancy and childbirth with the best possible chance of having a healthy baby seems hollow. Achieving these goals requires a policy action to placeskilled health workers at every birth, in every villageon a war footing.

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Table 1: Key MCH/FP Indicators and MD Goals 4 and 5 by Time

MCH/FP—MD GIndicators By Time	Early '60's	1976 NFS	1991 NDHS	'96	'01 NDHS	'06 NDHS	MDG Indicators by 2015	
							Goal 4	Goal 5
IMR/1000 LB		172	108	79	64.4	48	NA	
U 5 Mortality/	300/more		162	118	91	61	54	1000LB
MMR/100000 LB	1500/more		850 '88515	539	531	281		213 0r 129
% SBA AttendedBirths	Zero		7.4		10.8	20	100	
% CPRZero	Zero	2.9	24.1	26*	39	44		100
Total Fertility Rate		6	4.8	4.6	4.1	3.1	NA	

*Pradhan et al., 1997

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2. Worth, Robert M. and Shah, Narayan K, Nepal Health Survey, 1965-'66, Honolulu: University of Hawaii Press 1969
3. Census 1961, Nepal
5. Maternal Morbidity and Mortality Study, 2008/ 2009, Nepal, MOPH, Family Health Division