



THE UNIVERSITY *of* EDINBURGH

Edinburgh Research Explorer

Comment — WHO outsourcing dilemma

Citation for published version:

Sharma, J, Harper, I, Adhikari, R, Smith, P, Thapa, D, Chand, O & Malata, A 2017, 'Comment — WHO outsourcing dilemma: For whose benefit, at whose expense?' *BMJ Global Health*, vol. 2, no. Suppl 1, pp. i3-i4. DOI: [10.1136/bmjgh-2016-000237](https://doi.org/10.1136/bmjgh-2016-000237)

Digital Object Identifier (DOI):

[10.1136/bmjgh-2016-000237](https://doi.org/10.1136/bmjgh-2016-000237)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

BMJ Global Health

General rights

Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.



Politics of Measurement and Uses of Maternal Mortality Ratio in International Development

Maternal Mortality Ratio (MMR) is the single most authoritative indicator of maternal health. The growing significance of indicators like MMR and their use in global health policy and programmes is directly linked to new norms of 'outsourcing', 'evidence based development', 'value for money' and 'results framework. Programmatic and technical interventions funded by bilateral, multilateral, private and other donors are increasingly under political pressure to demonstrate that the disbursement of resources are linked to the achievement of measurable results and impact. These imperatives have resulted in development organisations spending considerable time and resources in setting up systems to record and collect data to capture measurable results. While exact figures are not available, global health institutions spend considerable resources to calculate and measure MMR in low-income countries where data based on vital registration is not available.

Despite massive efforts at getting evidence, data discrepancy on MMR remains a major issue in low-income countries such as Nepal, Malawi and Afghanistan. However, there is very little debate on this discrepancy beyond a recognition that there exists different methods that produce different results. This explanation is simplistic and uncritical, because data have powerful consequences on resource distribution, and more importantly in saving lives. Amongst other, challenges include limited statistical capacity in low-income countries for collection, management, processing and analysis of statistical data.

Increasing preoccupation with metrics-based evidence means that projects and programmes are often left with very little institutional space to undertake innovative work that does not fit predetermined metrics and targets. The influence of the broader political economy and specific socio-cultural context gets ignored under the pressure to demonstrate achievements circumscribed by measurable results. This commentary asks the questions: are MMR 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?

Awkward challenge in Nepal and other similar contexts

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. 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. Interestingly, significant data

discrepancy is an issue in other similar low-income countries such as Malawi and Afghanistan. In Malawi, while the estimates from UN agencies has been indicating decrease in MMR since 1990, data from Demographic and Health Survey (DHS) showed a sharp increase in MMR in 2000 and 2004 before decrease. In Afghanistan, UN group indicated a 64% decrease in MMR from 1,100 in 2000 to 396 in 2015. However, a recent article in Lancet writes that this figure is disputed; Institute for Health Metrics and Evaluation (IHME) reports maternal mortality of 716.3 deaths in 2003 and 885.0 deaths in 2013, implying a 24% increase over the last decade.

This commentary outlines limitations of MMR measurement and argues that spending resources to collect evidence on reliable statistics on MMR is not the best use of resources.

First, MMR has a narrow frame. While low income countries such as Nepal, Malawi and Afghanistan have 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. Programmatic interventions 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.

MMR statistics are often used at the national level without any disaggregation. 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 and amongst different class, ethnicity and religion demands a different narrative based on persistent inequalities, rather than as a success.

Second, data discrepancy on MMR statistics is not just a technical matter but a political one. Producing MMR in low-income countries is no doubt challenging. In the absence of vital registration and service statistics, it is the population based surveys and surveillance, that are taken as measures of MMR. There does not exist sufficient capacity to produce the statistics with rigour. Data is often unreliable producing apparent discrepancies.

As exemplified in Nepal case, the global success story has been based on data from a consortium of international agencies, while MMR statistics 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.

Third, in the current political pressure to demonstrate impact and attribute impact to specific interventions, the important contributions of non-health socio-economic changes get ignored. The focus on targets and results have made it easier to sideline pressing discussions around gender inequalities and women's health in low-income countries.

Whatever the statistics say on MMR in Nepal in the last 25 years, countries like Nepal, Malaw and Afghanistan have 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.

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

Conclusion

While data is certainly important for giving an aggregate longitudinal and comparative picture for policy and planning, investing large amounts of resources to get MMR statistics may not be the best use of resources especially when MMR statistics in low-income countries are particularly unreliable. Further, not only does the focus on targets and results leaves very little room for more politically informed, innovative and grounded approaches to improve women's health and influence positive changes, it also encourages competition amongst the organisations.

Improving the health infrastructure requires political engagement and collaborations 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.

Outsourcing of external development assistance and its links to measurable results has implications beyond the obvious finances/value for money; there are implications on organisations and institutions, which requires a sociological-anthropological analysis of shift in the field of international development more broadly.

(words: 1417. Maximum word count for commentary in Lancet is 1,500 words).