Imagine a world where motherhood is safe for all women-
We can help make it happen

The Hubert de Watteville memorial lecture
FIGO World Congress, Washington D.C. 2000

Dr Hubert De Watteville is best known for his instrumental role in getting the world obstetricians and gynecologists under the umbrella of FIGO. But those of us, who had the pleasure and honor to get closer to him, know that he was a man consumed by a strong passion. Particularly in his later years, he had a concern and a dream. He was concerned that the advances in science, which benefited the health of mothers and their babies in the North, did not filter down to their sisters in the South. His dream was to see our professional associations in the North and South working together, with resources mobilized for the purpose, to achieve this noble objective. This was in fact the rationale for his work to establish IAMANEH, the International Association for Maternal and Neonatal Health. When I think of him looking at us today from his rewarding life hereafter, and of what he would be trying to tell us, obstetricians of the world, gathered in this 16th World Congress. I feel his message to us would be: Imagine a world where motherhood is safe for all women- WE can help make it happen. This lecture is about how WE together can help make this world of safe motherhood a reality.
Imagine a world where motherhood is safe for **ALL** women

**We** can help make it happen

The world we want to change

- **380** women become pregnant
- **190** women face an unplanned or unwanted pregnancy
- **110** women experience a pregnancy-related complication
- **40** women have an unsafe abortion
- One woman dies from complications related to pregnancy and childbirth
In our world today, every minute: 380 women become pregnant; 190 women face an unplanned or unwanted pregnancy; 110 women experience a pregnancy related complication; 40 women have an unsafe abortion; and every minute one woman dies from complications related to pregnancy and childbirth [1]. A major study by the World Health Organization and the World Bank, quantified the burden of disease in the world. Among women of reproductive age in developing countries, maternity, that noble privilege of women, accounts for the major single cause (about 18 percent) of all the burden of disease [2].

Every year, 3.4 million neonatal deaths occur within the first week of life and are largely a consequence of inadequate or inappropriate care during pregnancy, delivery, or the first critical hours after birth. Moreover, for every neonate who dies, at least one other infant is stillborn.


A Joint WHO/UNFPA/UNICEF/World Bank Statement, issued last year highlighted that every year, 3.4 million neonatal deaths occur within the first week of life, and are largely a consequence of inadequate or inappropriate care during pregnancy, delivery or the first critical hours after birth [3]. Moreover, for every neonate who dies, at least one other infant is stillborn.
Dr Brundtland, the Director-General of WHO, in a recent statement, admits that “Because of our collective failure to solve this problem, the tragedy of maternal mortality represents a major source of suffering and injustice in our societies.” She then affirms that “This situation cannot be allowed to continue” [4]. This is the world we want to imagine differently, and to change.

Ten propositions for making motherhood safe for all women
I want to share with you ten propositions for making motherhood safe for all women, and the role we obstetricians of the world can play. The first two propositions are about principles to be upheld if motherhood is to be made safe for all women. The next four propositions are about services that must be made accessible to women. To make all this a reality, the next two propositions are about action at two fronts: an international commitment and country action. The last two propositions are about actors who have to step further forward, if motherhood is to be made safe for all women: women themselves and the global community of obstetricians.

1. Safe motherhood is a woman’s human right
Imagine a world where

- **Safe motherhood is considered a woman’s human right**

Maternity is not a disease. Maternity is the means for survival of our species. Women have a right, a basic human right, to be protected when they undertake the risky business of pregnancy and childbirth [5]. Society has an obligation to fulfill a woman’s right to life. This has been well expressed by a recent UN Expert Group, commenting on women’s right to life and the neglected tragedy of maternal mortality in developing countries [6]. It stated that safe motherhood is a human rights issue for which countries should be held accountable. How can we obstetricians help? We, health professionals, should not lump maternity with other disease problems and rank them for priority. Maternity is special, and society has an obligation to make it safe.

2. **A woman’s life is considered worth saving**
Imagine a world where:

- Safe motherhood is considered a woman’s human right
- A woman’s life is considered worth saving

Whether we like it or not, societies, consciously or subconsciously, put a price tag on the life of each of us. This invisible price tag decides whether our life is considered worth saving. What is the monetary value of a woman’s life? In many societies it is sadly not much [7]. When societies invest less in women, and when women’s work, much that it counts, is often not counted, and when few women are in decision making positions, it is no wonder that, in poor resource settings, societies would be less willing to invest what it takes to save the lives of women and mothers. It is true that the status of women is rising in most parts of the world. But women still have some steep mountains to climb. What can obstetricians do about this? I often think about the meaning of the term “obstetrics”.
Obstetric, obstetrical
[L. obstetrix, a midwife,
from obstare, to stand before]

To my knowledge, the word was derived from the Latin “obstare”, meaning to stand before [8]. We are defined as those who stand before the woman. I submit to you that our role cannot be only to stand before the woman, but to stand beside and behind women in their just struggle to take back their God-given rights and status.

3. All women have access to life-saving emergency obstetric care when they need it.
Imagine a world where

- Safe motherhood is considered a woman’s human right
- A woman’s life is considered worth saving
- All women have access to life-saving emergency obstetric care

From a global standpoint, severe bleeding, infection, eclampsia, obstructed labor and unsafe abortion still account for the majority of maternal deaths in the world today [9].

Causes of maternal deaths globally (WHO, 1998)

These fatal or life-threatening complications are neither completely preventable nor even always predictable. But they are treatable with the knowledge we have, and women’s life
and health can be saved. Pregnancy and childbirth are a risky business. The risk is shared
by all women rich and poor.

Let me try to illustrate this fact. All of us have seen or heard about the magnificent
architectural beauty: Taj Mahal in India, one of the world wonders. But few of us realize
that it is, in a sense, a monument for the sacrifice which women make in the process of
reproduction. Emperor Shah Jahan ordered it built in honor of his wife Momtaz-e-Mahal
who died in labor as a grand multipara married for 19 years.
Beautiful Momtaz was not a poor woman. She was a highly privileged woman. But this was not enough to save her life in the risky business of pregnancy and childbirth. The medical technology which we have today was unfortunately not available for her in the 17th century. We know, as obstetricians, and it is our duty to let the whole world know, that every woman may need access to emergency obstetric care when and if the need arises. This is not a call to over-medicalize what can be a normal labor. It is a call to make a life-saving service available, accessible and effective if and when needed.

**Emergency Obstetric Care (EOC)**

**Minimal standards**

At least 15% of all births in the population take place in either a Basic or Comprehensive EOC facility.

The case fatality rate among women with obstetric complications in EOC facilities should not exceed 1 per cent.

UNICEF, WHO, UNFPA Guidelines for monitoring the availability and use of obstetric services, 1997
Experience in the past two decades indicates that, as a rough minimal standard, at least 15 percent of all births in the population need to take place in either a basic or comprehensive care facility [10]. In addition, the efficiency of the service should be such that the case fatality rate among women with obstetric complications in these facilities should not exceed one percent. Is this minimal standard difficult to attain, or can we imagine a world where efficient emergency obstetric care can be made available and accessible to all women?

<table>
<thead>
<tr>
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<th>% average</th>
<th>% range among regions</th>
<th>Number of women (1000s)</th>
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<tbody>
<tr>
<td>World total</td>
<td>46</td>
<td>26-78</td>
<td>64780</td>
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<tr>
<td>More developed regions</td>
<td>98</td>
<td>97-99</td>
<td>14030</td>
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<tr>
<td>Less developed regions</td>
<td>40</td>
<td>26-78</td>
<td>50750</td>
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According to statistics collected by the World Health Organization, 46 percent of all deliveries worldwide take place in health facilities [11]. Even in the less developed regions of the world, the figure is 40 percent, with a range between regions of 26 to 78 percent. Health facilities for the most part are there. But we have three problems. First, these health facilities are very unevenly distributed. Many parts in countries are deprived of these facilities. Second, the 40 percent of women who deliver in these facilities do not often include all or most of the 15 percent who really need emergency obstetric care. Facilities are over-utilized by those not in need, and under-utilized by those in need. Third, the quality of the service, whether in terms of equipment or skilled personnel often leaves much to be desired. But the lesson of this is that making emergency obstetric care accessible to all women is not a mission impossible. In most cases, it does not mean building new facilities. It means a more rational allocation of available resources with more for those in more need, together with a modest infusion of new resources to upgrade existing facilities and improve the skills and performance of health personnel.

4. All deliveries are attended by skilled birth attendants
Imagine a world where:

- Safe motherhood is considered a woman’s human right
- A woman’s life is considered worth saving
- All women have access to life-saving emergency obstetric care
- **All deliveries are attended by a skilled birth attendant**

By skilled birth attendants, we mean health professionals who have the necessary training to detect, early diagnose, and as necessary, refer women with life-threatening complications to where they can get the necessary help.

**Estimated % and number of deliveries attended by skilled personnel (WHO, 1997)**

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<th>% average</th>
<th>% range among regions</th>
<th>Number of women (1000s)</th>
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<tr>
<td>World total</td>
<td>57</td>
<td>34-99</td>
<td>80690</td>
</tr>
<tr>
<td>More developed regions</td>
<td>99</td>
<td>98-99</td>
<td>14160</td>
</tr>
<tr>
<td>Less developed regions</td>
<td>33</td>
<td>34-86</td>
<td>66540</td>
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The World Health Organization estimates that, on average, 57 percent of deliveries in the world today are attended by skilled personnel [12]. The figure is 99 percent for more developed regions. But already 53 percent of deliveries in less developed regions are attended by skilled personnel, with a range between 34 and 86 percent for different regions. What can we do as obstetricians for the 47 percent who do not have this basic care? There will probably never be enough obstetricians to attend deliveries of all women. Nor that this is necessary, desirable or should be. But in situations where skilled attendants are in shortage, we obstetricians can help if we assume the role of team leaders and trainers, delegate responsibilities to other categories of health professionals and provide the necessary support and supervision.

5. All pregnant women have access to prenatal care

Imagine a world where

- Safe motherhood is considered a woman’s human right
- A woman’s life is considered worth saving
- All women have access to life-saving emergency obstetric care
- All deliveries are attended by a skilled birth attendant

**All pregnant women receive pre-natal care**
On average, about 68 percent or more than two thirds of pregnant women in the world receive prenatal care, according to WHO data [13]. The figure for less developed regions is 65 percent, and ranging from 52 to 73 percent between different regions. What can we obstetricians do to help? Let us admit that much of the traditional practice of prenatal care is not evidence-based. If we limit prenatal care to evidence-based interventions, resources will be freed to expand the availability of the services and also make them more cost-effective.

6. *For motherhood to be safe, it must be a voluntary woman’s choice*
Imagine a world where

- Safe motherhood is considered a woman’s human right
- A woman’s life is considered worth saving
- All women have access to life-saving emergency obstetric care
- All deliveries are attended by a skilled birth attendant
- All pregnant women receive pre-natal care

Motherhood is a voluntary woman’s choice

Every pregnancy should be a wanted pregnancy. In this context, we cannot ignore the global problem of unsafe abortion. Millions of women around the world risk their lives and health to end an unwanted pregnancy.

Unsafe Abortion: A Global Problem

Millions of women around the world risk their lives and health to end an unwanted pregnancy.

Every day, 55,000 unsafe abortions take place - 95% of them in developing countries - and lead to the deaths of more than 200 women daily.

According to WHO, every day, 55 000 unsafe abortions take place- 95 percent of them in developing countries- and lead to the death of more than 200 women daily [14]. Fertility by choice, a great thing for women, has already led to a significant decrease in total fertility rates, the number of births a woman is expected to have in her lifetime, and as a consequence, a decrease in their exposure to the risk of pregnancy and childbirth.

<table>
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<th>Total Fertility Rate</th>
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<tr>
<td>World</td>
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<tr>
<td>More developed regions</td>
</tr>
<tr>
<td>Less developed regions</td>
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<tr>
<td>– Excluding China</td>
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– 2000 World population data sheet
  – Population Reference Bureau

Women, as a world average, are now expected to have less than three births in their lifetime [15]. In less developed regions, the average is between three and four.
What is our social responsibility as obstetrician/gynecologists in making motherhood a voluntary choice for all women? We have to stand for the right of all women to have access to family planning, and, as affirmed last year by the United Nations General Assembly, “in circumstances where abortion is not against the law, health systems should take measures to ensure that such abortion is safe and accessible” [16]. We as professionals of women’s health can only have one stand. We have to stand for women’s reproductive rights.

7. An international commitment to make motherhood safe for all women.
Imagine a world where:

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- All women have access to life-saving emergency obstetric care
- All deliveries are attended by a skilled birth attendant
- All pregnant women receive pre-natal care
- Motherhood is a voluntary woman’s choice

Making motherhood safe is an international commitment

Do we have this international commitment? Thanks to the efforts of many organizations and a number of individuals, safe motherhood has made its way to the international agenda of major health concerns. The year 1998 was designated by the World Health Assembly to be the year for safe motherhood, under the slogan: Pregnancy is Special; let us make it safe.
Another expression of international commitment is the statement from the Twenty-first Special Session of the United Nations General Assembly in July 1999, where it puts the reduction of maternal mortality and morbidity, as the indicator for success or failure of health sector reform [17].
“In health sector reform, the reduction of maternal mortality and morbidity should be prominent and used as an indicator for the success of such reform.”

Twenty-first special session of the United Nations General Assembly, 1 July 1999. Paragraph 62

To build up and sustain international commitment for safe motherhood, there is power in partnership. Currently, eight large organizations, including our FIGO, are constituting themselves as the Safe Motherhood Inter-Agency Group.

SAFE MOTHERHOOD INTER-AGENCY GROUP

- World Health Organization
- United Nations Population Fund
- UNICEF
- World Bank
- International Planned Parenthood Federation
- Population Council
- International Federation of Gynaecology and Obstetrics
- International Confederation of Midwives

When we talk about commitment, the will does not mean much without the wallet.
From this forum, I applaud last year’s decision of the Bill and Melinda Gates Foundation to donate $50 million to fund the Columbia University Program for Averting Maternal Death and Disability in developing countries. I hope it gives a message to others.

8. Lack of resources is not to be accepted as an excuse for inaction

Imagine a world where

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- Making motherhood safe is an international commitment

- Lack of resources is not accepted as an excuse for inaction
In a world where motherhood is safe for all women, international commitment is not enough. We need action in countries by the countries. All countries, however poor, can afford to make motherhood safer for its women. Maternal mortality levels are not simply functions of socio-economic development.

Countries having the same level of low per capita income can have widely different levels of maternal mortality. At a low per capita income of $250-350, maternal mortality is much lower in Vietnam (Maternal mortality ratio MMR 160) than in Yemen (MMR 1400) [17]. At the higher but still low level of $690 to 950, the level in Sri Lanka (140) cannot be compared with that in Bolivia (650) or Cote d'Ivoire (810).
"The interventions that make motherhood safe are known and the resources needed are obtainable. The necessary Services are neither sophisticated nor very expensive, and reducing maternal mortality is one of the most cost-effective strategies available in the area of public health.

Message from WHO Director-General,
World Health Day, 1998

As stated by the Director-General of WHO, the interventions that make motherhood safe are known and the resources needed are obtainable; the necessary services are neither sophisticated nor very expensive, and reducing maternal mortality is one of the most cost-effective strategies available in the area of public health [18]. Even in countries with limited resources, a lot can be done to save mothers’ lives. Then, if we talk about resources in poor countries, let us recall the figures for military expenditure. Is it not sad that poor countries are spending more on the military than on health and education combined? [19]. Is it not sad that they are recruiting more soldiers than teachers and health workers? Lack of resources cannot be put forward as an excuse for inaction.

9. Women, North and South should mobilize for women’s right to life
Imagine a world where:

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- Making motherhood safe is an international commitment
- Lack of resources is not accepted as an excuse for inaction

- **Women, North and South, mobilize for their right to life**

It is true that women in the North may have forgotten what a maternal mortality is. But for their sisters in the South, pregnancy and childbirth are a journey from which many may not return. This year, this great city witnessed what was called the Million Moms March. Typical of women, they are more willing to act for their children than for themselves. They marched on this capital of the world for the cause of protecting their children from the danger of firearms. I dream of a day when we will have a million women’s march for women’s right to life. Instead, we see another sad march. Every day millions of women are marching on a maternal death road, and they are denied access to the safety exits along the dangerous road [20].
Imagine a world where

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- Women, North and South, mobilize for their right to life

- Obstetrics is without frontiers
Our charge should be women of the world, not just our individual patients. An obstetrician in the North may end her or his career without witnessing a single case of maternal mortality. For an obstetrician in the South, maternal mortality is not a statistic. It is women who have faces and names, who continue to haunt your dreams. Can we, obstetricians, rise to the global challenge, and fulfill our global responsibility? FIGO decided to put this question to the test. We asked Ob/Gyn societies in the North and South about their willingness and readiness to work together to demonstrate how obstetric interventions can save mothers’ lives at a cost that is affordable. We were overwhelmed by the response. The limiting factor was to get the necessary funding. This is why FIGO established its Save the Mothers Fund in 1997.

We were most grateful to generous support from Pharmacia Corporation, United Nations Population Fund, World Bank, and more recently the Columbia University Program funded by the Gates Foundation. Over the past 2 to 3 years, the movement of obstetricians without frontiers has been gathering momentum.
Obstetricians from El-Salvador, Nicaragua, Honduras, and Guatemala have joined hands with ACOG, Ethiopia with Sweden, Mozambique with Brazil and Italy, Pakistan with the UK, and Uganda with Canada. These dedicated partnership teams make one proud to belong to a profession with this sense of global social responsibility. They deserve our admiration and our support.

The challenge
Making motherhood safe for all women is a challenge to obstetricians worldwide. We know that it is not an easy challenge, and I conclude with three messages. First think about the reward. We, obstetricians, do not get our reward from reading statistics. We get our rewards in these happy faces of proud mothers with their healthy children, in all parts of the world. Then, when you think that the task is difficult, recall the words of one of the great women in this country, Eleanor Roosevelt: "We should do the things that are difficult to do. The future belongs to those who realize the beauty of their dreams."
“Ask, and it shall be given you; 
Seek, and ye shall find; 
Knock, and it shall be opened 
unto you.”

St. Matthew 7:7

Then, when you think that we need a lot to make it happen, take courage from the words of Jesus Christ in the Sermon of the Mount: “Ask and it shall be given you; seek and ye shall find; knock and it shall be opened unto you.” [21].

References
Fathalla MF. Guest editorial: Women have a right to safe motherhood. Planned Parenthood Challenges.. International Planned Parenthood Federation. 1998/1. P1-2
[12] ibid
[13] ibid

(A paper based on this lecture was published in the International Journal of Gynecology & Obstetrics 72 (2001) 207-2013)
It is uncool for a grown man to admit to having a hero. My generation and, worryingly, its successors— are cynics. Nevertheless, here goes. My hero is Mahmoud Fathalla, professor of obstetrics and gynaecology in Assiut, 375 km south of Cairo. In Egypt, maternal mortality is still high. In Sudan, female genital mutilation is endemic. A doctor can tackle these problems locally, but Fathalla saw the bigger picture. Worldwide, over half a million women die in childbirth annually. Millions of children are left uneducated or even deprived of food because they are female. Global statistics are so overwhelming that personal action seems pointless. Most of us content ourselves with short lasting indignation. We blame governments and tell ourselves that over the coming century female literacy should improve and things may start to get better. Professor Fathalla did more. Well respected in Egypt, he became president of the International Federation of Obstetrics and Gynaecology, an organization which used to pay lip service to the task of improving women's health in developing countries. Almost single handedly, he focused it. In 1988 in Rio, his lecture on "medicine's seven deadly sins" produced a standing ovation. Last month in Washington DC he received another, after telling a thousand doctors "how you can make a difference." The difference he had made was that in 2000 his message was being repeated throughout the meeting and people were no longer smiling. This took persistence. He must be a highly effective committee man and lobbyist. Organizations such as the World Bank are now trying to help save women's lives. But Fathalla understands that you need to win individual hearts as well as corporate minds. Close up, he is charming and modest. On a podium, he is inspirational, using not demagoguery but wisdom. He stands still, choosing words from global English and ideas that cross cultures. Speaking just after Labor Day, he mused on the political and obstetric connotations of the word "labour": "What a pity the world's women have not unionized."

James Owen Drife, professor of obstetrics and gynaecology.