

On Women's Health and Rights
Lectures, Speeches and Statements
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Safe Motherhood at Ten Looking Back, Moving Forward

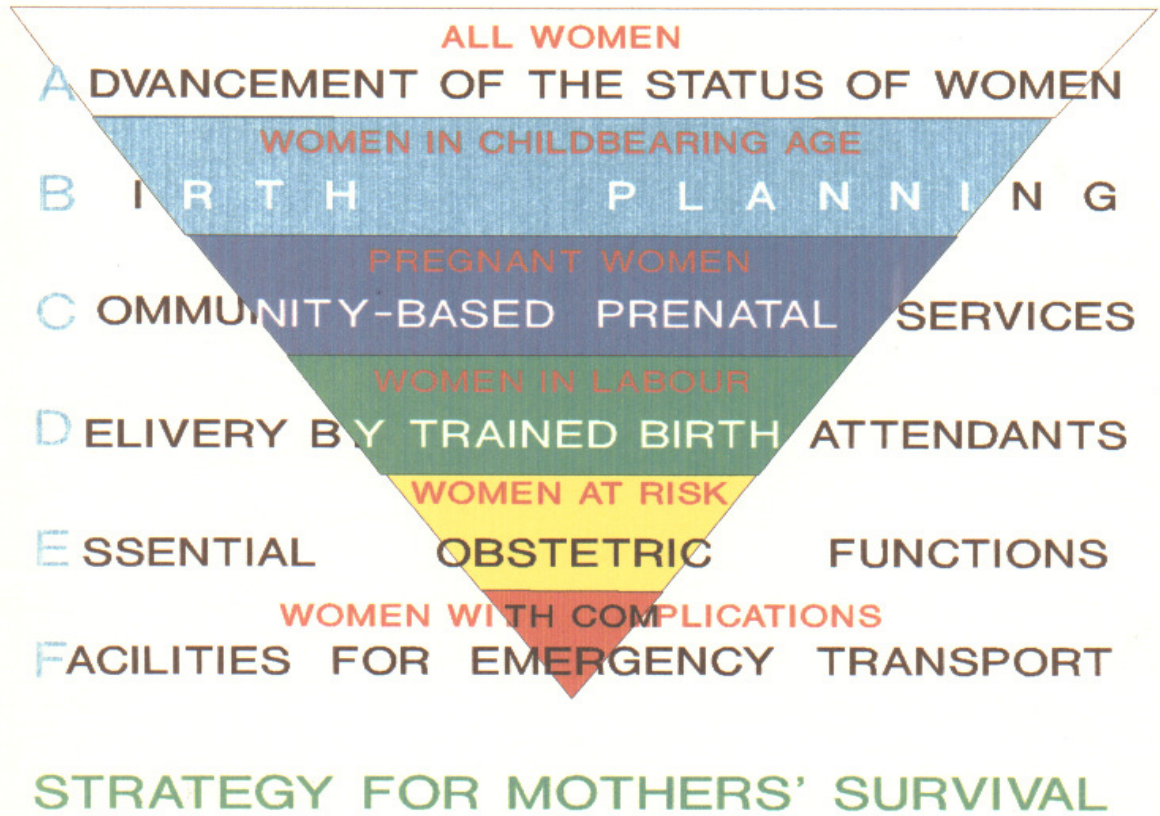
Opening Address

Safe Motherhood: Ten Years of Lessons and Progress
Technical consultation, Colombo, Sri Lanka
23 October 1997

The organizers asked me to prepare a historical perspective of the journey to safe motherhood. In doing this, I will have to take you along three historical roads in this journey. The first is the road to Nairobi; the second is the road from Nairobi to Colombo; the third and most important is the road ahead.

The road to Nairobi started when the world woke up to the reality, of a major tragedy. This was no new epidemic; throughout the ages women have died from complications of pregnancy and childbirth. But it was not until this time that three factors converged to awaken us. One factor was the accumulation of data from epidemiological research which showed that half a million women were dying every year as a result of pregnancy, and childbirth, and several million more were suffering from severe morbidity. The second factor was the realization that this suffering did not need to happen. Maternal mortality is largely avoidable, and in developed countries it has become something of the past. The third factor which was also very important was advancement of the status of women. The lives of women came to mean more and it was considered that their lives were worth saving.

The road to Nairobi was the road to make the case that motherhood should be made safe. The road from Nairobi to Colombo was not about the "should" but about the "could": can we make motherhood safe, and how can we do so? It was not easy, but ten years along the road we know that motherhood can be made safe. We know about the interventions that can make a difference, and we have learned some hard lessons along the way. I would like to briefly share with you first an outline of the interventions which we are going to discuss in the next few days, and then I want to spend some time on the hard lessons which we learned on the road from Nairobi to Colombo.



We know that there are three categories of interventions which can have an impact on safe motherhood. In my classes I use the letters A B, C, D, E and F to specify these interventions.

The first category contains interventions that are needed by all women and that are justified on their own, and not only for their potential impact on safe motherhood. These are:

**Advancement of women and
Birth planning**

The second category includes the interventions needed by all pregnant women, irrespective of whether they develop a life threatening complication. These are:

**Community-based prenatal care and
Delivery by a trained birth attendant**

The third category consists of interventions that are needed by women experiencing a life threatening complication. These are:

**Emergency obstetric care and
Facilities for referral**

We are going to hear a lot during this conference about these interventions and our experience with them over the past decade.

I want to spend some time on the hard lessons we have learned - and I say hard lessons because they are lessons that in one sense or another may defy conventional wisdom. Women die during pregnancy and childbirth because there are life-threatening complications which can develop. The first piece of conventional wisdom we defy is that prevention is better than cure. Unfortunately in this field we know that life threatening complications of pregnancy and childbirth are for the most part not preventable. In fact, we can only prevent two of the major causes: one is unsafe abortion, if we have the courage to make it safe, and the other is puerperal sepsis, which we can prevent by good care at delivery.

Another overturned piece of conventional wisdom is the risk approach, a good public health approach for the rational allocation of resources. In this approach, we identify from the outset the people who are at risk, and then target interventions and resources to these people. Unfortunately, most of the complications of pregnancy and childbirth are not predictable,

It is also a conventional wisdom that primary health care is the right approach to achieve health care for all, by an equitable allocation of resources and by emphasizing the low cost interventions that will benefit the majority, rather than the high-cost interventions directed to the few. For those of us who have put our faith in primary health care, it came as a shock to realize that, as far as safe motherhood is concerned, primary health care alone is not enough. We can detect complications of pregnancy and childbirth at the primary care level, but their management will need to be done at a higher referral level.

The last bit of conventional wisdom I need to dispel for you is a particularly hard lesson. We believe that development is the solution and that poverty is at the root of all health

problems in the Third World. This is correct, but where safe motherhood is concerned it needs a qualification. A well-off woman in the modern city is as likely to develop a placenta praevia (low-lying placenta) and serious ante-partum hemorrhage as a poor woman in a village. The only difference is the access to quality health care. The important lesson here is that pregnancy and childbirth are a risky business. Every woman is at risk and every woman should have access to the right health care if the need arises.

Now if the road to Nairobi was about "should," and the road from Nairobi to Colombo was about the 'could', the road ahead is the "will", and the "will" backed by the "wallet". I submit to you that there are three requirements to sustain this commitment for safe motherhood.

The first requirement is to raise the level of the issue of safe motherhood from being simply a health issue to being a human rights issue. Maternity is not a disease; maternity is a social privilege, and women have a basic right to be protected when they undertake it for us.

The second requirement is the support of the women's movement, and we need more of that support than we are getting now. It is true that women in the North have probably forgotten what a maternal death is; but for their sisters in the South, the journey of pregnancy and childbirth is still a dangerous one from which many do not return. Women's right to life is an issue around which all women should mobilize and act.

But the will without the wallet will not move us ahead in the road after Colombo. This is the third requirement. The question will be "Can we afford to do it?" and the answer is "yes we can". We can because we have learned from our experience of the last decade that in many cases the marginal cost to add and improve services in some type of existing infrastructure is affordable and has succeeded in saving women's lives. We can, because before we make a decision on costs, let us recall the faces of our mothers and then answer the question "How much are mothers worth?"

Before I conclude, I want to leave you with a message. It is not a message from me, but a message from the young women who have died because of pregnancy and childbirth. By the time we conclude this opening ceremony, about one hundred young women will have died. By the time we conclude our meeting here probably ten thousand young women will have died. I belong to an ancient culture that believes in a life hereafter and I can almost feel the presence of the thousands of souls of these young women in the prime of their lives, victims of social injustice. They will be with us here in Colombo today and throughout the conference. Their souls will be roaming in the space of these conference halls. They will be blessing us, they will be praying for us, and they will be hoping that our commitment and action which missed them will help save the lives of their sisters in years ahead.

Let us heed their message and say we will.