

On Women's Health and Rights  
Lectures, Speeches and Statements  
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## **Safe motherhood at 25 Looking back, moving forward**

A video-recorded speech, London 2012

### **Introduction**

The year of 2012 marks the twenty fifth anniversary of the launch of the International Safe Motherhood Initiative. Those of my generation, women and men, who have been campaigning and working from the beginning for the noble cause of women's right to safe motherhood, have either left the stage of our present world or are getting ready for their exit. A lot of progress has been made but we are leaving an unfinished agenda. Thousands of mothers, somewhere in our one world, are struggling for their life at this very hour. As we hand over the torch to a trusted younger generation, I want in this talk to look back at the history and challenges of the past, to present where we are now, and to express our hope for moving forward into brighter future.

### **Maternal mortality and an obstetrician**

As many others, I am an obstetrician who had the privilege to serve the health needs of women, in a part of a country where people are poor and women are the poorest of the poor. In the professional career of an obstetrician or midwife, there is no more tragic event than a maternal death. Most obstetricians in developed countries are fortunate enough to end their professional career without having to witness this tragedy. For those of us practicing in developing countries, maternal mortality is not words and is not numbers. It is women who have names. It is about human faces, seen in the throes of agony, distress, and despair, faces that live forever in our memory and continue to haunt our dreams. This is not simply because these are young women in the prime of their lives who die at a time of expectation and joy, leaving behind children and families in bad need of their care. It is not simply because a maternal death is one of the most terrible ways to die. It is difficult to think of a more terrible way to die than a maternal death as it occurs in parts of the developing world today. Think of the young woman in the process of giving life, when she consciously sees and feels the huge gushes of blood rapidly draining the life out of her body. Think of the face contorted by pain, and the body in the agony of convulsions in the condition of "eclampsia". Think of the complete helplessness of the woman in obstructed labor with her body taken over by distressing painful very strong but ineffective uterine contractions exhausting her completely to a fatal end. Think of the woman who gave birth and instead of the blissful joy of maternity, her body succumbs to invading microbes until death relieves her suffering. Then consider those women who have to risk and maybe sacrifice their lives because of a pregnancy they did not want, was imposed on them and they cannot cope with. Be aware that a majority of

these deaths are taking place in the absence of any medical help. If I have to go through another re-incarnation in a future life, I pray to God not to assign me as a woman in a poor developing country. But if such is God's will, so be it, and then I will only pray that God spares me the bitter cup of a maternal death.

But it is not only because of all this that maternal mortality is a tragedy that bears heavily, too heavily, on our morality and our collective conscience as obstetricians and midwives. The most distressing thing to us is that it is, in almost all cases, a tragedy that could have been avoided and should not have been allowed to happen.

### **The dawn of global awareness**

Then came the dawn of global awareness about the tragedy. Although maternal mortality accounted for a significant proportion of deaths among women of reproductive age in most of the developing world, its importance was not always evident from official statistics. In areas where the problem is most severe, the majority of maternal deaths simply went unrecorded, or the cause of death was not specified; hence the tendency to underestimate the gravity of the situation. It was only relatively recently that systematic efforts have been made to collect valid data from different sources on the prevalence of maternal mortality. The world woke up in the early 1980's with an almost nightmare, to hear an estimate that half a million women were giving up their lives every year during the noble process of pregnancy and childbirth.

The magnitude of the tragedy of maternal mortality is commonly expressed in terms of ratios, rates or numbers. While important as public health population indicators, they do not give the picture of the human tragedy of maternal mortality. The tragedy may be better presented as the adult lifetime risk of maternal death (expressed as the probability that a 15 year old girl will die eventually of a maternal cause). In African folklore, a mother, about to give birth, tells her older children "I am going to the sea to fetch a new baby, but the journey is long and dangerous and I may not return". And she is right. Many do not return, even today. Figures released by WHO and its partners for the year 2010 put this adult lifetime risk of maternal death as 1 in 39 for a woman in sub-Saharan Africa, while it is 1 in 3800 for her sister in the developed regions. Moreover, maternal mortality should be viewed as only the tip of an iceberg of maternal morbidity and acute or chronic suffering. Maternal mortality figures are just proxy indicators for the morbidity and suffering which women go through. The range of obstetric morbidities varies from the mild to the severe, and for some of them, like the uncontrollable urinary incontinence of obstetric fistula (an opening between the urinary bladder and vagina), death may have been, for the woman, a better alternative. Add, to all that, the burden on mothers of stillbirths and neonatal mortality and morbidity. Women make a major investment of themselves in pregnancy and childbirth. The unfavorable outcome of the pregnancy can be a frustration for loss or an additional burden on the woman for the care of an unhealthy infant and child.

### **The story of "Why did Mrs X die"**

It was then, back in the early 1980's, that many of us felt that maternal mortality in developing countries was the public health scandal of our time, and something has to be done about it. When we considered what to do, we were inspired by the success of the

system for confidential inquiries in maternal mortality implemented by the Royal College of Obstetricians and Gynaecologists. We hoped we could adapt and implement such a model in other countries. After all, it was the only game in town at the time. I remember, back then, moving around in countries of our region, as a consultant of the World Health Organization, preaching the message for safe motherhood, and advocating locally appropriate systems for confidential inquiries into these tragic deaths. To allay any fear about disclosures among the health profession, we raised the slogan “No name”, “No blame”. Interestingly, while I moved in other countries, a British consultant, my friend the late Dr John Tomkinson, was selected to preach the system in my country Egypt. I guess those who made that choice had in mind the passage in the New Testament about how the noble message of Jesus was received when he tried to preach in his home town Nazareth.

When we began to apply the system that worked so well in the UK, it soon became evident that maternal mortality in the South of our world is a somewhat different story from the maternal mortality now encountered in the North. Apart from differences in the magnitude of the problem and in the relative importance of the different causes of death, one big difference stands out.

For most cases of maternal death in the developed world, it is an unfortunate isolated medical incident, when a woman develops an unexpected life threatening complication, from which she could not be saved despite available medical care. The story is different for most of the cases in the developing world. A woman in a developing country often embarks on the risky journey of pregnancy and childbirth, already burdened with a heavy luggage of social injustice, which she accumulated from the time, as an innocent child, she suffered from girl discrimination and was not considered her brother's equal. She may be put (or shall we say sold) into marriage while still a young adolescent. As a married woman, she is denied any other choice in life except childbearing and child rearing, and children are considered the only goods that she is expected to deliver. She does not have access to family planning information and services. As a pregnant woman, she does not have the benefit of simple community-based health services. As a woman in labour, she is unlikely to have any skilled birth attendant at her side. There is an unfortunate saying in some developing countries: "Any fool can catch a baby". In our twenty-first century world, there are still millions of women who have access only to fools to catch their babies. When the mother develops a life threatening complication, she does not have access to timely transport and emergency obstetric care. She finally dies in this wilderness of social injustice. The ultimate tragedy of maternal mortality reflects this cumulative denial of women's human rights.

In 1987, at the meeting which launched the international safe motherhood initiative in Nairobi, I presented this concept about maternal mortality in developing countries with the metaphor of a maternal death road, a virtual treacherous slippery road, with millions of women marching along the road, looking for safety exits. The few fortunate among them find an exit out. Many are barred access to these exits, and continue their tragic march to the final destination of death at the blind end of the road. The metaphor of the maternal death road was illustrated by the story in a video with the title of “Why did Mrs

X die”, produced by the World Health Organization, and made available in English, French, Spanish and Arabic. The video follows the steps of one Mrs X in her journey along the road, without gaining access to any of the exits that could have saved her life.

### **Pregnancy is special: Let us make it safe**

I remember when the year 1998 was designated by the World Health Assembly to be the year for safe motherhood, WHO selected the slogan: “Pregnancy is special; let us make it safe”. Pregnancy is special in the sense that it should not be compared with the other causes of burden of disease, and compete for allocation of resources on the basis of body count or life years lost.

As health professionals, we know that women die because of many diseases, most of which are also shared by men. Although maternal death ranks high among the causes of mortality among women in reproductive age in developing countries, there are other major and important causes for the overall burden of disease on women. But there is a difference. Maternity is not a disease. Pregnancy is a privileged bio-social function entrusted to women, to ensure survival of our human species. If women, all women, stop getting pregnant, and they now can, thanks to contraceptive technology, our human species will be extinct. Unfortunately, the noble task of motherhood has not brought societal rewards to women. On the contrary, it has often led to their subordination, ignoring their worth and worse to gender discrimination practices which, among other consequences, adversely impact on their health. Mothers have often been seen as means and not ends. Health services have been targeted to mothers to help them to produce healthy babies. We forgot that there is a woman in the mother, who also has a right to health and survival.

It is hard to imagine the numbers of women, throughout human history, who gave up their lives, to fulfill the divine instruction to be fruitful and multiply and to replenish the earth. Considering demographic estimates of the total numbers of people ever born on our planet, and considering prevailing maternal mortality rates in the past and present, it will not be a scientific over-estimate to say that more than one billion women, throughout human history, gave up their lives in the battle of survival for our species. The numbers of these young noble women are certainly much more than the numbers of men who gave up their lives in battles for mutual human destruction. But women in the twenty-first century do not have to give up their lives when they give us a new life. Mothers are no longer dying because of conditions we cannot treat. Women should no longer accept maternal death as a matter of fate.

English is not my mother tongue, but I applaud the English language for using the term labour to describe what women do to give birth to a child. Unfortunately, it is a labour that has never been unionized. Nevertheless, women have a right to be protected while they labor for us in the risky business of pregnancy and childbirth. Society has an obligation to fulfill a woman’s right to life and health, when she is risking death to give us life. Maternal mortality should not be lumped with and ranked, for priority, against other disease problems. Society has more of an obligation for preventing maternal deaths

than for preventing deaths from other disease conditions, often resulting from our own unhealthy lifestyle behaviour.

## **Challenges in getting safe motherhood on the global agenda**

Putting safe motherhood on the global agenda was not easy. Several challenges had to be met.

Maternal mortality is a developing country problem that does not impact on developed countries. It is different from infectious diseases which can spread across borders, and from unregulated fertility that can upset the balance on our planet between population and the environment.

There were people in the development community who argued, in good faith, that maternal mortality is a question of poverty. Eliminate poverty and maternal mortality will take care of itself. But, historical data indicate that maternal mortality rates fell in Europe only after advances in midwifery practice and medicine in general, and not simply when the continent became wealthy. To be a rich woman does not ensure that you will not develop a life threatening complication in pregnancy and labour. Pregnancy and childbirth are a risky business. It is a risk that unites all women, and it is a risk that does not discriminate between the rich and the poor. Unfortunately, the risks are generally neither completely predictable nor completely preventable. While the risks are not predictable or preventable, they are all now medically manageable. I remember in the early days when we wanted to translate the term “safe motherhood” into different languages, our French translators came with the term “Maternite sans risque”. This immediately raised objection from the health professionals, who rightly argued that there is no maternity without risk. There are inherent risks in the process of pregnancy and childbirth. Only, these risks can now be managed.

Many of us have seen or heard about the magnificent architectural beauty: Taj Mahal in India, one of the world’s 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 labour after 19 years of marriage. 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.

Another challenge we met is that, to make pregnancy safer, we need a functioning health care system to be in place, which is lacking in many parts of the less developed countries. But this does not mean building new modern hospitals. In most cases, a lot can be achieved by 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. In fact, improving maternity services will enhance the capacity of the health care system to provide other services. Typical of mothers, what they need for themselves will always benefit others. Facilities and skills for essential and emergency care, when made available to women, will not be for their exclusive use. These include blood transfusion, simple anaesthetic procedures, moderate surgical skills (which can be even taught to non-medical health professionals),

and access to essential drugs. Sharing the benefit of what they have is something basic in the culture of women. It is there since the time of Eve. When Eve took of the tree thereof in the garden and did eat, what did she do? Keep it to herself? No, she gave unto her husband, and he did eat.

In another challenge, it took some time to get the right to safe motherhood on the agenda of women's movement. Women in the North have long forgotten what maternal mortality is. Their sisters in the South have come to accept maternal death as a matter of fate. One of my early disappointments happened in 1995. The Fourth World Conference on Women was convened in Beijing, and an excellent Platform for Action was declared. Twelve critical areas of concern to women were highlighted. All of them are important and I would fully endorse. But one critical area was conspicuous by its absence: women's right to safe motherhood. In a plea for women solidarity and for putting safe motherhood on the feminist agenda, I reminded my good feminist friends in the North that Mary Wollstonecraft, a British founder of the feminist movement and author of "Vindication of the rights of women", died because of pregnancy and childbirth. In the description given in Wikipedia; "Although the delivery seemed to go well initially, the placenta broke apart during the birth and became infected. After several days of agony, Wollstonecraft died of septicaemia" at age of 38, 12 days after she gave birth to her second daughter." Yes, this was in the year 1797, but it is still the fate of tens of thousands of women in the world every year. In her memory, feminists should vindicate the right of women to safe motherhood.

Reflecting back on meeting those challenges, I think the safe motherhood movement has achieved considerable success. But, one challenge remains to be worked upon. I submit that there is still an unspoken excuse for not investing what it takes to eliminate the tragedy of maternal deaths. I submit it is a question of how much the saving of a mother's life is considered worth. I am not making a rhetorical statement. Rational allocation of resources to prevent deaths requires, according to health economists, some monetary valuation of the life of different individuals. This notion may be repugnant to us, health professionals, who like to think that nothing is too expensive for the sake of saving life. However, societies unconsciously or consciously, put an invisible price tag on our lives, to decide, when the need arises, on who shall live and who shall die. One element in the valuation of a human life, economists say, is how much investment society has made in the individual. Another element is the productivity factor, based on the assumption that an individual contributes to society his production, which is equivalent to his earnings. This earnings-estimate, adjusted to expectation of working life, provides, for economists, a commonly utilized means for calculating the monetary value of a human life. Many societies in developing countries still invest less in girls than in boys. Girl education is lagging behind education of boys. A common misbelief is that women contribute a minor share of the country's economic product. Conventional measures of economic activity undercount women's paid labor and do not cover their unpaid labor. The economic invisibility of women is because their work, much that it counts, is not counted. The inconvenient truth, and let us face it, is that the tragedy of maternal mortality is now a question of how much the life of a mother and a women is considered worth. Mothers

are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.

I submit to you also that an additional factor not helping in getting enough of the will and the wallet for safe motherhood is that few women are in the position of decision making about the allocation of resources, particularly in countries where these resources are scarce.

After I completed fifty years in the noble profession of women's health, I was once asked what is the one prescription which I think women need most for their health. My answer was "power". Power is what women need to enjoy their right to health. Powerlessness of women, in my professional experience, is a serious health hazard, and particularly in maternal health. But women have to fill that prescription themselves and to keep a sustainable supply of it. No pharmacy will dispense it for them. When asked about the dose, my advice was to take as much as you get. There is no risk of over-dosage, and there are no reported side effects.

### **Where are we now?**

Enough about the challenges; let us look at where we are now. The safe motherhood initiative has come a long way. At the global level, there is good news. At the regional and country level, the picture is mixed.

According to a recent report issued by WHO and its partners, an estimated 287 000 maternal deaths occurred in 2010, a decline of 47% from levels in 1990. The global Maternal Mortality Rate (MMR) in 2010 was 210 maternal deaths per 100 000 live births, down from 400 maternal deaths per 100 000 live births in 1990.

At regional and country levels, there are still grounds for concern. The MMR in developing regions (240) was 15 times higher than in developed regions (16). A total of 40 countries had high MMR (defined as MMR  $\geq$ 300 maternal deaths per 100 000 live births) in 2010. Of these countries, Chad and Somalia had extremely high MMRs ( $\geq$ 1000 maternal deaths per 100 000 live births) at 1100 and 1000, respectively. The other eight highest MMR countries were all in Africa.

On the brighter side, ten countries have already achieved the target to reduce the MMR by 75% between 1990 and 2015. Nine other countries are "on track to achieve this target. Moreover, 50 countries are "making progress". Conversely, 14 countries have made "insufficient progress", and 11 are characterized as having made "no progress" and are likely to miss the target unless accelerated interventions are put in place.

We celebrate the glory of motherhood on a certain mother's day during the year in most countries of the world. I wish on that occasion we also remember and pay tribute to the seven or eight hundred women who gave up their lives on that same day on their way to motherhood. I wish we also celebrate, on the same occasion, the successes achieved in certain countries during the year for making motherhood safer for women.

### **Signals of hope**

I want to conclude with a message of hope. We, women and men, who campaigned for many years, can never give up hope on the beautiful dream of a world where motherhood is safe for all women. But we also have objective grounds for hope. The world is now taking notice. Progress is being made, though not up to our expectations. In the health profession, obstetricians and midwives are taking seriously their social and global responsibility. And most important, women are abandoning the language of silence and are claiming their God-given rights and status

The world is taking notice. At the Millennium Summit in 2000, representatives from 189 countries committed themselves toward a world in which sustaining development and eliminating poverty would have the highest priority. The Millennium Development Goals (MDGs) summarize these commitments and have been commonly accepted as a framework for measuring development progress. Improving maternal health is one of only eight MDGs adopted. Another goal is to promote gender equality and empower women.

But, safe motherhood did not rise on the development agenda only. It is now raised to the status of a human rights issue. There are occasions when an old man feels thankful about his age. In 1993, I published a scientific paper with the title “The neglected tragedy of maternal mortality in developing countries: a public health problem or a human rights issue?” How gratified I was, to live till 17 years later, when The United Nations Human Rights Council in 2010 put preventable maternal mortality on its agenda of human rights violations. I was one of the experts who addressed the distinguished Council on that occasion. The Council adopted a landmark resolution. Women’s right to safe motherhood is now recognized as a human right that should be respected, protected, and implemented, a right that implies both core obligations and progressive realization.

Progress is being made. As the recent report by WHO and its partners showed, several countries are delivering on the promise even with limited resources.

The health profession, obstetricians and midwives are taking seriously their social and global responsibility. They have stepped forward to be a part of the action positioning themselves as members of a socially conscious profession without national borders. When I was the President of the International Federation of Gynaecology and Obstetrics FIGO, we asked our member societies in the North and South about their willingness and readiness to work together to demonstrate through action and document through research, at the district level, in as many communities as resources will permit, that the lives of mothers can be saved and that many lives can be saved at a cost that is affordable to any society that upholds women's right to safe motherhood. We were overwhelmed by the response. The limiting factor was to get the necessary funding. This is why FIGO established at the time its *Save the Mothers Fund* in 1997. We were most grateful to generous support from Pharmacia Corporation, United Nations Population Fund, World Bank, and the Columbia University Program funded by the Gates Foundation. Over the past several years, the movement has been gathering momentum, with professionals from developed and developing countries working together in dedicated partnership teams to demonstrate that motherhood can be safe even where resources are limited.



But why I trust there is big hope is because women are making advances, in strides and in all parts of the world, in securing their God-given human rights and in asserting their real worth. They are speaking up, making their voices heard, from around the globe, saying we had enough, and enough is enough. Women in many developing countries are progressing towards gender equality. They still have some steep mountains to climb, but women are not for turning. The future is bright for women and mothers of the world as long as they are taking the future in their own hands.

I will not be around to see the dream of “safe motherhood for all” come true. But I pin my hope on the power of women, backed by the health profession, and supported by the global community.

Hope is a great thing to have. But I always remember the wisdom of the saying that hope is good for breakfast, but bad for supper. Hope is good when you take it and go to work on it. Hope is bad when you take it and go to sleep on it. Let us have hope and go to work on it.

(This speech is available for downloading from the FIGO website)