

**On Safe Motherhood
at 25 Years**

**Looking Back,
Moving Forward**

by
Professor Mahmoud Fathalla

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Watch, download and pass on the film:

**WHY DID MRS X DIE
RETOLD**

www.whydidsrxdie.com

Produced by



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FOREWORD

I owe my career to Professor Mahmoud Fathalla. Like countless other health and social care professionals, public health experts, maternal and women's rights advocates, politicians and all who care about healthy mothers and babies, my life changed when I first heard him speak, read his work and watched his iconic 1980s film *Why Did Mrs X Die?* In his understated way, his towering intellect, vision and eloquence, combined with an acute sense of injustice, started to reform the slow and sorry path of maternal health, long neglected, around the world. A new global Safe Motherhood movement was born, for which Professor Fathalla has been the midwife, obstetrician and proud father. The world started to listen and gradually things have started to improve.

However, there is still much to do. This is why the small educational charity, Hands On for Mothers and Babies, run by myself, Amy Gadney and Emily Goldner, supported by FIGO, is proud and honoured to work with Professor Fathalla to make his work widely available and to reinvigorate and inspire a new generation. We hope his vision will be continued through *Why Did Mrs X Die, Retold*, our remake of his ground breaking film. The film and the short essays contained within this leaflet are all available to download and pass on from our website:

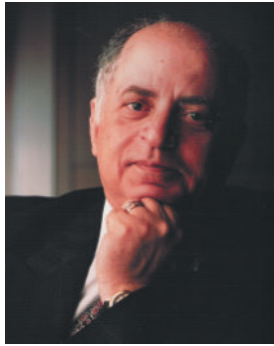
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Professor Fathalla is a prophet, a visionary, and a saviour to womankind.

by Professor Gwyneth Lewis OBE

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On Safe Motherhood at 25 Years Looking Back, Moving Forward

By Professor Mahmoud Fathalla

The year 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 for many years 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 small world, are struggling for their life at this very hour. As we hand over the torch to a trusted younger generation, I want to look back, highlight some of the challenges, and express hope for moving forward to end the tragedy of maternal deaths.

I had the privilege to serve the health needs of women, in a part of the world 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. 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 real need of their care. Moreover, maternal death is one of the most terrible ways to die. It is difficult to think of a worse way to die than a maternal death as it occurs in parts of the developing world today, be it bleeding to death, convulsive fits, severe pangs

of obstructed labour, or succumbing to microbial invasion. If I have to go through another re-incarnation in a future life, and God assigns me as a woman in a poor developing country, I will only pray that God spares me the bitter cup of a maternal death. But the most distressing thing to us, obstetricians and midwives, is that maternal death is, in almost all cases, a tragedy that could have been avoided and should not have been allowed to happen.

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 the World Health Organization WHO and its partners for the year 2010 put this adult lifetime risk of maternal death as one in 39 for a woman in sub-Saharan Africa, while it is one in 3800 for her sisters in the developed regions.

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 has been accumulating from the time, as an innocent child, she suffered from gender 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. Children are considered the only goods that she is expected to deliver. If services are provided to her as a pregnant woman, they are aimed to produce a living healthy baby. She is a means and not an end. When in labour, she is unlikely to have a skilled birth attendant at her side at those critical moments. 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. The ultimate tragedy of maternal mortality reflects this cumulative denial of women’s rights.

Putting safe motherhood on the global and national agendas was not easy. Several challenges had to be faced. Maternal mortality is a developing country problem that does not impact on developed countries. It is different from infectious diseases that can spread across borders or unregulated fertility that can upset the balance on our planet between population and environment.

It was also a challenge to make the case in the health system for a priority of safe motherhood. 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 in women in reproductive age in developing countries, there are other important causes for the overall burden of disease

on women. But there is a difference. Maternity is not a disease. Pregnancy is a privileged biosocial function entrusted to women, to ensure survival of our human species. Imagine if women, all women, stop getting pregnant, and they now can, thanks to contraceptive technology. Our human species will be extinct. It is hard to imagine the numbers of women, throughout human history, who gave up their lives to fulfil the divine instruction to ‘be fruitful and multiply and to replenish the earth’. The numbers of these noble, young women are certainly much higher 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.

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 labour for us in the risky business of pregnancy and childbirth.

Another challenge we faced is the need for a functioning health care system to be in place. This is lacking, or unevenly distributed, in many parts of the less developed countries. But this does not mean the need to build new modern hospitals. In most cases, a lot can be achieved by a more rational and equitable allocation of available resources, 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 in general. Typical of mothers, what they need for themselves will always benefit and will be shared with others. Facilities and skills for essential and emergency care, when made available to women, will not be for their exclusive use. Sharing is something basic in the culture of women. It is there since the time of Eve. When Eve took of the tree in the garden and did eat, what did she do? Keep it to herself? No. She gave unto her husband, and he did eat.

Another challenge was 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. The Fourth World Conference on Women was convened in Beijing in 1995, and ended with the declaration of an excellent Platform for Action. 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 the young 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 same fate and condition for tens of thousands of women in the world every year. In her memory, feminists should vindicate the right of all women to safe motherhood.

Reflecting back on these challenges, I can say that the safe motherhood movement has achieved considerable success. But, I submit that there is still an unspoken excuse for not investing what it takes to eliminate the tragedy of maternal deaths. It is the 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 already made in the individual. Another element is how much value the society sets on the individual's continued economic contribution. Many developing countries today still invest much less in girls than in boys. Also, a common misconception is that women contribute a minor share of the country's economic product. Conventional measures of economic activity undercount women's paid labour and do not cover their unpaid labour. 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 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 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 that I think women need most for their health. My answer was "power". 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 stock of it. When asked about the dose for that prescription, my advice was to take as much as you can get. There is no risk of over-dosage, and there are no reported side effects.

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 taking notice. At the Millennium Summit in the year 2000, representatives from 189 countries committed themselves to eight Millennium Development Goals. Improving maternal health is one of the eight goals adopted. Another goal is to promote gender equality and empower women.

Safe motherhood has now been raised to the status of a human rights issue. 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 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.

Progress is being made though not up to our expectations. The Millennium Development Goal for improving maternal health has set a target for countries with high levels of maternal mortality to reduce the maternal mortality rate by 75% between 1990 and 2015. As a recent report by WHO and its partners for the year 2010 showed, several countries are delivering on the promise. Ten countries have already achieved the target. Nine other countries are "on track". 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.

Obstetricians are taking seriously their social and global responsibility. They have stepped forward to be a part of the action. When I was the President of the International Federation of Gynecology 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, at district levels, that the lives of mothers can be saved at a cost that is affordable in low resource settings. We were overwhelmed by the response. The limiting factor was to get the necessary funding for the project. This is why FIGO established its Save the Mothers Fund in 1997.

But why I trust there is big hope is because women are making advances, in strides and in all parts of the world. They are claiming their human rights and asserting their real worth. They have abandoned the language of silence. Women in many developing countries are progressing towards gender equality. They still have some steep mountains to climb, but women are not for turning.

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.

Professor Mahmoud Fathalla's 10 propositions for safe motherhood for all women¹

1. Gender equity; raising the status of girls and women

Young girls are treated the same as their brothers, with equal access to food, education and health care resources. In this way they are healthier, literate and have better knowledge of pregnancy and the need for skilled care.

2. Maternity is special and society has an obligation to make it safe

Pregnancy is not a disease. It is the means for the survival of our species. All women have a basic human right to be cared for and protected when they undertake the risky journey of pregnancy and childbirth, and society has an obligation to fulfil this. Safe motherhood is a human rights issue for which countries should be held accountable.

3. A woman's life is worth saving

Women are valued for their contributions to their family, community, country and economy. Whether we like it or not, societies, consciously or subconsciously, put a price tag on the life of all. This invisible label decides whether a life is considered worth saving. In many resource poor societies the monetary value of a woman's life wrongly seen to be of little worth, thus they are less willing to invest what it takes to save their lives. Whilst it is true that the status of women is rising in most parts of the world, many women still have steep mountains to climb.

¹ Adapted and abridged from the International Journal of Gynecology and Obstetrics
Volume 72, No.3 March 2001. P 207-213

4. Pregnancy must be a voluntary choice

All women have the basic human right to have control their own fertility and reproductive health and every pregnancy is planned and wanted. Mothers need to be able to choose how many, and when, to have children and must have easy access to modern methods of family planning. Unsafe abortion, which kills so many mothers every day, must be reduced. And, in circumstances where abortion is not against the law, health systems should take measures to ensure that such abortion is safe and accessible.

5. All pregnant women must have access to antenatal/ prenatal care

All women have good care in pregnancy. On average, only about 55% of pregnant women in the world receive adequate antenatal/prenatal care. The figure for less developed areas is much higher. The World Health Organisation recommends that all pregnant women have four antenatal visits, more if requested by their doctor or midwife.

6. All deliveries are attended by skilled birth attendants

All women have a safe delivery assisted by a skilled birth attendant. These are health professionals who have the necessary training to assist women to deliver safely and detect, diagnose, and if necessary, refer women or babies with life-threatening complications to the necessary help. 34% of the world's mothers still deliver without such help. They and their babies have a far greater risk of dying.

7. All women must have access to high quality life-saving comprehensive emergency obstetric care if needed

All mothers receive high quality care if problems arise. . Complications in pregnancy or childbirth are neither completely preventable nor even predictable, but they are treatable and women's lives and health can be saved. High quality life-saving services must be available, accessible and effective if and when needed. 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.

8. An international commitment to make motherhood safe for all women

We must keep up the pressure on the international community. Thanks to the efforts of many organizations, and of individuals, safe motherhood has now made its way onto to the global agenda of the United Nations, its agencies and other key stakeholders and donors who can effect change. Improving maternal health is one of only 8 Millennium Development Goals to which 189 governments committed themselves in the year 2000. However we must not let progress slip because new and emerging issues push it down the priority list.

9. A lack of resources is no excuse for inaction

International commitment is not enough. We need action in countries, by countries. All countries, however poor, can redouble their efforts 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 capital income can have widely different levels of maternal mortality. 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

10. All of us, whoever we are and wherever we live, should mobilize to fight for women's right to life

As individuals we can lobby for better health care and equal rights for girls and women.

As communities we can make sure our pregnant women are informed and cared for. We can organise local education, support and transport for our mothers.

As health care workers we can provide quality care in a respectful environment, and we can continue to open the files and learn the lessons from mothers like Mrs X.

As local health planners we can provide high quality maternity and family planning services that reach out to more women.

And as politicians and policy makers we can strengthen human rights, we can improve education for girls and women, and we can provide the resources for better, more effective health care services across the world, wherever they're needed... now.

The Obstetricians' Role

As an obstetrician myself I am often asked what can obstetricians do about this? I often think about the meaning of the term “obstetrics”. To my knowledge, the word was derived from the Latin “obstare”, meaning to stand before. 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.

On the remake of Why Did Mrs X Die?

In 1987, at the launch of the international safe motherhood initiative I presented the concept of a maternal death road, a virtual treacherous slippery road, with millions of women in developing countries marching along it looking for safety exits. The fortunate among them find a way out. But many are barred access to these exits, and continue their tragic march to the final destination of death at the blind alley at end of the road with no way out. The metaphor of the maternal death road was illustrated by a 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.

When I wrote about the maternal death road, I was not looking forward to visiting the scene 25 years later. Given the declared commitment at that time, and being optimistic by nature, I expected that it will soon be a deserted road, maybe with only few unfortunate women still moving along the road, and most of them are finding an easy exit to safety. Progress has been made, but unfortunately, we fell too short of our expectations. The road is still busy with this one-way traffic, and more than one thousand women in the prime of their lives are to be found lying dead at the end of the road every day. Of those who manage to exit from the road, thousands emerge heavily traumatized with long lasting suffering. This is why the story of Mrs X and her tragic journey has to be re-told, in the new film Why Did Mrs X Die, Retold. And it must be told and retold until this road is cleared from the disgraceful health and human rights scandal of maternal death and disability.

When I look back at more than 25 years of campaigning for safe motherhood, I feel that one of our shortcomings may have been that we did not do enough to mobilize women for their right to go safely through the noble journey of pregnancy and childbirth. Women in the North have long forgotten what maternal mortality is. Many of their sisters in the South have come to accept maternal death as a matter of fate. It is hard to imagine the numbers of women, throughout human history, who gave up their lives, to fulfil the divine instruction to be fruitful and multiply and to replenish the earth. But women in the twenty-first century do not have to give up their lives. Mothers are not dying because of conditions we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.

As health professionals, we know that women die because of many diseases, most of which are also shared by men. But there is a difference. Pregnancy is not a disease. Pregnancy is a privileged biosocial function entrusted to women, to ensure survival of our human species. If women stop getting pregnant, and, thanks to contraceptive technology they now can, our human species will be extinct. Maternal mortality should not be ranked and compete for priority action with other causes of female death. It must be taken as a given unassailable human right.

I am still optimistic. We have seen improving maternal health rise to the top of the global development agenda, being recognized as one of only eight millennium development goals, adopted by the world community of governments. Women in many developing countries are progressing towards gender equality. There are still some steep mountains to climb, but women are not for turning. What makes me even more optimistic is that, thanks to the commitment in a number of developing countries, the global number of women dying as a result of complications during pregnancy and childbirth has decreased from 546,000 in 1990 to an estimated 287,000 in 2010. Progress has been uneven, and many countries still lag behind. But what some countries have done, others can do. I may not be around to see it. But I have trust in the power of women, backed by the health profession, to erase the disgraceful maternal death road from the world map. Maternity, a joy, celebration and pride for women, should no longer be a tragedy in a 21st century world.