The Safe Motherhood Initiative

Address

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President
The World Bank
and
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Proposals for Action
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Address to the Safe Motherhood Conference

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Sometimes we forget that development is the work of women as well as men.

We meet today to reaffirm that simple truth and to act on it.

The Safe Motherhood Conference recognizes a reality so basic that it has been easy to overlook. We have come together to remedy that oversight. But we are not here just to publicize a problem. We are here to attack it, to save lives, and to build better ones.

Thanks to the vision and hospitality of our host, the government of Kenya, we can put our shared resources of knowledge and experience to the service of women's health. Thanks to the support of the World Health Organization, the United Nations Fund for Population Activities, the U.N. Development Programme, and all the other donors, we can make this conference the beginning of a new commitment to common decency and common sense.

Common decency tells us that it is intolerable that 1,400 women die every day in the process of carrying or delivering their children. And common sense tells us that those needless deaths waste not only precious lives but precious human resources. All over the world women are the sustaining force of families, communities, nations. In the Third World women must also be full, forceful partners in sustaining development.

It is appropriate that we acknowledge this truth in Africa. For somewhere on this continent, sometime between 140,000 and 280,000 years ago, some biologists believe there lived a woman whom they call Eve and see as a common ancestor of all humanity. If so, her chromosomes are the shared inheritance of everyone living today. They link us each to one another. They make us not just "riders on the earth together, brothers on that bright loveliness in the eternal cold," but brothers and sisters with a single family history and a single destiny.

We can take charge of that destiny. We can take steps today to
ensure that millions of women live to see tomorrow and live to make their families’ futures and their nations’ futures more secure.

The first step is toward better health for childbearing women, a life-saving step toward safe motherhood, a life-giving step toward sustained human development.

We all know the statistics: almost half a million maternal deaths a year in the developing world, 80 percent of them in South Asia and Sub-Saharan Africa. Women in poorer countries often face 100 times the risk of death in pregnancy that women in developed countries face. They begin childbearing much earlier, end later, and have on average several more pregnancies. We all know how avoidable most maternal deaths are, how small an investment in basic health care and improved nutrition is needed to bring large returns in survival, in strength, in progress.

Those findings can be our guides to action. Those statistics must prompt us to act. For statistics, an English physician has said, only represent people with the tears wiped off. Let us look, dry-eyed, at the people behind the numbers.

The women of the Third World are the poorest of the poor, but their work can make the difference between poverty and hope.

It is their backs that are bent in the fields to till and plant, to weed and fertilize and harvest.

Their backs are bent at the well to draw water and to carry it home.

Their backs are bent under loads of fuelwood and the weight of young children.

Their backs are bent over cooking fires and looms and market stalls and sickbeds.

For too long, those bent backs have been too little visible to those who plan development in terms of macroeconomic policy, of roads and power lines, of schools and hospitals, of factories and ports and irrigation projects. We have assumed that the benefits of these programs would, in time, flow to men and women alike. But our assumptions have been imperfect, our
results uneven. Macroeconomic planners have slighted the growth that comes from the bottom up.

In developing nations—but not in those nations alone—too many women are at the bottom. Their arms hold the family together. Their hands build the foundation of stable, growing communities. But development efforts have not lent enough strength to those arms, have not entrusted enough resources to those hands. And, along with women, development itself has suffered. To sustain itself, development must help women up.

It already has. Only not far enough or fast enough. At the end of the United Nations Decade for Women, the World Conference here in Nairobi recorded satisfying advances. But those, like my wife, who attended that meeting, left it conscious of how much remains to be done to equip women to participate effectively in development and share in its rewards.

Female enrollment in schools has quadrupled since 1950, but in the developing nations, six out of every ten school-age girls are still at home, not in class. Female literacy has roughly doubled since 1960, but where more than two-thirds of the men in developing nations are now readers and writers, only half the women have the same skills. And in many of the poorest nations, 80 percent of the women over 25 years old have had no schooling at all. It is in those regions, as well, that women do the hardest work for the least pay. Often, for no pay.

While women all over the world have made significant gains in the job market—in both absolute and qualitative terms—farm and village women in the Third World and the urban poor remain overworked and underrewarded. In Africa, women produce as much as 80 percent of the food supply but earn little income and own even less property.

When, as in Bangladesh, credit for small business or agriculture is available to women, they have shown themselves to be excellent risks, with better repayment rates than men. Where, as here in Kenya, they can get agricultural extension services, such women have readily adopted improved farming methods. But the resources they have to invest—in seed, livestock, tools, and household technology, for example—are so minimal that wom-
en's productivity remains low. Their earnings may be enough to make the difference between starvation and subsistence, but not to pay the passage from disadvantage to opportunity.

Sustained development must bridge that gap. It must not only create opportunity, but expand access to it.

We who work in development cannot advance far if we leave women significantly behind. Their potential is great. Our efforts on their behalf have been uncertain. Frequently we have not even consulted them or included them in development planning. This makes it difficult to focus on the opportunities and the obstacles women face, to enhance women's productivity, and thus to improve the quality of life for entire families.

The World Bank will do its part. We have already started intensifying staff involvement in issues affecting women. Through the Bank's advisory, lending, and research efforts, we will place far more emphasis on the role of women in development. In cooperation with our member countries, we will make that emphasis operational. Let me mention a few specific steps the Bank will undertake.

- We will prepare action plans on women in development for our lending programs in selected countries, so that our agricultural, industrial, educational, and health programs promote women's progress along with other development goals.
- We will emphasize issues affecting women in our dialogues with member countries.
- We will encourage development policies that provide appropriate incentives for women and ensure that women have the means to respond.
- We will develop program initiatives in agricultural extension and agricultural credit targeted to women, and expand credit and training for women to improve their employment prospects outside agriculture.
- We will help promote both formal and informal education for women and girls.
- And we plan to double our lending for population, health, and
nutrition activities. By 1990 we expect to have projects in about
50 countries, with approximately twelve to fourteen new opera-
tions a year. Lending for population, health, and nutrition could
reach $500 million a year, about twice our level in 1984–85.

Women's health is basic to women's advance in all fields of
endeavor. And as a mother's health is the bulwark of her family,
it is the foundation of community and social progress. Working
for safe motherhood, we will be working for steady development
on all fronts.

Maternal health care—improved nutrition, early warning of like-
ly difficulties in pregnancy, more effective help during childbirth,
and improved family planning—is an investment in development.
It is an affordable and productive investment. A low-cost system
that provides basic health care in communities and timely trans-
portation to more advanced medical help at regional health cen-
ters can save thousands of mothers and children. We know that
such measures can succeed, particularly in conjunction with oth-
er development programs to improve women's incomes, food
supplies, and education.

A few hundred miles from my birthplace, a privileged young
American woman set out some fifty years ago to bring health to
the impoverished, isolated mothers of backwoods eastern Ken-
tucky. In 1925 Mary Breckinridge, who had lost a child of her
own at birth, founded the Frontier Nursing Service, sending mid-
wives on horseback over the hilly trails of one of America's
poorest regions. The problems she faced would be familiar to
most mothers and to most medical personnel who treat them in
developing nations: women too young and too old to have chil-
dren safely, too poorly fed, too far from hospitals, too vital to
the support of their families to die in childbirth. The Frontier
Nursing Service faced all those challenges and overcame them.
After fifty years and 20,000 births with only eleven maternal
deaths, its success also included the counseling that helped cut
the area's birth rate dramatically. "The glorious thing about it,"
Mrs. Breckinridge wrote, "is that it has worked."

Imaginative health care can also work in the Third World. The
World Bank believes it is feasible to strengthen basic health sys-
tems enough to reduce maternal mortality by about half within a
decade. What is required is a three-tiered approach:

First, stronger community-based health care, relying on health
workers other than physicians, to screen pregnant women, identify those at high risk, and refer them for help; provide good prenatal care and ensure safe delivery for women at less risk; provide family life education and family planning services; and generally encourage better family health and nutrition.

Second, stronger referral facilities—that is, a few hospitals and
health centers to act as a backup network for complicated deliveries and obstetrical emergencies.

Third, an “alarm” and transport system to transfer women with
high-risk pregnancies and emergencies from the community to the referral facilities in time to ensure their survival.

Such maternal health care should cost no more than about $2 per capita a year, compared with an average of $9 now being spent for all health care purposes in low-income countries. In many countries we can build on existing networks of basic health services that offer such medical support as immunization and child care. We can train and equip more community health workers, add and upgrade referral facilities, and augment their staff to prevent far more deaths in pregnancy and childbirth. In countries as diverse as China, Costa Rica, and Sri Lanka, such health services have already reduced the number of deaths in childbirth and the number of unwanted pregnancies.

We can, in short, be lifesavers, economically and effectively. But development is also a life-giving enterprise, and our maternal health programs must enrich the quality of life, as well as prolong it.

Safe motherhood initiatives should be a means and a spur to the education that fits women to earn an income and improve family well-being—education in work skills, education in nutrition, education in timing and spacing pregnancies, education in family health care. These efforts should express and reinforce the involvement of women in community self-help associations. Example and instruction can come from outside—from local and na-
tional leaders, from women’s groups and civic organizations, from the news media, schools and universities, even from the theater. But the effort that poor women make themselves to take charge of their productive and reproductive lives is what will matter the most.

Throughout the developing world, women aspire to become full partners with men in creating strong and productive societies. Development programs must help realize this aspiration by supplying the tools to help women help themselves. Education, better opportunities, higher earning capacity, and control over their own earnings can ensure greater dignity and productivity for women, thus fostering sensible decisions about childbearing and health care and guaranteeing that the next generation will be a happier, healthier one.

Unhappily, the reverse is also true. Families where mothers die in childbirth are families that disintegrate. Communities where women are treated as expendable are communities that waste vital resources. Families, communities, and nations that help provide for women’s health are providing wisely for their own future.

Almost 200 years ago, the great English philosopher and reformer, Mary Wollstonecraft, wrote that “progress in human virtue and improvement in knowledge” depended on women being “more rationally educated.” Mary Wollstonecraft, who died in childbirth, would agree that rational education for women begins with the knowledge that gives mothers the strength to bear children safely and to nurture them in hope.

The World Bank wants to help spread that knowledge and the resources to put it to work. That knowledge—its dissemination and application—is our new investment in the strength and progress of women.

To conclude my remarks as I began: development is women’s work. Like women’s work, it is never done.

This conference, indeed, is just the beginning of our work for Safe Motherhood. It must stimulate not merely thought and rhetoric, but effective action.
The World Bank has presented a program for action. In addition, we plan to help establish a Safe Motherhood Fund under the management of the World Health Organization to undertake operational research that will support the development of country programs and projects in the maternal health field. We plan a contribution of $1 million toward the proposed three-year budget of $5 million.

We believe that through the joint efforts of the developing countries, the Bank, other donors, nongovernmental organizations, and private groups, we can reduce by half the number of women who die in pregnancy or childbirth by the year 2000.

We believe that this initiative will advance the health, the dignity, and the productivity of women in the developing world and the coming generations that depend on them. We urge you to join in this campaign to save lives...to offer hope.

The goal is modest. We can reach it. Together, let us begin.
Governments throughout the world have adopted the goal of “Health for All by the Year 2000.” Many countries have made considerable progress toward that goal, particularly by improving child health. Over the past twenty years, life expectancy in low-income countries other than China and India has increased from 43 years to 52; including China and India, life expectancy has reached 60 years. Yet maternal mortality and morbidity still represent grave threats to the survival and well-being of women, at the height of their productivity and family responsibility, in much of the developing world. In poor countries, women often run a 50–100 times greater risk of dying in pregnancy than do women in developed countries. In fact, 500,000 women throughout the world die each year from causes related to pregnancy; almost 99 percent of these deaths occur in the developing world. This is not the only tragedy. At least that many infants and young children do not long survive their mothers. And of the women who do survive, many millions suffer lasting ill health and disability.

Maternal Mortality

The extent of maternal mortality reflects the risk of death that a woman faces on average each time she becomes pregnant (the maternal mortality rate) and her exposure to that risk (how many pregnancies she has during her lifetime). The risk varies, of course, for an individual woman. Generally, the risk is higher for very young women or those over age 35; for women in their first pregnancy or after four pregnancies; for women with certain preexisting health conditions; for poor, malnourished, and uneducated women; and for women beyond the reach of adequate health care.

About three-fourths of maternal deaths in developing countries are direct obstetric deaths, largely from hemorrhage, severe infection (sepsis), toxemia, obstructed labor, and abortion (particularly illegal, primitive abortion).
Improving Maternal Health

A woman's health and nutritional status substantially affect her capacity to withstand difficulties during pregnancy, childbirth, and the postpartum period; her capacity to produce a strong, healthy baby; and her capacity to nurse and care for her baby. Most pregnant women in developing countries are anemic. Many teenage mothers are not yet fully grown. Women could help themselves if they had basic information about nutrition and health, but many lack both the information and the resources to use it. Improving the income, education, health, and nutritional status of women can therefore help to reduce maternal mortality and morbidity substantially.

Family planning information and services can also improve maternal health by enabling women to time and space pregnancies. In many countries, from one-fourth to two-fifths of maternal deaths could be averted by avoiding unwanted pregnancies. Experience from diverse settings suggests that when safe and acceptable family planning services are provided, from one-fourth to two-thirds of eligible couples choose to use them.

Specific efforts to address maternal mortality and morbidity could have swift and substantial effect. Precisely what is needed will depend on individual country circumstances—on the pattern of maternal mortality and morbidity, its underlying causes, existing health care, and resource constraints. However, the three essential elements are prevention of complications, routine care, and backup for high risk and emergency cases. Much maternal mortality and morbidity can be prevented by pregnancy risk screening, referral care of women at high risk, and good prenatal care for all. Current evidence, although limited, suggests that it is possible to identify the one-fourth or so of all pregnant women who will have about three-fourths of the life-threatening complications of pregnancy. With risk screening and selective referral, scarce health resources can be focused on those in greatest need.

Adequate care for women with supposedly routine pregnancies is equally essential. Traditional birth attendants and other health workers can be taught improved techniques so that they can manage routine deliveries more effectively, provided they have an
Emergency backup system. Referral facilities for backup care are required for high-risk cases and problems that cannot be predicted. Some, notably hemorrhage, are genuine emergencies. Others, like infection or complications of primitive abortion, are far easier to deal with successfully at early stages.

Experience in developed countries and in Chile, China, and Sri Lanka suggests that most maternal deaths and lasting disability need not happen. In most countries with high maternal mortality, basic maternal health services, plus programs to strengthen women’s opportunities, can probably reduce the number of deaths by half or more at relatively moderate cost within a decade or so. Those same measures would simultaneously improve women’s productivity, strengthen family health, with resulting gains in productivity and learning capacity, and reduce birth rates.

To provide the necessary preventive, routine, and backup (first referral level) care, a three-pronged approach is required:

- **Stronger community-based health care** (relying on health workers other than physicians) to screen pregnant women, identify those at high risk, and refer them for help; to provide good prenatal care and ensure safe delivery for women at less risk; to provide family life education and family planning services; and generally to promote better family health and nutrition.

- **Stronger referral facilities**—hospitals and health centers with beds—to act as a backup network, to take care of complicated deliveries and obstetrical emergencies, and to provide clinical and surgical methods of family planning.

- **An “alarm” and transport system** to transfer women with high risk pregnancies and emergencies from the community to the referral facilities in time.

These maternal health services would normally be built into government or nongovernment programs of primary health care. Their cost to governments will depend on what services are made available and how thinly those services are spread. Management, logistics, and clients’ or communities’ ability to help pay for services (through cash or in-kind contributions) will also affect costs. The principal costs may often be in the referral system.
Community-based services and “alarm” and transport systems can also vary considerably by type and extension of service and hence in cost.

**Cost and Impact of Maternal Health Care**

The approximate cost and impact of two possible safe motherhood programs are shown in the table. The two programs illustrate the three-pronged approach to stimulating country-specific planning. They reflect experience in Africa and Asia but are not meant to fit any single situation. The moderate effort suggests a

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<th>Estimated Cost and Impact of Two Safe Motherhood Programs</th>
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<tr>
<td><strong>Cost and impact</strong></td>
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<tr>
<td><strong>Cost in U.S. dollars</strong></td>
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<tr>
<td>Annual cost per capita population</td>
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<td>Approximate annual cost per maternal death averted</td>
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<td>Annual cost per death averted (mothers and children)</td>
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<td>Annual cost per birth averted</td>
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<td><strong>Impact</strong></td>
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<tr>
<td>Percentage of fertile-age couples using contraception</td>
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<td>Maternal mortality rate per 100,000 live births</td>
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<td>Percentage reduction in maternal deaths</td>
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<td>Associated birth rate</td>
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—Not applicable.
cost of less than $2 per capita a year compared with average health expenditures of $9 per capita in low-income developing countries. But this level of expenditures, though modest, is not yet affordable in all countries. The limited effort therefore outlines an approach that costs less than $1 per capita a year and that could initiate the process of improving maternal health.

Although the more limited effort fails to prevent as high a proportion of maternal deaths, it is more cost-effective. But financing even basic health services remains a challenge in countries now facing severe resource constraints. Many countries do already have health facilities that could be upgraded at modest cost to deal more effectively with maternal health care. Most could strengthen community-based health and family planning care. Moreover, many communities would willingly contribute time and resources to help preserve maternal health and family well-being. Private expenditures on curative health care in poor countries demonstrate a willingness to pay if the investment will produce results.

Other Measures

Measures outside the health system, including increases in formal and nonformal education and in income for women, attention from the media, and support from national and local leaders, can also improve maternal health by encouraging women to seek health care and generally improve their well-being and self-esteem, and by encouraging communities to give greater priority to maternal health services.

Call for Action

The time is ripe to launch an initiative to improve maternal health. In the developing countries themselves, three things are required: first, political commitment to and higher priority for safe motherhood; second, allocation of the necessary resources to maternal health and family planning services; and third, supportive activities in other sectors. Clear policy on the priority of safe motherhood should accompany effective action in the health sector. Multilateral and bilateral development agencies, too, must give safe motherhood higher priority and stand ready to provide technical and financial assistance on request.
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