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Five Lessons for Advancing Maternal Health Rights in an Age of Neoliberal Globalization and Conservative Backlash

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Abstract

After considerable progress in recent decades, maternal mortality and morbidity (MMM) either stagnated or worsened in most regions of the globe between 2016 and 2020. The world should be outraged given that we have known the key interventions necessary for preventing MMM for over three-quarters of a century. Since the 1990s, human rights advocacy on MMM has gained crucial ground, demonstrating that entitlements related to maternal health are judicially enforceable and delineating rights-based approaches to health in the context of MMM. Nonetheless, evident retrogressions, coupled with ballooning social inequalities, redoubled austerity post-pandemic, and a conservative populist backlash against reproductive rights, underscore the steep challenges we face. This paper offers five lessons gleaned from what we have achieved during the past 30 years of human rights advocacy on maternal health, and where we have fallen short: (1) maternal health is not a technical challenge alone and is inseparable from reproductive justice; (2) reproductive justice requires strengthening health system infrastructures; (3) we must center the political economy of global health in our advocacy, not just national policies; (4) litigation is part of a larger advocacy toolkit, not a go-it-alone strategy; and (5) we must use metrics that tell us *why* women are dying and what to do.

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Introduction

After considerable progress in recent decades, a 2023 study from the World Health Organization (WHO) revealed that maternal mortality and morbidity (MMM) either stagnated or worsened in most regions of the world between 2016 and 2020.[1] WHO estimates that 287,000 women or gestating persons died in 2020, constituting almost 800 maternal deaths per day.[2] That number is staggering: it is the equivalent of more than two large jetliners falling out of the sky every single day. For every woman who dies, an estimated 70–80 more suffer from severe comorbidities that may result in permanent health impacts, from fistula to infertility.[3] Moreover, maternal deaths affect family and community members. For example, studies done in East Africa suggest that losing a mother exponentially increases the chances of children dying before the age of five and has devastating consequences on school attainment, nutritional outcomes, and the navigation of sexual roles, for girls in particular.[4]

What should enrage us all is that we have known the key public health interventions necessary for preventing maternal mortality for over three-quarters of a century. With advances in medical science and technology, as many as 98% of the maternal deaths that occur today are entirely preventable.[5] That MMM not only continues to be so widespread but is increasing in many parts of the world, including in the United States, indicates the extent to which intertwined structures of patriarchy, colonialism, racism, and other forms of minoritization, as well as neoliberal globalization, systemically consign so many women's lives to insignificance.

Since the 1990s, human rights advocacy on MMM has sat at complicated intersections in international and national law, including navigating deference to patriarchal medicine, avoiding essentializing women as mothers, and enforcing an array of affirmative legal entitlements within health systems. Human rights strategies have gained crucial ground, demonstrating that entitlements related to maternal health are judicially enforceable and delineating human rights-based approaches to health in the context of MMM.[6] Nonetheless, evident retrogressions, coupled with ballooning social inequalities, redoubled austerity post-pandemic, and a conservative populist backlash against a "gender ideology," underscore the steep challenges we face.[7] This paper offers five lessons gleaned from reflections on what we have achieved during the past 30 years of human rights advocacy on maternal health, and where we have fallen short: (1) maternal health is not a technical challenge alone and is inseparable from reproductive justice; (2) reproductive justice requires strengthening health system infrastructures; (3) we must center the political economy of global health in our advocacy, not just national policies; (4) litigation is part of a larger advocacy toolkit, not a go-it-alone strategy; and (5) we must use metrics that tell us *why* women are dying and what to do.

Lesson one: Progress on maternal health rights depends on reproductive justice.

Advancing maternal health is inseparable from the struggle for reproductive justice. Reproductive justice refers to the ability to decide if, when, and how we want to have children; the right to parent children in safe and healthy environments; and sexual autonomy and gender freedom for every human being.[8] The reproductive justice movement pioneered by Black US feminists in the 1990s re-centered the structural conditions and embodied realities of differently situated people, given the narrow formalistic approach to legal entitlements under US constitutional law. From the outset, reproductive justice had close synergies with efforts to advance sexual and reproductive health and rights (SRHR) under international law, including the landmark conceptualizations of reproductive rights in the International Conference on Population and Development (1994) and the Fourth World Conference on Women held in Beijing (1995).[9]

However, in 2001, the adoption of the Millennium Development Goals (MDGs) replaced the broad trans-sectoral emphasis on social and institutional change in those trans-sectoral conferences of the 1990s with a technocratic approach in which the only goal related to SRHR, MDG 5, centered solely on improving maternal health. Maternal

health subsequently became a "trojan horse" to advance the legal and structural issues pertaining to SRHR more broadly.[10] Along with efforts to generate greater accountability in maternal and child health through global health institutions, the Human Rights Council was a primary locus of this activity in the late 2000s and early 2010s.[11] The United Nations (UN) Special Rapporteur on the right to health issued a report on maternal mortality.[12] Additionally, the Human Rights Council itself passed a series of resolutions on maternal health and human rights based on reports from the Office of the UN High Commissioner for Human Rights.[13] These reports explicated connections between MMM and human rights, highlighted best practices, and ultimately culminated in the publication of the *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality* (UN Technical Guidance), the first intergovernmentally approved human rights-based approach to health.[14]

This UN Technical Guidance situated MMM within SRHR and a reproductive justice framework, and underscored that "in all countries, patterns of maternal mortality and morbidity often reflect power differentials in society and the distribution of power between men and women. Manifested in poverty and income inequality, gender discrimination in law and practice, and marginalization based on ethnicity, race, caste, national origin and other grounds are social determinants that affect multiple rights."[15] It also importantly delineated the obligations of states at every stage of the policy cycle and beyond the health sector and was followed by summary reflection guides for different actors implicated in improving maternal and reproductive health.[16] Nonetheless, using human rights-based approaches to advance reproductive justice issues more broadly has been only partially successful. The MDGs ushered in a focus on the "continuum of care" approach, exemplified by the creation of the Partnership for Maternal Newborn and Child Health and a shift toward programming based on reproductive, maternal, newborn, and child health, and later also adolescent health (RMNCAH).[17] The RMNCAH framework conceptually redefined women in accordance with their reproductive intentions and capacities. In turn, in underscoring the role of women as child-bearers, the continuum of care approach contributed to programming that placed women's roles in reproduction and caretaking of children—rather than their empowerment as independent social citizens with rights—at the center of the agenda.[18]

Advancing maternal health rights, understood as part of SRHR and reproductive justice, calls for a far more ambitious agenda, which recognizes women as agents of social change and subjects of dignity, and calls for action across an array of issues that transcend the health sector. Moreover, in a human rights framework, health systems themselves are understood not as technical delivery apparatuses but as social institutions that either mitigate or exacerbate "multiple and intersecting forms of discrimination," including those based on race, caste, gender, class, and ethnicity.[19] As Paul Hunt, Gunilla Backman, Judith Bueno de Mesquita, et al. have noted, stigma and discrimination in both law and practice "pose a serious threat to sexual and reproductive health," which simply cannot be addressed through care delivery interventions alone.[20]

Precisely at a time when there is an extraordinary backlash against abortion rights and sexual orientation and gender identity rights, our advocacy needs to lean into the need for maternal health rights to be understood in the context of broader reproductive justice demands. Empirically, pregnancy and childbirth are complicated processes where obstetric emergencies and spontaneous abortions can easily be confused with induced abortions. Indeed, there is often no way to accurately discern whether a pregnancy loss is attributable to an issue of fetal viability (approximately 25–30% of pregnancies result in spontaneous loss due to a variety of viability issues), an accident, or a deliberate action.[21] Normatively, the right to interrupt one's pregnancy is a crucial part of reproductive autonomy and gender equality. Beyond abortion, unwanted pregnancies are always high-risk pregnancies; advancing ma-

ternal health as a matter of rights cannot be done without guaranteeing access to contraception and comprehensive sexuality education that enables all pregnancy-capable persons to decide if, when, and how they want children. Transphobia has no place in maternal health advocacy; trans men face greater chances of pregnancy complications than cis gender women.[22] In short, reproductive justice, including safe motherhood, is key to gender justice, as well as to racial justice and social justice.

Lesson two: Reproductive justice requires strengthening health system infrastructures.

Just as we must refuse to separate maternal health from other reproductive justice struggles, it is crucial that we pay greater attention to the financing and infrastructure necessary to ensure safe motherhood as well as the availability of other sexual and reproductive health care. If health systems are understood as social institutions that reflect and reinforce societal values, how they are financed and organized determines both provider and patient rights.

In the United States, for example, the maternal mortality rate is the most elevated of any high-income country, with a maternal mortality ratio of 23.8 per 100,000 live births.[23] The situation, which has been getting progressively worse, is particularly dire for Black and Indigenous women, for whom pregnancy-related mortality rates are between two and three times higher than the rate for white women.[24] Increasing data point to the effects of white supremacy on Black and other minoritized women's health in the United States, which contributes to excess morbidity and mortality.[25] The privatized and fragmented US health care system exacerbates these overall patterns of structural racism, which leads to gross disparities in the availability and quality of health services. For instance, in rural and low-income areas, the lack of hospitals providing obstetric care has produced "maternity care deserts" because "childbirth doesn't pay, at least not in low-income communities."[26]

Likewise, the privatization of health care in low- and middle-income countries, and the introduction of public-private partnerships, has been shown to exclude remote rural communities and increase out-of-pocket costs for reproductive and maternal health care.[27] At the same time, austerity has exacerbated health care worker shortages and disparities in health care worker density between low- and high-income countries.[28] Among other things, the post-pandemic austerity now being pushed by the International Monetary Fund includes imposing draconian wage caps on public sector workers, which drives nurses and other health providers out of health workforces and often out of their countries.[29]

Globally, health systems are drastically underfunded, understaffed, and overcrowded. As a result of this underfunding, roughly a third of women do not have even half of the recommended antenatal checks or receive essential postnatal care, while some 270 million women lack access to modern family planning methods.[30] In the aftermath of the COVID-19 pandemic, the World Bank estimates that 41 governments will spend even less on health in 2027 than they did in 2019, before the pandemic.[31]

Not only does underfunding lead to more maternal deaths; it also leads to the disrespect and abuse of gestating persons seeking health care.[32] For example, a disturbingly common practice in many countries, including Nigeria and the Philippines, is the detention of people who recently gave birth and are unable to afford their hospital charges.[33] This practice is itself a gross violation of human rights and dignity. Further, it discourages people from going to the hospital in the first place, thereby increasing the risk of maternal and infant death.

Advancing maternal health rights in this context requires urgently shifting health financing away from privatized models and social insurance that fails to address inequities in the formal versus informal labor economies. Maternal health depends on sustained public funding for robust primary care systems, together with adequate referral and communications networks and emergency care. Moreover, we know in global health that these elements are indispensable for strengthening health systems more broadly, for achieving meaningful

universal health coverage, and for health security.[34] As the WHO Council on the Economics of Health for All states:

> *Rather than invest in healthcare industries and regulate the market to realize important but marginal and often unequal gains for health, we must first set ourselves ambitious goals to achieve Health for All and then work towards the goals by designing financial architecture and an economic system that can deliver on this mission.*[35]

Lesson three: The political economy of global health must be centered in advocacy.

Increasing funding for maternal health must be connected to the political economy of global health. Global health outcomes are heavily determined by political, economic, and commercial power structures.[36] There is simply not enough resource mobilization capacity in low-income countries to finance universal, resilient health systems. For 34 low-income countries alone, the annual external financing gap in health before the pandemic was estimated to be US$50 billion and is now far more, coupled with renewed austerity imposed in the aftermath of the pandemic.[37]

Moreover, loan conditionalities often mean that heavily indebted countries cede control of their spending policies in favor of "fiscal consolidation," or austerity. As mentioned above, after the pandemic new waves of austerity measures are being imposed across the majority of the world.[38] Austerity affects maternal health in a panoply of ways, including (1) in the health system, such as through wage cuts and layoffs of health personnel; increases in co-pays and out-of-pocket expenses, even for critical services such as antenatal and delivery care; reduced benefit packages or changes to eligibility criteria; disrupted access to insurance; and cuts to sexual and reproductive health; (2) indirectly, through cuts in the education sector; reductions in food-assistance and security programs; and reduced funding for temporary housing/shelters and housing subsidies that poor women and other reproductive subjects depend on; and (3) generally, through reduced unemployment support and the tightening of targeted social programs disproportionately needed by women and children.[39]

In advancing maternal health rights, we need to continually underscore and connect the dots regarding how the political economy of global health systematically perpetuates health disparities in the Global South, and how poor and marginalized women and girls are inevitably among the most affected.

Lesson four: Litigation is part of a toolkit, not a go-it-alone strategy.

Thirty years ago, a principal aim of applying human rights to health, including maternal health, was to advance legal accountability for ensuring entitlements to care. There has been a growing trend in MMM legal advocacy to seek the legal enforcement of the right to safe motherhood through domestic and international courts—much of which has yielded positive judgments. However, we have also learned that litigation must be embedded in broader social and political mobilization strategies.

For example, in 2011, the Center for Health, Human Rights, and Development filed suit with the Ugandan Constitutional Court, arguing that the government had failed to provide the necessary health care to avoid the preventable maternal deaths of two Ugandan women in 2009 and 2010.[40] Both women had suffered from obstructed labors and were denied care after refusing to pay bribes to medical personnel.[41] Between the filing of the initial petition and the final 2020 judgment, which produced a judicial construction of the right to maternal health care, a massive social mobilization was created and sustained: 29 grassroots organizations were brought together to form the "Coalition to Stop Maternal Mortality," which at one point mobilized over one thousand people.[42] Moreover, a positive judgment is an inflection point, not the end of the struggle. In the wake of the Constitutional Court's landmark judgment finding that Uganda's failure to adequately provide basic maternal health care services in public health facilities violated women's rights to health and life, the Center for

Health, Human Rights, and Development and the grassroots coalition have continued to mobilize to ensure implementation.[43]

Supranational judgments may face even greater obstacles to translate standards into institutional practices and enjoyment in practice. For example, in 2011 the UN Committee on the Elimination of Discrimination against Women issued a landmark decision in *Alyne da Silva v. Brazil*, the first case regarding maternal death decided by an international human rights body.[44] As Rebecca Cook wrote at the time, "Maternal deaths can no longer be explained away by fate, by divine purpose or as something that is predetermined to happen and beyond human control. Maternal deaths are preventable, and when governments fail to take the appropriate preventive measures, that failure violates women's human rights."[45] Not only did the committee find that Brazil's failure to provide emergency obstetric care was discriminatory, but it explicated intersectional discrimination on the basis of gender, class, and Afro-descendance and set out states' obligations to regulate private actors.[46] The committee recommended appropriate reparations, including financial compensation, to the victim's family, together with a series of systemic reforms aimed at guaranteeing non-repetition.[47]

However, an analysis by a follow-up commission in 2015 found several important gaps in Brazil's compliance with the recommendations of the Committee on the Elimination of Discrimination against Women, including a national plan of action and program ("Stork Network") rooted in RMNCAH as opposed to SRHR, which omitted key aspects of reproductive justice, and a failure of accountability and oversight at multiple levels.[48] Politics also soon intervened, with political dysfunction producing the election of Jair Bolsonaro, who normalized misogynistic and homophobic discourses and set about cutting health and social protections, with disproportionate effects on poor, Afro-descendant women.[49]

In short, litigation is neither the beginning nor the end of any advocacy on maternal health—or any systemic health issue, for that matter. Judicial involvement can critically change the landscape of politics and convert the tragedy of MMM into a broader injustice that calls for institutional legal remedies.[50] Yet, when courts place substantial demands on states with weak institutional capacities, or when judgments remain unmoored from broader social and political movements, they risk suffering from a lack of compliance and undermining public faith in the legal system to improve people's lives in practice.

Lesson five: We need to use metrics that actually tell us why women are dying and what to do.

Sèye Abímbólá argues that the gaping distance between knowledge and the actual delivery of care in global health arises "when people with resources to address delivery problems do not have the information or motivation to either make the discoveries available or tailor them to local circumstances" and when "feedback between actors at the global and national level, the national and subnational level, or the subnational level and the community, or between any of the parties to these combinations" does not work.[51] In short, "it is present when there are asymmetries of power, motivation and information between the helper and the helped."[52] The disconnect between the collection of algorithmically generated data by global institutions, such as the Institute for Health Metrics and Evaluation, and the people who need information to save lives is keenly evident in maternal health.

As noted above, the sole MDG relating to reproductive health was MDG 5, which called for the reduction of maternal mortality by three-quarters between 1990 and 2015, measured by maternal mortality ratios.[53] Such ratios are notoriously difficult to estimate due to statistical and practical reasons, and they do not translate into programmatic actions. They are calculated using algorithms that are based on inputs regarding the number of women of reproductive age, the percentage of women with HIV/AIDS, and other factors. Maternal mortality ratios are not actionable at the facility level, or even sometimes at national level given differing statistical capacities, and do not indicate the drivers of maternal death patterns among diverse populations.[54] Renewed efforts to legislate maternal death

reviews to examine causal factors in specific cases without punitively sanctioning frontline health workers are urgently needed.[55]

However, it is far past time for investment in national vital registration systems to track maternal deaths and other issues critical to SRHR. Further, indicators should be relevant to policy making and sensitive to policy interventions. We have process indicators relating to the availability and utilization of emergency obstetric and neonatal care, or EmONC, which are essential to use, along with outcome indicators.[56] The EmONC indicators focus on signal functions that can be monitored continuously and which literally *indicate* what may be driving maternal deaths, from lack of access to stored blood to delays in communication or referral. As a result, they allow for assessing compliance with international obligations and holding governments accountable for adopting "appropriate measures" on a nondiscriminatory basis, as is required under human rights law.

How indicators are used in global health is also problematic. For example, in part driven by imperatives set by international institutions such as the World Bank, skilled birth attendance has in practice translated into a measurement of institutional deliveries. When a facility does not have actual skilled birth attendance or the capacity to provide emergency obstetric care, that elision merely serves to drive overcrowding at facilities that produces breeding grounds for disrespect and abuse.[57]

As opposed to the MDGs, the Sustainable Development Goals were intended to be interdependent—so reproductive health was understood as linked to gender equality. However, in practice, donors' preferences for easy, fast, and cheap solutions still do not mesh well with the nuanced, complicated, and multifaceted problems involved in sexual and reproductive justice. What we measure is what gets funded, and advocates need to ensure that as the successor framework to the Sustainable Development Goals is now beginning to be discussed, we get the metrics right. It is long past time to track maternal health in ways that allow for actionable knowledge and corrective actions.

Conclusion

At a time when we face multiple complex crises in global health that challenge our current knowledge and capacities, maternal mortality is a problem we can solve. We have the tools and frameworks to improve the embodied lives of women and pregnancy-capable persons and advance maternal health rights. As renowned obstetrician Mahmoud Fathalla aptly noted in 2006, "Women are not dying of because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving."[58] Rajat Khosla and Flavia Bustreo argue that the stagnation and retrogression on maternal mortality in recent years reflect "a systematic erosion in commitment by governments and donors" to women's health and rights that should not just be ascribed to the COVID-19 pandemic.[59]

We cannot continue to allow national and global health leaders to cynically lament maternal deaths as tragedies. These painful and horrific deaths are the foreseeable consequence of global and national orders that relegate women's lives to insignificance. In human rights, we have learned crucial lessons from the last 30 years; now is the time for UN agencies, advocacy organizations, national governments, and donors to put them into practice.

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