Justice for Women and Society: The Case of Obstetric Fistula

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Obstetric fistula, a preventable childbirth injury, afflicts 2–3 million women worldwide. Obstetric complications of obstructed labor, such as when cephalo-pelvic disproportions prevent the baby from exiting the birth canal, can lead to abnormal tracts forming between the vagina and the rectum or bladder. Whereas 50,000–100,000 new cases develop in low- and middle-income countries annually, obstetric fistula has been eliminated since the late nineteenth and early twentieth centuries in high-income countries through standardizing health-provider training, increasing access to obstetric care, and improving surgical techniques. Over the past twenty-five years, human rights efforts—for example, the United Nations' Millennium Development Goals on maternal health and Campaign to End Fistula—have emerged as the prevailing international approach to reducing maternal morbidity and mortality. This Article advances a unified theory of justice and health, grounded in the health capability paradigm at the domestic level, provincial globalism at the global level, and shared health governance as a theoretical foundation for maternal health policy and specifically as a standard and guide for obstetric fistula. At the same time, this Article critically examines current approaches, including human rights, international law, and bioethical principlism, identifying normative, conceptual, and practical challenges with these movements.

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INTRODUCTION

Obstetric fistulas are formed when prolonged obstructed labor from cephalopelvic disproportion prevents the baby from exiting the birth canal,[1] resulting in obstetric complications such as abnormal tracts developing between the vagina

1. Cephalopelvic disproportion occurs when a fetus's head is too large for the birth canal. L. Lewis Wall, *A Framework for Analyzing the Determinants of Obstetric Fistula Formation*, 43 STUD. FAM. PLAN. 255, 261 (2012).

and rectum or bladder.[2] As part of the obstructed labor injury complex, fistula formation is comorbid with serious consequences including fetal death, total urethral loss, anal sphincter incompetence, stress incontinence, chronic skin irritation due to incontinence, rectal atresia, cervical destruction, secondary infertility, amenorrhea, renal failures, pelvic inflammatory disease, vaginal scarring, vaginal stenosis, musculoskeletal injury, and foot-drop, as well as negative neurologic, sexual, and psychological impacts including post-traumatic stress disorder (PTSD), depression, suicidal ideation, and social stigmatization.[3] An estimated 2–3 million women suffer from vaginal fistulas,[4] and 50,000–100,000 new fistula cases arise annually worldwide.[5] Although obstetric fistula has been virtually eliminated in high-income countries (HICs) since the late nineteenth and early twentieth centuries, women in low-and middle-income countries (LMICs) continue to suffer from unacceptably high rates of this treatable and preventable tragedy.[6] Because the costs and benefits of maternal health are unfairly distributed throughout the world, a theory of justice is needed to provide principles to right this wrong. An ethical solution to this problem must be sufficiently multifaceted to address both domestic and global ethical queries; thus, a theory that unifies principles of global and domestic justice and health is needed.

A paradigm shift undergirded by principles of justice is needed to address the prevalence and incidence of obstetric fistula, leading to eventual eradication of fistula and its traumatic sequelae. This Article advances a multilevel theory of justice and health comprised of three paradigmatic analytical components: (1) the health capability paradigm (HCP) at the domestic level, (2) provincial globalism (PG) at the global level, and (3) shared health governance (SHG). The interplay of HCP, PG, and SHG is a combined framework of justice and health that forms a theoretical and policy foundation for maternal health, and a standard and guide for eradicating obstetric fistula. At the same time, this Article critically identifies and examines substantial normative, conceptual, and practical issues with current approaches to obstetric fistula of human rights, international law, and bioethical principlism.

Differential rates of obstetric fistula incidence and prevalence between HICs and low-income countries (LICs) reflect significant levels of persistent health inequity, which current approaches, although laudable, have been unable to mitigate. Within HICs, standardization of health-provider training, improved access to obstetric care, and improved surgical techniques have eradicated obstetric

2. Types of obstetric fistulas include vesicovaginal fistula (between bladder and vagina), rectovaginal fistula (between rectum and vagina), and urethrovaginal fistula (between urethra and vagina). L. Lewis Wall, *Obstetric Vesicovaginal Fistula as an International Public-Health Problem*, 368 LANCET 1201, 1201–04 (2006).

3. *See id*. at 1203, 1205.

4. *Id*. at 1201.

5. Cynthia Stanton et al., *Challenges in Measuring Obstetric Fistula*, 99 INT'L J. GYNECOLOGY & OBSTETRICS S4, S5 (2007).

6. *See* Wall, *supra* note 1, at 257–59.

fistula since the late nineteenth century.[7] Twenty-first century studies have found low rates of vesicovaginal fistula incidence in HICs; the vast majority of fistulas in HICs are iatrogenic, rather than obstetric, in origin.[8] Yet, 95% of urogenital fistulas in LICs are of obstetric etiology,[9] and 45% are due to obstructed labor.[10] While obstructed labor is a natural risk of childbirth, disparities in skilled birth attendance,[11] antenatal care, and adolescent childbearing that are common in LMICs, particularly rural areas,[12] exacerbates its risks and negative consequences. Malnutrition, early marriage and childbirth, and lack of access to obstetric care fuel obstetric fistula formation,[13] whose sufferers face severe social stigmatization and psychiatric distress.[14]

Disparities in obstetric fistula incidence and prevalence between LICs and HICs have persisted despite global efforts to address the surmountable risk factors contributing to obstetric fistula formation.[15] Even with dramatic prevention and treatment successes in HICs and some South Asian LMICs, the disease burden of fistula remains heavy. International organizations, including the United Nations and foreign humanitarian missions have tried to fight the expanding numbers of obstetric fistula patients with limited success.[16] Over the past twenty-five years, human rights within the international legal framework has emerged as the

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7. Vincent De Brouwere et al., *Strategies for Reducing Maternal Mortality in Developing Countries: What Can We Learn from the History of the Industrialized West?*, 3 TROPICAL MED. & INT'L HEALTH 771, 775 (1998); T. E. Elkins, *Fistula Surgery: Past, Present and Future Directions*, 8 INT'L UROGYNECOLOGY J. 30, 31–32 (1997).

8. Karyn Schlunt Eilber et al., *Ten-Year Experience with Transvaginal Vesicovaginal Fistula Repair Using Tissue Interposition*, 169 J. UROLOGY 1033, 1034 (2003).

9. For example, because of pregnancy, childbirth, or the postpartum period.

10. Christopher J. Hillary et al., *The Aetiology, Treatment, and Outcome of Urogenital Fistulae Managed in Well- and Low-Resourced Countries: A Systematic Review*, 70 EUR. UROLOGY 478, 487 (2016).

11. Skilled birth attendance refers to the presence of a trained and accredited health professional (for example, a midwife, nurse, or doctor) during delivery. *See generally* WORLD HEALTH ORG., MAKING PREGNANCY SAFER: THE CRITICAL ROLE OF THE SKILLED ATTENDANT (2004), https://apps.who.int/iris/bitstream/handle/10665/42955/9241591692.pdf;jsessionid=3E62EFA2F6DF72BA1C7B520CC1CEE636?sequence=1 [https://perma.cc/EC8Y-REEW] (defining and listing skills and abilities of a skilled birth attendant).

12. *See* UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 8, 9, 42 (2015), https://www.undp.org/content/undp/en/home/librarypage/mdg/the-millennium-development-goals-report-2015/ [https://perma.cc/5MSF-P4W2].

13. SOUREN TEGHRARIAN & KATE RAMSEY, U.N. POPULATION FUND, REPORT ON SOUTH ASIA CONFERENCE FOR THE PREVENTION & TREATMENT OF OBSTETRIC FISTULA 7, 16 (2003).

14. A. Browning et al., *The Impact of Surgical Treatment on the Mental Health of Women with Obstetric Fistula*, 114 BRIT. J. OBSTETRICS & GYNAECOLOGY 1439, 1439 (2007); *see* MANISHA MEHTA & MAGGIE BANGSER, WOMEN'S DIGNITY PROJECT & ENGENDER HEALTH, RISK AND RESILIENCE: OBSTETRIC FISTULA IN TANZANIA 27 (2006); Mulu Muleta et al., *Health and Social Problems Encountered by Treated and Untreated Obstetric Fistula Patients in Rural Ethiopia*, 30 J. OBSTETRICS & GYNAECOLOGY CAN. 44, 49 (2008).

15. *See* Mathieu Maheu-Giroux et al., *Risk Factors for Vaginal Fistula Symptoms in Sub-Saharan Africa: A Pooled Analysis of National Household Survey Data*, BMC PREGNANCY & CHILDBIRTH, Apr. 21, 2016, at 2, 7; TEGHRARIAN & RAMSEY, *supra* note 13, at 4–6, 8, 12.

16. *See, e.g.*, G.A. Res. 69/148, Intensification of Efforts to End Obstetric Fistula, ¶ 12 (Dec. 18, 2014), https://undocs.org/en/A/RES/69/148 [https://perma.cc/E7LC-RMF4]; TEGHRARIAN & RAMSEY, *supra* note 13, at 8–9.

leading international approach to reducing high rates of maternal morbidity and mortality. The United Nations has explicitly adopted the human rights model as its underpinning in pursuing both its Millennium Development Goals of improving maternal health[17] and in its Campaign to End Fistula.[18] However, human rights remain devoid of a theoretical, normative justification to effectuate human rights fulfilment for fistula eradication. Accordingly, maternal health outcome discrepancies, and the injustice of obstetric fistula specifically, remain in need of a foundational theory of justice and health.

Since 2003, the United Nation's Campaign to End Fistula has completed more than 100,000 fistula repairs involving fifty-five countries, thirty-eight of which completed a fistula prevention and treatment situation analysis; trained more than 2,000 healthcare workers in fistula care; encouraged better data acquisition and sharing, such as from national demographic and health surveys (DHS); and increased international attention to fistula.[19] More recent reports state that twenty-three of sixty affected countries have national elimination strategies,[20] thirty of which have national task forces and 85,000 midwives have been trained and are providing services.[21] Though these achievements are laudable, the "Global Fistula Map" indicates increasing numbers of women with fistula, as new cases outnumber repairs.[22] In 2018, 82% of countries supported by the United Nations Population Fund's (UNFPA) Maternal Health Thematic Fund (MHTF) reported their fistula treatment services were inadequate

17. *See* U.N. Human Rights Council, Rep. of the Office of the U.N. High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights, ¶ 8, U.N. Doc. A/HRC/14/39 (Apr. 16, 2010), https://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.39_AEV-2.pdf [https://perma.cc/84G9-ULPU].

18. *Persistence of Fistula Is a Human Rights Violation, Says UNFPA Deputy Executive Director Dr. Natalia Kanem*, CAMPAIGN TO END FISTULA (Oct. 10, 2016), http://www.endfistula.org/news/persistence-fistula-human-rights-violation-says-unfpa-deputy-executive-director-dr-natalia [https://perma.cc/9HQB-A4NY].

19. *See* BASARANKUT ET AL., U.N. POPULATION FUND, CAMPAIGN TO END FISTULA, THE YEAR IN REVIEW: ANNUAL REPORT 2008, at 3–4, 19 (2008), https://www.unfpa.org/sites/default/files/pub-pdf/fistula_annual_report_2008.pdf [https://perma.cc/DYF7-QVMP]; U.N. POPULATION FUND, MATERNAL HEALTH THEMATIC FUND, TOWARDS THE 2030 AGENDA: LEAVING NO ONE BEHIND IN THE DRIVE FOR MATERNAL HEALTH: ANNUAL REPORT 2015, at 42 (2015) [hereinafter U.N. POPULATION FUND, TOWARDS THE 2030 AGENDA], https://www.unfpa.org/sites/default/files/pub-pdf/2015_MHTF_Annual_Report-FINAL-web.pdf [https://perma.cc/EBB9-QK4B]; *Fistula Is a Human Rights Violation – End it Now!*, CAMPAIGN TO END FISTULA (May 23, 2019), https://perma.cc/6B5Z-KDKH.

20. U.N. Secretary-General, INTENSIFYING EFFORTS TO END OBSTETRIC FISTULA WITHIN A GENERATION, ¶ 27, U.N. Doc. A/73/285 (July 31, 2018), http://www.endfistula.org/sites/default/files/pub-pdf/SG_Report_Fistula_2018_FINAL.pdf [https://perma.cc/ZKY4-K662].

21. U.N. POPULATION FUND, THE MATERNAL HEALTH THEMATIC FUND, ANNUAL REPORT 2017 AND REVIEW OF PHASE II (2014–2017), at v, http://www.endfistula.org/sites/default/files/pub-pdf/UNFPA_PUB_2018_EN_MHTF_AnnualReport2017.pdf [https://perma.cc/VDV7-KTWY].

22. Brittany Star Hampton et al., *Urinary Fistula and Incontinence*, 33 SEMINARS REPROD. MED. 47, 47 (2015); Margo S. Harrison et al., *Urogenital Fistula Reviewed: A Marker of Severe Maternal Morbidity and an Indicator of the Quality of Maternal Healthcare Delivery*, MATERNAL HEALTH, NEONATOLOGY, & PERINATOLOGY, Aug. 19, 2015, at 2, 6.

and inequitable.[23] The United Nations has recognized inadequate results: the General Assembly stated in a 2014 resolution that it was "deeply concerned" with the significant challenges that remained ten years after the Campaign to End Fistula launched.[24] A 2015 five-year review found that few countries had reallocated resources to the health sector despite promises to do so, and only fifteen out of fifty participating countries had developed five-year plans to end fistulas.[25] Much remains to be done to decrease obstetric fistula incidence and prevalence.

Obstetric fistula poses significant ethical and policy challenges to the global health community, which has not identified a viable, evidence-based strategy toward the eradication of this preventable condition. Current approaches to obstetric fistula have been limited by their individualistic, downstream, ad hoc, "pick and mix," and vertical approaches.[26] The current set of approaches lacks systematic relationships among principles of justice at both the domestic and global levels due to lack of a theoretically unified underlying basis. This Article presents a unifying moral theory of justice and health that provides principles of justice and a theory of responsibility allocation to guide the behavior and actions of moral agents.

This justice and health approach to obstetric fistula applies a coherent and comprehensive moral theory with three main paradigmatic components: (1) the health capability paradigm (HCP) at the domestic level, (2) provincial globalism (PG) at the global level, and (3) shared health governance (SHG). HCP is comprised of health capabilities, health functioning, and health agency, with the aim of achieving equity of central health capabilities. It is normatively undergirded by the substantive concept of human flourishing and the conceptual procedure of transpositionality. PG augments the normative foundation of HCP for global health justice, incorporating principles of ethical individualism, proportionality, and the measurement theory of shortfall inequality, also found in HCP. Finally, SHG, applied at the global level, consists of a theory of global health governance that involves public moral norms, incompletely theorized agreements, joint ethical commitments, and capability-based responsibility allocation to eradicate obstetric fistula and work toward global health justice.

Together, HCP, PG, and SHG embody an alternative approach to global and domestic health justice and governance that addresses current global health problems, including obstetric fistula. The justice and health approach has distinct advantages compared to approaches of human rights, international law, and

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23. U.N. POPULATION FUND, THE MATERNAL HEALTH AND NEWBORN HEALTH THEMATIC FUND, ANNUAL REPORT 2018, at 14, https://www.unfpa.org/sites/default/files/pub-pdf/013_MHTF_Annual_report_15-online.pdf [https://perma.cc/7ENL-KFWL].

24. G.A. Res. 69/148, *supra* note 16, at 3.

25. U.N. Secretary-General, *Intensifying Efforts to End Obstetric Fistula*, ¶¶ 17–18, U.N. Doc. A/71/306 (Aug. 5, 2016), https://undocs.org/A/71/306 [https://perma.cc/GG6T-32T3].

26. *See generally* K. Danner Clouser & Bernard Gert, *A Critique of Principlism*, 15 J. MED. & PHIL. 219 (1990) (discussing the problems with principlism when dealing with moral problems); K. Danner Clouser & Bernard Gert, *Morality vs. Principlism, in* PRINCIPLES OF HEALTH CARE ETHICS 251 (Raanan Gillon ed., 1994) (a general critique of "pick and mix" approaches, such as principlism, to ethics).

bioethical principlism, which have made progress in advancing some aspects of maternal health but have fallen short in eradicating obstetric fistula. HCP/PG/SHG is a cohesive, unifying framework that provides a coherent theoretical basis for understanding the systematic relationships among principles and values, at both the domestic and global levels, that are required to address an ethical problem with global and domestic dimensions. HCP/PG/SHG envisions a world where obstetric fistula is completely eradicated, so that all women have better opportunities to lead healthy, flourishing lives, regardless of where in the world they were born.

I. HUMAN FLOURISHING

Human flourishing is an underlying principle for the theory of justice which integrates the paradigmatic components of HCP/PG/SHG. Undergirding HCP/PG/SHG is the concept of human flourishing—the substantive freedom and ability to live a good life—defined as a set of valuable beings and doings, applicable to all human lives.[27] As a common human aim that promotes everyone's interests regardless of location, relationship, or community,[28] human flourishing provides a necessary, substantive, and robust theoretical foundation for eradicating fistula.

Currently, the human rights approach frames access and care as valuable primary goods, focusing on the right-holders' abilities to make claims for such goods. Rather than pursuing changes in the tangible enjoyment of rights, it focuses on the mechanisms for service delivery.[29] However, hospitalization alone has failed to effectuate the expected extent of decreased morbidity and mortality.[30] This strict deontological scope, centered on the means to health rather than health per se, falls short of achieving equitable health outcomes. Duties to offer and facilitate access to services may be fully met, but low participation and suboptimal outcomes may nonetheless persist.

The right to health is operationalized deontologically and legally, focusing on the possession of rights as sufficient and legally binding to effectuate claims from rights holders. Due to biological and genetic factors, as well as complex social systems influencing health, the right to health is rarely interpreted as the right to be healthy. For example, the Millennium Development Goals Report measures maternal mortality reductions through skilled birth attendance and universal access to reproductive health through antenatal care, adolescent childbearing, and

27. *See* JENNIFER PRAH RUGER, HEALTH AND SOCIAL JUSTICE 48 (2010).

28. *See* JENNIFER PRAH RUGER, GLOBAL HEALTH JUSTICE AND GOVERNANCE 81–82, 85, 91–92 (2018).

29. *See* Varun Gauri, *Social Rights and Economics: Claims to Health Care and Education in Developing Countries*, 32 WORLD DEV. 465, 466 (2004); Hans Peter Schmitz, A HUMAN RIGHTS-BASED APPROACH (HRBA) IN PRACTICE: EVALUATING NGO DEVELOPMENT EFFORTS, 44 POLITY 523, 536 (2012).

30. *See* Robert F. Porges, *The Response of the New York Obstetrical Society to the Report by the New York Academy of Medicine on Maternal Mortality, 1933–1934*, 152 AM. J. OBSTETRICS & GYNECOLOGY 642, 644 (1985). David Sando et al., *The Prevalence of Disrespect and Abuse During Facility-Based Childbirth in Urban Tanzania*, BMC PREGNANCY & CHILDBIRTH, Dec. 2016, at 1.

contraceptive use.[31] However, these vertical, biomedical interventions and service-uptake behavioral efforts have failed to follow through with tangible outcomes, often creating structures that perpetuate systemic paternalism and discrimination against girls and women.[32] Moreover, countries such as Saudi Arabia, Iran, and Algeria with poor sexual and reproductive health rights but good maternal health outcomes suggest that sexual and reproductive health rights alone are neither sufficient nor necessary to reduce maternal mortality.[33] Thus, more than a narrowly construed human rights approach is required to guide health policy to address maternal health.[34]

A checklist of bioethical principles also obscures the full range of moral obligations and options to promote human flourishing. Bioethical principlism identifies ethical principles, pursues redress, and discharges all identified moral obligations.[35] Bracketing cases when bioethical principles are utilized in bad faith as a cover for medical paternalism, a checklist gives inadequate reassurances where moral obligations may remain unaddressed, such as expressing regret, apologizing, making amends, and securing the patient's trust.[36] The adversarial framing of autonomy and interpersonal connection under bioethical principlism contributes to this narrowness.[37] Portraying these two ways of relating as mutually exclusive overlooks their interrelations and overlaps,[38] creating a false beneficence–autonomy dichotomy[39] which attributes health failings to patients' poor choice rather than the clinical and moral responsibility of healthcare providers.[40] Moreover, blindness to the patient–provider dynamic is especially harmful when dealing with individuals at an informational or social disadvantage.

Under HCP and PG, health is an intrinsically valuable and instrumentally important dimension of human flourishing; health itself, rather than healthcare, is the end of medicine and the primary objective of health policy. Inequitable access to health care is unjust, because of its inequitable effects on health. Although opportunities and processes are both intrinsically and instrumentally valuable, resources are means with instrumental rather than intrinsic value, and healthcare services are only morally important insofar as they enhance health capability.[41] A

31. *See* UNITED NATIONS, *supra* note 12, at 39–42.

32. *See* Oluwakemi C. Amodu et al., *Obstetric Fistula Policy in Nigeria: A Critical Discourse Analysis*, BMC PREGNANCY & CHILDBIRTH, June 27, 2018, at 6.

33. Olivier Weil & Hervé Fernandez, *Is Safe Motherhood an Orphan Initiative?*, 354 LANCET 940, 941 (1999).

34. *See* John Tasioulas & Effy Vayena, *The Place of Human Rights and the Common Good in Global Health Policy*, 37 THEORETICAL MED. BIOETHICS 365, 376 (2016).

35. *See* Autumn Fiester, *Why the Clinical Ethics We Teach Fails Patients*, 82 ACAD. MED. 684, 686 (2007).

36. *See* Donald C. Ainslie, *Bioethics and the Problem of Pluralism*, 19 SOC. PHIL. & POL'Y 1, 26 (2002); Fiester, *supra* note 35, at 689.

37. *See* Anne Donchin, *Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethical Principles*, 26 J. MED. & PHIL. 365, 373–74 (2001).

38. *See id.*

39. Fiester, *supra* note 35, at 689.

40. *See* Donchin, *supra* note 37, at 375.

41. *See* PRAH RUGER, *supra* note 27, at 45–47.

health capability perspective explains the finding that, in addition to service access, optimal health outcomes require long-term trust between patients and systems[42]—financial and infrastructural resource allocation alone are insufficient.[43] Accordingly, the high prevalence of preventable death and disease embodied by obstetric fistula implies public policies and the health sector are failing to develop health capabilities.[44] At a macrosocial level, a critique of human rights is that it aims to implement international norms and standards through legal tools rather than changing the power relations of local struggles.[45] The consequentialist criteria of HCP and PG accounts for these challenges by incorporating outcomes into its understanding of justice and providing a critical analysis of underlying power relationships.

As a key dimension of human flourishing, health capability encompasses a wide range of ethical obligations and options. This entails, for example, costed, timed, national plans to fistula eradication, a demonstrably achievable goal.[46] Moreover, HCP accommodates the intuitions of injustice that persist even when access to healthcare services is improved, because the full range of ethical obligations to and options for health capability includes immaterial social goods such as norms, ethical engagement, and health agency development.[47] For example, in addition to catastrophic and impoverishing spending, financial barriers to health include: inability to pay; illness vulnerability; economic vulnerability such as underinsurance; informal payments; debt or credit financing; diminished ability to repay loans; diminished ability to afford means of production; indirect costs of illness such as income loss and opportunity costs; coping strategies that are costly to current or future consumption or savings; and loss of household economic and health security over time.[48]

HCP is an ethical framework that addresses these numerous challenges. Barriers to health services must be addressed to the extent that they interfere with the goal of promoting human flourishing. Case studies of societal maternal health improvements have demonstrated the success of synergistic packages of health and social services that specifically reach out to the poor, such as telephone

42. *See* L. Lewis Wall, *Overcoming Phase 1 Delays: The Critical Component of Obstetric Fistula Prevention Programs in Resource-Poor Countries*, BMC PREGNANCY & CHILDBIRTH, July 18, 2012, at 10.

43. *See* Candace Johnson, *Health as Culture and Nationalism in Cuba*, 31 CANADIAN J. LATIN AM. & CARIBBEAN STUD. 91, 110 (2006) (noting Cuba as an example of a country that has a more just healthcare system as a result of notable effort).

44. *See* PRAH RUGER, *supra* note 27, at 90–91.

45. *See* Sarah Hamed et al., *Powerlessness, Normalization, and Resistance: A Foucauldian Discourse Analysis of Women's Narratives on Obstetric Fistula in Eastern Sudan*, 27 QUALITATIVE HEALTH RES. 1828, 1839 (2017).

46. *See* U.N. POPULATION FUND, MATERNAL HEALTH THEMATIC FUND, TOWARDS EQUALITY IN ACCESS, QUALITY OF CARE AND ACCOUNTABILITY: PHASE II (2014-2017) – PROGRESS REPORT 13–15 (2017) [hereinafter U.N. POPULATION FUND, TOWARDS EQUALITY IN ACCESS], https://www.unfpa.org/sites/default/files/pub-pdf/51375_MHTF_AnnualReport_web.pdf [https://perma.cc/3J5P-FMT4].

47. *See* Jennifer Prah Ruger, *Global Health Justice and Governance*, 12 AM. J. BIOETHICS 35, 39 (2012).

48. *See* Jennifer Prah Ruger, *An Alternative Framework for Analyzing Financial Protection in Health*, 9 PLOS MED., Aug. 2012, at 1.

hotlines and mobile clinics.[49] These interventions promote health capabilities because they strike a balance between vertical, isolated access to service and attempting to take on all the social factors that influence health. A substantive conception of the human good that prioritizes human flourishing enables HCP to robustly uphold moral objectives of health equity to deontological and consequential criteria.[50]

II. TRANSPOSITIONALITY

A unified normative grounding is also imperative because latent conceptions and multiple interpretations of the good underlie the universality of current approaches. Transpositionality serves as a unified and substantive perspective consistent with HCP's and PG's dual consequential–deontological approach, while also serving to independently substantiate HCP's and PG's consequential and deontological sources of legitimacy. The right to health suffers from a lack of concrete definition, which undermines its operationalization, implementation, and adjudication. The World Health Organization's (WHO) definition of health is broad, but social determinants of health literature suggest that an individual, clinical definition of health is narrow.[51] The pitfalls of an indeterminate ethical foundation are apparent when particular agendas, populations, or diseases are able to employ liberal, human rights rhetoric and infrastructure as a vehicle for hidden or alternative political agendas. For example, the HIV/AIDS community has been able to use the right to health approach to secure resources for its mission, but this approach does not secure the right to health for whole populations.[52] Scaling up comprehensive, prenatal through postnatal, universal obstetric care provision in the neediest seventy-five LMICs would require $39 billion, only 32% of the $122.5 billion invested in the global HIV/AIDS response as of 2012.[53]At the global health governance level, a critique of international human rights organizations, including the United Nations, is that their use of "power politics" of intergovernmental coalitions intimidates individual governments.[54]

The lack of a coherent high-level objective under the current approach undermines collaboration, creating instability and the need for alternative motivations to induce fistula eradication. The "dis/possession" framework of rights biases toward litigious adjudication.[55] Under a deontological framework of human rights

49. *See* INDRA PATHMANATHAN ET AL., WORLD BANK, INVESTING IN MATERNAL HEALTH: LEARNING FROM MALAYSIA AND SRI LANKA 8, 75 (2003); France Donnay & Kate Ramsey, *Eliminating Obstetric Fistula: Progress in Partnerships*, 94 INT'L J. GYNECOLOGY & OBSTETRICS 254, 256 (2006); *Intensifying Efforts to End Obstetric Fistula*, *supra* note 25, ¶ 26.

50. *See* PRAH RUGER, *supra* note 27, at 48.

51. *See id.* at 122; Tasioulas & Vayena, *supra* note 34, at 370.

52. *See* PRAH RUGER, *supra* note 28, at 150–51.

53. Harrison et al., *supra* note 22, at 6.

54. Annelie de Man, *Critiques of the Human Rights Framework as the Foundation of a Human Rights-Based Approach to Development*, 43 J. JURIDICAL SCI. 84, 96 (2018).

55. *See* Joel E. Correia, *Indigenous Rights at a Crossroads: Territorial Struggles, the Inter-American Court of Human Rights, and Legal Geographies of Liminality*, 97 GEOFORUM 73, 75 (2018).

and international law, negotiated settlements—particularly political ones needed to allocate scarce resources—inevitably appear as moral concessions or betrayals of principle.[56] Thus, the "inherent tension"[57] between bioethics, individual rights, and private morality, versus public health policy and values appears irresolvable.[58] Article 4 of the International Covenant on Economic, Social and Cultural Rights authorizes limiting individual rights on the grounds of public health.[59] In Cuba, democratic individual rights are often both practically and philosophically at-odds with public health.[60] In practice, appeals to self-interest and peer pressure ("naming and shaming," political pressure, economic sanctions, trade conditionalities) are needed to enforce government adherence to existing moral and political obligations, rectify violations, and commit to new health programs.[61] Repeated sections in the Sustainable Development Goals Global Strategy for Women's, Children's, and Adolescents' Health demonstrate how the lack of a high-level objective has been inappropriately filled by appeals to high returns on investments.[62]

The substantive conception of the common good, human flourishing, derives legitimacy from transpositionality—a view from everywhere. Grounded in empirical evidence – historically over time and comparatively across societies and cultures a transpositional perspective recognizes that health is a morally salient and central human interest that has been highly valued for decades across societies.[63] Whereas pure principlism does not adjust for pragmatic considerations or engage in the negotiations, experiments, and revisions necessitated by new experiences and empirical findings,[64] transpositionality works from human experience and knowledge rather than abstract theory with no basis in the reality of people's experiences.[65] This approach yields critical discoveries, such as the finding that maternal mortality is indeed perceived as a high priority problem warranting collective community action, even where women have lower social status.[66] In Sri Lanka, successful reductions of maternal mortality and morbidity have included public appeal to its historical cultural identity of having one of the oldest lie-in

56. *See* David A. Reidy, *A Right to Health Care? Participatory Politics, Progressive Policy, and the Price of Loose Language*, 37 THEORETICAL MED. BIOETHICS 323, 325 (2016).

57. Lawrence O. Gostin, *The Human Right to Health: A Right to the "Highest Attainable Standard of Health,"* 31 HASTINGS CTR. REP. 29, 29 (2001).

58. *See* Bernard M. Dickens & Rebecca J. Cook, *Reproductive Health and Public Health Ethics*, 99 INT'L J. GYNECOLOGY & OBSTETRICS 75, 76 (2007); Ainslie, *supra* note 36, at 19.

59. *See* International Covenant on Economic, Social and Cultural Rights, art. 4, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3, 5 (entered into force Jan. 3, 1976).

60. *See* Johnson, *supra* note 43, at 103.

61. *See* Schmitz, *supra* note 29, at 533; de Man, *supra* note 54, at 94.

62. *See* EVERY WOMAN EVERY CHILD, SUSTAINABLE DEVELOPMENT GOALS, THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016–2030), at 7, 16, 19 (2015).

63. Prah Ruger, *supra* note 47, at 38.

64. *See* Reidy, *supra* note 56, at 340–41.

65. *See* PRAH RUGER, *supra* note 28, at 133.

66. De Brouwere et al., *supra* note 7, at 776.

maternity waiting homes.[67] Appealing to a universal, objective conception of human flourishing that includes individual agency and empirical findings reconciles theoretical principles and empirical outcomes, as well as individual and societal interests.

III. HEALTH CAPABILITIES

HCP and PG conceptualize health capabilities—consisting of health functioning and health agency—as a central component of human flourishing. Functioning corresponds to realized actions, whereas agency correlates with potential actions. Health capabilities are thus a person's abilities to effectively pursue and achieve health goals.[68] The primary objective of HCP and PG is equality of individual abilities to achieve valuable health functionings, undergirded by a substantive and transpositional human flourishing foundation.[69] The development of internal, and external, individual and societal, health capabilities for obstetric fistula eradication gains a normative momentum, oriented around health and flourishing. HCP and PG also deontologically incorporate health agency as well as incorporating expertise in the joint scientific and deliberative approach.[70]

Unlike conventional approaches, focusing on health capabilities allows HCP to systematically and effectively address the complex coproduction of health. First, conventional approaches seek equal rights to clinical access, which often neglects social, economic, and cultural conditions that are critically relevant to obstetric fistula formation. Although civil, political, social, economic, and cultural rights constitute the human rights framework, international human rights law instruments distinguish "negative" civil and political rights from "positive" social, economic, and cultural rights.[71] For positive rights, legalistic concepts of causal responsibility are especially difficult to prove in complex, dynamic, emergent social systems. Accordingly, many countries fall short in providing legal protection for violations of social, economic, and cultural rights. Yet, for women at-risk for and living with obstetric fistula, even after transportation and free services are provided, many critical barriers to health persist due to social, economic, and cultural discrimination against poor women.[72] Poor hospital practices have led to fetal demise, hysterectomy, and obstetric fistula, even when women put into practice all national and international guidelines regarding institutional delivery.[73] Critical investigation into the experiences of fistula survivors indicates a "fourth delay" in information and access to fistula repair services that is primarily

67. Rohana Haththotuwa et al., *Models of Care That Have Reduced Maternal Mortality and Morbidity in Sri Lanka*, 119 INT'L J. GYNECOLOGY & OBSTETRICS S45, S46 (2012).

68. *See* PRAH RUGER, *supra* note 27, at 146.

69. *See id.* at 51.

70. *See infra* Parts IV, VII.

71. Gostin, *supra* note 57, at 30.

72. Donnay & Ramsey, *supra* note 49, at 256.

73. *See* Bonnie Ruder et al., *Too Long to Wait: Obstetric Fistula and the Sociopolitical Dynamics of the Fourth Delay in Soroti, Uganda*, 28 QUALITATIVE HEALTH RES. 721, 726 (2018).

due to macro-level social inequality, economic forces, and structural violence, rather than individual failures of agency.[74] Moreover, because negative rights also depend on legal recognition and protection by governments, they are ineffective when domestic capacity is limited or intention is lacking.

Similarly, the current bioethical principlism paradigm comprises a vertical emphasis on individual components. Applying the four principles of nonmaleficence, respect for autonomy, beneficence, and justice to each clinical case has left fistula efforts falling short of recognizing the multifaceted and holistic nature of health.[75] As part of bioethical principlism, the principle of justice applied to obstetric fistula has not constituted an unified theory. For example, its application has called for laudable goals of free medical and surgical care, local ownership of programs, microcredit cooperative financing, clinical efficiency, and specialized fistula-treatment centers.[76] These are useful ideas on their own, but as ad hoc and incomplete policy prescriptions, do not comprise an integrated and systematic approach required to eradicate obstetric fistula. "Tourist" surgeons visiting developing countries on short-term medical missions exemplify how moral duties that fall outside the scope of clinical interaction are overlooked. Ongoing attention and appropriate postoperative care are required to ensure complicated reconstructive operations done by visiting surgeons remain intact,[77] but moral duties of continuity of care are not apparent under this scope. Additionally, emphasizing surgical repair in the clinical setting forsakes providing guidance both for women whose incontinence persists after the fistula is closed (16%–32% of women[78]) and for the general psychosocial reintegration (for example, post-repair fertility and contraception[79]) that is integral to rehabilitating health capabilities.

Finally, a pure social determinants of health perspective discounts the limited ability of macrosocial development to directly improve health. Although the desire to recognize all human rights and fundamental freedoms as necessary for health[80] is laudable, given the complex, interrelated and causal mechanisms of health outcomes, simply modifying the general macrosocial conditions does not automatically guarantee consistent and equitable improvements for individuals' health capabilities. Although education and work opportunities have improved fistula outcomes, the relationship between maternal health and women's status and educational opportunities is neither direct nor straightforward, with unexpected

74. *Id*. at 730.

75. *See* L. Lewis Wall, *Ethical Issues in Vesico-Vaginal Fistula Care and Research*, 99 INT'L J. GYNECOLOGY & OBSTETRICS S32, at S33 (2007).

76. *See id*. at S34–35.

77. L. Lewis Wall et al., *Humanitarian Ventures or 'Fistula Tourism?' : The Ethical Perils of Pelvic Surgery in the Developing World*, 17 INT'L UROGYNECOLOGY J. 559, 560 (2006).

78. Wall, *supra* note 2, at 1204.

79. *See* Hampton et al., *supra* note 22, at 51; Harrison et al., *supra* note 22, at 5.

80. *See* Fourth World Conference on Women, *Beijing Declaration and Platform for Action*, ¶¶ 8–9, U.N. DOC. A/CONF.177/20 (Sept. 15, 1995), https://perma.cc/B872-82ND.

outcomes.[81] For example, obstetric fistula continues to develop among women with high socioeconomic parity.[82] Although economic growth forms a necessary basis for social development, it does not by itself guarantee social improvement will occur or occur equitably.[83] Despite the lack of rights to health, education, and housing, obstetric fistula was eradicated in the United States because public insistence—emanating from the New York Obstetrical Society reporting that from 1930–1932, 65.8% of maternal deaths in New York City could have been prevented—led to political will, medical professionalization, and clinical improvements in obstetric fistula outcomes.[84] This suggests that concerted efforts among professional and political groups to channel expertise, public sentiment, and other resources toward health is more urgently needed.

This example helps illustrate why the focus of HCP and PG on equality of health capabilities is critical to addressing health. HCP and PG recognize that health capability is developed through the nexus of an individual's biological and genetic predispositions; macrosocial, political, and economic environment; intermediate social context; and public health and health care systems.[85] A detailed health capability profile includes: internal factors of health status and functioning, health knowledge; health-seeking skills and beliefs; self-efficacy; health values and goals; self-governance and self-management; effective health decisionmaking, intrinsic motivation, and positive expectations; as well as external factors of social norms; social networks and capital; group membership influences; material circumstances; economic, political, and social security; access and utilization of health services; and enabling public health and health care systems.[86] Health capabilities are the sets of abilities individual and collective, internal and external, and conditions that enable optimal health.

These analytical components of the health capability model are oriented around achieving health potential, as individual circumstances permit, because human diversity renders attempts to equalize achieved health functioning both difficult and arbitrary. This framing does not rest on a direct causal link to a legalistically violated right to health. Rather, society has a duty to create the optimal conditions for health capability and flourishing. Accordingly, HCP and PG adopt a broader scope than principlism to include relevant social, economic, cultural, and moral considerations, while maintaining a more purposeful focus than social determinants on the meaningful consequences of health actions and policies on human flourishing. Health care is relevant because of its impact on the overarching aim of improving individuals' capability to function. As economic growth alone does not intrinsically secure improvements for population well-being, a

81. Weil & Fernandez, *supra* note 33, at 941.

82. Evelyn Landry et al., *Profiles and Experiences of Women Undergoing Genital Fistula Repair: Findings from Five Countries*, 8 GLOBAL PUB. HEALTH 926, 940 (2013).

83. Fourth World Conference on Women, *supra* note 80, ¶ 14.

84. Porges, *supra* note 30, at 643.

85. *See* Jennifer Prah Ruger, *Health Capability: Conceptualization and Operationalization*, 100 AM. J. PUB. HEALTH 41, 47 (2010).

86. *Id*. at 45–46.

holistic developmental strategy under HCP and PG would ensure that economic growth benefitted all individuals' capabilities, with an eye to the disparate impacts of social inequality and marginalization on health capabilities.

IV. HEALTH AGENCY

HCP and PG incorporate consequentialist criteria, such as health outcomes and functioning, and deontological processes, such as health agency and public participation, as morally meaningful goals. Health agency, the ability to achieve valuable individual and collective health goals, addresses concerns of differential ability. It focuses on vulnerability and individual responsibility, and in doing so, balances paternalism and autonomy. Contemporary scientific models tend to use individual autonomy primarily for securing informed consent or applying scientific principles. Moreover, increasing instrumentation and laboratory reports displace interpersonal clinician–patient communication and devalue patients' subjective knowledge.[87] As development priorities or medical professionals determine needs and responses, charity based approaches do not empower vulnerable populations' self-determination and agency.[88] The paternalism exhibited by the current approach to obstetric fistula not only disrespects individual self-determination and freedom, but is also practically inefficient in attempting to micromanage individuals.

Pursuing health agency, rather than autonomy, is critical to achieving health functioning, developing capabilities, and effectuating health equity. Bioethics and public health ethics principles that focus narrowly on material distributive and allocative solutions, overemphasize individual autonomy and procedural processes in evaluating justice. This de-emphasis of institutional responsibility puts an overwhelming and practicably impossible responsibility for securing individual entitlements primarily on individuals.[89] This is evident in the "legal boomerang" of the rights based approach, whereby international law reaches the daily lives of individuals only if advocated for and translated into rights-based principles and requirements by nongovernmental organizations (NGOs) and intergovernmental organizations (IGOs).[90] Otherwise, the burden is on the individual to develop and secure the actual use of international law in their daily lives. The narrow disease perspective of epidemiology neither accounts for individual ability to navigate health systems and environmental barriers, nor illuminates individual level barriers to health. For example, despite over a decade of recognizing the three-delays model, national Ugandan rhetoric continues to focus on individual pregnant women, who are imagined to have a high decisional

87. Donchin, *supra* note 37, at 372–73.

88. Hisayo Katsui & Jukka Kumpuvuori, *Human Rights Based Approach to Disability in Development in Uganda: A Way to Fill the Gap Between Political and Social Spaces?*, 10 SCANDINAVIAN J. DISABILITY RES. 227, 229 (2008).

89. PRAH RUGER, *supra* note 28, at 118.

90. *See* Paul Gready, *Rights-Based Approaches to Development: What is the Value-Added?*, 18 DEV. PRAC. 735, 738 (2008).

latitude in maternity care.[91] Autonomy fails to account for differential abilities, such as in translating resources into functioning. This could be due to individuals' unique environments, including the impacts of their social relationships on decisionmaking.

Women at risk for fistula are often directly denied public and private decisionmaking latitude in maternity care and indirectly denied health agency through social, economic, and religious oppression. Women living with fistula, who are already vulnerable by gender, usually vulnerable by social class, and additionally vulnerable by handicap, are at great risk for discrimination and isolation.[92] For many women, advice and guidance on healthy pregnancy practices are primarily acquired through their mothers. Mothers-in-law and other relatives often discourage antenatal care visits, which correlate with decreased rates of prolonged labor.[93] Delayed and diminished rates of hospital delivery are also widely attributed to social influences of husbands and mothers-in-law.[94] Rather than attributing these delays to personal failures, HCP recognizes that socioeconomic marginalization in other areas of life, including structural violence,[95] impacts one's ability to translate material and immaterial resources into health.

Scientific advancement and charitable sentiments are valuable but should be implemented in a manner that respects and promotes personal health agency. Health wisdom—the ability to make the right decision at the right time—develops over time, from cradle to grave, through stable and consistent habits and decisionmaking ability. Whereas human rights do not prevent individuals from freely engaging in unhealthy behavior, health agency includes developing normative personal health goals that drive personal motivation for health-seeking behavior. Qualitative studies of women's lived experiences with fistula suggest strong personal health goals to secure health functioning.[96] Health governance itself necessarily enlists these motivations and responsibilities, not only to address deontological concerns of health agency but also to pragmatically reduce the costs of micromanaging individual behavior.

Unlike the narrow focus of autonomy, community relationality and embeddedness are morally central features of human society recognized in health agency. Health agency entails local self-governance, collective agency, sensitivity to environmental structures, and shared and institutional responsibility. HCP and

91. Ruder et al., *supra* note 73, at 730.

92. Donchin, *supra* note 37, at 375.

93. *See* NASHID KAMAL WAIZ ET AL., ENGENDERHEALTH, SITUATION ANALYSIS OF OBSTETRIC FISTULA IN BANGLADESH 24 (2003); Prudence P. Mwini-Nyaledzigbor et al., *Lived Experiences of Ghanaian Women with Obstetric Fistula*, 34 HEALTH CARE FOR WOMEN INT'L 440, 444 (2013).

94. *See* Maggie Bangser et al., *Childbirth Experiences of Women with Obstetric Fistula in Tanzania and Uganda and Their Implications for Fistula Program Development*, 22 INT'L UROGYNECOLOGY J. 91, 93 (2011); Mwini-Nyaledzigbor et al., *supra* note 93, at 454; Ruder et al., *supra* note 73, at 725.

95. *See* WORLD HEALTH ORG., REDUCTION OF MATERNAL MORTALITY 2, 37 (1999); Kristen Hessler, *A Human Rights Approach to Health Disparities*, 18 AM. J. BIOETHICS 33, 34 (2018); Ruder et al., *supra* note 73, at 730.

96. *See* Allison Kay et al., *Giving Voice to the Experiences of Rwandan Women with Urogenital Fistula*, 81 ANNALS GLOBAL HEALTH 636, 643 (2015).

PG navigate the unreasonable burdens and unrealistic implications of autonomy through noncausal personal and social co-responsibility. For example, health agency involves conscientiousness about the impact of individual behavior on others' health and wellbeing, and collective agency emerges.[97] Individuals remain centrally important, but collective wholes also weigh in.[98] As what is in one's interest is recognized as compatible with other-regarding behavior, health agency not only directly benefits individuals but also positively impacts communities. Accordingly, short-term policies should be designed to improve individuals' behavior, but longer-term investments should develop individuals' health agency to make healthier choices and participate collectively in determining public policies to improve the health capabilities of others and of future selves.

The collective spirit of emphasizing institutions as well as individuals with a broad health capability focus beyond clinical settings is exemplified in fistula eradication strategies that engage boys, men, community leaders, and communities, such as awareness raising for women's and girls' needs, locally based outreach regarding obstetric risks and needs, obstetric fistula prevention and treatment education, strategic partnerships, and community action.[99] Women have attested to the central role of husbands, partners, and families in preparing for delivery, as well as seeking and obtaining obstetric fistula treatment. [100] Early grasp of the problem's gravity, recognition of avoidability, and mobilization of professional and public groups were preconditions for maternal mortality reduction in HICs;[101] this further supports the key role of collective agency in promoting maternal health. Health facility and community committees can investigate maternal deaths and monitor maternal health programs, as well as give recommendations and help implement improvements.[102]

Health systems also play a role in shouldering responsibility for creating external conditions conducive to health agency. Priorities of the MHTF include strengthening health systems to ensure that service provision matches individual abilities to obtain access to health care.[103] Nationally-operated hospitals, nationally-funded systems, enhanced management, monitoring systems, and client empowerment are all recommended strategies for improving maternal health and obstetric fistula outcomes that exemplify institutional obligations toward health agency.[104] In addition, centralizing fistula management in high prevalence or high workload regions[105]

97. *See* PRAH RUGER, *supra* note 28, at 102.
98. *See* Jennifer Prah Ruger, *Shared Health Governance*, 11 AM. J. BIOETHICS 32, 37 (2011).
99. *See, e.g.*, G.A. Res. 69/148, *supra* note 16, ¶ 3; Donnay & Ramsey, *supra* note 49, at 259.
100. *See* Landry et al., *supra* note 82, at 940.
101. De Brouwere et al., *supra* note 7, at 774–75.
102. *See* WORLD HEALTH ORG., *supra* note 95, at 25.
103. *See* U.N. POPULATION FUND, TOWARDS THE 2030 AGENDA, *supra* note 19, at 69.
104. *See, e.g.*, Hemantha Senanayake et al., *Achieving Millennium Development Goals 4 and 5 in Sri Lanka*, 118 BJOG 78, 85–86 (2011); PATHMANATHAN ET AL., *supra* note 49, at 28, 41.
105. *See* Hillary et al., *supra* note 10, at 490.

and standardizing and professionalizing care providers[106] can alleviate burdens on individuals to find, advocate for, and secure access to healthcare.

V. PRIORITIZING CENTRAL HEALTH CAPABILITIES

HCP also illuminates a strategy for prioritizing resource allocation for health, in contrast to approaches that are unable to prioritize. A human rights framework does not consider trade-offs amongst rights legitimate due to the incommensurability and indivisibility of human rights.[107] Similarly, without a unifying theory, principlism balances bioethical principles, struggling with questions of prioritization. This creates significant problems because resource scarcity requires considering trade-offs when allocating resources to promote flourishing.[108] Under a human rights paradigm, problems like clinical abuse, coercion, indignity, discrimination, abandonment, and detention are defined by their deviation from human rights of liberty, equality, transparency, accountability, and dignity; however, this conflict renders challenging producing guiding principles for policy.[109] For example, right-to-health litigation in Brazil has largely disregarded economic and policy considerations, ignoring the cost-effectiveness of treatments, efficiency of public spending on unproven, individual drug therapy, and urgency of alternative-resource needs.[110]

In addition, current maternal mortality statistics and interventions tend to neglect morbidity, near-misses, and avertable lifelong injuries, despite their long-lasting physiologic and psychosocial consequences.[111] Because the maternal mortality ratio (MMR) describes one pregnancy at a time rather than total pregnancies over a maternal lifespan, mortality risks appear much greater for infants. In addition, many deaths occur at home and are not documented by health systems. Accordingly, funding and planning agencies who are keen to visibly maximize impact prefer to invest in vertical child mortality or treatment programs that produce quick and dramatic results,[112] rather than engage with deep rooted problems and prevention efforts.[113] Thus, despite its preventability, obstetric fistula, in particular, is frequently neglected when subsumed under general maternal health efforts.[114] Out of the MHTF's five outcomes of midwifery, emergency obstetric

106. *See* PATHMANATHAN ET AL., *supra* note 49, at 41.

107. *See* de Man, *supra* note 54, at 92.

108. *See, e.g.*, Hugo Tremblay, *A Clash of Paradigms in the Water Sector? Tensions and Synergies Between Integrated Water Resources Management and the Human Rights-Based Approach to Development*, 51 NAT. RESOURCES J. 307, 353 (2011); Gauri, *supra* note 29, at 472.

109. *See* Joanna N. Erdman, *Bioethics, Human Rights, and Childbirth*, 17 HEALTH & HUM. Rts. J. 43, 45 (2015).

110. *See* Daniel Wei L. Wang, *Right to Health Litigation in Brazil: The Problem and the Institutional Responses*, 15 HUM. RTS. L. REV. 617, 629 (2015).

111. *See, e.g.*, Ruder et al., *supra* note 73, at 721–22.

112. *See* De Brouwere et al., *supra* note 7, at 776.

113. *See* Aduragbemi O. Banke-Thomas et al., *Current Evidence Supporting Obstetric Fistula Prevention Strategies in Sub Saharan Africa: A Systematic Review of the Literature*, 18 AFR. J. REPROD. HEALTH 118, 119 (2014).

114. *Id.*

and newborn care, obstetric fistula, maternal death surveillance and response, and first-time young mothers, obstetric fistula was the only outcome with an output that was off track to achievement.[115] Only recently have governments, donors, and health professionals recognized obstetric fistula as a public health problem on international- and national-development and health agendas[116] and combined efforts to eliminate fistula.[117] This low profile has also been attributed to the greater salience of "vertical" mass atrocities and grave violations to a human rights framework than "horizontal," routine oppressive structures and practices that contribute to the persistence of obstetric fistula.[118]

HCP delineates central health capabilities (CHCs) as the subset of health capabilities prerequisite to other capabilities and necessary for human flourishing regardless of social context; they include the capabilities to achieve good health, prevent premature mortality, and avoid escapable morbidity.[119] As vital elements of health, CHCs gain priority over noncentral capabilities as universally shared elements of flourishing. For example, obstetric fistula eradication would take precedence over non-health-enhancing administrative activities. Obstetric fistula also gains urgency according to the CHC of avoiding escapable morbidity, alongside infant and maternal mortality, in the quest for attention and resources. Targeted efforts toward fistula currently include the Campaign to End Fistula, national elimination efforts, national fistula studies, national fistula task forces, and dedicated fistula management centers.[120] Although these programs specifically address avoidable morbidity, successful interventions have additionally been undergirded by a justice orientation similar to HCP. For example, Bangladesh and Sri Lanka, both LMICs, have achieved remarkable maternal health outcomes with few resources using long-term, pro-equity strategies that elevate women's social status and decisional latitude.[121] Equitable social policies, particularly in education, have brought women to a higher status than in neighboring countries, leading to freer access to health information, healthcare, and contraception while decreasing maternal mortality and morbidity. A continuous national, political commitment to prioritizing health and obstetric fistula has been indispensable for better maternal health outcomes.[122]

115. *See* U.N. POPULATION FUND, TOWARDS EQUALITY IN ACCESS, *supra* note 46, at 13.

116. A. Velez et al., *The Campaign to End Fistula: What Have We Learned? Findings of Facility and Community Needs Assessments*, 99 INT'L J. GYNECOLOGY & OBSTETRICS S143, at S144 (2007).

117. *See* Donnay & Ramsey, *supra* note 49, at 254.

118. *See* de Man, *supra* note 54, at 92.

119. *See* PRAH RUGER, *supra* note 27, at 76, 92.

120. *See Intensifying Efforts to End Obstetric Fistula, supra* note 25, ¶¶ 24–34.

121. *See* Tracey Pérez Koehlmoos et al., *Health Transcends Poverty: The Bangladesh Experience, in* 'GOOD HEALTH AT LOW COST' 25 YEARS ON: WHAT MAKES A SUCCESSFUL HEALTH SYSTEM? 47, 49 (Dina Balabanova et al. eds., 2011); Senanayake et al., *supra* note 104, at 78.

122. *See, e.g.*, Koehlmoos et al., *supra* note 121, at 51–52.

VI. JOINT SCIENTIFIC AND DELIBERATIVE APPROACH

HCP employs a joint scientific and deliberative health governance approach, maintaining a deontological element of health agency and incorporating a deliberative element that provides procedural legitimacy to health governance. The scientific standards of medical necessity and appropriateness and economic efficiency ensure the best uses of resources in HCP's framework. This scientific clinical–economic stepwise approach addresses critical practical gaps in the current abstract deontological framework, which exhibits medical paternalism in failing to address lived experiences and victim blaming despite differences amongst patients.

Currently, lack of knowledge and lack of meaningful participation characterize attempts to respect autonomy, resulting in hollow agreement and shifting the burden of empowerment to the disadvantaged, who are then criticized for lacking self-motivation. For example, in Ghana, both healthcare professionals and patients were unaware of patients' rights; around 60% of patients were unaware of the Ghanaian Patient Charter.[123] This lack of knowledge precludes meaningful public participation in reform debates and in developmental programs. Where individuals embark on institutional redress, right-to-health litigation demands the poor prove their eligibility status by providing official documentation of their disadvantaged status when governments should be facilitating access to essential services.[124] This is a barrier to accessing essential services to which government should be facilitating access.[125]

Moreover, accepting an aggregated, idealized, supra-individual model of personhood that abstracts away from all particularities compares patients to an unreasonable, stigmatizing, and pathologizing standard. The human rights approach diverts attention from direct service provision to intangible resources and a change of agency and consciousness;[126] yet, the pure deontology of human rights will always be violated only through particular, embodied experiences.[127] Instead of the idealized supra-individual, a scientific stepwise approach takes the empirical individual, with her real-life experiences and outcomes, as the unit of analysis for health policy and institutions. Individual health capabilities are socially dependent, but information about health capability must be gathered from individuals as well as institutions.

The individually heterogeneous effects illustrate the necessity of evaluating group-level factors on their direct contextual effects on augmenting or

123. Ernest Owusu-Dapaah, *Empowering Patients in Ghana: Is There a Case for a Human Rights-Based Health Care Law?*, 1 LANCASTER UNIV. GHANA L.J. 91, 98 (2015).

124. *See, e.g.*, Joint Judgment, Laxmi Mandal v. Deen Dayal Harinagar Hosp. & Ors., W.P.(C) 8853/2008, and Jaitun v. Maternity Home MCD, Jangpura & Ors., W.P.(C) 10700/2009, (High Ct. of Delhi at New Delhi June 4, 2010).

125. *See id.*

126. Schmitz, *supra* note 29, at 536.

127. *See* Erdman, *supra* note 109, at 46.

diminishing each individual's ability to be healthy.[128] For example, women's perceptions and understanding of helpful interventions for fistula prevention and treatment were notably different from institutional recommendations.[129] This divergence of perspectives emphasizes the importance of incorporating firsthand experience and knowledge in health policies and programs. However, communication is often perceived as auxiliary to human rights and bioethical principles. The resulting approach lacks sensitivity to differences amongst patients shaped by experiences outside of the clinical setting, often manifested in varying attitudes and perspectives.[130] Most approaches to resolving perceived conflicts between bioethics principles are well-intentioned but don't recognize and resolve what is fundamentally driving the patient's disagreement.[131]

In addition, a strict deontological and litigation focus dissipates resources on ineffective and inefficient interventions, resulting in unacceptably high opportunity costs for society and economic gaps between high level political consensus and national systems' capacity. For example, in Brazil, the growth of right-to-health litigation and the courts' disregard of economic and policy consequences of their rulings increased expenditures by 9,660% in six years, from around $1.38 million to around $135 million.[132] Yet, the practical insensitivity of courts and lack of evidence based health entitlements have precluded the maximization of population health, despite enormous resource expenditures.[133] Brazil's creation of technical budgetary advising for judges and extrajudicial settlement chambers[134] signifies the inefficiency and inability of the legal system to adjudicate and effectuate the right to health. On a conceptual level, the large number of healthcare service transactions and the sheer complexity of systems involved in the coproduction of health can obscure whether a litigant's rights are being denied.[135] The abstract idealism of human rights overlooks practical questions of resource scarcity, material constraints, social environments, relational sensitivity, differential capabilities, and enforcement.[136]

A stepwise clinical economic approach involves individual and public health policy processes with expert medical and policy input to reduce inappropriate care, misuse, and underuse, while improving health outcomes. Deliberating citizens in a democratic society still require help from experts, especially those with expertise or firsthand experience.[137] Individual medical input includes criteria of

128. *See* Prah Ruger, *supra* note 85, at 44.
129. *See* MEHTA & BANGSER, *supra* note 14, at 38.
130. *See* Kay et al., *supra* note 96, at 643.
131. *See* Fiester, *supra* note 35, at 689.
132. Wang, *supra* note 110, at 627.
133. *See id*. at 629.
134. *See generally* Leandro Molhano Ribeiro & Ivar Alberto Hartmann, *Judicialization of the Right to Health and Institutional Changes in Brazil*, 3 J. CONST. RES. 35, 41 (2016).
135. *See* Gauri, *supra* note 29, at 467.
136. *See* de Man, *supra* note 54, at 91; Tremblay, *supra* note 108, at 334.
137. Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 YALE J.L. & HUMAN. 273, 291 (2006).

medical need and medical appropriateness that are specific to the individual and empirically determined through science, research, and practice. The clinical component also requires individual input as experts of their personal health goals and lived experiences to build a context sensitive conception of health agency. Clinical input entails evidenced based standards, guidelines, and best practices from research, individuals, physicians, and public health experts, as well as evaluations of medical need and appropriateness for individual interventions. Policy input includes evidence based educational, clinical, and administrative guidelines for health systems. Instead of engaging with scientific, moral, economic, and policy issues, courts could enforce procedural fairness and the transparency of specialized authorities' decisionmaking processes, adjudicating governmental authority instead of precise healthcare provision and allocation.[138] On this view, the right to health is reconceptualized as an ethical demand for equity in health, guaranteed and effectuated through public policy.

The opportunity costs of resources mean that economic efficiency is an appropriate and important social concern. Applying cost-minimization analysis (CMA) and cost-effectiveness analysis (CEA) in a stepwise manner after clinical input guards against waste and promotes objectives effectively.[139] For example, Bangladesh's health policies have strategically improved health outcomes by emphasizing low-cost, proven interventions and targeting technologies such as community- and household-level service delivery.[140] Unlimited spending on healthcare that is beneficial, but not necessary or appropriate, decreases the provision of other social goods. Analysis reveals that 56%–98% of fistulas can be closed without high-technology resources; as such, the constraint for health facilities is not technological resources, but surgical capacity.[141] Investing in universal, quality-surgical obstetric and anesthesia (SOA) care in LMICs is highly cost-effective, with benefits for preventing obstructed labor and obstetric fistula.[142] Addressing LMICs' surgical burden of disease by 2030 is estimated to cost fifty times less than the $12.3 trillion lost from those diseases; additionally, investments in SOA would spill over to benefit healthcare systems.[143]

Moreover, a public process of deliberation addresses deontological concerns of human rights and bioethical principles about participation and self-determination. Public reasoning is a valuationally transparent and democratically respectful test of ethical objectivity, characterized by informed scrutiny and survivability in unobstructed discussion.[144] The deliberative process respects and incorporates

138. *See* Wang, *supra* note 110, at 640–41.

139. *See* PRAH RUGER, *supra* note 27, at 12.

140. Koehlmoos et al., *supra* note 121, at 51–52.

141. Wall, *supra* note 1, at 255–56.

142. *See* Katherine Albutt et al., *Healthcare Leaders Develop Strategies for Expanding National Surgical, Obstetric, and Anaesthesia Plans in WHO AFRO and EMRO Regions*, 43 WORLD J. SURGERY 360, 362 (2018); Harrison et al., *supra* note 22, at 6.

143. Albutt et al., *supra* note 142, at 362.

144. *See* Amartya Sen, *Human Rights and Capabilities*, 6 J. HUM. DEV. 151, 157 (2005).

individual health goals and motivations,[145] meaningfully engaging with the socio-cultural and attitudinal barriers that characterize obstetric fistula formation.[146] HCP's concept of health agency accords additional meaning to this procedural mechanism because it incorporates substantive, scientific conceptions of health capabilities.

HCP's joint scientific and deliberative approach also implies more precise societal duties to foster meaningful health agency. Education for women and girls contributes to better health outcomes,[147] greater ability to understand and acquire health knowledge, and higher social status which may enhance decisionmaking abilities.[148] However, because education is more likely to improve maternal health indirectly, through improving the effects of maternal health interventions,[149] societies must go beyond education levels in developing health agency. Target groups for education include community and religious leaders, young men, and older women, particularly mothers-in-law. Health care workers and former patients could lead mass messaging campaigns and community education programs regarding prolonged and obstructed labor, as well as corresponding prevention and treatment strategies.[150] In addition, health agency yields practical benefits in cooperation. Although laws and other forms of external motivation are important and necessary to bring the unwilling on board, developing individual health agency critically tilts actors' motivations away from avoiding punishment toward becoming locally and globally responsible individuals, especially when supported by enabling conditions.[151]

VII. EXTERNAL SOCIETAL CAPABILITIES

The sustained effectiveness of health interventions requires external capabilities. For example, childbirth is a salient health condition that requires the long-term, holistic, and systematic governance that HCP ensures. However, disease-specific approaches and immediate stopgap measures have dominated public health

145. *See* Norman Daniels, *Just Health: Replies and Further Thoughts*, 35 J. MED. ETHICS 36, 39 (2009); Fiester, *supra* note 35, at 687–88; Tasioulas & Vayena, *supra* note 34, at 376; Wall, *supra* note 42, at 3.

146. Landry et al., *supra* note 82, at 931.

147. *See* France Donnay & Laura Weil, *Obstetric Fistula: The International Response*, 363 LANCET 71, 71 (2004); Nawal M. Nour, *Global Women's Health – A Global Perspective*, 74 SCANDINAVIAN J. CLINICAL & LABORATORY INVESTIGATION 8, 11 (2014); H.R. Seneviratne & L.C. Rajapaksa, *Safe Motherhood in Sri Lanka: A 100-Year March*, 70 INT'L J. GYNECOLOGY & OBSTETRICS 113, 114 (2000); *Intensifying Efforts to End Obstetric Fistula*, *supra* note 25, ¶ 2; Banke-Thomas et al., *supra* note 113, at 121; Hampton et al., *supra* note 22, at 49; Haththotuwa et al., *supra* note 67, at S47.

148. *See* Ramesh Adhikari & Yothin Sawangdee, *Influence of Women's Autonomy on Infant Mortality in Nepal,* REPROD. HEALTH (2011), at 1–2.

149. *See* Harrison et al., *supra* note 22, at 6.

150. WAIZ ET AL., *supra* note 93, at 14; *see Intensifying Efforts to End Obstetric Fistula*, *supra* note 25, ¶ 35; MEHTA & BANGSER, *supra* note 14, at 40–41; TEGHRARIAN & RAMSEY, *supra* note 13, at 9; U.N. POPULATION FUND, TOWARDS EQUALITY IN ACCESS, *supra* note 46, at 33; U.N. POPULATION FUND, TOWARDS THE 2030 AGENDA, *supra* note 19, at 17–18; WORLD HEALTH ORG., *supra* note 11, at 14; Banke-Thomas et al., *supra* note 113, at 122; Donnay & Ramsey, *supra* note 49, at 259.

151. *See* PRAH RUGER, *supra* note 28, at 102.

responses, creating fragmented, vertical, and siloed programs that ignore the fundamental determinants of health outcomes and undermine overarching health systems.[152] As discussed, most fistulas can be closed without high-technology resources; rather, repair is constrained by the surgical capacity of health systems. Yet, the MHTF spent 15% of its available resources on supporting repairs and reintegration at the individual level but only 5% on developing an expert workforce, 4% on developing ownership, and 2% on developing sectoral coordination.[153] In fact, disease-specific approaches exacerbate inequities and competition in allocation at primary, secondary, and tertiary levels of the system, compromising the overall effectiveness of health systems.[154] Moreover, vertical biomedical interventions are unsustainable not only because the narrow clinical focus fails to build capacity, but also because they create parallel structures to local political and leadership structures rather than truly integrated ownership.[155]

Instead of expecting people to solve problems in isolation, HCP seeks to implement robust learning systems—beyond international declarations—to develop horizontal and local capabilities in clinical, normative, cultural, macrosocial, economic, and policy settings for countries and individuals to flourish. Given the capacity constraints of LMICs, social problems require legal strategies in combination with other norm-based approaches[156] to change systems that perpetuate mistreatment. Transpositional human flourishing unifies norms of equity and justice, which are sociocultural prerequisites[157] for fair access and health equity. HCP also prioritizes building and maintaining horizontal systems, which enable sustained opportunities for individuals to be healthy, over financial transfers of foreign aid.[158] Indigenous, low-cost, long-term policies have demonstrated effectiveness in improving maternal health outcomes,[159] perhaps because holistic care requires long-term commitments and enduring institutional systems that horizontally span the various dimensions of life that contribute to health. This has been recognized in shifts from a campaign approach to eradicating fistula toward a national approach that integrates maternal health into national health strategies, plans, and budgets.[160]

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152. *See, e.g.*, Susana Fried et al., *Integrating interventions on maternal mortality and morbidity and HIV: A human rightsbased framework and approach*, 14 HEALTH HUM. RTS. 21, 22 (2012); Amodu et al., *supra* note 32, at 2.

153. *See* U.N. POPULATION FUND, TOWARDS THE 2030 AGENDA, *supra* note 19, at 64.

154. *See id.*

155. *See* Amodu et al., *supra* note 32, at 2.

156. *See* Meghana Shah, *Rights Under Fire: The Inadequacy of International Human Rights Instruments in Combating Dowry Murder in India*, 19 CONN. J. INT'L L. 209, 228 (2003).

157. *See* Jimoh Amzat, *The Question of Autonomy in Maternal Health in Africa: A Rights-Based Consideration*, 12 J. BIOETHICAL INQUIRY 283, 287 (2015).

158. *See* Jennifer Prah Ruger, *Ethics of Development Assistance for Health*, 45 HASTINGS CTR. REP. 23, 24–25 (2015).

159. *See* BASARANKUT ET AL., *supra* note 19, 15–18; PATHMANATHAN et al., *supra* note 49, at 5–8; Senanayake et al., *supra* note 104, at 78.

160. U.N. POPULATION FUND, TOWARDS EQUALITY IN ACCESS, *supra* note 46, at 8.

VIII. MORAL IMPERATIVES FOR ERADICATING FISTULA

Provincial globalism (PG) builds on the normative and procedural principles of HCP for global health justice and governance. PG's transpositional, human flourishing foundation addresses multiple challenges with conventional approaches, establishing moral imperatives for fistula eradication, replacing global charity with global justice, and critiquing a political power paradigm of health governance. PG, like HCP, also involves principles of ethical individualism, health equity, shortfall inequality, and proportional justice.

The human rights based approach lacks normative, consequentialist substance, creating high level conceptual indeterminacy that allows realism to dominate the international political arena. Currently, capacity limitations of domestic governments function as both reasons and excuses for low domestic standards and outcomes. In many instances, national health plans are systemically constrained.[161] The United Nations' promotion of national ownership in addressing obstetric fistula lacks clear alignment with individual countries' policies and capacities; for example, Nigeria's health and public systems have not been prepared to enact comprehensive fistula eradication strategies.[162] Unfortunately, the "ought implies can" rule of human rights responsibility ascription[163] addresses these cases by absolving countries that do not live up to their moral obligations due to capacity constraints. This has unacceptable conclusions. For example, the current approach has suggested that the mental health services critical to comprehensive fistula treatment and rehabilitation may not be feasible in low resource settings,[164] despite the moral obligation of providing such services to women recovering from fistula.

Thus, despite prevalent rights based ideology, the Ugandan government's lack of resources, combined with low priority of marginalized populations' health issues, rationalized limited statutory interventions.[165] The progressive realization of rights approach is constrained to the resources of the situation, presenting piecemeal interventions, and fails to imagine a society where the domestic government is fulfilling its ethical obligations to the fullest extent. The suboptimal care from health systems held to low standards withers resources, as long-term costs result from failing to properly and fully treat diseases early on. Furthermore, evading responsibilities may be a disingenuous strategy to secure basic needs where social and managerial burdens on governments are overwhelming. Domestic governments facing challenging capacity limitations may strategically create deliberate gaps in public systems that shift social responsibility to extant private systems, such as institutions or families. In these situations, legislative and legalistic mechanisms for accountability, such as the Inter-

161. Mary Robinson, *Realising the Human Right to Health*, 374 LANCET 1121, 1121 (2009).
162. Amodu et al., *supra* note 32, at 2, 7–8.
163. Tasioulas & Vayena, *supra* note 34, at 373.
164. *See* Donnay & Ramsey, *supra* note 49, at 255.
165. Katsui & Kumpuvuori, *supra* note 88, at 235.

American Court of Human Rights' reliance on the political will of guilty governments to self-impose remedies for human rights abuses,[166] will be ineffective.[167]

Even at the international level, legal instruments and political intentions that fall short of health equity requirements have not been addressed. Governments often ratify human rights documents due to political interests or pressure rather than a sense of moral obligation. This is evident in the inequality focused 1986 Declaration on the Right to Development, which displayed a global North–South split, particularly when precise obligations were put into place: high income funder countries were unwilling to acknowledge their duties to citizens of recipient countries, preferring a discretionary or voluntary approach to development assistance (DA).[168]

Under PG, universal ethical norms—general duties owed to all persons—are due to all human beings by virtue of their humanity. All individuals have equal dignity, are worthy of respect, and are owed equal respect. Our common humanity establishes common moral duties that transcend national boundaries. Rather than consent to hypothetical choices, justice arises from health capability as a central and fundamental human interest. As the social determinants of heath perspective is too broad and the adequate care for all standard is too low, PG concentrates on CHC as the focal variable for health equity and demands that all individuals' health be brought to the highest international average as efficiently as possible. Accordingly, politics and capacity limitations are collectively surmountable barriers to health equity.

Achieving universal health coverage (UHC) is linked to political commitment and sound policy decisions that shift from out-of-pocket payments toward greater pooled spending.[169] Increasing inequality and poverty levels link globalization to violations of economic and social rights, such as the economic leverage that powerful international privately owned companies have over LMICs.[170] A continuous, national, political commitment and global support to prioritizing health is critical for improving maternal health outcomes.[171] Cuban health systems, public health policies, and commitments to health have surmounted significant external resource constraints to produce positive health outcomes and a healthcare workforce that also engages in global health diplomacy.[172] Contemporary case studies of Sri Lanka and Bangladesh illustrate how maternal health may be achieved, despite national poverty and resource limitations, if societal values prioritize

166. Correia, *supra* note 55, at 76.

167. *See* Shah, *supra* note 156, at 219.

168. Andrea Cornwall & Celestine Nyamu-Musembi, *Putting the 'Rights-Based Approach' to Development into Perspective*, 25 THIRD WORLD Q. 1415, 1422 (2004).

169. PRAH RUGER, *supra* note 28, at 96.

170. de Man, *supra* note 54, at 99.

171. *See* Tarja Halonen et al., *Realisation of Human Rights to Health and Through Health*, 389 LANCET 2087, 2088 (2017); MEHTA & BANGSER, *supra* note 14, at 44; Amodu et al., *supra* note 32, at 4; Wall, *supra* note 1, at 259.

172. Johnson, *supra* note 43, at 101–02.

women's social and health status and resource allocation for maternal health.[173]

IX. JUSTICE, NOT CHARITY

In the absence of justice, current ethical and equity efforts are dominated by a charity orientation. Fistula Foundation, a prominent nonprofit IGO, appeals simultaneously to charity and self-promotion in order to solicit donations: "selfless acts of generosity," the "precious gift of fistula surgery," and the power to change thousands of lives and "end the suffering" for "women whose bodies have been broken by childbirth."[174] This results oriented, donor centric paradigm has resulted in limited progress, funding, data, and interest in obstetric fistula eradication efforts. For example, global efforts and international aid are severely limited by the desire to see quick results from treatment interventions and a reluctance to fund programs for the poor women of the world.[175] This lack of progress is tied to the donor centric paradigm's inability to pursue structural redress because the results oriented preferences of donors and NGO watchdogs value quantifiable results over critical analysis and engagement with beneficiaries, systemic challenges, and large scale reform.[176] This was acutely exemplified in the late twentieth century, when the preoccupation of mainstream development communities with declining aid levels shelved demands for structural transformation and gender equality because they were too difficult to embed in programs.[177] Constraints abound in a donor politic paradigm, as funding states stipulate requirements for national and international NGOs, including U.N. bodies, to fulfill. For NGOs that are financially reliant on donors, advocating for socioeconomic rights that do not align with donors' political agendas poses an existential threat.[178]

Even where there is interest for funding, it varies dramatically over time and depending on whether the issue is glamorous. The funding cycle is deeply destabilizing for organizations; when interest decreases, the funding stops but the problem remains.[179] The MHTF, for example, is highly dependent on four major donor countries, private for-profit organizations, private nonprofit actors, and individual donors.[180] Under the conventional paradigm, these actors are only accountable to themselves, at most monitored by NGOs and activists. Yet without direct accountability, aid recipients remain passive beneficiaries, not empowered

173. *See, e.g.*, Rebecca J. Cook & Bernard M. Dickens, *Ethical and Legal Issues in Reproductive Health: Human Rights to Safe Motherhood*, 76 INT'L J. GYNECOLOGY & OBSTETRICS 225, 226 (2002); Koehlmoos et al., *supra* note 121, at 49–52.

174. *See* MELISSA L. JOHNSON, FISTULA FOUND., LEAVE A LEGACY OF HEALING (2017), https://www.fistulafoundation.org/wp-content/uploads/2017/06/Fistula-Foundation-Legacy-Gift-Information.pdf [https://perma.cc/V4L2-Y6KT].

175. *See* De Brouwere et al., *supra* note 7, at 776; Wall, *supra* note 2, at 1202.

176. *See* Schmitz, *supra* note 29, at 525.

177. Alicia Ely Yamin, *From Ideals to Tools: Applying Human Rights to Maternal Health*, 10 PLOS MED., Nov. 5, 2013, at 1.

178. de Man, *supra* note 54, at 95–96.

179. Nour, *supra* note 147, at 12.

180. *See* U.N. POPULATION FUND, TOWARDS THE 2030 AGENDA, *supra* note 19, at ii.

rights holders.[181] The results oriented, donor centric paradigm is uncoordinated, inefficient, unaccountable, and paternalistic.

PG insists that DA evaluate individual flourishing, the recipient beneficiary dichotomy, the design of institutions and policies, and social arrangements and structures from a perspective of justice.[182] This ethical perspective reframes deprivations in health capabilities not as tragic accidents to be ameliorated by charity, but rather as acts of structural violence and unethical indifference by responsible parties.[183] Only recently have governments, donors, and health professionals recognized obstetric fistula as a public health problem on international and national development and health agendas and combined their efforts to eliminate fistula.[184] Obstetric fistula must move up on the global health priorities list as a set of concrete duties for governments, IGOs, and other actors.[185]

The general duties owed to all persons on a PG view are critical: absent an authoritative world government enforcing international law, a stable and effective global order must be undergirded by moral authority. The African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa illustrates members' willingness to reciprocate increased personal accountability for increased and reliable domestic funding.[186] Country led and country driven national ownership and leadership for self-determination and capacity-building, supported by technical and financial global official DA, are critical for improving maternal health outcomes.[187] For example, national and global cooperation is needed for the strategic management of health worker migration. Home countries should adjust professional training to local needs and demands while improving local conditions, and receiving countries must ensure migrant workers are recruited responsibly and treated fairly while providing human resource support to home countries.[188] International instruments play a role in establishing ethical recruitment policies, codes of practice, and various guidelines to set global norms for ethical behavior.[189]

X. JUSTICE AND GLOBAL HEALTH VIS-À-VIS POWER POLITICS

At the global level, power politics dictates that the current international human rights regime is inaccessible to less powerful groups and countries. The dominant

181. *See* Cornwall & Nyamu-Musembi, *supra* note 168, at 1433.

182. *See* Prah Ruger, *supra* note 158, at 24.

183. *See* Gready, *supra* note 90, at 742.

184. *See* Donnay & Ramsey, *supra* note 49, at 254; Velez et al., *supra* note 116, at S143.

185. Wall, *supra* note 2, at 1207; *see* Gauri, *supra* note 29, at 468.

186. *See* Gorik Ooms et al., *A Global Social Contract to Reduce Maternal Mortality: The Human Rights Arguments and the Case of Uganda*, 21 REPROD. HEALTH MATTERS 129, 135–36 (2013).

187. *See* G.A. Res. 69/148, *supra* note 16, ¶¶ 5–6; TEGHRARIAN & RAMSEY, *supra* note 13, at 7; U.N. POPULATION FUND, TOWARDS THE 2030 AGENDA, *supra* note 19, at 48; Amodu et al., *supra* note 32, at 2; Halonen et al., *supra* note 171, at 2088; Hampton et al., *supra* note 22, at 51.

188. *See* CHEN ET AL., WORLD HEALTH ORG., WORKING TOGETHER FOR HEALTH: THE WORLD HEALTH REPORT 2006, at 102–04 (2006), https://www.who.int/whr/2006/whr06_en.pdf [https://perma.cc/DX8G-CQCH].

189. *Id*. at 104–05.

global human rights regime—a structure of laws, norms, courts, and organizations—claims moral authority to control resources, knowledge, media, and local politics.[190] Under a purely political paradigm, health competes with non-CHC policies for resources and commitment, only receiving attention when it aligns with the narrow self-interest of better-off actors. Countries unable to "add value" under an international realism paradigm are thus excluded from this global regime. Realist international politics, whereby power and political interests dominate moral and ethical considerations, focuses on security, competition, economic advantage, and trade agreements.[191] The prioritization of military over human security continues to be seen in disproportionately financed expenditures. For OECD countries in 2018, military expenditures were over seven times the levels of DA.[192]

Furthermore, countries able to participate in the human rights regime face complex national and local implementation problems with implementation, because high level international meetings occur in a different context.[193] At domestic levels, gaps in legal systems and perceived cultural uneasiness limit the operationalization of international norms and legislation.[194] Moreover, a genuine cultural gap between high level legal declarations and local circumstances often results in implementation failures. Creating national and international political change does not directly translate to social improvements at local and individual levels, particularly where economic, social and cultural factors intersect. Gaps between high level leaders and general lived experience, as well as within group heterogeneity, have limited the efficacy of rights legislation in securing equality and justice in the public space.[195] This fallacy of legalism is particularly pronounced where redress and accountability mechanisms are inaccessible or weak.[196]

Without a normative foundation, the latent discrimination, exploitation, and abuse of vulnerable patient populations is perpetuated by power structures. Despite increases in emergency obstetric care, skilled birth attendance, and institutional delivery, maternal mortality persists due to inadequate clinical care and abuse. Overworked nursing staff may resent the intensive care needed after fistula surgery, leading to clinical abuse; other income insecure surgical patients may resent the reduced user fees that aim to increase accessibility for low income fistula patients. Patients and providers interact and negotiate power within health facilities, where institutional cultures, norms, hierarchies, and conventions can

190. de Man, *supra* note 54, at 107.

191. *Id*. at 96.

192. *See World Development Indices – Military Expenditure (Current USD)*, WORLD BANK, https://databank.worldbank.org/reports.aspx?source=2&series=MS.MIL.XPND.CD&country= (last visited May 14, 2020); *Statistics on Resource Flows to Developing Countries*, ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, http://www.oecd.org/dac/financing-sustainable-development/development-finance-data/statisticsonresourceflowstodevelopingcountries.htm [https://perma.cc/7MCN-VL2P] (last visited May 14, 2020).

193. *See* Katsui & Kumpuvuori, *supra* note 88, at 230.

194. *See* Shah, *supra* note 156, at 229.

195. *See* de Man, *supra* note 54, at 98; Katsui & Kumpuvuori, *supra* note 88, at 234.

196. *See* de Man, *supra* note 54, at 98.

rationalize and normalize acts of abuse and disrespect.[197] Factors underlying clinical abuse include poor work environments; ineffective health systems, policies, and institutions; and structural inequalities such as poverty, gender inequality, hierarchical thinking, and colonial legacies.[198]

Under HCP, CHCs gain global moral, social, and political importance and priority as vital, universally shared elements of flourishing that are intrinsically valuable for flourishing and instrumentally valuable for other capabilities. Under PG, societies have moral duties to citizens' flourishing, and people have moral duties to humanity's flourishing. Given these ethical imperatives, health budgets are unlikely to be displaced as long-term political commitments secure investments in systematic development.[199] It is imperative to strengthen national and local health systems through workforce professionalization, increased primary and secondary care, and fully equipped institutions.[200] Better healthcare and public health systems allow individuals to achieve better health outcomes. Community-based maternal healthcare systems and emergency referral systems for advanced care in China, Cuba, and Malaysia highlight the importance of health systems interventions.[201]

PG conceptualizes responsibility as a continuum from individual to social; society should err on the side of greater social responsibility while simultaneously supporting the development of individual responsibility and choice. For example, health facilities could promote conditions for health by improving pay and working conditions, enhancing management and monitoring systems, and empowering patients.[202] It is necessary to strengthen both formal institutions, which have a greater ability than individuals to impact broad societal transformation, and the capacity of organizations, such as community based organizations that augment access to formal institutions, promote active participation to indirectly improve service quality,[203] and secure equitable treatment for marginalized groups.[204] The model of autonomous, voluntary behavior and "self-caused" health problems (that is, vis-à-vis habits, environment, genetics, and social factors) invites scrutiny. Individual responsibility is salient to creating the conditions for good health, not as an excuse to leave people to their own devices, shift blame away from society, and diminish societal responsibilities.

PG utilizes participatory moral reasoning and social decisionmaking, especially in setting priorities within resource limitations. Ample evidence on the relative effectiveness of clinical interventions exists, but knowledge about effective

197. Erdman, *supra* note 109, at 47.

198. *See id*.; Ruder et al., *supra* note 73, at 729.

199. *See* CHEN ET AL., *supra* note 188, at 146–47.

200. Robinson, *supra* note 161, at 1121.

201. WORLD HEALTH ORG., *supra* note 95, at 21.

202. *See* PATHMANATHAN ET AL., *supra* note 49, at 40–41; U.N. POPULATION FUND, *supra* note 46, at 34; U.N. POPULATION FUND, TOWARDS THE 2030 AGENDA, *supra* note 19, at 68; Ruder et al., *supra* note 73, at 729; Senanayake et al., *supra* note 104, at 86; Weil & Fernandez, *supra* note 33, at 942.

203. *See* Schmitz, *supra* note 29, at 533.

204. Cornwall & Nyamu-Musembi, *supra* note 168, at 1418.

implementation of strategies in LMICs is lacking.[205] Accordingly, solving public health problems necessitates practicing health agency within procedural mechanisms such as public process deliberation. Fistula survivors, as experts of the fistula experience, have been impactful fistula ambassadors and advocates.[206] Greater agency in self-determination of broader social factors is also a recognized strategy to improve health outcomes.[207] Individual agency in engagement and participation,[208] community action,[209] and national ownership of health systems[210] are examples of health agency contributing to more local public deliberation in health care, health policy, and healthy environments. Moreover, respecting individual and collective health agency helps safeguard universal ethical individualism from paternalism.

XI. ETHICAL INDIVIDUALISM

The principle of ethical individualism recognizes the moral significance of the health capabilities of every person worldwide. Fistula prevalence in LICs and national rural areas exemplify health inequity and structural violence and indifference toward poor women in poor countries,[211] premised on the morally arbitrary criterion of place of birth and compounded by international preferences under a charity paradigm. There is over a 100-fold difference in lifetime maternal mortality risk between LICs and HICs; a mother's lifetime mortality risk is as high as 6.9% in Chad, but only 0.002% in Italy.[212] Compared to well-resourced countries, low resourced countries have almost five times the incidence of fistula, 95.2% of which are associated with childbirth.[213] Yet despite these health inequities, donors overwhelmingly provide aid for economic, political, and military reasons including trade relations, economic advantage, geopolitical power, regional peace and security, supporting strategic alliances, and combating terrorism.[214] As such, the greatest amount of DAH is not allocated according to economic or medical need. Only four of the top ten DAH recipient

205. *See, e.g.*, PATHMANATHAN ET AL., *supra* note 49, at 1.

206. *See Intensifying Efforts to End Obstetric Fistula*, *supra* note 25, ¶ 26; Landry et al., *supra* note 82, at 929.

207. *See* Gready, *supra* note 90, at 742.

208. *See* Markella Boudioni et al., *The Role of Citizenship, Culture and Voluntary Community Organisations Towards Patient Empowerment in England and Greece*, 10 INT'L J. CARING SCI. 303, 310 (2017).

209. *See* Donnay & Ramsey, *supra* note 49, at 259.

210. *See Intensifying Efforts to End Obstetric Fistula*, *supra* note 25, ¶ 25; Amodu et al., *supra* note 32, at 7; Catherine Arsenault et al., *Emergency Obstetric Care in Mali: Catastrophic Spending and its Impoverishing Effects on Households*, 91 BULL. WORLD HEALTH ORG. 207, 207, 214 (2013).

211. Wall, *supra* note 1, at 257–59.

212. *See Lifetime Risk of Maternal Death (%)*, WORLD BANK, https://data.worldbank.org/indicator/SH.MMR.RISK.ZS (last visited May 14, 2020).

213. Hillary et al., *supra* note 10, at 487.

214. Prah Ruger, *supra* note 158, at 24.

countries also ranked in the top ten for burden of disease.[215]

Micro-level exploitation and abuse can also occur within charitable settings. Medical volunteers may lie about their qualifications or have hidden agendas that exploit vulnerable patients' trust.[216] A visiting surgeon in northern Nigeria performed surgeries without anesthesia and without attention to the most rudimentary perioperative care.[217] Moreover, fistula repair campaigns are essentially experiments in foreign, low resource health care provision.[218] Patient exploitation is exacerbated when patients are unaware of their clinical rights or feel that they should be indebted to health care providers, which is common amongst marginalized groups.[219] Thus, under a human rights framework, patients who are already vulnerable by virtue of the patient provider knowledge imbalance and power dynamic are ill equipped to advocate for themselves. Furthermore, the inaccessibility of accountability mechanisms tends to exacerbate existing social disparities. Institutions that protect rights by helping individuals navigate the systems that govern their access to entitlements are less accessible to economically vulnerable individuals, who already live within various systems of social marginalization that inhibit political power and self-determination.

It is difficult to address these problems within extant political frameworks, such as international realism and charity, because they undermine actors' abilities to pursue justice for structural violence and indifference and to make progress. The human rights approach has been criticized as a moral façade for an international system of realist power politics. An analysis of rights based development principles reveals their common bias toward changing the practices of development actors, rather than critically addressing the latent power dynamics and colonial histories of funders and recipients.[220] Most systemic reforms have been conceived of and enacted by those in power, who may be also the most threatened by deep changes, suggesting that a fundamental restructuring of the established order is yet to be seen.[221] Donors, governments, NGOs, and international organizations must apply the rights agenda to their places of privilege within a global political economy.[222] A rights based approach makes the process of development explicitly political,[223] but without an authoritative world government there is no political legitimization at the global level; rather, a moral foundation is needed to create stability and effectiveness.[224]

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215. *Id.*

216. *See* L. Lewis Wall, *Ethical Concerns Regarding Operations by Volunteer Surgeons on Vulnerable Patient Groups: The Case of Women with Obstetric Fistulas*, 23 HEC F. 115, 119 (2011).

217. Wall, *supra* note 75, at S35–S36.

218. *See* Wall, *supra* note 216, at 119–24.

219. Owusu-Dapaah, *supra* note 123, at 92.

220. Cornwall & Nyamu-Musembi, *supra* note 168, at 1421.

221. Peter Uvin, *From the Right to Development to the Rights-Based Approach: How 'Human Rights' Entered Development*, 17 DEV. PRAC. 597, 603–04 (2007).

222. Gready, *supra* note 90, at 741–42.

223. Cornwall & Nyamu-Musembi, *supra* note 168, at 1417.

224. Reidy, *supra* note 56, at 335.

Under PG, universal ethical norms are general duties owed to all persons that produce specific moral duties to ameliorate global health inequalities and injustices at individual, domestic, and global levels. Ethical individualism counts the lives of poor and marginalized women at risk or suffering from fistula the same as others; thus, HCP and PG prioritize these women's CHCs, and the conditions for their achievement. Accordingly, the CHCs of worse-off countries are brought to a morally acceptable threshold through a global progressive funding scheme, instead of through charitable donations. This deprioritizes domestic spending in non-CHC areas of better off countries. For example, resources expended on fistula tourism trips should be spent on building up local infrastructure or developing long term institutional partnerships.[225]

The moral imperative to prioritize the CHCs of the worse-off, measured by shortfall inequality, specifically seeks to develop the agency and flourishing of vulnerable individuals. Whereas the current approaches posit human rights or a right to health specifically in the legal sense, PG advances an ethical demand for equity in health and its corresponding societal obligations, going beyond existing international justice and public health frameworks. Establishing the social conditions for all individuals to be able to achieve health requires examining injustices besides inequitable distribution of health care resources, and responding appropriately to macro-level forces, societal power relations, and structural violence.[226] For example, inequity sensitive synergistic packages of health and social services that reach the poor, such as direct transfers of cash, clothes, and reimbursements for lost income, address group based disparities in health outcomes without requiring individuals to prove they are morally worthy of assistance.[227] Indeed, advocacy is more successful when shifted from a choice paradigm to a justice emphasis,[228] which benefits from a framework undergirded by the common good.[229] PG provides a normative grounding for international health politics that complement and expediate political work.

XII. HEALTH EQUITY

On an HCP and PG view, the principle of health equity replaces the "adequate care for all" standard. "Adequate care for all," stemming from medical ethics, does not address differences in quality of care, health norms, and health agency.[230] This has led to a two-tiered system of healthcare predicated on individuals' socioeconomic status and ability to litigate. Patients who have the time, money, education, and social capital to litigate receive better treatment, even if

225. Wall, *supra* note 75, at S37.

226. *See* Erdman, *supra* note 109, at 45; de Man, *supra* note 54, at 92; Ruder et al., *supra* note 73, at 729; Yamin, *supra* note 177, at 1.

227. *See* PATHMANATHAN ET AL., *supra* note 49, at 8; Hampton et al., *supra* note 22, at 47; Hessler, *supra* note 95, at 34.

228. Cook & Dickens, *supra* note 173, at 226.

229. Reidy, *supra* note 56, at 325.

230. *See* PRAH RUGER, *supra* note 27, at 144–45.

those resources could better serve other people.[231] In Brazil, for example, the constitutionalization and subsequent judicialization of the right to health increased access to health resources for wealthier citizens with greater capacities to litigate.[232] Due to poverty, unawareness, illiteracy, and geographic segregation, patients' rights conflicts that are redressed in court or quasi-judicial forums present along lines of social stratification, where the urban elite and middle class have more access than poor and working class patients.[233] A two-tiered public health system, premised on the morally arbitrary criterion of capacity to litigate, effectively arises. The core distinctions between the two tiers are basic coverage for catastrophic health needs versus additional coverage for other health care needs[234] and unacceptable care versus quality care.[235] This legalistic right to health approach is often counterproductive to goals of health equity.[236]

HCP and PG demand effective access to high quality, timely, efficient, and medically necessary and appropriate preventative and remedial care. In other words, institutions and providers must provide high quality health care to all individuals.[237] Fistula eradication and maternal health advocacy efforts have shifted focus from increasing the prevalence of facility delivery to increasing the quality of care, which includes technical and clinical expertise, respectful and humane treatment, service utilization, and patient empowerment.[238] Adherence to a quality principle includes reducing barriers to care: geographic, cultural, ethnic, socio-linguistic, financial, supply and distributional, informational (for example, unawareness, misinformation, misapprehension), and demand (that is, limitations individuals face in exercising health agency to convert resources into maximal functioning).[239]

Measures to reduce and eliminate barriers to care include outreach, transportation, and linguistic services; health information about treatment options and health education; and communication campaigns that are socially, linguistically, and culturally appropriate. Firsthand experiences of clinical abuse and discrimination, as well as secondhand knowledge of other women's negative experiences, have contributed to reluctance and refusal to utilize institutional health care services.[240] Thus, meaningful attempts toward health equity must not only account for primary goods such as access to services, but also for individual ability to use primary goods in pursuing health goals. Society should support individual health

231. Wang, *supra* note 110, at 629.

232. Tasioulas & Vayena, *supra* note 34, at 369.

233. *See* Owusu-Dapaah, *supra* note 123, at 94; Shah, *supra* note 156, at 221.

234. *See* PRAH RUGER, *supra* note 27, at 150–51.

235. *See* Wang, *supra* note 110, at 629.

236. *See* Tasioulas & Vayena, *supra* note 34, at 369.

237. PRAH RUGER, *supra* note 27, at 146, 159.

238. *See* PATHMANATHAN ET AL., *supra* note 49, at 137; Erdman, *supra* note 109, at 44–45; Velez et al., *supra* note 116, at S147 tbl.3.

239. *See Intensifying Efforts to End Obstetric Fistula*, *supra* note 25, ¶ 5; PATHMANATHAN ET AL., *supra* note 49, at 26, 40, 41 fig.12; PRAH RUGER, *supra* note 27, at 47; Banke-Thomas et al., *supra* note 113, at 124; Muleta et al., *supra* note 14, at 49.

240. *See* Bangser et al., *supra* note 94, at 93; Ruder et al., *supra* note 73, at 726.

agency through the health norms that govern individuals' health behavior and choices, as well as high quality, medically appropriate and necessary health care resources. Under HCP and PG, the guiding goal of access to care is for all to be able to achieve health functioning and health agency, not access for the sake of equality of access.

XIII. SHORTFALL INEQUALITY

Shortfall inequality is a measurement and evaluation method that integrates ethical concerns of equality, priority, and sufficiency to directly support the permanent eradication of fistula. Attainment equality, another conception of equality, risks leveling everyone down to the condition of the lowest achiever, preventing individuals from realizing their full potential.[241] As such, adequate care for all stops at equal access to care, but fails to follow through with differential clinical outcomes. For example, the delays framework is stuck in the descriptive paradigm, highlighting barriers to access that should be eliminated, but unable to transcend the incomplete goal of equal access.

Shortfall inequality measures the gap between individuals' freedom to achieve and the optimal, average achievement. Sufficiency describes leveling up all to the CHC benchmarks of better off groups, whereas priority entails achieving threshold CHC goals without redistribution threatening or sacrificing others' existing CHCs. Although equal outcomes amongst all individuals cannot be guaranteed, there is nevertheless an ethical obligation to prevent, ameliorate, and eradicate deprivations in individual capabilities from the optimal average and from individual potential. The health outcomes of privileged groups are a benchmark for what all should be able to achieve. Thus, on a PG view, the shortfall inequality principle builds on the ethical individualism principle by giving equal weight to the health capabilities of all individuals worldwide. In the case of obstetric fistula, eradication in HICs and some LMICs should be the reality everywhere.

XIV. PROPORTIONAL JUSTICE

The principle of proportional justice ascribes vertical and horizontal equity, meaning that different situations should be treated differently and similar situations should be treated alike. Paternalistic approaches do not balance individual vulnerability and individual responsibility, ignoring important individual differences. Access oriented approaches aim to secure more resources for delivery of services to certain groups, whereas primary goods based and rights based approaches aim to share existing resources more equally and empower people to claim their rights to particular resources.[242] Despite these laudable goals, the distributive focus of these approaches means that differing individual situations and

241. PRAH RUGER, *supra* note 28, at 106.
242. Cornwall & Nyamu-Musembi, *supra* note 168, at 1417.

abilities are overlooked.[243] Accordingly, individuals who require more than what is expected under an idealized supra-individual are blamed for their personal shortcomings.[244]

At the other extreme, an absolute autonomous respect for persons is also inappropriate in a health care setting where the patient is not fully independent, but rather vulnerable to exploitation and abuse. Patients whose rationality does not correspond to biomedical ideals, but rather reflects their subjective experiences and goals, are thus irrational according to the standards of liberal legalism, which demands that the individual achieve an unrealistic ideal of liberal personhood in order to become eligible for the full scope of rights entitlements.[245]

Under HCP and PG, global health justice aims for all to have opportunities to be healthy, not simply the opportunity for more or equal resources.[246] This approach recognizes that different people need different levels of resources. Proportional justice adeptly balances individual vulnerability with individual responsibility because its conception of equality is informed by individual difference. The concept of disproportionate effort gives more weight to the needs of the worse off in proportion to their distance from the better off, bringing disadvantaged individuals to their highest possible threshold level of functioning. In the case of obstetric fistula, this has been demonstrated by specially targeted media- and radio- outreach campaigns and case-identification efforts.[247] In addition, Cuba aims to achieve social equity by ensuring inclusive universal social services, differentiated according to individual and community need. Universal health coverage with differentiated access for vulnerable populations secures a level of health status unmatched in other LMICs.[248]

XV. GLOBAL HEALTH GOVERNANCE AS SHARED HEALTH GOVERNANCE

Shared health governance (SHG) is a framework that can be applied at the domestic and global levels. It posits shared individual and social responsibility as central to creating the domestic and global conditions for health capabilities because health is produced when actors perform their core functions and fulfill their key responsibilities.[249] SHG thus seeks to coordinate actors to empower individuals and create health enabling environments. Governing for the common good of health flourishing establishes the legitimacy of shared responsibility allocation, creating shared attitudes, identities, values, and fair procedures that promote cooperation and trust amongst actors.

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243. *See* Zöe Baker et al., *Barriers to Obstetric Fistula Treatment in Low-Income Countries: A Systematic Review*, 22 TROPICAL MED. & INT'L HEALTH 938, 949–50 (2017); Gauri, *supra* note 29, at 466, 468.

244. Donchin, *supra* note 37, at 367–68.

245. Mary Neal, *Dignity, Law and Language-Games*, 25 INT'L J. SEMIOTICS L. 107, 118 (2012).

246. PRAH RUGER, *supra* note 28, at 104, 146.

247. *See Intensifying Efforts to End Obstetric Fistula*, *supra* note 25, ¶¶ 27, 52; TEGHRARIAN & RAMSEY, *supra* note 13, at 5; Landry et al., *supra* note 82, at 929.

248. *See* Johnson, *supra* note 43, at 110.

249. PRAH RUGER, *supra* note 28, at 122, 136–37.

Under an SHG framework of global health governance, an effective and equitable global health regime is achieved through universal participation and health agency, directed toward human flourishing. The common good and the recognition of shared identity in plural subjecthood undergirds public moral norms, which inspire collective action and support voluntary ethical commitments. This moral foundation, along with a process of mutual collective accountability, forms the basis for effective responsibility allocation.

XVI. PLURAL SUBJECTHOOD

Plural subjecthood is a concept that acknowledges the group memberships of human beings in various subnational and domestic communities, as well as in a global community. This shared identity is a more empirically compelling and morally useful conception of social relations than isolated, individual, self-interest because it confers an equal and common moral status on all persons and respects individuals' commitments in multiple communities. Individualistic self-interested approaches to normative and empirical health policy create a conflict paradigm that produces suboptimal outcomes at the cost of health equity. Attempts to integrate ethics and social relations have primarily formalized social contract theory; however, the rationalizing premise underlying acting in accord with agreed upon moral principles is still narrow self-interest.[250] Right to health litigation in Brazil illustrates this underlying premise of narrow self-interest, where individual claims for expensive drugs not covered by the national public health system dominate the courts.[251] Unfortunately, using law to resolve conflicts is inflexibly and bluntly absolute; judges can either uphold or reject claims but they cannot assess a ruling's cost-effectiveness or the efficiency of a given public expense.[252] Thus, in Brazil, governmental compliance with judicial orders still required the provision of drugs that lack evidence of benefits to patients and those unregistered with the Brazilian Health Regulatory Agency, which calls into question their scientific validity.[253]

Similarly, in maternal health, bioethical principles frame maternal fetal relations as two principles in conflict—maternal autonomy and fetal beneficence—rather than a fetus that is biologically dependent on the pregnant woman with her own agency.[254] Hospital policies, obstetricians, and researchers must then prioritize one principle over the other. The adversarial approach at both the clinical and legal levels is ill-equipped to understand and navigate the complexity of social problems, which often extend into macrosocial conditions and implicate resource trade-offs and political commitments.[255] Moreover, the human rights approach

250. *See, e.g.*, Prah Ruger, *supra* note 98, at 33–35.

251. Wang, *supra* note 110, at 626.

252. *See* Tremblay, *supra* note 108, at 355.

253. Wang, *supra* note 110, at 621.

254. *See, e.g.*, Raymond De Vries, *Obstetric Ethics and the Invisible Mother*, 7 NARRATIVE INQUIRY BIOETHICS 215, 219 (2017); Donchin, *supra* note 37, at 371.

255. Wang, *supra* note 110, at 629–30.

constrains the scope of obligations to individuals' relationship with the government, neglecting collective identities as well as interpersonal relations.

Plural subjecthood recognizes that as plural subjects, we owe each other social justice. SHG seeks to align self-interest, national interest, and the common good with shared goals through ethical commitments to seek societal conditions to concurrently achieve individual and common interests.[256] Indeed, plural subjecthood and the coproduction of health situate individual interest as compatible with and contributing to collective interest. Other regarding or prosocial altruistic behavior is motivated by considering and promoting the interests of others, as well as advancing one's own interest. Calling forth this common subjecthood to coproduce a healthy society entails mutually understanding common problems and committing jointly to solving them, as well as general duties of social justice. Accordingly, the fundamental human interest in health shared by plural subjects leads to shared health goals.

Although distinct from communitarianism, plural subjecthood prioritizes empirical and ethical human interconnectedness. A mature society fosters responsibility, self-awareness, and societal awareness in its citizens. The ethos of plural subjecthood has been demonstrated by community fistula initiatives that not only raise awareness but also focus community action on maternal mortality and morbidity.[257] Developing a community funding scheme for hospital transport is one such strategy that supports advocacy efforts to eliminate obstetric fistula.[258] Families are a large part of support for women living with and recovering from fistulas, and UHC is a central example of plural subjecthood operationalized, where the neediest are covered by the better off in society with an exemption system.[259]

XVII. PUBLIC MORAL NORMS AND JOINT ETHICAL COMMITMENTS

Authentic cooperation of interdependent parties is critical for creating global health equity. All must do their part in fostering healthy environments—using scarce resources wisely, making prudent health decisions and actions for oneself and for society—that create the conditions, structures, institutions, and norms to bring about flourishing. Currently, international treaties and conventions lack formal and informal accountability and enforceability mechanisms for implementation.

International political realism is limited to its inadequate coercive methods, such as unregulated economic sanctions and political pressure. Without an international government, coercion is an unsubstantiated cooperation mechanism, yet international human rights structures expect these unwilling states to internalize accountability for implementing their mechanisms. Yet, legal rights frameworks

256. Prah Ruger, *supra* note 98, at 32.

257. *See* Donnay & Ramsey, *supra* note 49, at 259.

258. *See* WAIZ ET AL., *supra* note 93, at 14.

259. *See* Marga Kowalewski et al., *Can Mothers Afford Maternal Health Care Costs? User Costs of Maternity Services in Rural Tanzania*, 6 AFR. J. REPROD. HEALTH 65, 73 (2002).

on paper are meaningless if the state is unwilling to provide those rights.[260] Accordingly, lack of political will easily undermines human rights enforcement. In addition, "perceived cultural uneasiness" may prevent international human rights documents and treaties from being implemented.[261] Cultural realities that are unfavorable toward women continue to play out on the international stage, where cultural orders of gender discrimination and household-level rights violations persist.

SHG employs public moral norms (PMNs) and incompletely theorized agreements (ITAs) to contribute to the effectiveness of joint, voluntary, ethical commitments as a foundation for self-motivated action. PMNs refer to individual and collective moral values in the public domain.[262] Internalized PMNs serve to self-motivate joint, voluntary, ethical commitments, which have distinct deontological and consequential advantages over coercive realist approaches. As a form of thin universalism and consistent with transpositionality, ITAs unite health values that have been maintained across different societies and throughout time while allowing disagreement about noncentral dimensions of health and multiple logical paths to the same conclusion.[263] Consistent with PMNs, ITAs permit consensus on specific issues without requiring agreement on a larger theory, thereby achieving consensus amongst pluralistic conceptions of the good within the scope of human flourishing.

Even if shared for different reasons, shared values generate the social agreement necessary for policy and legislation. Social cooperation requires more than regulations and laws because the government cannot micromanage all people.[264] Public reasoning and democratic practices facilitate the willing embrace of ethical commitments and the internalization of PMNs and their correlate social sanctions; legalism lacks mechanisms to achieve such standardization and motivation. Health culture exemplifies PMNs and ITAs in action.[265] Global health responsibility and cosmopolitanism are authoritative elements of national identity;[266] the collective good, community spirit, and volunteering are considered alongside liberalism, unity, and pride in England;[267] and Bangladesh's postwar development processes were characterized by pro-equity, social mobilization, institutional pluralism, and civil dynamism.[268] Bangladesh's health gains have also been attributed

260. *See* Joel E. Correia, *Adjudication and Its Aftereffects in Three Inter-American Court Cases Brought Against Paraguay: Indigenous Land Rights*, 11 ERASMUS L. REV. 43, 55 (2018).

261. *See* Amzat, *supra* note 157, at 291.

262. PRAH RUGER, *supra* note 27, at 14.

263. *Id*. at 74, 98.

264. Prah Ruger, *supra* note 98, at 33.

265. *See* Wendy K. Mariner & George J. Annas, *A Culture of Health and Human Rights*, 35 HEALTH AFF. 1999, 2000 (2016).

266. Johnson, *supra* note 43, at 93.

267. Boudioni et al., *supra* note 208, at 305.

268. A. Mushtaque R. Chowdhury et al., *The Bangladesh Paradox: Exceptional Health Achievement Despite Economic Poverty*, 382 LANCET 1734, 1734 (2013).

to public–private collaborations that help the government extend their reach in implementing national strategies.[269]

SHG motivates partnership toward a shared goal, coordination, cooperation, accountability, and agency through justice and through aligning rational self-interest with shared goals. For example, a collective process can establish mutual collective accountability (MCA) amongst global health actors that hold all actors across the global health enterprise to joint standards. Actors on an issue first collectively identify the group's goals, individual roles and responsibilities, desired results, and key outcomes and metrics for evaluation. Voluntary compliance with these publicly attested standards is undergirded by joint ethical commitments among actors.

This process emphasizes shared norms and facilitates their internalization while creating substantive and procedural legitimacy, using ITAs and PMNs that form a significantly more stable foundation for collective action than adversarial coercion or traditional political science models of political bargaining.[270] An overlapping consensus of shared values taps into core interests and universally shared objectives, which are primary motivations to achieve global health justice.[271] This overlapping consensus does not have to be fully determinate; it resists a single, unique social ordering and exhibits incomplete specification with dominance partial ordering. This allows the common good, and related efforts to further it, to achieve diverse and popular public support. For example, mandatory HIV testing and full sexual-history disclosure requirements that would seemingly violate North American beliefs about privacy are socially accepted in some countries as necessary for public health.[272] Public legitimacy of and widespread adherence to this norm is an instance of social internalization.

XVIII. RESPONSIBILITY ALLOCATION

As a framework that reflects the complex coproduction of health, SHG's conceptualization of responsibility allocation is more suitable for health governance than causal blame. Currently, the concept of responsibility is predicated on a perceived social contract of the state as the duty bearer, creating political gaps and capacity constraints at the domestic level for nations that cannot fulfill their duties.[273] Vulnerable individuals are left out, including socially, sexually, economically, politically, and medically marginalized fistula patients, who cannot consent or contribute to the social contract for mutual good. The current approach is stuck perpetuating existing power structures because extant systems of medical authority and legal redress are subordinate to extant structures of systemic mistreatment.[274]

269. *See* Koehlmoos et al., *supra* note 121, at 49.
270. *See* PRAH RUGER, *supra* note 27, at 207–09, 213–14.
271. *See* Prah Ruger, *supra* note 85, at 42.
272. Johnson, *supra* note 43, at 103.
273. *See* Owusu-Dapaah, *supra* note 123, at 91.
274. *See* Erdman, *supra* note 109, at 47.

Furthermore, the limits of legal causality are particularly challenged with regard to positive rights such as health, which require institutional structures for specifying duties and allocating responsibility. Even when institutional structures are missing or weak, the content of negative political rights and duties and the agent specifically responsible are clear; however, in the absence of institutional structures, violations of positive rights become untethered.[275] In a globalized world characterized by complex causal chains, few to none of the actors implicated can be directly blamed for perpetrating harm against a given victim, because most harms are created through unjust and violent systems.

In addition to the limitations of responsibility attribution based on legal causality, narrow responsibility assessment and assignment to individuals and particular institutions (for example, domestic legal systems, for-profit hospitals, managed care organizations, and the medical profession) diverts attention from the interdependent roles of various actors in fostering individual and societal health. This narrowed scope has discouraged nonprofits from collaborating with domestic social movements and civil society and from confronting the national government. Rights based challenges to power that emerge are typically fragmented and limited to particular programs, rather than systemic.[276] Accordingly, global health actors are ineffectively, unaccountably, and inefficiently coordinated, if at all mobilized. This fragmented dynamic of actors in international health means that even NGOs fighting to protect human rights must partake in the political chess game, partnering with professional medical associations such as FIGO and WHO to maximize their chances of obtaining favorable government responses.[277]

Finally, a narrow legal state focus has resulted in extensively inconsistent enforcement. Courts are weak actors in implementing judgements, requiring ally organizations, national networks, and international networks to sustain pressure instead.[278] Private charitable organizations are even less accountable to marginalized groups than formal public institutions.[279] Nonprofits have failed to critically consider the accountability and responsibility arising from their presence in local communities across LMICs.[280]

Transcending the legal model of causality, SHG allocates responsibilities according to criteria of functions, capabilities, effectiveness, and efficiency; its orientation attributes responsibility to actors who are capable of serving key functions in global health. Collective structures such as domestic governments have moral responsibilities shaped to the contours of health producing conditions, because health is the product of institutions and actors performing

275. Elizabeth Ashford, *The Inadequacy of Our Traditional Conception of the Duties Imposed by Human Rights*, 19 CAN. J.L. & JURIS. 217, 217 (2006).

276. Gready, *supra* note 90, at 744; *see* Schmitz, *supra* note 29, at 540.

277. Dorothy Shaw & Rebecca J. Cook, *Applying Human Rights to Improve Access to Reproductive Health Services*, 119 INT'L J. GYNECOLOGY & OBSTETRICS S55, at S55 (2012).

278. Yamin, *supra* note 177, at 2.

279. *See* Cornwall & Nyamu-Musembi, *supra* note 168, at 1432.

280. *See* Schmitz, *supra* note 29, at 523.

core functions and responsibly fulfilling key roles.[281] Backward looking perspectives establish responsibility based on cause or contribution—either by commission or omission—to the current situation and ability to have foreseen the resulting harm. A forward-looking perspective seeks out actors able to address current and future global health injustices due to their roles, resources, and capabilities. Under an SHG framework, actors have direct and specific responsibilities to fulfil their role effectively.[282] Cross-sector collaboration between governments and nonnational actors, supported by international prioritization, is a successful example of the benefits of greater coordination.[283] A forward-looking perspective also looks toward future innovations, supporting investment in biomedical and health research, because obligations to global health transcend currently available technology and information.

Under SHG, nations hold primary responsibility for health objectives because the country level is most suitable for addressing health protection, prevention, and promotion.[284] This includes raising and redistributing revenue, enacting and implementing policy, conducting research and education, developing environments that support CHCs, enacting universal health coverage, and serving as political units of self-determination and collective action.[285] However, although the nation is a primary duty bearer, universal ethical duties extend beyond the state to many nongovernmental actors.[286] SHG coordinates and mobilizes a range of actors—individuals, governments, NGOs—held accountable by MCA.

Multi-actor coordination has proven critical in improving obstetric fistula outcomes.[287] NGOs coordinate with and complement national strategies; for example, universities and research institutes create and disseminate knowledge. In the private sector, medical providers (for example, hospitals, clinics, the medical profession) efficiently provide high quality goods and services; insurers provide all citizens with medically necessary and appropriate, cost-minimized, universal comprehensive benefits packages. Global health institutions support national and local health systems in meeting their populations' health functioning and health agency needs by creating global public goods (for example, knowledge, addressing externalities), empowering LMICs, supporting development and sustainability of fully functional national and local health systems, reducing overlap and

281. *See* PRAH RUGER, *supra* note 28, at 168.

282. Prah Ruger, *supra* note 98, at 41.

283. *See, e.g.*, *Intensifying Efforts to End Obstetric Fistula, supra* note 25, ¶¶ 28–29, 37; UNITED NATIONS POPULATION FUND, TOWARDS EQUALITY IN ACCESS, *supra* note 46, at 8; Donnay & Ramsey, *supra* note 49, at 256.

284. *See* Prah Ruger, *supra* note 85, at 48.

285. PRAH RUGER, *supra* note 28, at 117.

286. John Tasioulas & Effy Vayena, *Public Health and Human Rights*, 316 J. AM. MED. ASS'N 103, 104 (2016).

287. *See, e.g.*, BASARANKUT ET AL., *supra* note 19, at 35; Johnson, *supra* note 43, at 101–02; TEGHRARIAN & RAMSEY, *supra* note 13, at 9; Donnay & Ramsey, *supra* note 49, at 256; Weil & Fernandez, *supra* note 33, at 940.

redundancies, and providing more long-term, stable, technical and financial development assistance.[288]

CONCLUSION

A theory of justice provides the principles required to right the wrong of the unfair global distribution of the costs and benefits of maternal health. The global community urgently needs a theory of justice and health to address the preventable tragedy of obstetric fistula, which continues to afflict maternal health and societal well-being around the world. It is far past time that fistula is completely and finally eradicated, as it has been in HICs for years. A theory of justice and health provides the analytical tools for fistula eradication. Applying the health capability paradigm at the domestic level, provincial globalism at the global level, and shared health governance to the case study of obstetric fistula illustrates a dramatic counterfactual where fistula eradication is achieved through HCP's substantive principles for domestic policy, PG's universal ethical norms and responsibility allocation, and SHG's collective action mechanisms.

288. Tasioulas & Vayena, *supra* note 286, at 103–04.