

Equitable Global Health Governance– a pathway to reducing global maternal mortality

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Abstract

Maternal mortality remains unacceptably high in many low- and middle-income countries (LMICs), revealing structural inequities rooted in colonial history, power imbalances, and marginalisation of local leadership. This paper examines how equitable global health governance can serve as a pathway to reducing maternal mortality, especially through the lens of decolonisation. It identifies three critical shifts. First is a paradigm shift which is adopting a justice-based approach that prioritises resilient, locally led health systems over external aid models. Second is a knowledge shift that is, promoting equitable research practices by reforming authorship structures, strengthening local research institutions, and ensuring representation from the Global South. Third is a leadership shift which is building leadership capacity within LMICs and increasing their influence in global decision-making. Achieving equitable maternal health outcomes will require both internal reforms and global restructuring. By fostering mutual accountability and shared leadership between the Global South and North, LMICs can move from recipients of aid to co-creators of sustainable health systems.

Keywords:

Introduction

According to the World Health Organization (1), a woman dies every two minutes from pregnancy or childbirth-related complications, the vast majority in low- and middle-income countries. These deaths are largely preventable, yet maternal mortality remains one of the clearest indicators of global health inequity. In 2017 alone, approximately 810 women died each day from pregnancy-related causes, with rates about 42 times higher in developing nations compared to high-income countries (2). This stark contrast reflects more than gaps in medical care; it points to deeper structural inequities and persistent failures in global health governance. To address this crisis, the international community adopted Sustainable Development Goal (SDG) 3.1, which aims to reduce global maternal mortality to fewer than 70 deaths

per 100,000 live births by 2030 (3). While some countries have made progress, of which many especially in the Global South are still far from meeting this target. The disparities are rooted in long-standing historical injustices, including colonial legacies and power imbalances that continue to shape global health systems and policies. Current health governance structures often sideline perspectives from the Global South, reinforcing priorities and frameworks dominated by actors from the Global North.

As the 2030 deadline draws closer, it is increasingly clear that technical solutions alone will not close the gap. Reducing maternal mortality on a global scale requires a shift toward more equitable governance one that centres justice, acknowledges historical context, and meaningfully includes leadership from the regions most

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affected. This paper explores how global power dynamics, colonial history, and governance mechanisms contribute to maternal health outcomes. It argues that systemic reform, inclusive leadership, and a decolonised approach to global health are essential to achieving the SDG 3.1 target and eliminating preventable maternal deaths.

Background and Historical Context of Global Health Initiatives

Global health governance has evolved over centuries in response to shared health threats and the growing need for cross-border collaboration. In the 19th century, the threat of widespread disease outbreaks such as cholera and plague led European powers to convene the first International Sanitary Conferences. These meetings resulted in agreements on quarantine and other public health measures designed to protect populations and economies from disease transmission (4). However, these early efforts were primarily driven by colonial powers, motivated not by equity or global solidarity, but by economic self-preservation and the protection of trade routes. From the outset, global health efforts were shaped by unequal power dynamics, privileging colonialist interests over collective well-being. The devastation wrought by World War II further highlighted the need for a robust and institutionalized global health framework. In 1948, this culminated in the establishment of the World Health Organization (WHO), tasked with leading and coordinating international health activities (4). The WHO was granted legal authority to develop international health regulations, provide technical guidance, and support national health systems. While the WHO marked a turning point in global health leadership, its governance structures and financing mechanisms remained heavily influenced by high-income countries (HICs), limiting the influence of low- and middle-income countries (LMICs) in shaping global health agendas.

By the 1980s, maternal mortality had emerged as a major global health concern, with nearly half a million women dying annually from largely preventable causes related to pregnancy and childbirth (5). This public health crisis prompted the WHO, the United Nations Population Fund (UNFPA), and the World Bank to convene the first global conference on maternal mortality in Nairobi, Kenya, in February 1987. The resulting Safe Motherhood Initiative (SMI) called for a 50% reduction in maternal deaths in developing countries over the subsequent decade (6). While this was a significant milestone,

the initiative struggled to gain sustained political attention and funding. Like many global health programs, its effectiveness was hindered by limited political prioritisation and weak integration into broader health systems (7).

In 2000, the adoption of the Millennium Development Goals (MDGs) introduced MDG 5, which aimed to reduce maternal mortality by 75% by 2015. The MDGs helped bring increased attention to maternal health and contributed to a 44% decline in the global maternal mortality ratio (MMR), from 385 to 216 deaths per 100,000 live births between 1990 and 2015 (8). However, this progress was uneven, with Sub-Saharan Africa and South Asia still accounting for 86% of global maternal deaths by 2015 (9). The MDGs were also widely criticised for their vertical, disease-specific approach, which failed to strengthen national health systems or address underlying power asymmetries and the historical marginalisation of LMICs in global decision-making processes (4, 10).

To address these limitations, the Sustainable Development Goals (SDGs) were launched in 2015, offering a more integrated and holistic framework for global health. SDG 3.1 specifically targets a reduction in global maternal mortality to fewer than 70 deaths per 100,000 live births by 2030. Unlike the MDGs, the SDGs emphasise universal health coverage, health systems strengthening, and the social determinants of health. However, despite this broader scope, global health governance under the SDGs continues to operate within political and economic structures that perpetuate inequality and favour the interests of HICs (4). The agendas of powerful donors, foundations, and international institutions often overshadow the voices and priorities of LMICs—particularly countries in the Global South where the maternal health burden remains highest.

As of 2017, maternal mortality remained alarmingly high, with approximately 810 women dying each day due to pregnancy-related complications (11). The risk of maternal death was still approximately 42 times higher in developing countries than in developed nations (11). Between 2003 and 2009, direct causes such as haemorrhage (27.1%), hypertensive disorders (14%), sepsis (10%), unsafe abortion (7.9%), embolism, and other direct complications (7.9%) were major contributors to maternal deaths. In addition, more than a quarter of maternal deaths were attributed to indirect causes, including infectious and non-communicable diseases (12).

Importantly, most maternal deaths are preventable.

Experts have highlighted that the persistence of maternal mortality particularly in the Global South is closely linked to social and political determinants of health, such as weak health systems, harmful gender norms, economic inequality, and discriminatory barriers to sexual and reproductive health services (4, 13). The de-prioritisation of women's health rights and the fragility of healthcare systems reflect broader patterns of global health governance that continue to marginalise LMICs and entrench inequities. Yet, despite these evident structural drivers, insufficient attention has been paid to how global political priorities and systemic power imbalances within global health governance continue to obstruct progress toward SDG 3.1. Without confronting these root causes, global efforts to reduce maternal mortality will remain incomplete and unsustainable.

Current status of global health governance

Global health governance continues to be disproportionately shaped by actors and institutions based in the Global North, often sidelining voices from the Global South even though the latter bears the greatest burden of health challenges such as maternal mortality (14). This imbalance reflects enduring colonial legacies that persist in how global health priorities are defined, funded, and operationalised. Financial and decision-making power typically flows from North to South, constraining the agency of low- and middle-income countries (LMICs) to design and implement solutions that reflect their specific sociopolitical and health system contexts. This asymmetry is evident in the misalignment between disease burden and funding priorities. High-burden conditions such as pneumonia and cardiovascular disease in LMICs often receive less attention and financing than donor-preferred areas like immunisation and family planning, which have historically aligned with Northern political and philanthropic agendas (15). Such patterns reinforce global health architectures that are more responsive to donor interests than recipient needs. The COVID-19 pandemic further exposed these inequities: vaccine nationalism, supply hoarding, and conditional aid highlighted how emergency responses often reproduced, rather than challenged, colonial-era hierarchies (16). These realities have intensified calls for the decolonisation of global health and for redistributing power within global health institutions.

Despite growing advocacy, global political

commitment to maternal health remains uneven.

Chronic underfunding persists: in 2006, an additional \$1 billion was needed to meet basic maternal and child health goals, with more recent estimates calling for a \$3.9 billion annual increase sustained over a decade (17). These shortfalls are symptomatic of broader systemic inequities that deprioritise maternal health particularly in LMICs within both international and domestic policy agendas. Without bold leadership and strategic investment from within the Global South, achieving meaningful reductions in maternal mortality will remain out of reach, undermining progress toward the Sustainable Development Goals. There is increasing momentum to build a more inclusive and equitable global health architecture, one that elevates leadership from the communities and regions most affected by health disparities. Yet structural inertia remains a major barrier. Leadership across major global health organisations remains highly skewed: approximately 70% of leaders are male, 80% are from high-income countries, and 90% received their training in high-income settings (17). This concentration of power limits the diversity of perspectives necessary for transformative change and often results in top-down interventions misaligned with local realities. Addressing these imbalances requires more than rhetorical support—it demands institutional reform, equitable financing, and a genuine shift toward shared governance that centres and empowers leadership from the Global South.

Discussion

This paper does not intend to absolve governments in the Global South of their responsibilities to their citizens particularly in contexts where internal political dynamics, corruption, and governance failures have contributed significantly to weak health systems and poor maternal health outcomes. It is, however, essential to situate these challenges within the broader context of global health inequities. While many high-income countries (HICs) historically built their health systems through the exploitation of Global South resources, they have also demonstrated consistent investment and accountability in maintaining and improving those systems. Conversely, several countries in the Global South continue to struggle with health system development due to a combination of historical exploitation, institutional weakness, and policy

neglect. Nonetheless, positive examples from within the Global South demonstrate that progress is possible. Brazil, for instance, reduced maternal mortality by 49% between 1990 and 2019 and currently reports a maternal mortality ratio (MMR) of approximately 72 deaths per 100,000 live births (18). In stark contrast, Nigeria is a country with significant economic potential which continues to report one of the highest global MMRs at 814 deaths per 100,000 live births, largely due to persistent systemic and political barriers (19). These disparities highlight the urgent need for national leadership and reform within the Global South, alongside global solidarity.

As the Global South increasingly asserts itself in global health governance, it must seize the opportunity to transition from donor-dependency to self-sufficiency. This involves strengthening the six World Health Organization (WHO) health system building blocks: leadership and governance, health financing, service delivery, health workforce, health information systems, and access to essential medicines and technologies. Strategic investment in regional manufacturing capabilities, health workforce development, civil society engagement, and transparent governance will be essential to sustain progress and build resilience against future shocks (20). A critical area for reform is health financing. Shifting away from fragmented, donor-driven models toward sustainable domestic funding will enable greater autonomy and responsiveness. This can be achieved through increased national budget allocations to health, public-private partnerships, regional financing frameworks, and innovative funding mechanisms that prioritize long-term outcomes over short-term gains.

Equally important is the advancement of research and knowledge production within the Global South.

Local research must be valued and supported, not only to inform context-specific policies but also to shape global discourses. Strengthening regional academic platforms, ensuring equitable authorship policies in international publishing, and encouraging South-South knowledge exchange will elevate the visibility and influence of Global South scholars in global health (14). Ultimately, transforming maternal health outcomes in the Global South demands a twofold approach: first, addressing internal governance and systemic weaknesses; and second, restructuring global health governance to enable equitable collaboration, mutual accountability, and shared leadership. By centering contextually driven solutions, building regional capacity, and fostering

equitable partnerships with the Global North, countries in the Global South can redefine their roles from aid recipients to co-leaders in global health.

Recommendations

Improving maternal health outcomes in the Global South requires a major shift in how global health is governed, how knowledge is produced, and who leads. This transformation must confront colonial legacies and structural power imbalances that continue to shape global health. A more equitable system depends on three key changes: a paradigm shift, a knowledge shift, and a leadership shift.

1. **Paradigm Shift: Advancing Health Justice:** A just global health system must acknowledge how colonial histories and structural inequities shape present-day outcomes. This shift requires global health interventions to be viewed not as charity, but as a responsibility to address historical and systemic injustice. Donors and international organisations must direct more flexible, unconditional funding to institutions in the Global South. Locally governed health systems should be strengthened through long-term investment and institutional capacity building, rather than through externally imposed models. Sustainable change depends on empowering local systems to respond to their own contexts.

2. **Knowledge Shift: Decolonising Research and Education:** The dominance of high-income countries in global health research and publishing continues to marginalise voices from the Global South, even when research focuses on their realities. This imbalance must be addressed by promoting inclusive academic partnerships, increasing support for South-South collaborations, and funding studies led by Global South institutions. Funders, publishers, and universities should reform authorship practices that exclude LMIC researchers. Studies conducted in LMICs should be led by local investigators whose work informs both local policy and global thinking.

3. **Leadership Shift: Building Sovereign Health Agendas:** True decolonisation requires a major rebalancing of leadership. Global South institutions must not only be involved in global health governance but must take the lead in setting priorities, implementing solutions, and evaluating progress. This shift requires moving beyond aid models that treat the Global South as passive recipients. Instead, equitable partnerships must be built through mentorship, investment in leadership development, and increased representation of LMIC

professionals in international institutions. The Global South must also take active ownership of its health agenda and demand accountability from global actors. These three shifts offer a path toward a more just, inclusive, and collaborative global health system. Ending maternal mortality and reducing health inequities will require more than technical fixes. It will take political will, structural reform, and shared leadership between the Global South and North. This change is not optional. It is essential for achieving sustainable and equitable health outcomes worldwide

Conclusion

Decolonising global health and improving maternal health outcomes in the Global South demand a fundamental reconfiguration of existing power dynamics, knowledge hierarchies, and leadership structures. While the path forward is complex and requires sustained national reforms and coordinated international cooperation, it is both necessary and achievable. Meaningful progress hinges on the commitment of global health actors to support sovereign, context-driven solutions, and on the Global South's determination to assert leadership and shape its own health agendas. With genuine allyship, equitable partnerships, and investment in local capacity, a more inclusive and just global health architecture, capable of addressing systemic inequities such as maternal mortality, can be realised within a generation.

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References

- World Health Organization. A woman dies every two minutes due to pregnancy or childbirth: UN agencies. 2023. Available from: <https://www.who.int/news/item/23-02-2023-a-woman-dies-every-two-minutes-due-to-pregnancy-or-childbirth--un-agencies>
- World Health Organization. Maternal mortality. 2019. Available from: <https://iris.who.int/bitstream/handle/10665/329886/WHO-RHR-19.20-eng.pdf>
- World Health Organization. Sustainable development goals (SDGs): Goal 3. Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. 2024. Available from: <https://iris.who.int/handle/10665/208272>
- Gostin LO, Meier BM, editors. Global health law & policy: ensuring justice for a healthier world. Oxford University Press; 2023.
- Smith SL, Rodriguez MA. Agenda setting for maternal survival: the power of global health networks and norms. Health Policy Plan. 2016 Apr;31 (Suppl 1):i48–59.
- Mahler H. The safe motherhood initiative: a call to action. Lancet. 1987 Mar 21;1(8534):668–70.
- Shiffman J. Generating political priority for maternal mortality reduction in 5 developing countries. American journal of public health. 2007 May;97(5):796–803.
- United Nations, Department of Economic and Social Affairs, Population Division. Accessed online at <http://www.un.org/en/development/desa/population/publications/mortality/maternal-mortality-report-2015.shtml>
- Tiwari C, Jain N, Goli S, Puri P. Political determinants of health:(re) examining the role of governance in reducing maternal mortality. Health Economics, Policy and Law. 2023 Jul;18(3):248–73.
- Fehling M, Nelson BD, Venkatapuram S. Limitations of the Millennium Development Goals: a literature review. Global public health. 2013 Dec 1;8(10):1109–22.Mahapatro SR, Mishra US, Swain S. Introduction: Perspectives on Maternal and Child Health and Nutrition in Empowered Action Group States. In:Health and Nutrition of Women and Children in Empowered Action Group States of India 2023 Sep 20 (pp. 1–8). Routledge India.
- Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, Gülmezoglu AM, Temmerman M, Alkema L. Global causes of maternal death: a WHO systematic analysis. The Lancet global health. 2014 Jun 1;2(6):e323–33.
- World Health Organization. Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. World Health Organization; 2023 Feb 22.
- Pai M, Bandara S, Kyobutungi C. Shifting power in global health will require leadership by the Global South and allyship by the Global North. The Lancet. 2024 Nov 2;404(10464):1711–3.
- Shiffman J. Generating political priority for maternal mortality reduction in 5 developing countries. American Journal of Public Health. 2007 May;97(5):796–803.
- Kwete X, Tang K, Chen L, Ren R, Chen Q, Wu Z, Cai Y, Li H. Decolonizing global health: what should be the target of this movement and where does it lead us?. Global health research and policy. 2022 Jan 24;7(1):3.
- Powell-Jackson T, Borghi J, Mueller DH, Patouillard E, Mills A. Countdown to 2015: tracking donor assistance to maternal, newborn, and child health. The Lancet. 2006 Sep 23;368(9541):1077–87.
- Leal LF, Malta DC, Souza MD, Vasconcelos AM, Teixeira RA, Veloso GA, Lansky S, Ribeiro AL, França GV, Naghavi M. Maternal Mortality in Brazil, 1990 to 2019: a systematic analysis of the Global Burden of Disease Study 2019. Revista da Sociedade Brasileira de Medicina Tropical. 2022 Jan 28;55(suppl 1):e0279–2021.
- Ope BW. Reducing maternal mortality in Nigeria: addressing maternal health services' perception and experience. Journal of Global Health Reports. 2020 May 18;4:e2020028.
- Africa CDC. Call to action: Africa's new public health order. 2022. Available from: <https://africacdc.org/news-item/call-to-action-africas-new-public-health-order/>