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THE RIGHT TO RESPECTFUL MATERNITY CARE

Access to skilled and respectful birth attendants in facility-based deliveries and women’s experiences of intersectional discrimination

A comparison between Angola and Mozambique

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To my grandmother Benvinda,

who passed away after bringing my mother to the world.

To my mother and my aunt,

who never felt the love of a mother.

To my cousin Dulce,

who passed away one year ago during childbirth.

To my little cousins Francisca and Claudia,

who will never feel the love of their mother.

To all mothers and daughters,

hoping the history stop repeating itself.

Abbreviations

ACHPR	African Commission on Human and Peoples' Rights
ANC	Antenatal care
AU	African Union
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CHW	Community Health Worker
GC	General Comment
GDP	Gross domestic product
HDI	Human Development Index
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goals
MMM	Maternal mortality and morbidity
MOH	Ministry of Health
NGO	Non-governmental organization
OAU	Organization of African Unity
OHCHR	Office of the High Commissioner for Human Rights
PNC	Postnatal care
RMC	Respectful maternity care
SBA	Skilled birth attendant
SDG	Sustainable Development Goal
TBA	Traditional birth attendant
UDHR	Universal Declaration of Human Rights
UN	United Nations
WHO	World Health Organization

Abstract

Maternal mortality and morbidity is a widespread epidemic. Sub-Saharan African countries are the most affected and in most of them this issue is pervasively neglected by the governments. The main causes of this epidemic are the unavailability of quality maternal care services and trained health care personnel. One key strategy for addressing this issue is to increase facility-based deliveries, thereby increasing the proportion of women utilizing skilled care at birth. The issue of high rates of maternal mortality and morbidity is multidimensional and must be addressed on several fronts. These include working to eliminate wrongful gender stereotyping and intersectional discrimination, overcoming cultural, financial, and geographic barriers to health care access, as well as reforming poor quality of care at facilities. Ultimately, this study intends to answer the question of whether Angola and Mozambique are complying with the international standards of quality and respectful maternity care. Thus, this study will analyse if each respective state is investing the maximum of their available resources in bolstering their national health workforce and whether they are successfully seeking and receiving international assistance thereby guaranteeing equitable and non-discriminatory access to the highest attainable standard of health during facility-based deliveries.

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Introduction

Maternal mortality and morbidity is a widespread epidemic. Every day approximately 830 women die while giving birth globally[1]. Nearly all of these deaths occur in low-income countries with Sub-Saharan Africa being the most affected area. Most of these deaths could have been prevented. The main causes of this epidemic are the unavailability of quality maternal care services and trained health care personnel. One key strategy for addressing this issue is to increase facility-based deliveries, thereby increasing the proportion of women utilizing skilled care at birth. The issue of high rates of maternal mortality and morbidity is multidimensional and must be addressed on several fronts. These include working to eliminate wrongful gender stereotyping and intersectional discrimination, overcoming cultural, financial, and geographic barriers to health care access, as well as reforming poor quality of care at facilities. Ultimately, this study intends to answer the question of whether Angola and Mozambique are complying with the international standards of quality and respectful maternity care. Thus, it will be analysed if each respective state is investing the maximum of their available resources in bolstering their national health workforce and whether they are successfully seeking and receiving international assistance thereby guaranteeing equitable and non-discriminatory access to the highest attainable standard of health during facility-based deliveries.

This study begins by critically analysing the evolution of international and regional human rights law on protecting a woman's right to non-discriminatory access to maternal health care. The first chapter is thereby intended to identify the relevant international human rights instruments and to clarify to which extent these instruments protect the right to dignified and respectful health care throughout pregnancy and delivery. Additionally, it aims to review these rights recent developments drawn by treaty monitoring bodies, such as the Committee on Economic, Social and Cultural Rights and the CEDAW Committee. Lastly, the chapter focuses on the assessment of the measures states parties' should implement in order to comply with their international human rights law obligations, namely the obligation to provide training for skilled and respectful birth attendants.

After discussing the international human rights system's ambit of protection of dignified and respectful health care throughout pregnancy and delivery, it is important

[1] WHO. (November de 2016). *Maternal mortality fact sheet*. July de 2017 Retrieved from http://www.who.int/mediacentre/factsheets/fs348/en/

to scrutinize the African human rights system. Thus, this chapter will analyse the most relevant available regional human rights law and the work of regional institutions, such as the African Commission, in order to determine how they are contributing to the improvement of women's maternal health in the region. Further, it will expand upon the main regional instruments and its approach to the right to health and the interrelated rights such as the right to non-discriminatory treatment on the grounds of the gender. The pertinence of this chapter is related to the posterior analysis of Angola and Mozambique. Therefore, it is appropriate to understand not only the international duties such states are obliged to comply with, but also which regional obligations stem from the African system.

The third chapter will focus on questioning how gender roles and wrongful gender stereotyping may present an obstacle for women's access to the highest attainable standard of health, namely the access to quality and respectful maternity care. This chapter aims to shed the light on the existent feminist literature concerning gender stereotypes and traditional practices and on how gender stereotypes are pre-empting governments' willingness to address this issue. The stereotype of women as primarily mothers may lead governments, communities and families to not take into consideration women's health care needs. Moreover, the secondary role that women hold in most societies might be a reason for families' lack of investment in women's health. Thus, it will be assessed how the gender roles are perpetuating women's poverty and how that contributes to the scarce access to health care. This chapter begins the in-depth analysis of African women's reality regarding access to quality and respectful care during childbirth, which will be expanded upon in the subsequent chapters of the study. In initiating such a task, it is necessary to unveil hidden and pervasive reasons behind women's discrimination. Solely by recognising the existence of stereotypes and addressing them in an explicit manner, the problems they contribute to can be addressed. Ultimately, this chapter will introduce the idea of wrongful gender stereotyping amongst health providers and how it might contribute to limiting women's access to respectful maternal health care as it exacerbates behaviours of abuse and disrespect.

Following the analysis of the impediments caused by wrongful gender stereotyping in regards to women's access to health care, it is essential to clarify the specific maternal mortality and morbidity related figures, especially for sub-Saharan African women. Further, this study will assess the main obstacles women face in having a facility-based delivery, especially women living in remote rural areas with both inexistent health facilities and skilled birth attendants. This chapter will assess the

benefits of facility-based delivery in the hands of a skilled birth attendant with reference to the widespread presence of traditional birth attendants in sub-Saharan African countries and the changing nature of this role. Thus, divergent ideas about the importance of incentivising their work so as to tackle high rates of maternal mortality and morbidity in remote areas will be presented. Moreover, this study will show different approaches taken by various studies towards the diverse perceptions of quality of care by both traditional and skilled birth attendants and how this can impact a women's ultimate decision of the place of delivery. An important, yet little understood component of poor care received by women during childbirth in facilities is disrespect and abuse. The fear of experiencing this negatively influences women's decisions to seek care at a health facility during delivery. Thus, further analysis will be made regarding the parturient women's experiences of disrespect and abuse perpetuated by birth attendants and how this poor quality of care might be contributing to push women away from facility-based deliveries. Therefore, this study intends to present the main causes for the situation of mistreatment by health care providers and present the most recent international standards of quality and respectful maternal care.

The final chapter of this study will analyse health services in the sub-Saharan African countries of Angola and Mozambique. As further enlightened, despite the common historical background, these countries developed in very different directions in terms of democratic systems, national incomes and resource allocation to health care. Thus, both countries' compliance with the international, regional and national human rights law standard, namely the women's right to the highest attainable standard of health during pregnancy and deliveries will be analysed. Further, this part of the study will look into Angolan and Mozambican's women's experiences of intersectional discrimination and the impact it has on their access to health care services. The study will also expand upon the current maternal health situation in both countries, through presenting the most relevant figures, the main obstacles women face and the maternal health policies that these countries are implementing. Lastly, the study will set out a comparison between the countries which will allow an understanding of how the political will to address maternal mortality and morbidity or even their different approaches towards international assistance might shape the opportunities women have to health care.

First Chapter – Women's Right to Health in International Human Rights Law and Institutions

According to the World Health Organization, 'every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination'[2]. The first chapter of this study is intended to analyse and to clarify to which extent the existent international human rights law protects the right to dignified and respectful health care throughout pregnancy and delivery. Thus, the objective is to identify the instruments and enshrined related rights and to review the recent developments to those rights created by the treaty monitoring bodies. The study focuses specially on the assessment of these recent developments regarding states parties' obligations to ensure access to health care to all pregnant and parturient women, namely through the training of skilled birth attendants.

1. The context

For a comprehensive understanding of the right to health, it is essential to recognise the gender aspects of this right, and the extent to which the international human rights community and the governments are sensitive to women's health needs.

The right to health was first articulated in the preamble of the World Health Organization Constitution which states that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition'[3]. Women's right to health recognition commenced with the adoption of the Universal Declaration of Human Rights (UDHR)[4]. The Declaration condemned discrimination on the grounds of sex, and set forth a network of rights relevant to the promotion and protection of the health of women. Article 25.2 of the Declaration refers to health and well-being, pointing out

[2] WHO. (2017, May). *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*. Retrieved from http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf

[3] The Constitution of the WHO was adopted by the International Health Conference, New York, 19-22 June 1945.

[4] The Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 and adopted through the General Assembly resolution 217 A.

that 'motherhood and childhood are entitled to special care and assistance'. Subsequently, the UN General Assembly adopted two general Covenants, namely the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) which were responsible for developing the content of the UDHR rights and to grant it binding value[5]. The ICESCR was the first international binding instrument to enshrine the right to health and a non-discriminatory provision for the access to the enjoyment of that right[6]. Other more specific conventions might be considered to encompass provisions for women's right to health, such as, the International Convention on the Elimination of all forms of Racial Discrimination, which prohibits discrimination against women of racial groups[7], and the Convention on the Rights of the Child, which protects the rights of girl children[8]. Whilst the aforementioned conventions helped pave the foundations, the leading instrument for the protection of women's right to health is the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) since it is an instrument specifically envisioned for observance of women's human rights.

Whilst these international human rights instruments were set up, human rights institutions such as the United Nations demonstrated for decades a lack of awareness about gender inequalities and the demand for a comprehensive approach to women's right to health[9]. The first visible step of the international community aimed at specifically addressing sexual and reproductive health was the International Conference on Safe Motherhood, held in Nairobi in February 1987. As a result of this event, the Safe Motherhood Initiative was launched, and aimed to increase attention to high rates of maternal mortality and morbidity through making maternal health a priority for governments. Further international events occurred which shaped the world's view on this subject. Women's right to sexual and reproductive health underwent major

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[5] The Covenants were adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966.

[6]Articles 12, 2.2 and 3 of the ICESCR

[7]Johnstone, R. L. (2006, February). Feminist influences on the United Nations Human Rights Treaty Bodies. *Human Rights Quarterly, 28*(1), 148-185. p.170 - "The text of the CERD does not specifically refer to gender equality in its application. Noneteheless, as a human right treaty it can be assumed to apply to all humans".

[8] Article 2.1 of the CRC prohibits any form of discrimination on the grounds of gender.

[9] Leeuwen, F. V. (2010). *Women's rights are human rights: the practice of the United Nations Human Rights Committee and the Committee on Economic, Social and Cultural Rights*. Antwerp: Oxford: Intersentia.p.2

development during the 1994 International Conference on Population and Development (Cairo) and the 1995 Fourth World Conference on Women (Beijing). The Cairo and Beijing outcome documents were explicit about the need to promote and protect women's rights, particularly in matters relating to reproduction and sexuality. Both documents drew attention to the need for women to go through pregnancy safely[10]. The mid-1990s proved to be an important time for international community acknowledgment of the 'centrality of women's human rights to achieve health and well-being, including the right not to die from preventable, pregnancy-related causes'[11].

Following that acknowledgment, in 2000 during the United Nations Millennium Summit, states agreed on the adoption of the Millennium Declaration. This Declaration established the Millennium Development Goals (MDG), which included a commitment to reduce maternal mortality by three quarters by 2015 and to improve maternal health generally. However, the final results of these international efforts were not as successful as expected. In the 2015 report of the United Nations concerning the implementation of the MDG, the UN declared that even though 'significant progress has been made, it fell far short of the global goal and targets', which 'leaves an unfinished agenda to ensure that all people receive comprehensive sexual and reproductive health services'[12]. More recently, the 2030 Agenda for Sustainable Development included goals to be achieved in the area of sexual and reproductive health [13]. In order to respond effectively to the demands of the Sustainable Development Goals, it recently launched the High Level Working Group for the Health and Human Rights of Women, Children and Adolescents by the World Health Organization (WHO) and the Office of the High Commissioner for Human Rights (OHCHR)[14]. Thus, it can be ascertained that the UN has solely recently

[10] United Nations. (1994). *International Conference on Population and Development Programme of Action.* Cairo : UNFPA para 7.2
United Nations. (1995). Platform for Action of the Fourth World Conference on Women, Beijing. UN. para 96

[11] Gruskin, S., Cottingham, J., Hilber, A. M., Lincetto, O., & Rosemand, M. J. (2008). Using human rights to improve maternal and neonatal health: history, connections and a proposed practical approach. *PubMed Central (PMC), 86(8)*, 589–593. P. 591

[12] United Nations. (2015). *The Millennium Development Goals Report.* New York.Retrieved from: http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf p. 39

[13] United Nations, (2015) *Transforming our World: the 2030 Agenda for Sustainable Development*, adopted by the General Assembly in September 2015. Goal 3 of the 2030 Agenda is 'Ensure healthy lives and promote well-being for all at all ages', '3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births', '3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries' ; and Goal 5 is 'Achieve gender equality and empower all women and girls'

[14] WHO (2017, May). Retrieved from http://www.who.int/life-course/news/hhr-working-group-meeting-feb2017/en/

commenced to addressed in a serious and committed manner the right to dignified, respectful health care throughout pregnancy and childbirth. In this way, it is relevant the following clarification regarding the extent to which the existent the ICESCR and the CEDAW Convention protect that right.

2. ICESCR and women's right to health

As previously mentioned, the International Covenant on Economic, Social and Cultural Rights was the first binding international human rights instrument to require states to progressively realise the right to the highest attainable standard of physical and mental health through its article 12. The Committee on Economic, Social and Cultural Rights (CESCR) is the monitoring body responsible for observing the implementation of Covenant rights by the States parties[15]. It is of common knowledge that many states parties to human rights instruments do not demonstrate enough commitment towards its effective promotion and protection[16]. Thus, CESCR's efforts are highly relevant for the effectiveness of the right to health since it clarifies to what extent it is being implemented, exposes the barriers to the access to health services and uncovers breaches of compliance. The Covenant and its Optional Protocol[17] set forth different mechanisms for the monitoring of states' compliance with their international obligations, such as the reporting procedure[18]. Furthermore, the Committee develops general comments on the provision of the Covenant. While preparing the reports for submission to the CESCR, the states should use the general comments as guidance regarding the obligations that must be fulfilled and the concrete measures to undertake in order to progressively achieve the full realisation of economic, social and cultural rights. The general comments issued by the CESCR are valuable contributions of this body for the development and the growth of the scope of protection of economic, social and cultural rights. Therefore, as article 12 of the ICESCR does not provide enough details about the obligations it places on governments regarding the right to health, the CESCR issued General Comment No. 14 on the Right to the

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[15] The Committee was established under ECOSOC Resolution 1985/17 of 28 May 1985.

[16]Cook, R. (1994). *Women's health and human rights: the promotion and protection of women's health through international human rights law*. Geneva: World Health Organization. p.2

[18] The reporting procedure is one of the mechanisms, and it consists on the states parties' obligation to submit regular reports to the Committee regarding the implementation of the Covenant rights (Article 16). Following the states reports' submission, the Committee examines each report and addresses its concerns and recommendations to the state party in the form of 'concluding observations'.

Highest Attainable Standard of Health. Although not formally binding, this document is considered the most comprehensive authoritative interpretation of the right to health at the UN level[19].

2.1 The definition of the right to health

At this point of study it is relevant to clarify to which extent the ICESCR protects women's right to health, especially the right to dignified and respectful health care throughout pregnancy and delivery. For achieving that purpose the content of the right to health enshrined in article 12.1 must be explained. The mentioned article provides a definition which comprehends both freedoms and entitlements[20]. The freedoms laydown "the right to control one's health and body, including sexual and reproductive freedom". According to Paul Hunt, former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 'rape and other forms of sexual violence, including forced pregnancy, and forced marriage represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health'[21]. The entitlements of the right to health comprise "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health"[22]. In short, the right to health is understood as the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health[23].

Additionally, article 12.2 enumerates illustrative and non-exhaustive examples of states parties' obligations. Under this provision, states have obligations concerning maternal, child and reproductive health; healthy natural and workplace environments; prevention, treatment and control of diseases; and facilities, goods and services. The Committee interpretation of article 12.2 a) affirms this provision as including obligations for the states parties towards the realisation of maternal and reproductive health.

[19] Aasen, H. S. (2013). Maternal mortality and women's right to health. In H. S. Aasen, & A. Hellum, *Women's Human Rights: CEDAW in International, Regional and National Law* (pp. 292 - 320). Cambridge University Press .p.302

[20] Article 12 establishes that 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

[21]Special Rapporteur on the right to health. *Economic, Social and Cultural Rights: The right of everyone to the enjoyment of the highest attainable.* E/CN.4/2004/49 (2004).para.25

[22]CESCR *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (art. 12 of ICESCR), 11 August 2000E/C.12/2000/4, para.8

[23] Ibid, para 9

Nevertheless, article 12 does not explicitly reference women, only addressing 'stillbirth rates', 'infant mortality' and 'the healthy development of the child'. The non-reference to women in this provision could be considered a mirror of a general lack of acknowledgement of women's rights and women's special needs regarding health. The ICESCR is a gender neutral or symmetric international instrument since it entails the idea that women and men should have equal access to the enjoyment of human rights[24]. The neutrality of this international instrument might have contributed to the continued negligence towards the issue of women's health. Following this line of reasoning, Leeuwen states that the insertion of non-discrimination principles in the Covenant does not guarantee that the human rights of both women and men are protected and moreover, it appears that they benefit women less than men[25]. As an attempt to rectify this shortcoming of the ICESCR, the CESCR began to incorporate a gender perspective in a number of its general comments since the mid 90's[26] including in the General Comment No.14 thereby contributing to the development of women's right to health.

2.2 Committee General Comments on the right to maternal healthcare

Women's right to sexual and reproductive health is integrated in the right to health enshrined in article 12. According to the Committee, the fulfilment of the right to reproductive health presupposes the 'freedom to decide if and when to reproduce' and comprises the 'right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning'[27]. This definition also entails the right of access to appropriate health-care services that enable women to go safely through pregnancy and childbirth[28]. Thus, to ensure access to maternal healthcare is one of the core obligations of states parties included in the right to health. In General Comment No. 14, the CESCR states that the provision of article 12.2 a) for "the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" should be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care and emergency obstetric services[29]. Further, the Committee emphasizes the importance of 'reducing

[24] Art. 3 of the International Covenant on Economic, Social and Cultural Rights
[25] Leeuwen, F. V. (2010).p.9
[26] Johnstone, R. L. (2006), p.163
[27] General Comment 14, footnote 12
[28] Ibid, footnote 12
[29] Ibid, para 14

women's health risks, particularly lowering rates of maternal mortality'[30]. To achieve that goal, public health infrastructures should provide for sexual and reproductive health, especially safe motherhood, in rural areas[31].

Even though the CESCR notes the obligation of the states parties to undertake steps to progressively realise the right to sexual and reproductive health in General Comment No. 14, a more comprehensive source for the interpretation of article 12 was required. The Committee justifies this demand through their view that the discrimination disproportionally affects women's access to sexual and reproductive health facilities, goods and services[32]. The treaty body goes further in its justification, and states that this was a catalyst for a separate general comment considering the continuing grave violations[33]. Thus, the CESCR developed the General Comment No. 22 which provides a detailed analysis of the right to sexual and reproductive health in close articulation with the prohibition of discrimination outlined in article 2.

In General Comment No. 22, the CESCR highlights that due to women's reproductive capacities their health needs are distinct from those of men, thereby states must provide different services in accordance to their specificities[34]. It calls for attention to the necessity of the states to remove all barriers that stand in the way of women's enjoyment of reproductive health care. In achieving that purpose, the states must have a 'comprehensive understanding of the concept of gender equality in the right to sexual and reproductive health'[35]. According to the Committee, the first step to alleviate 'the inherent disadvantage that women experience in exercising their right to health'[36] is to eradicate the gender-based stereotypes related to women's subordination to men and their role as primarily caregivers and mothers. Therefore, states must put into effect affirmative measures to eradicate social barriers in terms of norms or beliefs, such as social misconceptions, prejudices and taboos about pregnancy and delivery[37].

Women are not solely discriminated in the access to health care on the basis of their gender. The CESCR comprehensively approaches intersectionality and instructs states to specifically protect people from vulnerable groups including young women, poor

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[30] Ibid, para 21
[31] Ibid, para 36
[32]CESCR *General Comment No. 22 on the right to sexual and reproductive health* (*article 12 of the International Covenant on Economic, Social and Cultural Rights),* 2 May 2016, E/C.12/GC/22, para. 2
[33]Ibid, para 4
[34]Ibid. para 24
[35]Ibid. para 26
[36]Ibid. para 27
[37]Ibid, para 48

women and rural women. Accordingly, the general comment explicitly addresses the question of multiple discrimination and how women who belong to these groups have their access to sexual and reproductive health care disproportionately diminished[38].

Moreover, the states are incentivised to take into consideration the underlying determinants of sexual and reproductive health such as ‘access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing’ and the social determinants of health, such as, poverty, income inequality and unequal distribution of power based on gender, ethnic origin, age, disability and other factors[39].

2.3 The right to reproductive health and access to skilled health personnel

As previously mentioned the high maternal mortality and morbidity rates in low-income countries are intrinsically related to the lack of available quality maternal care services and the shortage trained health care personnel. Addressing this issue is an effective manner is only possibly by the increasing of facility-based deliveries, and the consequent increasing of the proportion of women utilizing skilled care at birth. It is of note that article 12.2 d) refers to this need by claiming that the states should ensure medical service and medical attention in the event of sickness. Thus, the Covenant establishes that states should guarantee access to trained medical staff and other health professional personnel during pregnancy and deliveries. As it will be further analysed in the fourth chapter, skilled birth attendants are accredited health professional who have the skills needed to manage deliveries, the immediate postnatal period, and who can contribute to the identification, management and referral of complications in women[40]. Moreover, the Committee notes that to lower rates of MMM requires availability of emergency obstetric care and skilled birth attendance in remote and rural areas[41]. Rural areas frequently lack such necessary facilities and services, and further, rural women often do not have the necessary financial resources to cover the transportation costs to the nearest health facilities. Accordingly, states should address the barrier created by poverty and lack of geographical and physical access by ensuring that trained health-care providers are equitably distributed throughout their territory[42]. Cook states that the

[38]Ibid, para 30
[39]Ibid, para 9
[40] United Nations. (2015). *The Millennium Development Goals Report.* New York. p. 39
[41] CESCR General comment No. 22, para 28
[42] Ibid, para 46

obstruction of available health services and non-provision of reasonable access to otherwise unavailable health services deny women the right to health care[43].

Moreover, states must ensure that the health professionals are adequately trained on the provision of quality and respectful sexual and reproductive health[44]. Therefore, the recommendation sets out the necessity of the abolition of obstetric violence during childbirth and post-partum interventions. In addition, the recommendation suggests the education of birth attendants to adopt a human rights approach and to conduct these procedures in a sensitive manner. One of the core obligations enshrined in the right to reproductive health is the duty of the states parties to enact and enforce the legal prohibition of harmful practices which can occur during delivery for instance and gender-based violence, such as obstetric violence[45]. In addition, violations of that states' obligation occur when they fail to ensure that health-care providers treat all individuals seeking sexual and reproductive health care in a respectful and non-discriminatory manner[46]. In this regard, the state has to take into consideration several recommendations of the Committee such as to remove all barriers interfering with access to health and to adopt a gender-sensitive approach to health. For instance, the states fail in complying with this obligation if they restrain or fail to incentivise women to be trained as health care professionals in communities where women cannot be treated by male nurses or doctors. The Committee has further reaffirmed that one of the states' obligation comprised in article 12 is to ensure that health care professionals are trained to recognize and respond to the specific needs of vulnerable or marginalized groups[47].

2.4 Monitoring the right to reproductive health

On assessing the implementation by the states of the necessary measures to comply with the right of health, the Committee takes into account four elements, such as, availability, accessibility, acceptability and quality. According to Asher, the implementation of the four criteria 'reflect how monitoring within a health and human rights framework requires a shift in focus in comparison with traditional public health and

[43]Cook, R. (1994).p.36

[44] CESCR General comment No. 22, para 46
[45] Ibid, para 49 c)
[46] Ibid, para 63
[47] CESCR General comment No. 14, para 37

development perspectives'[48]. The author notes that a 'traditional development approach to monitoring maternal health in a given community would be expected to look at maternal mortality ratios and the number of health facilities available'[49]. Nonetheless, a human rights approach would 'evaluate indicators such as the availability and accessibility of prenatal health services, their quality and the proportion of births attended by trained personnel'[50].

Accordingly, in order to ensure the implementation of sexual and reproductive health, an adequate number of functioning health-care facilities, services, goods and programmes should be available[51]. Availability relates to the existence of medical and professional personnel and skilled providers who are trained to perform the full range of sexual and reproductive health-care services[52]. The Committee notes the need to provide medical services within a reasonable geographical reach in order to fulfil this requirement[53].

In regards to accessibility, the Committee underlined the importance of non-discrimination in the access to facilities, services and goods, namely to people belonging to disadvantage groups including women living in remote and rural areas. The states are therefore incentivised to undertake measures to ensure that women have communication and transportation, when providing sexual and reproductive services to remote areas is impracticable[54]. Accessibility also means that reproductive health services must be affordable to all and the states must ensure people with less monetary resources are provided with the support necessary to cover the costs of health insurance and access to health facilities[55]. Lastly, the acceptability standard requires that all facilities, goods and services must be culturally respectful and sensitive to gender, age, disability, sexual diversity and life-cycle requirements[56] and, the services related to sexual and reproductive must be of good quality, meaning they are 'evidence-based and scientifically and medically appropriate and up-to-date'[57].

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[48]Asher, J. P. (2010). The right to healt: a resource manual for NGOs. In L. Holmstrom, *The Raoul Wallenberg Institute professional guides to human rights* (Vol. 6). Leiden. P.61
[49] Ibid, p. 61
[50] Ibid, p.61
[51] CESCR General comment No. 22, para 12
[52] Ibid, para 13
[53] Ibid, para 14
[54] Ibid, para 16
[55] Ibid, para 17
[56] Ibid, para 20
[57] Ibid, para 21

2.5 Article 12 interrelatedness with other significant provisions

Article 12 of ICESCR must be interpreted in close articulation with article 3 regarding 'the equal right of men and women to the enjoyment of all economic, social and cultural rights'. Such provision is considered a 'cross-cutting obligation' since it applies to all the rights enshrined in the Covenant and requires 'addressing gender-based social and cultural prejudices, providing for equality in the allocation of resources'[58]. CESCR General Comment No. 16 regarding the equal right of men and women to the enjoyment of all economic, social and cultural rights contributed to diminishing the neutrality or symmetry of the ICESCR. Through this document, the Committee shows concern about substantive equality and requires the states to ensure that laws, policies and practices do not maintain, but rather alleviate, the inherent disadvantage that particular groups experience in enjoying those rights[59].

Likewise, article 2.1 of ICESCR is a key provision for the interpretation of the states parties' obligations to provide the 'highest attainable standard of health'. On evaluating the states' compliance with the content of economic, social and cultural rights, the Committee must ascertain if the states set forth the measures required for 'achieving progressively the full realization of the rights'[60]. For that purpose, the states must undertake steps 'to the maximum of its available resources'. On making reference to the 'progressive realisation' of economic, social and cultural rights, the drafting committee of the Covenant recognized that often those rights demand high budget efforts and require gradual implementation. However, the Committee underlines that some obligations have immediate effect not being qualified for progressive realisation[61]. For instance, article 2.2 imposes on the states parties the immediate obligation to guarantee that the right to health will be exercised without discrimination of any kind. Moreover, the states should undertake steps towards the full realization of the right to health and those steps must be deliberate, concrete and targeted[62]. In accordance with CESCR "the progressive

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[58]CESCR *General comment No. 16 (2005) The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3 of the International Covenant on Economic, Social and Cultural Rights)*, para 22

[59] Ibid, para 7

[60] Article 2.1 of the ICESCR

[61] International Commission of Jurists. (2008). *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative experiences of justiciability.* Geneva. p.25

[62] General Comment No. 14, para 30

realisation means that states parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realisation of article 12”[63].

Ultimately, international cooperation and assistance are fundamental for the realisation of the right to sexual and reproductive health. In the words of article 2.1, ‘each state party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation’. Thus, states that cannot realise the right to sexual and reproductive health due to a lack of resources must seek international cooperation and assistance[64].

3. The CEDAW and women’s right to health

The Convention on the Elimination of All Forms of Discrimination against Women constitutes the first meaningful tool for the protection of women’s reproductive health. It was adopted in 1979, entering into force in 1981 and has been ratified by 189 states to date[65]. The CEDAW Convention is an asymmetric international legal instrument which concentrates on women’s enjoyment of human rights and on the practical realisation of substantive equality. As stated by Cook, the CEDAW Convention ‘goes beyond the goal of non-discrimination between sexes’ to address the disadvantaged position of women in all areas of their lives[66]. The Convention extensively addresses the numerous forms of discrimination affecting women and the role of gender stereotypes to reinforce discrimination. Cook affirms that the Women’s Convention ‘recognises that women are subject not only to specific, obvious inequalities but also to pervasive and subtle forms of gender discrimination that are woven into the political, cultural and religious fabric of their societies’[67] and requires states to confront the social causes of women’s inequalities in all systems, including the health system[68].

As other important UN legal instruments, the CEDAW Convention has its own treaty monitoring body, the Committee on the Elimination of Discrimination against

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[63] Ibid, para.31
[64] CESCR General comment No. 22, para 50
[65] United Nations. (2017, 05 29). *United Nations Treaty Collection*. Retrieved from https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en

[66] Cook, R. (1994). *Women's health and human rights: the promotion and protection of women's health through international human rights law.* Geneva : World Health Organization.pp. 19-20

[67] Ibid, p. 20
[68] Ibid, p. 21

Women, established in 1982. The CEDAW Committee is composed by 23 experts on women's issues whose main responsibility is to monitor the states parties' implementation of the CEDAW Convention provisions[69]. The monitoring function of the Committee is mainly exercised through the reporting procedure, which consists of the analysis of regular reports submitted by the states parties on the measures they have adopted to implement the Convention[70]. In its concluding observations on the states' reports, the Committee has consistently addressed the importance of the reports' reference to maternal mortality and to existent conditions for safe motherhood. In conjunction with the reporting procedures, the Committee has competence to issue general recommendations[71]. Those recommendations played an important role for the effectiveness of the Convention since they have been "contributing to a conceptual expansion of the understanding of human rights violations suffered primarily by women"[72].

The UN General Assembly's adoption of the Optional Protocol to the CEDAW Convention in 1999[73]represented a further step towards the strengthening of the Convention and the role of the Committee in protecting the right to access sexual and reproductive health. The Optional Protocol created mechanisms that allow women whose rights were violated, to seek redress before the CEDAW Committee[74]. The Optional Protocol enhances the possibility of individuals or groups to submit complaints regarding breaches of the CEDAW Convention[75]. For instance, the Committee confirmed states' obligations to ensure 'women's right to safe motherhood' in the *Alyne da Silva Pimentel*

[69] The monitoring function of the Committee is mainly exercised through the reporting procedure, which consists of the analysis of regular reports submitted by the states parties on the measures they have adopted to implement the Convention. According to article 20 (1), the Committee should consider each report and address its concerns and recommendations to the state party in the form of concluding observations.

[70] Article 18 CEDAW Convention

[71] Article 21 CEDAW Convention

[72]Schöpp-Schilling, H. (2007). Treaty Body Reform: the Case of the Committee on the Elimination of Discrimination against Women. *Human Rights Law Review*. p.217

[73] The Protocol was adopted by resolution A/RES/54/4 of 6 October 1999 at the fifty-fourth session of the General Assembly of the United Nations.

[74] One of the mechanisms enshrined in this document is the inquiry procedure. When the Committee receives information about "grave or systematic violations by a State Party of rights set forth in the Convention" it can invite the states parties to submit observations about those violations. The Committee can also designate one or more of its members to conduct an inquiry and to report urgently to the Committee. Examples of grave violations are violations relating to the right to life, physical and mental integrity, and security of person while systematic violations are a pattern of violations resulting from customs or traditions or discriminatory laws or policies. Additionally, the Optional Protocol enhances the possibility of individuals or groups to submit complaints regarding breaches of the CEDAW Convention (Article 2 Optional Protocol)

[75] Article 2 Optional Protocol

v Brazil case[76]. The Committee's decision on this case represents the first international treaty monitoring body's decision holding a state accountable for failing to provide appropriate and timely access to emergency obstetric care and to avoid a preventable maternal mortality cause. Whilst one may suggest that the wide ratification of the CEDAW Protocol was often to enhance state prestige, the effectiveness of the legal regime as demonstrated in *Alyne da Silva Pimentel* goes to show that states can be held to account over their actions and omissions. In this sense, the CEDAW Convention and Protocol go beyond existing as a decoration for states parties´ international soft-power but rather, can aid the implementation and strengthening of progressive policy within the international community.

3.1 Article 12 and the right to non-discriminatory access to health care

Article 12.1 of the CEDAW provides that 'the states parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services'. This provision protects the right to non-discriminatory access to health care services, rather than the right to health as such. Applying this definition to the field of health care requires 'determining how laws or practices make a distinction, exclusion or restriction that impairs or nullifies women's access to health care services on the basis of equality with men'[77].

In order to set a standard by which the state's compliance with the women's right to health can be measured, the CEDAW Committee elaborated General Recommendation No 24. In this document, the Committee emphasized the urgency of the elimination of discrimination on the access to health care through the implementation of comprehensive substantive and transformative equality measures. Therefore, it established that states parties should report on 'how policies and measures on health care address the health rights of women from the perspective of women's needs and interests'[78] and how it addresses distinctive features and factors that differ for women in comparison to men,

[76] CEDAW Committee, *Alyne da Silva Pimentel v Brazil* (10 August 2011) UN Document CEDAW/C/49/D/17/2008.
[77] Cook, R. J., & Undurraga, V. (2012). Article 12. In M. A. Freeman., C. Chinkin, & B. Rudolf, *The UN Convention on the Elimination of all Forms of Discrimination against Women : a commentary.* Oxford University Press . p.323
[78] CEDAW General Recommendation No. 24, para 12

such as: biological factors like their reproductive function and socio-economic factors[79]. Moreover, the realisation of substantive equality in regard to the access to healthcare requires a reasonable accommodation for the existent differences between men and women, between urban and rural women, and between rich and poor women[80]. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. Article 12.2 provides that states parties shall guarantee for women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary. According to the CEDAW Committee 'the states parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women'[81]. The Committee also notes that 'it is the duty of states parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources'[82].

3.2 States parties obligations regarding maternal health

In the general recommendation, the CEDAW Committee clarifies that the duty of the states parties to ensure access to health-care services implies obligations to respect, protect and fulfill women's rights to health care. The obligation to respect requires States parties to refrain from restricting women's access to healthcare[83]. The obligation to protect women's health requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations[84]. The duty to fulfill such rights places an obligation on states parties to take appropriate measures to the maximum extent of their available resources to ensure that women realise their right to access to health care[85]. To realise this right, the states should allocate adequate budgetary, human and administrative resources to ensure that

[79] Ibid, para 12
[80] Cook, R. J., & Undurraga, V. (2012), p. 325

[81] CEDAW General Recommendation No. 24
[82] Ibid, para 27
[83]Ibid, para 14
[84] Ibid, para 15
[85] Ibid, para 17

women's health receives a share of the overall health budget comparable with that for men's health[86]. Accordingly, Cook affirms that transformative equality requires relocation or reorientation of health care resources, including budgets and health personnel, to achieve universal coverage for women on a basis of equality with men[87]. In this author's opinion, the states violate the obligation of non-discriminatory treatment in regards to access to health when governments neglect to allocate health resources fairly to women's particular needs to go safely through pregnancy and childbirth[88].

The CEDAW General Recommendation No. 24 sets out more concrete obligations such as the duty of the states to report on the implementation of measures to eliminate barriers that women face in access to quality health-care services and to ensure women timely and affordable access to such services. Those barriers include requirements or conditions that prejudice women's access, such as high fees for health-care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and the absence of convenient and affordable public transport[89]. To conclude, the Committee recommends that states parties 'reduce maternal mortality rates through safe motherhood services and prenatal assistance'[90]; 'to monitor the provision of health services in ensuring equal access and quality of care'[91]; 'to require all health services to be consistent with the human rights of women'[92] and 'to ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights'[93].

3.3 Article 12 and its interrelatedness to other provisions

Article 12 of CEDAW must be interpreted in light of article 2 f) which requires states parties to take all appropriate measures 'to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against women'. This provision is applicable when a law, regulation, custom, or practice applied a gender

[86] Ibid, para 30
[87] Cook, R. J., & Undurraga, V. (2012), p. 325

[88] Cook, R. J. (1998). Human Rights Law and Safe Motherhood. European Journal of Health Law, 5, 357-375. p. 366
[89]CEDAW General Recommendation No. 24, para 21
[90] Ibid, para 31 c)
[91] Ibid, para 31 d)
[92] Ibid, para 31 e)
[93] Ibid, para 31 f)

stereotype that resulted in discrimination against women[94]. As stated by the CEDAW Committee, direct discrimination against women refers to different treatment explicitly based on grounds of sex and gender differences; whilst indirect discrimination occurs when a law, policy, programme or practice appears to be neutral as it relates to men and women, but has a discriminatory effect in practice on women, because pre-existing inequalities are not addressed by the apparently neutral measure[95]. This provision directly influences article 12 and its protection for the non-discriminatory access to health care. Thus, the Committee points out that it constitutes discrimination 'if a health-care system lacks services to prevent, detect and treat illnesses specific to women'[96].

On the other hand, article 5 a) requires states parties to take all appropriate measures to 'modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women'. This provision requires the elimination of wrongful gender stereotyping. The CEDAW Committee, referring to article 5 has through different procedures called attention for social and cultural patterns, prejudices and harmful practices that restrain the right of equal access to health goods and services. Thus, it has often criticised patriarchal societies in which men dominate women in areas of health and has urged states parties to change these patterns that prevent women from enjoying their rights.[97] According to Cook, 'examining how women are stereotyped in the health context can provide important insights that foster understanding of how, and in what ways, women are disadvantaged in relation to the availability, accessibility, acceptability and quality of health care services and information'[98]. The relation between wrongful gender stereotyping and discrimination in the access to quality maternal health services during childbirth will be further developed in the third chapter.

[94] Cusack, S., & Cook, R. J. (2009). Stereotyping Women in the Health Sector: Lessons from CEDAW. *Washington and Lee Journal of Civil Rights and Social Justice, 16*(1), 47-78. p. 71

[95]CEDAW *General Recommendation No. 28 on the Core Obligations of States Parties under Article 2 of the Convention*, 16 December 2010, CEDAW/C/GC/28, para 16

[96] CEDAW General Recommendation No. 24 , para 11

[97] Donders, Y. (2015). Exploring the cultural dimensions of the right to the highest attainable standard of health. *Potchefstroom Electronic Law Journal, 18*(2), 179-222.p. 199

[98] Cusack, S., & Cook, R. J. (2009), p. 51

To conclude this chapter, it is important to mention that further developments on the role of the CESCR and CEDAW Committee for the effective implementation of the right to maternal health care and the right to non-discriminatory treatment will be set forth in the final chapter. Thus, the final chapter will evaluate the effective compliance of Angola and Mozambique with the international standards of quality and respectful maternity care explained during this part of the study. The evaluation will mainly rely on the analysis of states reports and concluding observations set out by the CESCR, the CEDAW Committee. This examination aims at understanding if these states are investing the maximum of their available resources in bolstering their national health workforce and whether they are successfully seeking and receiving international assistance thereby guaranteeing equitable and non-discriminatory access to the highest attainable standard of health during facility-based deliveries.

Second Chapter –Women's Right to Maternal Health in the African Human Rights Protection System

After discussing the international human rights system´s ambit of protection of dignified and respectful health care throughout pregnancy and delivery, it is important to scrutinise the African human rights system. Several recent studies have shown that sub-Saharan African countries are the most affected by the ongoing epidemic of maternal morbidity and mortality[99]. The main causes for this epidemic are of public knowledge, such as the lack of available quality maternal care services and trained health care personnel. The present chapter will look at the most relevant available regional human rights law and to the regional institutions, such as the African Commission, in order to ascertain how they are contributing to the improvement of women's maternal health in the region. Thus, the chapter commences with a short description of the human rights system´s evolution in the African context, the main obstacles encountered in the effective implementation of socio-economic rights and progressive legislative developments. Further, it will analyse the main regional instruments and its approach to the right to health and the interrelated rights such as the right to non-discriminatory treatment on the grounds of the sex. The pertinence of this chapter is related to the posterior analysis of two sub-Saharan African countries, namely Angola and Mozambique. Therefore, it is appropriate to understand not only the international duties such states are obliged to comply with, but also which regional obligations which stem from the African system.

1. The African Human Rights Protection System and African Charter on Human and Peoples' Rights

The establishment of the Organization of African Unity (OAU) in 1963 was responsible for the settlement of the African regional system. Its foundation document,

[99] lkema, L., Chou, D., & Hogan, D. (2016). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *Lancet*, 462-474; Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.-B., Daniels, J., . . . Alkema, L. (2014). Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*, 323–333.

the OAU Charter[100], determined that the organization´s main purposes were to promote the unity of the African states, to defend sovereignty, territorial integrity and independence and to eradicate all forms of colonialism from Africa[101]. Even though the Charter incentivises the states parties to take in due regard the UDHR[102], it is noticeable in its scope that the concern for human rights was not one of the factors that was on the basis of the OAU's creation. However, through the OAU's substitution for the African Union in 2000, the African states demonstrated a renewed commitment to human rights' protection. In accordance, the African Union Constitutive Act mentions the respect and promotion of human rights as one of the organization's cornerstones[103].

The African regional system of human rights was solely founded in 1981 when the OAU adopted the African Charter on Human and Peoples' Rights[104] (African Charter)[105]. This instrument was implemented partly as a result of external pressure on African governments to establish a regional human rights regime and partly as a response to the gross human rights violations committed by some African leaders[106]. The African Commission on Human and Peoples' Rights (African Commission or ACHPR)[107] is the body responsible for the monitoring of the state's parties compliance with the African Charter. Together with the African Court on Human and Peoples' Rights (the Court)[108], they have been responsible for the effectiveness of the Charter and the advancement of human rights in the region. The Court has jurisdiction over the interpretation and application of its founding Protocol, the African Charter, and any other relevant human rights instrument ratified by the member-states[109]. Even though the African Commission

[100] The Charter of the Organization of African Unity entered into force Sept. 13 1963. The Charter was replaced by the Constitutive Act of the African Union in 2001.
[101] Article 1 a), b) c) and d) of the OAU Charter
[102] Article 1 e) of the OAU Charter
[103] Constitutive Act of the African Union entered into force May 26, 2001; Article 4 m) mentions 'Respect for democratic principles, human rights, the rule of law and good governance' as one of the main principles of the AU.
[104] African Charter on Human and Peoples' Rights approved in 27 June 1981, entered into force Oct. 21, 1986. It has been ratified by all 53 member States of the OAU/AU.
[105] According to article 60 of the African Charter, this instrument gives due regard to the United Nations treaties and affirms that they are mutually reinforcing in Africa.
[106] Chirwa, D. M. (2006). Reclaiming (wo)manity: the merits and demerits of the African Protocol on Women's Rights. *Netherlands International Law Review*, 63-96. p. 67
[107] The Commission was established in 1987 in accordance to article 30 of the African Charter that states as follows: An African Commission on Human and Peoples' Rights, hereinafter called 'the Commission', shall be established within the Organisation of African Unity to promote human and peoples' rights and ensure their protection in Africa.
[108] Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights, June 9, 1998. The Court was established by virtue of Article 1 of the Protocol and came into force on 25 January 2004.
[109] Article 3 of the Court's Protocol

and the African Court have contributed to the development of the rights enshrined in these treaties, there is a lack of implementation at a national level which represents a significant obstacle for its effectiveness, usually a result of the lack of enthusiasm displayed by the national governments. According to some commentators' opinion, this is contributes towards the public´s perception of such institutions as 'nothing more than symbolic gestures of a progressive judiciary in delineating the meaning of the [Charter's] rights'[110]. As it will be further demonstrated, despite the African Commission´s efforts in addressing the importance of maternal health care, many states have still a long way to go to protect women's health.

Moreover, during the early 2000's, concerns began to rise about the states' negligence in regards to the implementation of economic, social and cultural rights. Thus, as the result of a seminar on economic, social and cultural rights, held in Pretoria, in 2004, the African states adopted the Pretoria Declaration on Economic, Social and Cultural Rights in Africa[111] which has an authoritative value in the interpretation of economic, social and cultural rights enshrined in the African Charter[112]. In its preamble it is noted that notwithstanding the protection conferred by the African Charter of economic, social and cultural rights, those rights remain marginalised in their implementation. Later, the African Commission adopted the Principles and Guidelines on the Implementation of Socio-economic Rights guaranteed under the Charter[113] which contain a broad interpretation of the right to health in a manner similar to the CESCR General Comment No. 14. The aforementioned documents are both important tools which set out guidelines for the implementation of the right to health in the region. Moreover, they are intended to guide the monitoring work of the African Commission for states' effective implementation of the Charter's rights.

[110]Khoza, S. (2004). Promoting economic, social and cultural rights in Africa : the African Commission holds a seminar in Pretoria : recent developments. *African Human Rights Law Journal, 4*(2), 334-343.p.335

[111] The Declaration was adopted by the Commission at the 36th Ordinary Session of the African Commission on Human and Peoples' Rights in Dakar, Senegal, on 7th December 2004.

[112] Khoza, S. (2004) .p.339

[113] African Commission on Human and Peoples' Rights. (2010). *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights*

1.1 The African Charter and the right to maternal health

Under the African human rights system, the first attempt to guarantee the right to health is found in article 16 of the African Charter. Article 16.1 of the Charter provides that 'every individual shall have the right to enjoy the best attainable state of physical and mental health'; whilst article 16.2 orders that state parties to the Charter 'shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.

Taking into account that the lack of access to quality healthcare facilities and services represents a problem that pervasively affect women's reproductive health in Africa, it is of note that article 16 of the African Charter fails to address this particular issue. Nonetheless, the African Commission clarified that the right to health 'includes effective access to health-related education and information, including on sexual and reproductive health [and] it also includes freedoms such as control over one's own body and health, including sexual and reproductive freedom'[114]. The Commission have consistently expanded upon the obligations set out by the right to health, specifically the right to sexual and reproductive health. According to the Commission guidelines, in order to reduce the maternal mortality rate, states must ensure the 'provision of comprehensive, high-quality maternal health services, including adequate equipment and supplies for preventive, diagnostic and curative service'[115]. The Commission further recognises the need for the states to ensure physical and geographic accessibility of these services, guaranteeing access in rural areas. Moreover, it has given special emphasis to the need to inform pregnant women on potential problems related to pregnancy and childbirth, such as the impact of tropical diseases and precautions to take in order to prevent them. Lastly, the Commission underlines the states' obligation to train medical staff and to develop treatment guidelines or protocols for the management of maternal complications[116]. Concomitantly, the states must invest in the education of medical personnel in relation to safe-motherhood and appropriate health practices.[117] Furthermore, states are obliged to guarantee 'that health systems respect cultural differences, and ethnic diversity, while

[114] Ibid, para 64
[115] Ibid, para 67 rrr) 4
[116] Ibid, para 67 rrr) 4
[117] Ibid, para 67 rrr) 4 and 5

encouraging members of vulnerable and disadvantaged groups to study medicine and public health and to join health systems as service providers'[118]

What is interesting to note about the interpretation of the African Commission of the right to health is its specific mention of the need for the states parties to provide adequate 'conditions of service for medical staff to ensure adequately staffed health facilities, to prevent brain drain and the improvement of national health infrastructure'[119]. This leads to the conclusion that states have not only the obligation to provide training to ensure that qualified health personnel adopt a respectful and human rights approach in delivering its services but also, that there is an obligation to create the necessary conditions to retain trained health personnel in their countries or remote rural areas. In order to avoid the brain drain to 'more developed' countries or to urban areas that provide better standards of living, the states must create special incentives for those professionals. The inclusion of this obligation in the Commission's interpretation is much related to the shortage of health care personnel that African countries experience which can be 'explained by the fact that many health care settings are grossly underfunded and health providers poorly remunerated'[120]. Nonetheless, even with limited resources a state will be expected to adopt the necessary measures to provide health professionals, especially for vulnerable and marginalised groups in society. Unfortunately, this has not been the case with many African countries as many of them have continued to rely heavily on foreign donors to meet their obligations regarding the right to health[121]. This issue will be further developed in the fourth chapter regarding the need to engage skilled birth attendants for the improvement of quality health care services of women during pregnancy and delivery.

1.2 The other relevant rights for effective access to maternal health

As previously mentioned, the UN treaties often entail cross-cutting non-discrimination obligations that must be taken into consideration for the interpretation of the states' duties. The African Charter followed the example and enshrined in its' article

[118] Ibid, para 67 aa)
[119] Ibid, para 67 o)
[120] Durojaye, E. (2013). The approaches of the African Commission to the right to health under the African Charter. Law, Democracy & Development. pp. 401-402
[121] Ibid, p.402

2 the obligation of the eradication of discrimination on the grounds of sex regarding the enjoyment of the rights and freedoms set out in this instrument[122]. This provision resembles the ICESCR article 2.1 thereby, as previously analysed in the first chapter, such legislative measures act to merely guarantee formal equality and is not suitable to address the specific situations of discrimination faced by women[123]. Nonetheless, the Commission guidelines entail a comprehensive view as to states' obligations to guarantee equality and non-discrimination on the basis of gender in the access to socio-economic rights. The Commission begins by recognising that 'women often do not enjoy equality in relation to economic, social and cultural rights' and thereby the 'states must abolish customary and traditional rules and practices which are major obstacles to the equal enjoyment of rights by women and girls'[124]. The right to equality includes the adoption of special measures for the purpose of securing the enjoyment of economic, social and cultural rights by members of vulnerable and disadvantaged groups, such as temporary special measures which aim to reduce or suppress conditions that perpetuate discrimination and to realise substantive equality[125]. As it will be considered in the next chapter, wrongful gender stereotypes constitute one of the main obstacles for women's access to quality health care and can also lead to violence during facility-based deliveries. Therefore, the right to non-discriminatory treatment must always be taken into consideration while analysing access to maternal health care.

Further, article 18.3 of the African Charter affirms that 'the state shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions'. Despite comprising a provision that reinforces the protection of women against discrimination, it has proved controversial since some authors consider that 'this lumping together of women and children', contributes to the reinforcement of 'out-dated stereotypes about the proper place and role of women in society'[126]. The critiques that this has generated have been 'partially responsible for the drive to [the posterior adoption

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[122] Article 2 of the African Charter establishes that 'every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status'

[123] See point 2.5 of the first chapter

[124] African Commission Principles and Guidelines, para 37

[125] Ibid, para 34

[126] Heyns, C., & Killander, M. (2004). Promoting economic, social and cultural rights in Africa: The African Commission holds a seminar in Pretoria. *African Human Rights Law Journal*, 334-343.

of] the Protocol to the African Charter on the Rights of Women in Africa'[127]. As mentioned in the first chapter[128], due to the Cairo and the Beijing conferences, during the early 1990s women's rights started to receive more attention from the international community in general and also from the African Commission. The occurrence of this paradigm shift culminated with the establishment of the position of the Special Rapporteur on the Rights of Women in Africa in 1998 and the adoption of the Protocol on the Rights of Women in Africa.

2. Protocol to African Charter on Human and Peoples' Rights on the Rights of Women in Africa

In July 2003, the AU Assembly adopted the Protocol on the Rights of Women in Africa[129] more commonly referred to as the Maputo Protocol, as an allusion to the place of its adoption[130]. In accordance with the Protocol's preamble, despite the ratification of the African Charter on Human and Peoples' Rights and other international human rights instruments by the majority of states parties, African women still continue to be victims of discrimination. Thus, the African Charter was perceived as providing inadequate protection for women and further, the Protocol reminded the states as to their obligations in relation to women's rights.

The African Women's Protocol is complimentary to the African Charter and aims to elaborate upon the relevance of African women's rights in an explicit manner. Thus, the Protocol is prone to comparisons with the CEDAW. Some commentators hold the opinion that the Protocol 'goes further than the CEDAW in terms of its content'[131]and that in comparison with the CEDAW, 'the Protocol speaks in a clearer voice about issues

[127] Ibid, p.688
[128] See point 1 of the first chapter
[129] Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003). Entered into force on 25 November 2005.
[130]The African Commission was responsible for the supervision of the drafting process of this document which by June 2017 was signed and ratified by 36 states members of the African Union. Tunisia, Egypt and Botswana are the only countries that did not signed or ratified. (2017, 06 07). Retrieved from African Commission on Human and Peoples' Rights: http://www.achpr.org/instruments/women-protocol/ratification/

[131] Murray, R. (2004). *Human rights in Africa: From the OAU to the African Union.* New York: Cambridge University Press.p. 151

of particular concern to African women and locates CEDAW in African reality'[132]. In this respect, the Protocol enlarges the protective scope of women's rights by addressing issues that specifically affect African women and which were not included in CEDAW, such as, the right of a woman to be protected against HIV infection and to know the HIV status of her sexual partner[133] as well as the right to circumscribed medical abortion[134]. As previously discussed, it is a matter of fact that the CEDAW Committee has expanded the scope of the CEDAW Convention through its general comments and concluding observations. As a result, it might be argued that the differences between the African Women's Protocol and CEDAW Convention ambit of protection are not as noticeable as would be expected. However, the CEDAW Committee's recommendations do not constitute binding obligations. Therefore, by legally entrenching more specific and developed legal obligations, the African Women's Protocol contributes to the strengthening of those rights.

Regarding the effectiveness of the Protocol, there is still much progress to be made. On one hand, at the regional level, the effectiveness depends on the successful deployment of the African Commission's mechanisms and the states compliance with their decisions; on the other hand, at the national level it depends on the legal adjustments and the domestic application of the regional legal framework[135]. Moreover, the utilisation of the Protocol's provisions as an interpretive guide for the application of domestic law depends on the 'knowledge and initiative of lawyers, who need to bring these possibilities to the attention of judicial tribunals, and on the keen understanding of judicial officers, who should grasp the opportunities to develop the law in line with the Protocol'[136]. Raising awareness amongst the legal profession as to the protection of women's rights conferred by the Maputo Protocol is thereby seen as a determinant move towards the practical efficacy of this legal instrument.

Further, the effort for the decision's effective application should be encompassed with education and awareness-raising about the systematic discrimination of women in the access to socio-economic rights. The African Women's Protocol makes clear in its preamble that it aims to promote the principle of gender equality in African

[132] Viljoen, F. (2009-2010). An introduction to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. *Wash. & Lee J. Civil Rts. & Soc. Just*, 11-46 .p.21

[133]See article 14.1 b) of the Protocol
[134]See article 14.2 c) of the Protocol
[135]Viljoen, F. (2009-2010), p.32
[136] Ibid, p. 32

countries. In keeping with this promise, article 2.1 places a clear obligation on states parties to combat all forms of discrimination against women, namely through incentives to adjust their legislation to the provisions of the Protocol and taking in due regard gender equality in all the adopted and implemented policies and measures. Furthermore, as with the CEDAW Convention, the Protocol sheds light on the importance of exposing stereotypes about African women and incentivises the states to promote campaigns to educate and sensitize the population regarding the culturally engrained patterns of 'men's superiority' and 'women's inferiority' or on stereotyped roles for women and men[137]. As previously mentioned, the next chapter of this thesis will elaborate on the main pervasive wrongful gender stereotypes that especially affect African women's health.

2.1 The protocol and the right to maternal health

Article 14 of the Protocol is probably one of the most comprehensive provisions on the right to reproductive health under international human rights law. Aiming to clarify and to develop the content and nature of the women's right to health[138], the African Commission has adopted relevant resolutions, such as the Resolution on Maternal Mortality in Africa (expanded upon below), and a General Comment No. 2 on article 14 of the Protocol on the Rights of Women in Africa[139]. This comment is a comprehensive interpretative guide to article 14 and develops on the states parties' obligations towards promoting its effective implementation. The African Commission validates the adoption of this general comment through the argument that a considerable number of states parties did not make the necessary legal adjustments for the transposition of the Protocol's relevant provisions, including in the area of women's sexual and reproductive rights[140].

Article 14 is divided into two parts. The first part ensures the "right to health of women, including sexual and reproductive health, is respected and promoted"' and sets out particular areas of decision-making, such as right to decide whether to have children, the number of children and the spacing of children[141]. The second part refers to the

[137]See article 2.2 and 5 a) of the Protocol
[138] Under its promotional mandate stipulated in Article 45 of the African Charter
[139]The African Commission approved the General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa at its 55th ordinary session held in Luanda, Angola in 2014
[140] Preface of the General Comment No. 2

appropriate measures states parties shall undertake to accomplish three goals. The first goal is to provide access to health services to women especially those in rural areas. The second is to 'establish and strengthen existing prenatal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding'. And the third provides for the authorisation of medical abortion.

As the main purpose of this study is to focus on the importance of training health care providers to ensure women's access to quality maternal health care, article 14.2 a) is the provision that best achieves this objective. This article enshrines 'the right to adequate, affordable health services at reasonable distances, including information, education and communication programs for women, especially those living in rural areas'. Regarding this provision, the Commission notes that it is crucial to ensure availability, financial and geographical accessibility as well as the quality of women's sexual and reproductive health-care services[142], namely through the availability of qualified and respectful birth attendants. Likewise, the Commission affirms that the 'state parties have the obligation to provide services that are comprehensive, integrated and rights-based'[143]. In this case, as it will be further developed in the fourth chapter, the practice of respectful maternal care by birth attendants is one of the main concerns in respect of the strategy to decrease maternal mortality and morbidity in sub-Saharan African countries. Therefore, for instance, the states must implement monitoring mechanisms regarding the standards of care provided by health professionals, and to ensure that in conjunction with technical capabilities, the birth attendants develop the necessary interpersonal relationship skills needed to provide quality care and to avoid disrespect and abuse of patients in facility-based deliveries.

Additionally, as it will be further analysed in the third chapter, health professionals are influenced by the societal perception of women and general stereotypes. These can contribute to the perpetuation of discrimination in health facilities and can obstruct the effective implementation of more progressive legislation concerning sexual and reproductive rights. An example, is the deprivation concerning services by health care providers for reasons of conscientious objection. In this case, state parties must ensure that the necessary infrastructure is in place to enable women to be knowledgeable and referred to other health care providers in a timely manner[144]. As a result, the right to health

[142] Preface of the General Comment No. 2
[143] African Commission General Comment No. 2, para 29
[144] Ibid, para 26

care without discrimination requires state parties to remove impediments to health services reserved for women, including ideology or belief-based barriers[145]. According to the Commission, an essential step towards eliminating stigmatization and discrimination related to reproductive health includes, supporting women's empowerment, sensitizing and educating communities, religious leaders, traditional chiefs and political leaders on women's sexual and reproductive rights as well as training health-care workers. Thus, state parties should remove all obstacles to the enjoyment by women of their rights to sexual and reproductive health and address gender disparities, patriarchal attitudes, harmful traditional practices and importantly prejudices of health care providers[146].

Finally, it is of note that in sub-Saharan Africa, pregnancy and childbirth-related complications are the leading causes of maternal morbidity and mortality[147]. To address this issue, the African Commission adopted the Resolution on Maternal Mortality in Africa which affirms that maternal mortality should be declared a state of emergency in Africa[148] and criticises African leaders for their lack of action in addressing the issue in their respective countries[149].The Commission further declares that preventable maternal mortality in Africa is a violation of women's right to life, dignity and equality enshrined in the African Charter. Therefore, the resolution approved a recommendation that incentivises the states to 'adopt a human right based approach in the formulation of country programs and strategies to reduce maternal mortality in Africa'[150]. In order to achieve that, the states should 'ensure participation of women and civil society in the formulation and implementation of policies aimed at addressing maternal mortality' and should 'take all appropriate measures including positive discrimination in providing funds for specific programs and projects to secure maternal health'[151]. The Commission specifically recognised the importance of training birth attendants for an effective approach to maternal mortality and specially mentioned the importance of these measures for rural women. Thus, the Commission recommends the states to 'provide well-staffed and equipped maternity centres in rural areas', 'to employ and retain skilled health personnel and birth attendants at rural and semi urban areas' and to 'train and retain health

[145] Ibid, para 25
[146] Ibid, para 60
[147] Ibid, para 16
[148]The African Commission on Human and Peoples' Rights Meeting at its 44 the Ordinary session in November 2008 approved the Resolution on Maternal Mortality in Africa
[149] African Commission on Human and Peoples' Rights *Resolution on Maternal Mortality in Africa* ACHPR/Res.135 (XXXXIIII), para 1
[150] Ibid, para 2
[151] Ibid, para 2

workers in emergency obstetric care'[152]. Another relevant recommendation was the necessity for the states to 'develop community led emergency transport systems to cushion the effect of delays in getting medical attention'[153]. Finally, it urges the member states of the African Union that have not already done so, to urgently ratify the Protocol to the Africa Charter on Human and Peoples' Rights on the Rights of Women in Africa.

[152] Ibid, para 3
[153] Ibid, para 2

Third Chapter – Exposing stereotypes to overcome inequalities

More than trying to understand how women bodies' reproductive capabilities may seriously contribute to endangering their lives, this chapter focuses on questioning how gender roles and wrongful gender stereotyping may present an obstacle for women's access to quality and respectful maternity care. It is of note that gender roles are not only highly oppressive for women in general, but men are also discriminated against and even ostracised when their behaviour deviates from the established patterns of manliness. However, gender roles and stereotypes especially impact women's lives and lead to the discriminatory treatment of half of the world's population. The stereotypes further analysed are transversal to several societies and are connected with universal conceptions of femininity and motherhood. Gender stereotypes and women's roles vary significantly in different societies but there are common conceptions, such as the role of women as primarily mothers. This chapter focuses on the main stereotypes affecting African women. On approaching this controversial topic, the ethnic, cultural, religious and historical diversity of sub-Saharan African countries should be taken into account since it is not sensible or reasonable to categorise African women as a cohesive group.

This chapter begins the in-depth analysis of African women's reality regarding access to quality and respectful care during childbirth, which will be expanded upon in the subsequent chapters of the thesis. In initiating such a task, it is necessary to unveil hidden and pervasive reasons behind women's discrimination. As previously mentioned, unveiling harmful gender stereotypes is one the most decisive steps the governments should undertake to eradicate discrimination against women. Solely by recognising stereotypes' existence and addressing it in an explicit manner, the problems it contributes to can be addressed. Further, it is relevant to question whether the sub-Saharan African governments are responsible for perpetuating wrongful gender stereotyping whilst deciding women's reproductive health needs to be of less importance in regards to resource allocation. Ultimately, this chapter will introduce the idea of wrongful gender stereotyping amongst health providers and how it might contribute to limiting women's access to respectful maternal health care as it exacerbates behaviours of abuse and disrespect.

1. Wrongful gender stereotyping's impact on women's access to health care

As previously discussed[154], international law obligates states to address wrongful gender stereotyping and the CEDAW Committee has repeatedly called for the elimination of social and cultural patterns, prejudices and harmful practices that restrain the right of equal access to health services[155]. Gender stereotyping is described as the 'practice of ascribing to an individual woman or man specific attributes, characteristics, or roles by reason only of her or his membership in the social group of women or men'[156]. Thus, gender stereotypes lead to the idea that all individuals in the social groups of men or women possess certain characteristics, behave in a certain way, and have pre-determined roles. Nonetheless, to a certain degree, stereotypes might be useful to understand complex realities. Cook affirms that stereotyping is so fundamental to human thought and action that it would not be beneficial to eradicate all gender stereotypes, but only to transform or modify those stereotypes that are detrimental to the realization of women's rights[157].

Yet stereotypes are harmful when they serve to 'ignore individual women's characteristics, abilities, needs, wishes, and circumstances in ways that deny them their rights, and when it creates gender hierarchies by constructing women as inferior to men'[158]. Doyal asserts that women 'may be revered as mothers for instance [whilst], fundamentally less valuable than men'[159]. This idea is linked with the preconception of women not only biologically distinct from men, but physically and socially inferior[160]. Thus, the biological differences between men and women are often utilized to explain the 'natural order' of the world as the natural subjection of women due to men's physical strength, therefore entrenching the longstanding patriarchal hegemony. Moreover, it is of common knowledge that in most cultures, the male is more valued than the female.

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[154] See first chapter point 3.3

[155]Cook, R. J., & Undurraga, V. (2012). Article 12. In M. A. Freeman., C. Chinkin, & B. Rudolf, *The UN Convention on the Elimination of all Forms of Discrimination against Women : a commentary.* Oxford University Press .p.371

[156] Commissioner, U. N. (2014). *Gender stereotypes and Stereotyping and women's.* Geneva.

[157] Ibid, p.149

[158] Cusack, S., & Cook, R. J. (2009). Combating Discrimination Based on Sex and Gender. In C. Krause, & M. Scheini, *International Protection of Human Rights.p.13*

[159] Doyal, L. (1995). *What Makes Women Sick: Gender and the Political Economy of Health1.* London: Macmillan Press LTD.p.2

[160] Ibid, p. 2

Misconceptions about women's alleged inferiority are entrenched in society and negatively impact governments' will to address women's specific health-care needs. A reliable way of proving this argument is by comparing countries with same gross domestic product (GDP) which have very different rates of maternal mortality and morbidity (MMM); or countries with disparate average incomes and very similar rates of MMM. In this way, it has been evidenced that mother's lives depend much more on the level of effort governments are willing to expend to solve the problem, than the sum of the government's budget[161]. This specific issue will be further analysed in the final chapter, since it will make a comparison between two different sub-Saharan African countries (Angola and Mozambique) with very different GDPs and similar rates of MMM leading to the conclusion that GDP is not the deciding factor in tackling MMM rates but rather governmental enthusiasm and coordinated and effective administration.

Studies have shown that only 65% of deliveries in Africa are attended by a skilled birth attendant (SBA), such as a doctor, nurse or other trained health provider[162]. Whilst this percentage reveals very low levels of health spending overall, it also suggests a particular reluctance to invest in women's reproductive health. As a matter of fact, training SBAs is considered one of the most crucial steps to combatting maternal mortality and the necessary resource allocation for this goal is not disproportionately high. Moreover, as it has been previously mentioned, low-income countries which are financially struggling should request and receive international cooperation and assistance[163] since they are under the international obligation to move as effectively as possible towards the full realisation of the right to health. In explaining the on-going inertia of some governments, Cook claims that "the challenge of achieving safe motherhood […] is that the reforms that are necessary threaten conventional practices and value systems'[164]. This author asserts that 'no government opposes safe motherhood', but the fact is that 'their leaders often consider the circumstances that condition maternal mortality to be part of the natural order including the subordination and powerlessness of

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161 lkema, L., Chou, D., & Hogan, D. (2016). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *Lancet*, 462-474.p.469

162Diamond-Smith, N., & Sudhinaraset, M. (2016). Drivers of facility deliveries in Africa and Asia: regional analyses using the demographic and health surveys. *Reproductive Health*, 1-14.p.4

163 Article 2.1 of the ICESCR

164 Cook, R. J. (1998). Human Rights Law and Safe Motherhood. *European Journal of Health Law, 5*, 357-375. p. 358

women'[165]. Bearing the potential harmful bodily consequences of childbirth and ultimately dying during or after delivering might be perceived has the ultimate sacrifice women should passively accept as it happens because it is their fate. Thus, MMM may be accepted as a natural consequence of women's reproductive capacities and social obligations. In this regard, Cook states that the high rates of maternal mortality and morbidity are a symptom of 'social injustice of discrimination against women'[166] and that 'the re-characterisation of avoidable maternal mortality from a health disadvantage to a social injustice place governments under a legal obligation to remedy the injustice'[167].

In conjunction with the stereotype related to women's inferior status, it is crucial to scrutinise the stereotype of women as primarily mothers, which is responsible for an immeasurable strain for motherhood. When analysing African women's roles in society, the concept of domesticity should be taken into account. Tamale asserts that 'the domestic roles of mother, wife and homemaker are the key constructions of women's identity in Africa'[168]. The reason behind those ascribed roles is women's reproductive capacities which ultimately make them 'predisposed' to childbearing, to childrearing and housewifery. On the words of this author, 'the ideology of domesticity in Africa marks the maternalisation (and sexualisation) of women's bodies'[169]. As a consequence of this stereotype, single childless women are discriminated against and perceived as an incomplete person not committed to their social role[170]. Cook explains that the stereotype of women as primarily mothers 'implies that women should prioritize childbearing and childrearing over all the other roles they might perform or choose'[171] and that occasionally, 'women are put on a pedestal' 'especially with respect to her caring or nurturing capacities', but this is contingent on 'fulfill[ing] the traditionally, customary, or religiously determined duties that come along with primarily or exclusively being a mother'[172]. The pressure for motherhood can also be harmful if a woman is compelled to go through multiple pregnancies and to bear the physical burdens of procreation. Health complications associated with too-frequent deliveries, limited spacing between births,

165 Ibid, p.358
166 Ibid, p.357
167 Ibid, p. 358
168 Tamale, S. (2004). Gender Trauma in Africa. *Journal of African Law, 48*(1), 50-61.p.51
169 Ibid, 52
170 Adjetey, F. N.-A. (1995). Reclaiming the African woman's individuality: the struggle between women's reproductive autonomy and African society and culture. *American University Law Review*, 1351-1381.p.1352

171 Cook, R. J. (1998). p. 370
172 Cook, R. J., & Undurraga, V. (2012). .p.146

and underlying health conditions increase the potential for harm to women[173]. In accordance with Adjetey, expectations related to motherhood 'keep African women in cultural subordination and put them in such a low bargaining position that they have little, if any, control over decisions which affect their bodily integrity'[174]. This role of women as primarily mothers has relegated them to the household, childbearing and childrearing activities (non-paid and time-consuming) which hold them in poverty and in dependence on the breadwinner of the family - usually a male figure. Working mothers also hold motherhood as their primary function and often do not have control over the family's finances. According to Cook, the pressure for motherhood act to 'restrict women's right to be economically active and financially independent'[175]. All these obstacles give women a very limited bargaining position within their families, resulting in the fact that family money is not spent on their health care needs, further inhibiting their access to quality reproductive health care services.

2. Wrongful gender stereotypes within health care providers

Healthcare providers are social human-beings influenced by normal processes of socialisation and by broader problems in society. As such, they experience the same cultural values and are also influenced by general prejudices and stereotypes, often projecting these stereotypes on their patients. Uncovering stereotypes held by health professionals is thereby crucial to understand women's experiences of discrimination concerning the access to quality respectful maternal care. Studies have shown that stereotypes about women amongst health professionals are mainly related to women's 'capacity to make free and informed decisions', 'moral agency to make decisions about their reproduction and sexuality', and 'autonomy to determine their own roles in society'[176]. These harmful stereotypes are intrinsically connected with the stereotype of women as weak, vulnerable and inferior which leads to the misconception of women as incompetent decision-makers. Besides, the health sector tends to be a mirror of societies where, in general, men often hold the highest and more prestigious positions. Male's prevalent authority regarding medical decisions is part of 'a broader ideology of

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[173] Adjetey, F. N.-A. (1995), p. 1352
[174] Ibid, p. 1352
[175] Cook, R. J., & Undurraga, V. (2012)., p.146
[176] Cusack, S., & Cook, R. J. (2009). Stereotyping Women in the Health Sector: Lessons from CEDAW. Washington and Lee Journal of Civil Rights and Social Justice, 16(1), 47-78. p 55

patriarchy that enables the subordination of women generally, and the control of their sexuality and reproduction more specifically'[177].

Diverse studies conducted in sub-Saharan African countries demonstrated how the ideology of health providers' superiority often lead to abuse and disrespect towards patients, especially during childbirth[178]. For instance, in research conducted in a South African maternity, birth attendants used the words 'ignorance', 'illiteracy', 'dirty', 'irresponsible' and 'very obstreperous' to describe pregnant women attending that service[179]. According to the authors of the research, those perceptions about the patients are much related to 'ideologies of patient inferiority'[180]. Nurses in their health centres are a local elite that looks down on a population considered "ignorant". The population looks up to them as representatives of the 'State', representing a different culture and often perceived as hostile to traditional values[181].

Moreover, it has been proved that violence against patients, such as obstetric violence, can occur when medical or nursing authority is threatened, or perceived as being threatened[182]. As an example, in South Africa, nursing training has been linked to 'ideas of civilisation and moral superiority'[183]. Moral instruction is perceived as one of the functions of a good nurse and violence can be utilised as a manner of punishment applied to those who violated social moral codes, for example, teenagers who are sexually active or women who have had abortions[184]. Exposing this ideology of moral superiority is especially relevant to unveil obstetric violence which occurs in public and private facilities. As it will further debated, obstetric violence is considered to be any violation, dehumanization, abuse or threat to a woman's autonomy during pregnancy, childbirth or

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[177]Sherwin, S. (1992). *No Longer Patient: Feminist Ethics and Health Care.* Temple University Press, 228-229.

[178] d'Oliveira, A. F., Diniz, S. G., & Schraiber, L. B. (2001). Violence against women in health-care institutions: an emerging problem. *The Lancet, 359*(9318), 1681-1685; Dowdy, D. W. (2015). Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. *PLoS One, 10*(4), 1-13; Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine, 47*(11), 1781-1795.

[179] Jewkes, R., Abrahams, N., & Mvo, Z. (1998)+6

[180] Ibid, p. 1790

[181] Bossyns, P., & Lerberghe, W. V. (2004). The weakest link: competence and prestige as constraints to referral by isolated nurses in rural Niger. *Human Resources for Health*, 1-8.

[182] d'Oliveira, A. F., Diniz, S. G., & Schraiber, L. B. (2001). p. 1683

[183] Jewkes, R., Abrahams, N., & Mvo, Z. (1998), p.1791

[184] Ibid,p.1791

the postpartum period[185]. Abuse and disrespect both by traditional birth attendants and SBAs during childbirth is a form of obstetric violence which can be materialized in different manners, such as verbal abuse. Studies have revealed that whilst managing women's deliveries, less respectful birth attendants would make use of violent speech but insult these same women about their sexuality for instance[186]. According to d'Oliveira, 'women who make noise or complain of pain during delivery are frequently shamed or scolded by health providers for having sex in the first place'[187]. Undignified treatment and disregard for women's pain during childbirth is partly connected to the stereotype of women as primarily mothers. If the process of giving birth is considered part of social function of motherhood, it is perceived as something natural that women should not complain about. The same happens to women who deliver at home, since they are expected to endure delivery quietly, and follow the instructions of traditional birth attendants or older women present at the birth without questioning[188]. Moreover, the above-mentioned verbal abuse 'establishes a certain symmetry of sin between the pains and complaints of childbirth versus the pleasure and cries during intercourse'[189]. The idea that the women deserve the pain comes from a general social and religious misconception of pregnancy as a consequence of sexual debauchery. Likewise, quality of care is also conditioned by health workers' assessment of the socio-demographic profile of their patients, and the expectations and actions that emerge from such judgments[190]. For instance, 'poor women who arrive at the hospital without sanitary pads or clean bed sheets may be scolded harshly by health workers who see them as unfit mothers'[191]. Studies have shown that women from marginalized communities, such as racial and ethnic minorities, refugees, unmarried women, and adolescents, are more vulnerable to abuse in facility-based deliveries[192].

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185 WHO. (2017, May). *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth* . Retrieved from http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf

186 d'Oliveira, A. F., Diniz, S. G., & Schraiber, L. B. (2001). p. 1683
187 Ibid, p. 1684
188 Roush, K., Kurth, A., Hutchinson, M. K., & Devanter, N. V. (2012). Obstetric Fistula: What About Gender Power? *Health Care for Women International*, 787-798. p.792

189 Jaffre, Y., & Suh, S. (2016). Where the lay and the technical meet: Using an anthropology of interfaces to explain persistent reproductive health disparities in West Africa. *Social Science & Medicine, 156*, 175-183. p. 179
190 Ibid, p.180
191 Ibid,p.180
192 M. Turan, S. M. (2008).H IV/AIDS and maternity care in Kenya: How fears of stigma and discrimination affect uptake and provision of labor and delivery services. *AIDS care*, 938-945.

Ultimately, wrongful gender stereotyping in the health sector is contributing to the impairment and nullification of women's access to reproductive health care. Stereotypes can easily lead to the perpetuation of different forms of obstetric violence during facility-based deliveries and can lead ultimately to the alienation of women from the reproductive health services. It cannot be overstated that this study solely intends to provide a brief glimpse of the main widespread gender stereotypes across the region. However, the historical, cultural and religious specificities of each country or even within a country mean that the stereotype may manifest itself in different ways in regards to childbirth practices.

Further analysis on the issue of abuse and disrespect committed by SBAs during facility-based deliveries will be provided in the following chapter. Lastly, it is important to mention that the limited research on the relationship between gender power and childbirth practices represented a shortcoming for this specific part of the study.

Fourth Chapter – The Role of TBAs and SBAs in promoting Quality Maternal Health

Between 1990 and 2015, 10.7 million women worldwide lost their lives whilst giving life[193]. The actual figure might be much higher since the countries where most maternal deaths occur do not have functioning vital registration systems and the misclassification of maternal deaths is a great obstacle to measurement of maternal mortality[194]. As mentioned previously, the reduction of the shockingly high MMM rates has been a priority of the United Nations as well as other international human rights organizations. Recently, the Sustainable Development Goal 3 (SDG 3) of UN established the goal of reducing the mortality ratio to less than 70 maternal deaths per 100 000 live births globally by 2030. In order to achieve this goal it is necessary to improve the global health workforce. This is explicitly addressed in SDG 3c which aims to "substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries"[195]. This goal also implies that a strategy for addressing high MMM should increase the proportion of women utilizing skilled care at birth and consequently facility-based deliveries.

Following the analysis of the impediments caused by wrongful gender stereotyping in regards to women's access to health care, it is essential to clarify the specific MMM figures, especially for sub-Saharan African women. Further, this study will assess the main obstacles women face in having a facility-based delivery.

This chapter will assess the benefits of facility-based delivery in the hands of a skilled birth attendant with reference to the widespread presence of traditional birth attendants in sub-Saharan African countries and the changing nature of this role. Thus, divergent ideas about the importance of incentivising their work so as to tackle high rates of MMM in remote rural areas will be presented. Moreover, this study will show different approaches taken by various studies towards the diverse perceptions of quality of care by both traditional and skilled birth attendants and how this can impact on women's ultimate decision of the place of delivery. Further analysis will be made regarding the parturient women's experiences of disrespect and abuse perpetuated by birth attendants and how

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[193] Alkema, L., Chou, D., & Hogan, D. (2016). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *Lancet*, 462-474.p.467

[194]Ibid,p.472

[195] United Nations, (2015)*Transforming our World: the 2030 Agenda for Sustainable Development*

this poor quality of care might be contributing to push women away from facility-based deliveries. Thus, this study intends to present the main causes for the situation of mistreatment by health care providers and present the most recent international standards of quality and respectful maternal care which aim to tackle a situation that has been pervasively neglected by governments.

1. Situating maternal mortality and morbidity in context

Maternal death is defined as 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes'[196]. The largest proportion of maternal deaths in 2015 occurred in sub-Saharan Africa (201, 000 deaths)[197]. There are large disparities between countries, but also within countries, and between women with high and low incomes and women living in rural areas versus urban areas. Women in low-income countries have, on average, more pregnancies than women in high-income countries, and their lifetime risk of death due to pregnancy is higher. A woman's lifetime risk of maternal death is 1 in 4900 in developed countries, versus 1 in 180 in developing countries and in countries designated as fragile states, the risk is 1 in 54[198]. The leading direct causes of maternal death worldwide were postpartum haemorrhage, hypertension, sepsis, abortion, complications in delivery and obstructed labour[199]. Obstetric complications not always fatal and many women survive pregnancy and delivery with short or long-term disabilities. Short-term morbidity can include haemorrhage, convulsions, cervical tears, shock and fever and long-term, and often chronic sequelae of childbirth are often in the form of uterine prolapse, depression, and obstetric fistula[200]. The avoidance of these disabilities should be made a priority and also their existence should be recognised. As non-fatal conditions have a lasting effect on women, and require continuous medical attention, it is in the best interest of the state to adequately address the ailments. The

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[196] Alkema, L., Chou, D., & Hogan, D. (2016).p.463
[197] Ibid, p.467
[198] http://www.who.int/mediacentre/factsheets/fs348/en/
[199] Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.-B., Daniels, J., . . . Alkem, L. (2014). Global causes of maternal death: a WHO

[200] Filippi, V., Goufodji, S., Sismanidis, C., Kanhonou, L., Fottrell, E., Ronsmans, C., . . . Patel, V. (2010). Effects of severe obstetric complications on women's health and infant mortality in Benin. *Tropical Medicine & International Health*, 733–742. P. 741

impact of these diseases on women's health justifies investment in post-natal care as much as in the facility-based quality deliveries. There seems to be little recognition of the particular difficulties of women who have suffered severe obstetric complications. This is partly because the debate on the content of post-natal care in developing countries is driven by the desire to reduce child mortality and much less on the need to improve maternal health and survival[201]. To end preventable maternal and new-born morbidity and mortality, every pregnant woman and new-born needs skilled care at birth with evidence-based practices delivered in a humane, supportive environment. Quality of care requires the ´appropriate use of effective clinical and non-clinical interventions, strengthened health infrastructure and optimum skills and attitude of health providers, resulting in improved health outcomes and positive experience of women and providers'[202].

2. Benefits of facility-based deliveries and main obstacles

The proportion of births attended by a SBA was an important indicator for monitoring progress towards the MDG 5 of a 75% reduction in the maternal mortality ratio between 1990 and 2015. In actuality, global coverage of skilled attendant during childbirth increased from 61% in 2000 to 78% in 2016[203]. Nonetheless, progress has been slower in achieving the skilled birth attendance targets in sub-Saharan African countries (the target being 90% coverage by 2015[204]). Improvements require the overcoming of cultural, financial, and geographic barriers to its access, as well as reforming the poor quality of care at facilities. Thus, despite steady improvement globally and within regions, millions of births were not assisted by a midwife, a doctor or a trained nurse. In low-income countries, only 56% of births in rural areas are attended by skilled health personnel, compared with 87% in urban areas[205]. In sub-Saharan Africa approximately only half of all live births were delivered with the assistance of skilled birth attendant in 2016[206].

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[202] Tuncalp, Ö., Were, W., MacLennan, C., Oladapo, O., Gulmezoglu, A., Bahl, R., & Daelmans, B. (2015). Quality of care for pregnant women and newborns—the WHO vision. *BJOG, 122*, 1045–1049. p. 1046

[203] United Nations. (2015). *The Millennium Development Goals Report.* New York. p. 39

[204] WHO (2008) Proportion of birth attended by a skilled health worker

[205] Ibid

[206] WHO. (15 de 06 de 2017). *Global Health Observatory (GHO) data*. Obtido de Skilled attendants at birth: http://www.who.int/gho/maternal_health/skilled_care/skilled_birth_attendance_text/en/

Except for some cases of negligence (discussed below), delivering at a facility means that the delivery is performed by an SBA which also links women to referral systems, essential medical equipment and drugs where complications arise[207]. An SBA is defined as 'an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in identification, management and referral of complications in women and newborns'[208].

As it has been proven, almost one in four women do not have access to crucial medical care during childbirth[209]. It is therefore crucial to investigate why still so many women are excluded from the health system and are not delivering in health facilities. Many reasons have been mentioned in the previous chapters for women's lack of access to maternal care such as poverty, geographical distance, lack of information, inadequate services and other forms of discrimination. Geographical distance to health facilities is noted as one of the main factors affecting women's delivery locations. Rural women living in remote areas face the obstacle of lack of transportation to the nearest hospitals. Taking in due account the relatively unpredictability of most of the deliveries, distance and lack of proper transportation to reach health facilities in a timely manner play a decisive role on women's decision to deliver at home. Lack of access to transportation, good roads, adequate funds, and communication systems also make organising referrals for obstetric complications a time-consuming process[210].

There is still a need to increase accessibility to facilities for delivery for poorer and more rural women in all regions of the globe. Ultimately, this begs the question of whether the solution is to create 'close-to-community care centres' to provide maternal care instead of women travelling long distances to avail of these services. The main problem is that 'in lower-level facilities, qualified physicians may be a rarity, leaving unskilled nurses to attend to labour management, complications, and decisions regarding

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[207] Diamond-Smith, N., & Sudhinaraset, M. (2016). Drivers of facility deliveries in Africa and Asia:regional analyses using the demographic and health surveys. *Reproductive Health*, 1-14.p.1

[208] WHO (2004) Making pregnancy safer the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO. Geneva: World health organization (WHO). Department of Reproductive Health and Research (RHR).

[209] United Nations. (2015). *The Millennium Development Goals Report.* New York .p. 39

[210] Bohren, M. A., Hunter, E. C., Munthe-Kaas, H. M., Souza, J. P., Vogel, J. P., & Gülmezoglu, A. M. (2014). Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. *Reproductive Health, 11*, 1-17.

referrals'[211]. Some authors argue that these centres will continue to be important for many health services but not deliveries since 'safety and other aspects of quality cannot be maintained'[212]. These facilities are usually associated with low-quality care which women might be reluctant to access. Thus, said authors propose several measures for the governments to improve the utilisation of quality health facilities such as 'an expansion of investment in mid-tier facilities for delivery services and a shift away from low-volume rural delivery facilities'[213] and at the same time to 'assure access for rural women through funding for transport infrastructure, travel vouchers, targeted subsidies for services, and residence support before and after delivery'[214]. Further recommendations go in the direction of the need for the 'specialisation of maternity facilities and dedicated maternity wards within larger institutions'[215] and 'a renewed focus on quality improvements at all levels of delivery facilities, in both private and public settings'[216].

It has been proven that some hospitals are not prepared to receive all the women that seek their services, namely they are overcrowded and have very poor conditions, such as lack of beds, health staff and drugs[217]. Therefore, some people contend that institutional birth has not been shown to be the answer[218]. With increasing numbers of births in health facilities, attention has shifted to the quality of care, as poor quality of care contributes to MMM. The WHO states that in order to achieve quality of care is 'health care must be safe, effective, timely, efficient, equitable and people-centred'[219]. Studies have shown that variables strongly associated with delivering in a facility include antenatal care (ANC) visits, higher socioeconomic status, and residence in urban areas[220]. The most powerful correlation in this analysis was between a woman having ANC or a larger

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[211] Bohren, M. A., Vogel, J. P., Hunter, E. C., & Lutsiv, O. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine*, 1-32. p.13

[212] Montagu, D., Sudhinaraset, M., Diamond-Smith, N., Campbell, O., Gabrysch, S., Freedman, L., . . . Donnay, F. (2017). Where women go to deliver: understanding the changing landscape of childbirth in Africa and Asia. *Health Policy and Planning*, 1–7.p.6

[213] Ibid, p.6
[214] Ibid, p.6
[215] Ibid, p.6
[216] Ibid, p.6
[217] https://www.newsecuritybeat.org/2017/05/respect-saraswathi-vedam-reducing-over-intervention-maternal-care-autonomy/
[218] Ibid
[219] WHO. (2016). *Standards for improving quality of maternal and newborn care in health facilities.* Geneva, Switzerland: World Health Organization. p.14

[220] Diamond-Smith, N., & Sudhinaraset, M. (2016). p.2

percent of women in a community having ANC, and facility delivery. Maternal care is defined by WHO and the Partnership for Maternal, Newborn and Child Health as the set of interventions that support the "continuum of care" for women during reproductive age with ANC being the first step in the continuum. It prepares women for birth and parenthood[221]. Its purpose is to 'prevent, detect, alleviate, or manage the three types of health problems occurring during pregnancy, pregnancy related, pre-existing conditions that worsen during pregnancy and effects of unhealthy habits'[222]. In this sense ANC is a fundamental utensil in bringing women under the scope of health services, therefore allowing a general culture of medical awareness to pervade the somewhat neglected communities.

3. The role of traditional birth attendants in maternal health care

Traditional birth attendant (TBAs) have long held a constant, established, and respected position within the community but often lack the necessary skills to manage complicated deliveries. The WHO defines a TBA as 'a person (usually a woman) who assists a pregnant woman at childbirth, and who initially acquired her skills delivering babies by herself or working with other TBAs'[223]. TBAs played an important role as first-line providers for many women. Studies have shown that some women perceived TBAs as providing high quality delivery care, often referring to the supportive and emotional role that TBAs play. Further, women emphasized the close bond that they felt with TBAs, due to their status in the community and the trust they developed over years of experience[224]. Compounding the issue of the lack of access to centralised professional health services, many women display a preference for home-based births attended to by a TBA rather than by SBA in a facility[225]. Nonetheless, perceptions of TBAs are clearly diverse depending on previous experiences and other factors. For example the study conducted by Bohren *et al.* demonstrates that some women perceived TBAs as providers of low quality delivery care. These women did not trust the TBAs' skills, knowledge, or

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[221] UN (2010). *Global Strategy for Women´s and Children´s Health.*
[222] Kerber,K.J., et al., *Continuum of care for maternal, newborn, and child health: from slogan to service delivery.* Lancet, 2007. **370**(9595): p. 1358-69
[223] World Health Organization. Report of the Alma Ata Conference on Primary Health Care. Health for All series, No. 1. Geneva, WHO
[224] Bohren, M. A., Hunter, E. C., Munthe-Kaas, H. M., Souza, J. P., Vogel, J. P., & Gülmezoglu, A. M. (2014).p.10
[225] Ibid, p10

ability[226] to handle complications and may be more likely to seek facility-based delivery[227]. This is much related to the fact that TBAs have no formal training and some are illiterate and as a result cannot deal with medical notes and records. Regardless, every village has at least one TBA and as they are from the villages, they understand the traditions, cultures, and languages of the women that they attend to, an obvious advantage during antenatal care and childbirth[228].

The manner in which governments should deal with TBAs is subject of much controversy and extremely divergent opinions. Some authors suggest that TBAs should have due recognition since they provide a needed service to the community due to the shortage of health workers[229]. Notwithstanding, many of these authors agree that some TBAs practices 'carry an element of risk of varying degrees contributing to the maternal and/or infant morbidity/mortality', it is also affirmed that the quality of service can be increased with training[230]. Other authors go even further, suggesting that African governments should integrate TBAs into formal systems of health care in order to improve maternal health[231]. They are considered to be very 'helpful as "counsellors," comforting frightened rural women with complicated labour, often in the middle of night, in difficult to reach remote villages without electricity, water, or transport and no skilled health worker'[232]. These suggest that providing training to TBAs might increase women's usage of health facilities since TBAs would learn how to make use of referral systems, would incentivize women to deliver in a facility and enhance women's usage of ANC. According to Sibely *et al*, most training programs for TBAs have emphasized the important role of ANC in the prevention, early detection, and treatment of obstetric complications, as well as the role of the TBA in promoting ANC[233]. Nonetheless, this study found little effect on the training programs for TBAs in the increased usage of referral programs by those trained TBAs. Though, other studies have shown that some

[226] Ibid, p.5
[227] Ibid, p.6
[228] Ana, J. (2011). Are traditional birth attendants good for improving maternal and perinatal health? Yes. *BMJ*, 1-2. p. 1
[229] Kamal (1998), S45
[230] Ibid, S45
[231] Okonofua, F., & Ogu, R. (2014). Traditional Versus Birth Attendants in Provision of Maternity Care: Call for Paradigm Shift. *African Journal of Reproductive Health*, 11-12.p. 12

[232] Ana, J. (2011). Are traditional birth attendants good for improving maternal and perinatal health? Yes. *BMJ*, 1-2. P.2
[233] M.Sibley, L., AnnSipe, T., & MargeKoblinsky. (2004). Does traditional birth attendant training increase use of antenatal care? a review of the evidence. *Journal of Midwifery & Women's Health*, 298-305.

traditional birth attendants are hesitant to refer women with complications because they fear losing their positions in their communities[234].

Some authors, categorically reject that any benefits can come from the training of TBAs and go so far as to claim that 'they do more harm than good'[235] and that their use is a distraction in that it seeks to manage extreme poverty instead of working to eliminate it.[236] In high-mortality setting, where health systems are failing, investment solely in an intervention deployed outside the health system, for instance through TBAs, whose effectiveness in addressing maternal mortality depends on the existence of the health system represents more than simply an inefficient use of resources. It is arguably a violation of women's right to health. Thus, it can be claimed that it should be given due regard to TBAs since they hold an important position in their communities. Training TBAs might a significant positive result if the trainings are conducted in a proper manner and if TBAs have a back-up support system. Transforming TBAs in trained Community Health Workers (CHWs) can be beneficial to tackle high MMM rates as long as they abstain from performing deliveries. Thus, any progress in relation to delivery practices must rest on a nuanced understanding of traditional practices and positions, and must incorporate such elements in formulating a culturally sensitive and sustainable programme.

4. Women's experiences in facility-based deliveries

As stated previously, only SBAs should conduct deliveries. The two main reasons for that is that SBAs are trained to use safe and hygienic techniques, thereby reducing the risk of complications, like infections, through mismanagement of the delivery[237]. Secondly, SBAs can manage the third stage of labour, which is the period after the baby is born when the placenta is being expelled and most of the postpartum haemorrhages occur[238]. Nonetheless, when obstetric complications such as uterus rupture take place, the SBA must be furnished with a functional system and medical supplies in

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[234] Bossyns, P., & Lerberghe, W. V. (2004). The weakest link: competence and prestige as constraints to referral by isolated nurses in rural Niger. *Human Resources for Health*, 1-8.

[235] Harrison, K. A. (2011). Are traditional birth attendants good for improving maternal and perinatal health? No. *BMJ*, 1-2.
[236]Ibid,p1
[237] UN Millennium Project. (2005). p.82
[238] Ibid, p.82

order to save women's lives. No matter how skilled the attendants are, if deliveries are performed in a place without the necessary drugs and equipment to treat the complication a certain percentage of women will die[239]. Moreover, 'the number of deliveries SBAs perform affects their competence since specific skills such as manual removal of placenta require regular practice'[240]. Inexperienced or poorly trained health providers are often responsible for inappropriate levels of care and their failure to manage severe obstetric complications might contribute to women's lack of confidence in facility-based deliveries.

Additionally, as mentioned in the last chapter, poor quality care during facility-based deliveries is manifested in the form of disrespect and abuse perpetuated by SBAs and other health staff. Different countries, organizations, and authors have adopted different terminology to define that phenomenon, such as 'obstetric violence', 'dehumanized care', 'mistreatment of women' and 'disrespect and abuse'[241]. The WHO proposes a definition of disrespect and abuse as "interactions or facility conditions that local consensus deems to be humiliating or undignified and those interactions or conditions that are experienced as or intended to be humiliating or undignified"[242]. Bowser and Hill's research sets out an evidence-based definition of disrespect and abuse in childbirth which includes 'physical abuse, non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific attributes, abandonment or denial of care [and] detention in facilities'[243].

Verbal violence is the most referenced form of violence during facility-based delivery and can include rough treatment, threats, scolding, shouting, and intentional humiliation[244]. Many women have described providers as 'verbally abusive, rude, bossy, unhelpful, disrespectful, critical, easily angered, having a poor attitude, and lacking compassion'[245]. Physical violence can also assume varied forms such as 'denial of pain-relief when technically indicated, excessive or inappropriate medical treatments in

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[239] Ibid, p.83
[240] Ibid, p.82
[241] Bohren, M. A., Vogel, J. P., Hunter, E. C., & Lutsiv, O. (2015). p.10

[242] Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., . . . Mbaruku, G. (2014). Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. *Bulletin of the World Health Organization*, 915-917.

[243] Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility-based childbirth report of a landscape analysis, 1–57.
[244] d'Oliveira, A. F., Diniz, S. G., & Schraiber, L. B. (2002), p. 1681
[245] Ibid, p. 1681

childbirth, such as doctors doing caesarian sections for reasons related to their social or work schedules or financial incentives; or adhering to obstetric practices that are known to be unpleasant, sometimes harmful, giving enemas and routine induction of labour'[246].

Non-dignified care also includes preventing women to have companions in labour. Studies prove that the perceived lack of supportive attendance at birth in a facility and the 'policies limiting the involvement of TBAs and family members during birth induced anxiety in many women'[247] which was leading them to prefer to deliver at home. Lack of rapport between health providers and patients is also a symptom of non-dignified care. For instance, in a study conducted by Ewkes *et al.*, the interviewed women complained about 'frequently not being told when they were due to deliver, how the baby was getting on, or what was expected from them and what would happen to them in labour'[248]. Women's autonomy and decision-making power is also denied, for instance when the health providers do not respect women's preferred birth positions, which ultimately make them feel passive participants in their childbirth process.[249] Lastly, upon arrival to a facility, women often experienced delays in care provision and health workers were often slow to respond to patient needs. A common sign of neglect in reproductive health-services is women giving birth unattended within health facilities[250].

As already discussed in the third chapter, abuse and disrespect perpetuated by health providers towards parturient women is deeply connected with the socialisation of health-care professionals and the health training system. By virtue of their 'superior knowledge' and social status, health providers hold a privileged and powerful situation in relation to their patients. In this context, poor quality of care in many facilities becomes a serious obstacle to the effective fight against preventable MMM. The qualitative evidence study conducted by Bohren *et al* study found that mistreatment during childbirth is a potent disincentive for women who may attend facilities in low- and middle-income countries[251]. Hence, efforts to implement respectful maternity care can represent a strong

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[246] Ibid, p. 1681

[247] Bohren, M. A., Hunter, E. C., Munthe-Kaas, H. M., Souza, J. P., Vogel, J. P., & Gülmezoglu, A. M. (2014). p.6

[248] EWKES, R., ABRAHAMS, N., & MVO, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine, 47*(11), 1781-1795. p.1791

[249] Bohren, M. A., Vogel, J. P., Hunter, E. C., & Lutsiv, O. (2015).. p.12

[250] d'Oliveira, A. F., Diniz, S. G., & Schraiber, L. B. (2002), p. 1682

[251] Bohren, M. A., Hunter, E. C., Munthe-Kaas, H. M., Souza, J. P., Vogel, J. P., & Gülmezoglu, A. M. (2014). p.7

incentive for more women to use facilities during pregnancy and childbirth. Nonetheless, it must be said that most health workers around the world make considerable efforts to provide proper care, even in adverse working conditions. Thus, addressing the problem of violence by health workers is necessary to support the efforts of dedicated staff that are committed to improving clinical practice and therefore bolstering domestic efforts[252].

5. Respectful maternity care

As argued in the first chapter, respectful maternity care (RMC) is not only a crucial component of quality of care; it has developed into a human right[253]. In 2014, WHO released a statement calling for the prevention and elimination of disrespect and abuse during childbirth, stating that 'every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth'[254]. The concept of RMC leads to the need to humanize birth, taking a woman-centered approach[255] meaning that women's specific needs should be given special emphasis. One of the measures that must be implemented to ensure RMC is to prevent and eliminate disrespect and abuse during facility-based childbirth. Thus, the governments must restructure the health system and invest seriously in the education of their health workforce. The training of qualified health professionals should envisage not only instruction in technique and dexterity but also in sensitivity and ethical responsibilities[256]. The health professionals be aware of the human rights of the patients including reproductive and sexual rights and should have 'relevant information about the distinctive physiological, psychological and social features of women's health'[257]. Further, in order to improve the rapport levels between women and health providers and implement effective respect for women's autonomy and dignity during childbirth, health workers need training in genuine communication with patients.

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[252] d'Oliveira, A. F., Diniz, S. G., & Schraiber, L. B. (2002). p. 1681

[253] WHO. (2017, May). *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*. Retrieved from http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf

[254] Ibid

[255] Ibid

[256] Ibid

[257] Cook, R. (1994).pp. 48-49

As previously mentioned, most health care providers are doing their best with very limited resources and very poor working conditions. Thus, working conditions need to be improved so that 'staff have the time and privacy necessary to attend to patients properly, and have service training, access to laboratory services, treatment, and drugs'[258]. Studies indicate that factors such as 'understaffing, high patient volume, low salaries, long hours, and lack of infrastructure' are responsible for creating stressful environments which has contributed to the health workers' negative attitudes or lack of motivation and ultimately deterring would-be health care recipients[259]. Moreover, effective monitoring and accountability systems should be implemented within the health facilities. The supervisors or administrators of hospitals should be strongly incentivised to identify abusive staff, and to take 'effective disciplinary action' which would promote a more professional and responsible culture within the health service.

WHO also called for the mobilization of governments, programmers, researchers, advocates and communities to support RMC. Despite a very recent increase in the interest of researchers for the issue of abuse and disrespect in facility-based deliveries, as shown by the various studies mentioned in this chapter, 'there is still a need for international consensus on how disrespect and abuse should be scientifically defined and measured'[260]. Further, there is still much to learn on different forms of disrespect and abuse during facility-based deliveries in different countries and its impact on women's maternal health given the differences in cultural sensitivities across sub-Saharan Africa. While many researchers, international organizations and civil society groups and communities[261] have already highlighted the need to address this problem, there is little data regarding effective implementation on countries' measures regarding policies to promote RMC.

More than undertaking measures to ensure accessible health facilities and skilled birth attendance to decrease MMM and improve women's maternal health in general, states must guarantee, through their policies, that health staff are prepared to 'meet women's emotional, physical, and medical needs and guarantee that human rights are

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[258] Ibid, p.20

[259] Ibid, p. 20

[260] WHO. (2017, May). *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*. Retrieved from http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf

[261] The Network for the Humanization of Labour and Birth (ReHuNa) was founded in Brazil in 1993, followed by the Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN)

respected'[262]. Emphasizing the rights of women to dignified, respectful health care throughout pregnancy and childbirth plays an important role for the states compliance with international obligations to protect women's health. Thus, rights-based approaches to organizing and managing health systems can facilitate the provision of respectful, quality care at birth. According to a recent study on the matter, 'human rights standards are an important accountability tool for recognizing and protecting the human rights of women during childbirth in facilities, and for supporting health system reform to prevent mistreatment in the future'[263]. In order for these human rights to serve as efficient and effective monitoring standards, it is necessary to develop general understanding on this issue, such as 'to gather information about the conditions of service access and delivery' and 'to identify where and why patient-provider relations break down'[264]. Moreover, there is a need to 'develop innovative human rights accountability measures to enforce standards both for individual remedy and redress for victims of mistreatment', and to hold accountable health professionals in order to prevent future violations. These are measures that can effectively and sustainably transform health systems to shape and change the experience of service provision and access.

[262] khosla, r., zampas, c., vogel, j. p., bohren, m. a., roseman, m., & erdman, j. n. (2016). p.138

[263] Ibid, p.138

[264] Ibid,p.138

Fifth Chapter – Study case on Angola and Mozambique

This study will analyse health services in the sub-Saharan African countries Angola and Mozambique. Both countries fought in the Portuguese colonial war for their right to self-determination, culminating in their independence in 1975. After the independence, Mozambique and Angola descended into devastating civil wars which ultimately ceased in 1992 and 2002 respectively. The struggle against Portuguese colonialist rule and subsequent civil wars, culminated in approximately 2 million fatalities, millions of refugees, widespread internal displacement, and the decimation of internal infrastructure. Despite the common historical background, these countries developed in very different directions. Angola is now considered an upper-middle-income country, whilst Mozambique is still considered a low-income country. Angola's GDP per capita of 7649 Int $ (2015) is seven times higher than that of Mozambique's GDP per capita of 1101 Int $ (2015)[265]. The total expenditure on health as percentage of GDP (in 2014) was 3.3% in Angola and 7% in Mozambique, with the investment in health as a percentage of total national expenditure in the poorer country dwarfing that of the wealthier Angola[266]. Nonetheless, as will be put forward in this final chapter, both countries have very similar maternal mortality and morbidity rates. In the gender inequality index Angola and Mozambique are considered to have low human development rates, occupying the place 150 and 181 respectively[267].

The question arises as to what the different governments are doing to comply with the right to maternal health, namely regarding their expenditure on health systems and the way they have been requesting and receiving international assistance. This chapter will summarise the differences in governmental compliance with the right to health between Angola and Mozambique, and their political will to address maternal mortality through ensuring the training of health professionals and skilled birth attendants. We must then analyse why the maternal mortality rates remain so high within Angola despite their superior economic position. Further, it is relevant to question whether these sub-Saharan

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[265] WHO (2017, July). *Angola Maternal mortality in 1990-2015.* Retrieved from http://www.who.int/gho/maternal_health/countries/ago.pdf?ua=1

WHO (2017, July). *Mozambique Maternal mortality in 1990-2015.* Retrieved from http://www.who.int/gho/maternal_health/countries/moz.pdf?ua=1

[266] WHO. (2017, July). *Data on Mozambique*. Retrieved from http://www.who.int/cou ntries/moz/en/

[267] United Nations Development Programme. (2016). *Human Development Report 2016 - Human Development for Everyone.* New York: UNDP.p.214

African governments are responsible for perpetuating wrongful gender stereotyping whilst deciding women's reproductive health needs to be of less importance in regards to resource allocation.

1. ANGOLA

Angola is a sub-Saharan African country located on the west coast of southern Africa with a total population of 25 million. According to the Human Development Report 2016, Angola ranks as a country with a low Human Development Index and retains a position near the bottom of the league[268]. In the last decade, the economy of Angola experienced robust growth, mainly due to oil revenues which generated 55% of the GDP[269]. Angola's economic growth rate is considered to be one of the highest in the world, with an average annual GDP growth rate of 9.2%[270]. Nonetheless, Angola lacks basic health care infrastructure and struggles with extreme poverty.

A report from *Bertelsmann Stiftun* affirms that Angola is 'an authoritarian state that presents the formal trappings of democracy and allows for some political participation, so long as it does not threaten the stability of the regime'[271]. The recently drafted Constitution of 2010 abolished the direct election of the president, and even though it limits the president to two five-year terms, the 30-year term already served by the current president would start from the parliamentary elections in 2012, allowing him to remain president until 2022. The constitutional revision has the intention of perpetuating the position of power of the current president and to consolidate the privileged position that his family have occupied for the last 30 years. In its report, *Bertelsmann Stiftun* accuses Angola of the 'lack of transparency, and excessive hierarchy [which] undermine the smooth functioning [of public services]' and of being responsible for the 'widespread corruption which further hamper their efficiency'[272]. This is demonstrative of the presently pervasive political corruption within Africa. According to

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[268] United Nations Development Programme. (2016). *Human Development Report 2016 - Human Development for Everyone.* New York: UNDP.p.214

[269] Ibid, p.215

[270] WHO Regional Office for Africa (2016). *WHO Country Cooperation Strategy Angola 2015-2019.* WHO Country Office in Angola. p.4 http://www.who.int/countries/ago/en/

[271] Bertelsmann Stiftung. (2016). *BTI 2016 | Angola Country Report.* p.12

[272] Ibid, p.13

Transparency International, 'large scale official corruption has become a serious menace in Africa thereby posing threats to the enjoyment of socio-economic rights, including the right to health'[273]. Indeed, it has been argued that 'corruption not only undermines development, but is also a great threat to social wellbeing and basic services that have been undermined by the misappropriation of funds'[274].

Mainly due to its increasing determination to become an authoritarian regime, 'the government views any potential development assistance with suspicion, and as meddling in internal affairs'[275]. Several international cooperation NGOs, which are determinant actors for the development of the socio-economic rights in the country, complain about the impediments created by the government. For instance, in 2015 the Presidential Decree No. 74/15 was published, regulating NGOs within the country and raising serious concerns regarding the ability of civil society to operate freely in Angola, including severe funding restrictions[276]. The president justified this decree as a measure to prevent money laundering and the funding of terrorism but one may contend that it stemmed from the fear of international interference and the support of these international organisations to the protection of civil and political rights in Angola. This general attitude has undermined the possibility of external assistance in the country and fails to alleviate and even exacerbates extreme poverty in Angola. Further, according to the most recent report of Amnesty International, 'the drop in the price of oil put Angola's oil-dependent economy under severe pressure, prompting the government to cut the budget by 20%' [277]. Thus, despite the Angolan state's attempts to hide human rights violations and to portray an international image of a thriving economy which is bringing prosperity for all Angolans, this does not bear a semblance to the realities of life within the Angolan state.

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[273] Transparency International. (2016, July 1). *CORRUPTION PERCEPTIONS INDEX 2016*. Retrieved from https://www.transparency.org/news/feature/corruption_perceptions_index_2016

[274] Ibid, p. 30
[275] Ibid. p 31
[276] The International Center for Not-for-profit Law. (2015, September). *Comments on Angola's Presidential Decree No. 74/15 on the*. Retrieved from http://fatfplatform.org/wp-content/uploads/2015/10/ICNL-Comments-on-Angolas-Presidential-Decree-No-74-15-4-Sept-15.pdf

[277] Amnesty International. (July de 2017). *ANGOLA 2016/2017*. Obtido de https://www.amnesty.org/en/countries/africa/angola/report-angola/

1.1. National Legal framework

The Constitution of Angola of 2010 contains a bills of rights, which protect civil and political rights alongside economic, social and cultural (ESC) rights. In addition to recognizing ESC rights, the Constitution of Angola requires the courts to interpret the fundamental principles in respect of fundamental rights harmoniously with the UDHR and the African Charter, both of which recognise ESC rights, and other international treaties[278]. In general, these ESC rights are recognised as individual rights in that the intended beneficiaries can claim them individually[279]. Amongst the rights protected are the rights to medical and health care. Article 77 of the Angolan Constitution enshrines the right to health and social protection, stating that 'the state shall promote and guarantee the measures needed to ensure the universal right to medical and health care, as well as the right to child care and maternity care'. Thus, the Constitution merely recognises the right to health care. This is not the same as the right to the highest attainable standard of health as recognised in the African Charter and the ICESCR. Moreover, article 77.2 c) claims the importance of 'encouraging the development of medical and surgical training and research into medicine and health care'. The choice of the word 'encouraging' is vague and does not seem to be enforceable. Thus, it does not take into account that all the recommendations regarding the implementation of the right to health set out the states' obligation to provide training to health providers and more specifically to skilled and respectful birth attendants.

1.2. The CESCR and CEDAW Committee concluding observations on Angola

Angola ratified the ICESCR on 10th January 1992[280]. In the last CESCR concluding observations on Angola, the Committee refers to the efforts of Angola to facilitate access to health-care services, namely through the 'reconstruction of

[278] Article 26.2 of the Angola Constitution 2010
[279] Madlate, A. C., Nhampossa, J., & Chirwa, D. M. (2016). Direct Constitutional Protection of Economic, Social and Cultural Rights in Lusophone Legal Systems: Angola and Mozambique. In D. M. Chirwa, & L. Chenwi, *The Protection of Economic, Social and Cultural Rights in Africa - International, Regional and National Perspectives* (pp. 372-395). Cambridge University Press.p.378
[280] http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=118&Lang=EN

infrastructure, as well as the decentralization of the national health system'[281]. The Committee highlights the fact that 'access to basic health services, especially in rural areas, remains inadequate', largely due to 'the insufficient resources allocated to the health sector'[282]. As it has been said, Angola has one of the highest rates of maternal mortality in the world. The CESCR has repeatedly made clear the need for Angola to address this problem via the promotion of various policies and programmes. Further, the Committee suggests that this state should have a human rights-based approach regarding the implementation of these policies and programmes, such as, 'ensuring that births are assisted by skilled birth attendants and that all women have access to basic obstetric and neonatal care'[283].

The CEDAW Convention was also ratified by Angola in 1986 and the Optional Protocol to the Convention in 2007[284]. In the CEDAW Committee's concluding observations on the sixth periodic report of Angola, it addresses the question of stereotypes and harmful practices regarding Angolan women. The Committee expresses 'its deep concern at the persistence of adverse cultural norms, practices and traditions as well as patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men in the family and society'[285]. It goes on to consider that Angola has not taken 'sufficient sustained and systematic action to eliminate stereotypes and negative cultural values and harmful practices'[286]. Thus, the Committee urges Angola to act 'in conformity with articles 2 (f) and 5 (a) of the Convention, to eliminate stereotypes and harmful practices that discriminate against women'. This implies that the state should work in 'collaboration with civil society, the school system, the media and traditional leaders, to educate and raise awareness about negative gender stereotypes, targeting women and men at all levels of society'[287]. Regarding the committee's analysis of the state's compliance with the right to health[288], the Committee showed its concerns about 'the limited access to basic healthcare services, in particular

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[281] CESCR, *Concluding Observations on the fourth and fifth periodic report of Angol*a 15 July 2016, E/C.12/AGO/CO/4-5, para 49
[282] Ibid, para 49
[283] Ibid, para 49
[284] Committee on the Elimination of Discrimination against Women. (2013). *Concluding observations on the sixth periodic report of Angola adopted by the Committee at its fifty fourth session.* CEDAW/C/AGO/CO/6. para 17

[285] Ibid, para 17
[286] Ibid, para 17
[287] Ibid, para 18
[288] Article 12 of the CEDAW Convention

for rural women', 'the existence of sociocultural factors that prevent women from accessing these services and the lack of adequate health infrastructure and the insufficient human and financial resources allocated to the health sector'[289]. Likewise, the Committee specifically addresses the high maternal mortality rate, explaining that one of its main causes is 'the lack of extended obstetrical care and the low number of births attended by skilled personnel'[290]. The critiques addressed by the CEDAW Committee and the CESCR concerning the weak performance of the state of Angola, in the implementation of the rights enshrined in the respective international conventions, its revealing of the state's unwillingness to address one of its most pressing violations of women's human rights.

1.3. African Commission's analysis of Angola

Angola ratified the African Charter on 2nd March 1990, which became an integral part of the Angolan Constitution through the application of their monist system. Under a monist system, international treaties ratified by the country form part of domestic law once they are officially published[291]. Nonetheless, the African Commission has had a very superficial role in promoting the implementation of the African Charter and the African Women's Protocol in Angola. In researching this area, one is limited to the 2nd Periodic Report of the state of Angola concerning the period of 1999-2010 which was submitted by the state of Angola in 2011. The African Commission has since then failed to publish its concluding observations on the report[292]. As can be observed on the African Commission's website[293], the Commission adopted the Concluding Observations on the Cumulative Periodic Reports (2nd, 3rd, 4th and 5th) of the Republic of Angola in February 2014 but they were not published on the website or through another forum and therefore are not available to the public. Without publicity, the reports and concluding observations are not of worth. As contended by Viljoen this is the general practice of the African Commission which consistently fails to provide publicly accessible concluding observations on the reports[294]. Whilst the African Commission state that they frequently

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[289] Ibid, para 30
[290] Ibid, para 31
[291] Madlate, A. C., Nhampossa, J., & Chirwa, D. M. (2016). p.379
[292] African Commission (July de 2017). *African Commission on Human and Peoples' Rights*. Obtido de http://www.achpr.org/sessions/12th-eo

[293] *African Commission on Human and Peoples' Rights*. (July 2017). Retrieved from http://www.achpr.org/search/?y=2014&t=831

[294] Viljoen, F. (2012). *International Human Rights Law in Africa.* Oxford: Oxford University Press.p. 297

adopt the concluding observations, it is suggested the Commission demonstrates a 'deferential attitude towards states, allowing them to evade accountability'[295] through their refusal to publish the concluding observations and the absence of sanctions for a state's late provision of a report. However, whether this 'deferential attitude' is demonstrative of unenthusiastic enforcement or lack of resources is difficult to determine.

1.4. Angolan women's intersectional discrimination in the access to maternal health

Poverty in rural areas in Angola is considered to be severe and gendered[296]. According to Chant, the widespread phenomenon of gendered poverty is not only a consequence of lack of income, but is also the result of 'gender biases present in both societies and governments'[297]. A study conducted in rural communities of the Angolan municipality of Kalandula, proved that 'female poverty is characterized by limited opportunities for income and subsistence, extensive physical hardship, and entrenched social vulnerability'[298]. Women's lives in this area are extremely hard, as they have to 'grow their own plots from which they feed themselves and their children, in addition to doing all household chores and tasks related to child rearing'[299]. In accordance with patriarchal social norms, 'men are not expected to participate in household labour' and women are responsible for 'fetching water, preparing food, washing clothes, cleaning the home and its surroundings, bringing children to and from school (if they attend) and any other household tasks'[300]. Moreover, polygamy is a common, acceptable and even culturally incentivised practice. Polygamous arrangements are often 'a source of conflict and reduce women's share of economic support and labour input from her husband'[301], cumulating with the fact that 'local patriarchal norms dictate female obedience to the

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[295] Ibid, p. 297

[296] Strønen, I. Å., Silva, O., Nangacovie, M., & Fortuna, C. (2017). Perpetual Hardships:Female Poverty in Rural Malanje, Angola. *Chr. Michelsen Institute, 16*. p. 1

[297]Chant, S. (2006). Re-thinking the "Feminization of Poverty" in Relation to Aggregate Gender Indices. *Journal of Human Development, 6*, 201-220.

[298] Strønen, I. Å., Silva, O., Nangacovie, M., & Fortuna, C. (2017), p.1

[299] Ibid, p.2

[300] Ibid, p.2

[301] Ibid, p.2

husband'[302]. Consequently, women are not supposed to protest if the husbands spend the family's finances and are not in position to demand that the husband to contribute to their share of household chores[303]. All these social norms based on wrongful gender stereotyping, namely the stereotype of the women as primarily mothers, plus the inferior status of women in comparison to men as visible in the widespread practice of polygamy is definitely impacting women's access to maternal health in Angola. This situation arises as polygamy contributes to putting women in a situation of financial dependence, reducing their decision-making power to an almost non-existent level.

1.5. Maternal health situation – obstacles and health policies

Angola presents one of the highest rates of maternal mortality in the world of 477/100,000[304]. Moreover, female life expectancy is 54 years, which positions it at the 178th place among 187 countries[305]. This high ratio stems from a combination of the low percentage of births attended by skilled birth attendants of 65% in 2015[306], and the low capacity of health facilities to provide emergency obstetric care services. As for the place of delivery, it is estimated that only 47 % of all births in Angola occurred at a health facility. This number increased to 67.6 % of births among those living in urban areas[307]. According to a study conducted in Luanda, remote rural areas are the most affected by this lack of access since many villages 'are only accessible by extremely poor and ill-maintained roads, and many are near-inaccessible when it rains'[308]. Thus, lack of transport represented a major obstacle and women frequently 'have to walk for hours—often with

302 Ibid, p.2
303 Ibid, p. 4
304 WHO. (2017, July). *WHO country cooperation strategy at a glance: Angola.* Retrieved from http://apps.who.int/iris/bitstream/10665/136994/1/ccsbrief_ago_en.pdf

305 Solomon, J.A., et al., (*2010)* Healthy life expectancy for 187 countries, 1990---2010: a systematic analysis for the Global Burden Disease Study. *Lancet, 2012*. p. 2144-2162.
306 WHO (2017, July). *Angola Maternal mortality in 1990-2015.* Retrieved from http://www.who.int/gho/maternal_health/countries/ago.pdf?ua=1

307 Humbwavali, J. B., Giugliani, C., Duncan, B. B., Harzheim, E., Lavor, A. C., Lavor, M. C., . . . Hauser, L. (2014). Health and Health Care of Mothers and Children in a Suburban Area of Luanda, Angola. *J Community Health* , 617–626.p.623

308 Strønen, I. Å., Silva, O., Nangacovie, M., & Fortuna, C. (2017). Perpetual Hardships:Female Poverty in Rural Malanje, Angola. *Chr. Michelsen Institute, 16*. p. 1

children on their back—in order to obtain pre-natal check-ups, vaccination for infants and medical help'[309].

According to a very recent report of the WHO on the country's cooperation strategy, some of the main health needs and problems currently encountered are the 'insufficient coverage and poor maintenance of health centres' and the 'limited human resources and health technicians, in quality and quantity, and poor distribution of personnel in rural and peri-urban areas'[310]. The government has been putting in place programmes to address the shortage of health professionals. For instance, in 2007 the Health Ministry of Angola launched the Community Health Agents Program[311] which had as one of main aims being the reduction mother and child mortality. As suggested previously[312], CHWs such as TBAs can have an important role in improving maternal and child health namely through the increase of access to health care. The goal of the Angolan government was thereby that 'the CHWs would act as a 'connecting point' between the community and the health service'[313]. A study conducted in Luanda concerning the impact of this programme showed that the work of the CHWs contributed to the increased demand for health facilities and one of the main reasons being the reduction in unauthorized charges for medical visits[314]. The CHWs helped to eradicate some taboos of the community, such as the allegation that there is illegal charging and mistreatment perpetuated by health professional at health centres. Thus, the CHWs increased the awareness and were then able to educate the community with regards to seeking the nearest health facility.

The mentioned study reported an increased demand for maternal and child health care, namely due to the fact that the pregnant women who refused to attend prenatal care or delivery at a health facility were incentivised to do so by the CHWs[315]. Angolan women in general are reluctant to go to public clinics which could be explained by the mistreatment perpetuated by the health workers, by the lack of financial resources to afford the travel expenses or because of their very poor equipment, infrastructures and,

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[309] Ibid. p.2

[310] WHO. (2017, July). *WHO country cooperation strategy at a glance: Angola.* Retrieved from http://apps.who.int/iris/bitstream/10665/136994/1/ccsbrief_ago_en.pdf

[311] Camila Giugliani, B. B. (2014). P.1

[312] See point 3

[313] Ibid, p.4

[314] Ibid, p.7

[315] Ibid. p.7

unhygienic conditions. Recent news indicates that, for instance the main maternity facilities in the capital Luanda do not have the capacity to respond to the high demand. Thus the facilities are over-crowded and health professionals do not have the necessary time to attend to every delivery and obstetric emergency in a timely-manner or to practice good standards of respectful maternity care[316]. In regards to the implementation of measures to comply with international standards of respectful maternity care, there is no available data or any studies were published that can serve as indicators for this country. Moreover, there is no literature on the assessment of human resources for health work in the field of maternal health, specifically research which focuses on understanding the impact of training skilled birth attendants in Angola. This suggests an urgent need for evidence-based research on effective health human resources' interventions for improved maternal health outcomes in this country.

Ultimately, as a minimalistic manner to address the problem, the Ministry of Health of Angola (MOH) adopted the 2012–2025 National Health Development Plan (NHDP)[317], which is considered the country's main public policy implementation tool in regards to the national health system (NHS). In this policy, the MOH recognises the problem of the shortage of qualified health professionals in the country, claiming that one of the biggest challenges for the NHS is the reduction of asymmetries in the access to health care. It claims that despite the fact that more than 45% of the population resides in rural areas, less than 15 % of the health workforce of the country is located is these areas. Thus, the MOH demonstrates in this plan its willingness to address the problem by creating mechanisms for the equal distribution of the health professionals in the territory, namely through providing incentives to the health professionals[318]

Moreover, the important role of the churches regarding the provision of health services in Angola is noteworthy. Religious institutions are considered the most trusted institution in the country thereby enjoying an extensive network and reaching into even the most remote areas of the country[319]. Thus, the churches are strong partners in the field

[316] Diário de Notícias. (24 de 05 de 2017). *Maternidade de Luanda tem de colocar duas mulheres na mesma cama devido à procura*. Retrieved from http://www.dn.pt/lusa/interior/maternidade-de-luanda-tem-de-colocar-duas-mulheres-na-mesma-cama-devido-a-procura-8504385.html

[317] Ministerio da Saude da Republica de Angola. (2014). *Plano Nacional de Desenvolvimento Sanitário 2012-2025 (PNDS).* Luanda.

[318] Ibid, p. 81
[319] Jensen, S. K., & Pestana, N. (2010). *The Role of the Churches in Poverty Reduction in Angola.* Bergen: Chr. Michelsen Institute .

for international NGOs aiming to implement projects regarding the right to health and more specifically to improve maternal health in Angola.

2. MOZAMBIQUE

Mozambique is a south-eastern African country with an estimated population of 24 million. According to the Human Development Report 2016, Mozambique occupies the 182nd place amongst 188 countries and is classified as a low Human Development country[320]. Like Angola, Mozambique is a country of contradictions since it is considered one of the most economically dynamic countries in Africa with a GDP growth rate of 8.4% in 2014[321]. Nonetheless, the 'economic growth has had a limited effect on poverty reduction, as [it] has not created enough jobs to match the rate of growth in the labour force'[322]. Thus, it remains one of the poorest and least developed countries in the world, with lack of human capital, poor physical infrastructure and high levels of dependency on international aid. The government's estimates indicate that 55% of the population live on less than $0.60 per day. Additionally, 70.2% of the population is considered multi-dimensionally poor, meaning that despite living above the poverty line they suffer deprivations in, among other things, education and health care[323]. The persistence of poverty, despite government and international donor efforts, indicates the structural weaknesses in policy approaches towards rural areas since these are the areas most affected by the lack of access to services and job opportunities. In order to evaluate the compliance of Mozambique regarding maternal health care implementation, it is relevant review the national, regional and international legal framework and the work of the treaty monitoring bodies to expose the shortcomings of the governments' policies

[320] United Nations Development Programme. (2016). *Human Development Report 2016 - Human Development for Everyone.* New York: UNDP.p.214

[321]Stiftung, B. (2016). BTI 2016 | Mozambique Country Report, p. 15
[322]Ibid, p.7
[323] Ibid, p.16

2.1. National legal framework

The Mozambican Constitution of 2004 contains a Bill of Rights which protects the right to health, establishing in its article 89 that 'all citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and protect public health'. In addition, article 17. 2 of that Constitution establishes that Mozambique 'shall accept, observe and apply the principles of the Charter of the United Nations and of the Charter of the Organisation of African Unity'. Article 18.1 establishes that ratified International treaties have direct application in the national judicial system and thus are judicially enforceable which indicates that Mozambique established a monist system. Further, the Constitution requires the courts to interpret it in harmony with the UDHR and the African Charter, both of which recognise ESCR.

2.2. The CESCR and CEDAW Committee Concluding observations on Mozambique

Curiously, Mozambique is amongst the twenty-five countries that neither signed nor ratified the ICESCR yet therefore the Committee does not have a input regarding the implementation of the right to health in the country. As mentioned in the first chapter, the UN Special Rapporteur on the right to the highest attainable standard of health has an important role in the development of that right and whilst visiting Mozambique in 2003, made several recommendations for the Government, such as the need 'establish accountability mechanisms that bear upon health-related human rights, including the creation of a national human rights institution, a charter for the protection of patients' rights, and a statutory medical council responsible for regulating, registering, supporting and disciplining health professionals'. Moreover, he incentivized the government to ratify the ICESCR and to 'increase significantly the number of health professionals and improve their working terms and conditions, including levels of remuneration'[324]. Although not a party to the ICESCR, Mozambique has ratified other international and regional human

[324] WHO Mozambique. (2017, July). Health and Human Rights: Country Fact Sheet Mozambique. Maputo: WHO. Retrieved from http://www.who.int/countries/moz/publications/fact_sheet_r2h_moz.pdf?ua=1

rights treaties that address women's right to health, such as the CEDAW Convention and its Optional Protocol and the UDHR.

Likewise, the CEDAW Committee adopted its last concluding comments on Mozambique in 2007[325], in which it shows its concerns about the persistence of harmful traditional practices, such as early or forced marriage and polygamy[326]. Thus, this state party is encouraged 'to adopt a comprehensive strategy to promote cultural change and eliminate discriminatory stereotypes with respect to the roles of women and men, in line with its obligations under articles 2 (f) and 5 (a) of the Convention'[327]. Regarding the implementation of women's right to health, the CEDAW Committee highlights the need to address the 'obstacles that women still face in terms of access to health services' such as difficulties related to lack of resources, deficient infrastructure and poor roads and transport'[328]. The Committee urges the State party to undertake measures to improve women's access to health care services and to address the identified causes of maternal mortality[329].

2.3.African Commission's analysis of Mozambique

Mozambique is a State Party to the African Charter, having ratified the same on 22 February 1989. In 2014, the African Commission adopted its Concluding Observations and Recommendations on the Second and Combined Periodic Report of the Republic of Mozambique on the Implementation of the African Charter on Human and Peoples' Rights (1999 – 2010)[330].[331] Regarding the implementation of article 16 of the African Charter, the Commission commented that 'the public health system includes a very small number of rural hospitals[332]. Thus, it recommends that the state makes 'efforts to expand

[325] CEDAW. *Concluding observations on the sixth periodic report of Angola adopted by the Committee at its fifty fourth session. 2013* CEDAW/C/AGO/CO/6
[326] Ibid, para 22
[327] Ibid, para 21
[328] Ibid, para 36
[329] Ibid, para 37
[330] African Commission on Human and Peoples'Rights. (2014). *Concluding Observations and Recommendations on the Second and Combined Periodic Report of the Republic of Mozambique on the Implementation of the African Charter on Human and Peoples' Rights (1999 – 2010).* Banjul: African Commission on Human & Peoples'Rights.

[331] Adopted at the 17th Extra-Ordinary Session of the African Commission on Human and Peoples' Rights, held from 19 to 28 February 2015, in Banjul, The Gambia
[332] Ibid, para 62

the public health system by prioritizing construction and rehabilitation of health centres in the rural areas' and to 'to provide adequate resources to rural health centers and to ensure provision of medical services to these areas'. Moreover, it strongly advises the state to 'strengthen existing programs to reduce the high rate maternal mortality rate'[333]. The state followed these recommendations and included them in its Five-Year Government Program (2015-2019) in which the governments expresses its intentions to strengthen the Mozambican health system through 'increasing access and utilization of health services, improve quality of service provision and scale up the health workforce and expansion of the health facility network'[334]. This might be perceived as evidence of a strong commitment of the state to comply with its human rights obligations and to enforce the image of trustworthy government that despite its few resources still addresses the problems.

2.4.Mozambican women's intersectional discrimination in the access to maternal health

Mozambique ranked 144 out of 149 countries for gender equality in the 2013 HDI[335].Mozambique's population is primarily rural and dispersed, and its health facilities are distant from most rural families. Of the population, 69% live in rural areas. In a study conducted in a southern area of Mozambique, the researchers reached interesting results regarding the women's access to maternal care in relation to their position in the communities[336]. For instance, it is considered that a woman's marital status during pregnancy is an important health determinant, and single women were perceived as particularly vulnerable due to financial constraints[337]. A study conducted by Munguambe et al. proves that 'single women and adolescents had more difficulty accessing services in pregnancy, as they had less support' namely from a husband or partner[338]. Most women

[333] Ibid, para 79
[334] Conselho de Ministros da Republica de Mocambique, C. d. (2015). *Plano Quinquenal do Governo 2015-2019.* Maputo. Retrived from: file:///F:/Plano+Quinquenal+do+Governo+2015-2019.pdf
[335] Bertelsmann Stiftung. (2016). *BTI 2016 | Mozambique Country Report.* p.16

[336] Firoz, T., Vidler, M., Makanga, P. T., Boene, H., Chiaú, R., Sevene, E., . . . Munguambe, K. (2016). Community perspectives on the determinants of maternal health in rural southern Mozambique: a qualitative study. *Reproductive Health*, 124-162.

[337] Ibid, p. 127
[338] Munguambe, K., Boene, H., & Vidler, M. (2016). Barriers and facilitators to health care seeking behaviours in pregnancy in rural communities of southern Mozambique. Reproductive Health, 84-97. p.92

in these areas did not have their own source of income, nor did they participate in community savings schemes. Therefore, pregnant women were financially dependent on their partners. As mentioned earlier, when partners were not able to provide financially, treatment was delayed or not sought at all[339].

Further, women in polygamous relationships were exposed to added-risks due to the conflicts that it generates which contribute to high rates of domestic violence. Intimate partner violence was described as important factor affecting health and well-being in pregnancy[340]. In the aforementioned research, community leaders interviewed held understandings which demonstrate wrongful gender stereotyping whilst excusing men's act of violence and explaining that it occurs when women insult the husbands, make noise or misuse money. Nonetheless, the interviewees acknowledged that beating a pregnant woman *is "not good"* and could lead to complications such as abortion and premature delivery but they also explained that it *'happens because when the man is already angry, he no longer looks where he hits'* [341].

2.5.Maternal health situation – obstacles and health policies

Mozambique presents one of the highest rates of maternal mortality in the world of 489/100,000 and the female life expectancy is 59.4 years[342]. The SBA coverage in this country is estimated of 60% in 2015[343] and the exact same percentage of deliveries occurred at a health facility, with marked differences across regions[344]. In addition, ANC attendance has been increasingly gaining an important role as over 90 % of women reported having received at least one ANC visit, with slightly higher proportions in urban compared to rural areas[345]. Although ANC and delivery services are free of charge, indirect costs, primarily from transport and medication, were strong barriers to care seeking among pregnant women. Regarding the main obstacles Mozambican women face

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339 Ibid, p.92

340 Firoz, T., Vidler, M., Makanga, P. T., Boene, H., Chiaú, R., Sevene, E., . . . Munguambe, K. (2016). p.127

341 Ibid, p.128

342 WHO. (2017, July). *WHO country cooperation strategy at a glance: Mozambique.* Retrieved from http://apps.who.int/iris/bitstream/10665/136951/1/ccsbrief_moz_en.pdf?ua=1

343 WHO (2017, July). *Mozambique Maternal mortality in 1990-2015.* Retrieved from http://www.who.int/gho/maternal_health/countries/moz.pdf?ua=1

344 Munguambe, K., Boene, H., & Vidler, M. (2016).p.85

345 Ibid, p. 85

to access to skilled birth attendance during delivery and facility-based deliveries is inadequate geographic coverage of health services, inadequate financing, shortage of health professionals and essential medicines and lack of money for transportation and medical costs, lack of decision making power and distance from health facilities[346]. The lack of money for transportation is not the only impediment, but actually the lack of transportation also occurs. Health workers complain about the lack of ambulances and affirm that they are only available to transport patients from health facility to health facility. Those with access to ambulances are precisely those who have already been privileged to be able to reach the health facility[347]. Lastly, the research conducted by Munguambe et al. also proved that 'despite the recognition that the hospital was crucial, pregnant women generally hesitate in the moment of seeking assistance at the health facility. This is mainly due to their fear of mistreatment by health care providers[348].

In Mozambique, policies have been implemented to improve maternal health, such as increased institutional deliveries, delayed age of first pregnancy, increasing the coverage of skilled birth attendance and ensuring resources for emergency obstetric care are urgent interventions. Government programmes and health strategies attempt to put such policies into practice; however, their success equally depends on the support from pregnant women and their communities. Policy recommendations must consider current behaviors, as well as the barriers and facilitators to desired care-seeking practices[349]. Further, it is of relevance to address the importance of not disregarding the role of TBAs and the possibility of training them to support rural women or women from the peri-urban areas. The MOH of Mozambique has realized that adequate access to health coverage would not be achieved for many years, so it began to encourage TBA training[350]. In a study conducted in Mozambique, CHWs were proven to be in many cases the first point of contact for complications in pregnancy and were reported to help pregnant women to

[346] David E, Machungo F, Zanconato G, Cavaliere E, Fiosse S, Sululu C, Chiluvane B, Bergstorm S. (2014) Maternal near miss and maternal deaths in Mozambique: a cross-sectional, region-wide study of 635 consecutive cases assisted in health facilities of Maputo province. *BMC Pregnancy Childbirth*.
[347] Munguambe, K., Boene, H., & Vidler, M. (2016). p.93

[348] Ibid.p.90
[349] Ibid.p.91
[350] Gloyd, S., Floriano, F., Seunda, M., Chadreque, M. A., Nyangezi, J. M., & Platas, A. (2001). Impact of Traditional Birth Attendant Training in Mozambique: a controlled study. *Journal of Midwifery & Women's Health*, 210-216.p.210

reach the health facility. It was also mentioned that in many emergency situations, pregnant women were assisted by TBAs and other community members[351].

The government of Mozambique went further in its efforts to tackle MMM and Mozambique has been seen as a 'leader in Africa in implementing large-scale initiatives to increase the supply of health workers and in incentivising the implementation of policies of RMC'[352]. That is intrinsically related to the Mozambican Model Maternity Initiative which started in 2008 and which is a program supported by USAID Maternal and Child Health Integrated Program (MCHIP) that aims to improve the quality and humanization of maternal care. This program has been presenting significant results in the improvement of maternal health in this country[353]. This programme was responsible for the training of 1,200 health providers and 36% of the births in Mozambique in 2014 occurred in one of the 124 Mozambique's Model Maternities spread all over the country. The initiative aims to promote good practices during labour and deliveries such as respect for beliefs, tradition and culture, the right for information and privacy, the right to have liberty of movement during labor, the right to choose and have a companion, the right to choose the position for childbirth, promoting newborns with immediate skin-to-skin contact with the mother[354]. Simple ways of humanizing the childbirth were implemented such as placing curtains in between the beds in the delivery rooms which constitutes a simple and effective manner of promoting the right to privacy of the parturient women[355].

Moreover, the Mozambique Ministry of Health initiated the implementation of its 'National Health Plan for the promotion of Sexual and Reproductive Rights'[356] which aimed at addressing determinant factors for the improvement of maternal health such as the qualified health worker shortages, through the increasing competencies through on-the-job training of nurses and doctors, mentoring and supportive supervision. The MOH committed in this plan to create mechanisms to meliorate the health professionals working

[351] Munguambe, K., Boene, H., & Vidler, M. (2016). p.89

[352] Samuels, F., Amaya, A. B., & Balabanova, D. (2017). Drivers of health system strengthening: learning from implementation of maternal and child health programmes in Mozambique, Nepal and Rwanda. *Health Policy and Planning*. p.11

[353] United States Agency for International Development. (2015). Mozambique: Final Report April 12, 2011–June 30, 2015 p.8

[354] Ibid. P.10

[355] Ibid.p.11

[356] Ministério da Saúde da República de Angola. (2011). *Politica Nacional de Saude e Direitos Sexuais e Reprodutivos.* Maputo.

conditions, such as, providing better wages, working benefits, less working hours and shifts. The enumerated measures are also aimed at incentivising health workers working in rural health facilities.[357] One of the main goals of this National Plan was to significantly reduce maternal and neonatal morbidity and mortality through the increase of the quality and coverage of ANC and PNC, facility-based deliveries and access to obstetric emergency care.[358] Lastly, Mozambique has more than 20 development partners aiming at supporting the government to improve the health system[359].

3. Comparison between Angola and Mozambique

As previously mentioned, Angola and Mozambique are countries which despite the common historical background, have a very different economic situation. Angola is considered an upper-middle-income country, whilst Mozambique is still considered a low-income country and Angola has a GDP seven times higher than that of Mozambique's GDP. Nevertheless, the countries have totally different approaches regarding the expenditure on health and thereby the importance that each of them give to the effective social development of its population is accentually discrepant. As analysed, both countries are monist as far as the application of international treaties in domestic courts is concerned, which means that both countries state that international treaties ratified by their respective countries form part of domestic law once they are officially published[360]. Even though Mozambique presents a shortcoming in not being a party of the ICESCR, this country shows good will in addressing human rights violations in the country. For instance, whilst conducting this research, it was relatively easy to access the diverse governmental documents, such as national plans and policies and even some transparent reports on the country's reproductive health situation. On the other hand, whilst evaluating the compliance of the Angolan state with the international human rights instruments, it was disappointing to see the shortage of national policies which should contribute to the effective implementation of international and regional human rights law. For more than two decades, Angola has been a state party of the ICESCR and the CEDAW Convention, but it is noticeable in the concluding observations of both of their

[357] Ibid. p.34
[358] Ibid. p.24
[359] Ibid. p.24
[360] Madlate, A. C., Nhampossa, J., & Chirwa, D. M. (2016). p.379

treaty monitoring bodies that this state persistently breaches international obligations and recommendations in regards to women's right to health. As it was observed in the first chapter of this study, article 2.1 of the ICESCR sets out the obligation of the states to implement the measures required for 'achieving progressively the full realization of the [economic, social and cultural] rights'. For that purpose, the states must undertake steps 'to the maximum of its available resources', taking into account the high levels of oil revenues that the state of Angola enjoyed during the last years, creates the appearance that this state is intentionally not complying with this obligation.

Additionally, as it was explained, Angola is going towards a dictatorial regime where the words 'human rights' are highly stigmatising and even banned by the government. Moreover, the widespread practice of corruption mainly at the governmental level is undermining the possibility of a real investment in maternal health and in tackling the shortage of SBAs in an effective manner. Thus, it can be affirmed that the lack of democratic transparency and proper resource allocation is definitely interfering with the health of parturient women. Further, since the civil war the state has been relying on assistance provided by international partners which attempt to grant some technical and financial support to the Angolan health system. Nonetheless, the government of Angola looks at international human rights institutions and NGOs with suspicion and recently imposed restrictive laws to their work. Thus, it is of notice that the Angolan government is incurring into non-compliance with international cooperation and assistance obligation which is fundamental for the realisation of the right to sexual and reproductive health. In the words of article 2.1 of the ICESCR, 'each state party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation'. Thus, states that cannot realise the right to sexual and reproductive health due to a lack of resources must seek international cooperation and assistance and not to exclude it or drive it out.

In Mozambique, recent clashes between supporters of the opposition Mozambique National Resistance (RENAMO) and the ruling Front for the Liberation of Mozambique (FRELIMO) have generated political instability, which has been raising concerns in the international panorama[361]. Nevertheless, a report from *Bertelsmann*

[361] Freedom House. (2017). *Populists and Autocrats:The Dual Threat to Global Democracy*. Retrieved from Freedom in the World 2017 : https://freedomhouse.org/report/freedom-world/freedom-world-2017?gclid=CN-30-O-_tQCFRc6GwodBq8HaQ

Stiftun affirms that 'since its peace accord in 1992, Mozambique has regularly organized presidential, parliamentary and provincial elections as well as elections in the independent municipalities'[362]. This implies that the country has a reasonable effective implementation of democracy. As mentioned, Mozambique relies on international aid and its government recognises the benefits of international assistance and has presented itself as a credible partner for the international donor community[363].

The shortage of evidence-based available data concerning Angola and Mozambique's efforts to comply with the obligation to implement measures towards the elimination of discrimination against women regarding the access to maternity health care represented an obstacle during this study. Nonetheless, it is of note that both countries show alarming levels of gender inequality and, as highlighted in the CEDAW Committee concluding comments, the governments are not complying with article 5 a) of the CEDAW Convention regarding the obligation of the elimination of wrongful gender stereotyping. Therefore, it can be asserted that both countries are responsible for perpetuating wrongful gender stereotyping whilst omitting efforts to work with communities to eliminate it. As previously evidenced, the underprivileged status women hold in both countries has been contributing to women's intersectional discrimination, being the poor and rural women the most affected. Besides, even though Angola and Mozambique have forbidden by law the practice of polygamy, it remains a common harmful practice which undermines the right to equality and contributes to domestic violence. A lack of enforcement for laws which protect women are thus contributing to their further discrimination. Polygamy and other forms of discrimination against women within a familial context undermines their decision-making power and their access to the family's finances to spend on their maternal health care. Mozambican and Angolan women are both trapped in the hardships of childbearing, childrearing and housewifery activities. Most of the countries' population is rural and subsists of the incomes of agriculture, which has contributes to keep women in a situation of extreme poverty. Furthermore, as it has been explained, the SBA coverage and the percentage of deliveries occurred at a health facility in both countries are remarkably low, and both present marked differences between rural and urban areas. Rural women in Mozambique as in Angola still face geographical obstacles such as inadequate geographic coverage of health

[362] Stiftung, B. (2016). BTI 2016 | Mozambique Country Report p.7
[363] Ibid, p.4

services, shortage of SBAs and lack of money for transportation or even lack of transportation altogether.

Nonetheless, it is important to note that even with its small budget to implement the right to health and to provide training to qualified health professional that can perform facility-based quality deliveries, the Mozambican government managed to implement policies of RMC through the Mozambican Model Maternity Initiative which is a clear sign of the governments will to decrease its shocking high rates of MMM. This is a form of tackling the negative impact of wrongful gender stereotyping within the health facilities and amongst health professionals. Regarding the implementation of RMC in Angolan maternities there is still not evidence-based available on this particular issue and the government does not mention that possibility in its policies. Thus, the Angolan government does not seem to be willing to create better conditions for the parturient women. As previously mentioned even the few maternities available in the capital of the country are overcrowded, poorly equipped and suffering from a severe shortage of health personnel, such as SBAs.

Ultimately, the comparison between Angola and Mozambique underlines how different governmental approaches can be the basis to save women’s lives and to improve women’s health.

Conclusion

High rates of maternal mortality and morbidity specially affect sub-Saharan African countries and must be addressed with the seriousness it deserves. MMM constitutes a multidimensional issue which particularly affects African women's lives and must be addressed from several fronts. These include working to eliminate wrongful gender stereotyping and intersectional discrimination, overcoming cultural, financial, and geographic barriers to health care access, and reforming poor quality of care at facilities.

The research conducted allows one to understand that human rights organizations only recently began to recognise in a serious and committed manner a woman's right to dignified and respectful health care throughout a her pregnancy and childbirth. Because of this, it is relevant to note that the CESCR and CEDAW Committee general comments' clarifying the extent to which the ICESCR and the CEDAW Convention protect that right are valuable contributions for the development of the scope of the mentioned right. Additionally, the CESCR and CEDAW Committee's efforts are highly relevant for providing efficacy to the right to health. This is found in the concluding observations on the states reports since they clarify the extent to which the right to health is being implemented, expose the barriers in accessing health services and uncover breaches of compliance.

Whilst analysing the African Commissions role in promoting women's right to maternal health in the African continent, it is seen that on a legislative level much has been achieved by the African human rights' system of protection. As it was explained, even though the African Charter failed to directly address the right to maternal health, the African Commission later clarified that the right to health includes reproductive health. Nonetheless, regarding the effectiveness of the African Charter and African Women's Protocol, there is still much progress to be made since these instruments mainly depend on the successful deployment of the African Commission's mechanisms and the states compliance with their decisions. As previously noted, the African Commission consistently fails to publish concluding observations on states' reports. Without publicity, the reports and concluding observations are not of worth. Therefore, this represented a shortcoming on the analysis of the Angolan state compliance with the African Charter and the African Women's Protocol.

Further, the study proved that misconceptions about women's alleged inferiority are entrenched in society and negatively impact governments' will to address women's

specific health care needs. Bearing the potential harmful bodily consequences of childbearing and childbirth and ultimately dying during or after delivering might be perceived as the ultimate sacrifice women should passively accept justifying this as their fate. Thus, in the most extreme cases MMM is accepted as a natural consequence of women's reproductive capacities and social obligations. This chapter was ultimately important to understand that a mother's life depends much more on the level of effort governments are willing to expend to solve the problem, than on the sum of the government's budget to health care. A reliable way of proving this argument is by comparing countries with disparate average incomes and very similar rates of MMM, such as Angola and Mozambique.

During this study, it was argued that respectful maternity care has developed into a human right. Thus, it is concluded that uncovering stereotypes held by health professionals is crucial to understand women's experiences of discrimination concerning the access to quality respectful maternity care. Even because abuse and disrespect, perpetuated by SBAs and poor quality of care, becomes a serious obstacle to the effective fight against preventable MMM. Many women fear mistreatment perpetuated by health professionals and for that reason refuse to deliver in health facilities. Therefore, providing RMC for all women should be made a priority. In order to achieve this goal, the governments must restructure the health system and invest seriously in the education of their health workforce and the training of qualified health professionals should envisage 'not only instruction in technique and dexterity but also in sensitivity and ethical responsibilities'[364]. Likewise, health professionals' working conditions need to be improved and effective monitoring and accountability systems should be implemented within the health facilities. Hence, there is an urgent need for investment in research to create evidence-based data concerning the forms of abuse and disrespect women face in facility-based deliveries and its relationship with women's intersectional discrimination.

Moreover, one asserts that part of the solution for MMM can also be the training of TBAs if the trainings are conducted in a proper manner and the TBAs have a continuous back-up support system. This opinion is mainly based on the fact that TBAs might enhance women's usage of ANC and increase facility-based deliveries. Thus, transforming TBAs into trained community health workers can be beneficial to tackle high MMM rates as long as they abstain from performing deliveries.

Regarding the practical results of the case study conducted in the final chapter, it was proven that sub-Saharan African women still bear the burden of lack of access to maternal health care, which is partly related to the lack of political will on the part of some African leaders. As stated by Cook, 'governmental neglect of preventable causes of maternal death is not only an affront to women's dignity, but is only one aspect of a larger pattern of systemic unlawful discrimination against women'[365]. Whilst conducting the necessary desk-based research for this study, it was seen that there is still a particular reluctance to invest in women's reproductive health. Whilst analysing Angola and Mozambique, this study proved that these countries have totally different approaches regarding the expenditure on health. Because of this, the importance that each of them give to the effective social development of its population is accentually discrepant. For instance, aforementioned training SBAs is considered one of the most crucial steps to combatting maternal mortality and the necessary resource allocation for this goal is not disproportionately high. Nonetheless, one of the states under scrutiny (Angola) systematically fails in complying with this obligation that stems from the right to health enshrined in diverse international human rights instruments. As previously mentioned, low-income countries which are financially struggling should request and receive international cooperation and assistance to accomplish this goal and if they fail to do so they are again breaching their international obligations.

Even though Mozambique presents a shortcoming in not being a party of the ICESCR, this country shows good will in addressing women's human rights violations. For instance, it is relatively simple to access the diverse governmental documents, such as national plans and policies and even some transparent reports on the country's reproductive health situation. On the other hand, whilst evaluating the compliance of the Angolan state with the international human rights instruments, it is discouraging to see the shortage of national policies which should contribute to the effective implementation of international and regional human rights law.

In regards to the implementation of measures to comply with international standards of respectful maternity care, there is no available data or any studies that were published which can serve as indicators for Angola. Moreover, there is no literature on the assessment of human resources for health work in the field of maternal health,

[365]Cook, R. J. (1998). p. 370

specifically research which focuses on understanding the impact of training skilled birth attendants in Angola. This suggests an urgent need for evidence-based research on effective health human resource interventions for improved maternal health outcomes in this country.

Thus, through examining if each state is investing the maximum of their available resources in bolstering their national health workforce and whether they are successfully seeking and receiving international assistance thereby guaranteeing equitable and non-discriminatory access to the highest attainable standard of health during facility-based deliveries, one might conclude that whilst Mozambique is doing its best efforts with very scarce economic resources, Angola does not seem to be committed to improving Angolan women's reproductive health or in saving their lives.

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