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Maternal healthcare as an international human right: the influence of culture and religion on access to maternal healthcare in Southern African states of Botswana, South Africa and Zimbabwe

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MATERNAL HEALTHCARE AS AN INTERNATIONAL HUMAN RIGHT: THE INFLUENCE OF CULTURE AND RELIGION ON ACCESS TO MATERNAL HEALTHCARE IN SOUTHERN AFRICAN STATES OF BOTSWANA, SOUTH AFRICA AND ZIMBABWE

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A Dissertation Submitted in Partial Fulfilment of The Requirements for PhD INTERNATIONAL RELATIONS University of Witwatersrand

March 2020

DECLARATION

I hereby declare that this work is entirely the result of the authors' sole effort and other people's work that have been used, have been duly acknowledged. Furthermore, I declare that this work has never been submitted, either in whole or in part to any institution for a similar or any other degree.

Khumo Nokuthula Mngomezulu Date: 13 March 2020



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My foremost gratitude goes to God Almighty, the source of all wisdom for granting me the resources, strength and the wisdom that saw me throughout the study. Without His sustaining power, this journey would not have been possible. Secondly, I am also grateful to my Mother Mme Keabetswe Pone for her love and unwavering support. My special and sincere thanks to various government departments such as the registrar of societies, health institutions, religious institutions and civic organisations from the three countries for granting me permission to contact and engage with persons in their respective institutions. I will forever be grateful. Lastly, my special thanks go to my supervisor (Dr Jacqui Ala) for her guidance and encouragement and to the rest of the University staff in the Wits Department of International Relations, my colleagues and friends and all those who supported me throughout this study.

DEDICATION

I dedicate this research study to my mother for being the source of inspiration and those who fight for the cause of the girl child and the right to maternal healthcare. I also dedicate this research to the memory of my late father who always encouraged me to be committed to my studies. Finally, this study is dedicated to all women as the procreators and nurturers of humankind, “you deserve to live, giving birth does not have to kill”.

ABSTRACT

Although globally, there has been a significant decline of maternal mortality, as evidenced by 44% decline in maternal mortality recorded between 1990 to 2015, the maternal mortality is still unacceptably high. Globally, there has been a growing concern about the unacceptably high maternal mortality, and it is estimated that in 2017 approximately 810 women died every day from pregnancy- or childbirth-related complications around the world.(WHO, 2017). Moreover, it has been observed that the countries that suffer most are the ones in less developed economies. Therefore, the aim of the study was to critically assess the implementation and internalisation of international norms related to maternal health with a view to recommend strategies that might address the current challenges being faced in the provision and uptake of maternal healthcare in the Southern African region. The study population was drawn from three case studies, that is, Botswana, South Africa and Zimbabwe. The target population comprised health care workers, traditional healers, religious leaders, spiritual healers and senior health care officers and government officials. Data for the study was collected through interviews and documents review. The study made use of the norm cascade model to critically evaluate the level of internalisation of the international norms related to maternal health. Findings from the study revealed that despite the existence of international norms related to maternal health, internalisation of those norms were a challenge in those three countries, due to a number of factors. Some of the factors were identified as socio-cultural factors, religious ideological factors, economic factors and education levels. Another finding showed that the medicalisation of maternal related issues has been proven to be less effective , especially in the context of African people who find themselves in the middle of other factors that the entrepreneurs of the international norms were not familiar with due to diversity of background and experience. The research design used in the study is a comparative case study design that encompasses qualitative semi-structured in-depth interviews, focus group discussion, document and thematic analysis. Persons interviewed in the depth interviews included, medical doctors, midwives, traditional healers, religious leaders and experts on culture. The study recommends an all-inclusive approach to maternal related issues, thus Southern African governments should integrate both allopathic approach and traditional / cultural approach in order to get a buy in into the norms and internalisation.

Keywords: maternal mobility, maternal morbidity, norm cascade, international norms, reproductive health, women's rights, Botswana, South Africa, Zimbabwe

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LIST OF ABBREVIATIONS

ACHAP- African Comprehensive HIV/AIDS Partnerships

AIDS- Acquired Immunodeficiency Syndrome

AIPPA- Access to Information and Protection of Privacy Act

ANC- Antenatal Care

ARV- Antiretroviral Treatment

AU- African Union

BNDP-Botswana National Drug Policy

BRICS-Brazil-Russia-India-China-South Africa association

CAMFED- Campaign for Female Education

CARMMA- Campaign for Accelerated Reduction of Maternal and Child Mortality in Africa

CBOs- Civil Based Organizations

CDC- Centre for Disease Control and Prevention

CEDAW- Convention on the Elimination of all Forms of Discrimination Against Women and Children

CSO- Civil Society Organization

CRL Commission- Cultural, Religious and Linguistic Commission

CSVR- Centre for Study of Violence and Reconciliation

ECOSOC- United Nations Economic and Social Council

EPMM- Ending Preventable Maternal Mortality

FBOs- Faith Based Organizations

GEC- Gender Equality Commission

1. GEM- Girls' Education Movement

GDI- Gender Development Index

GDP- Gross Domestic Product

GPA- Global Political Agreement

HDI- Human Development Index

HFA- Health for All

HIV- Human Immunodeficiency Virus

HOCD- Head of Christian Denominations

HPV- Human Pappilomavirus Infection

HTF- Health Transition Fund

IBSA- India-Brazil-South Africa Dialogue Forum

ICCPR- International Covenant on Civil and Political Rights

ICESR- International Covenant on Economic Social and Cultural Rights

ICT- Information Communication Technology

IUD- Intrauterine Device

LEA- Botswana Local Enterprise Authority

MDC- Movement for Democratic Change

MDDA- Media Development and Diversity Agency

MDGs- Millennium Development Goals

MMR- Maternal Mortality Ratio

MOHCC- Ministry of Health and Child Care

NAP- National Action Plan

NCEMD- National Confidential Enquiry into Maternal Deaths

NDP- National Development Plan

NEPAD- New Partnership for Africa's Development

NGOs- Non-Governmental Organizations

NHI- National Health Insurance

OHCHR- Office of the High Commissioner for Human Rights

PEPFAR-President's Emergency Plan for AIDS Relief

PIH- Partners in Health

PMTCT- Prevention of Mother-to-Child Transmission

PPIP- Perinatal Problem Identification Program

PPPs- Private Public Partnerships

RNPE- Revised National Policy on Education

RWM- Rural Women's Movement

SADC- Southern African Development Community

SDGs- Sustainable Development Goals

SMASH- Social Marketing for Adolescent Health

SRHR- Sexual and Reproductive Health Rights

TAC- Treatment Action Campaign

TFR- Total Fertility Rate

UNICEF- United Nations International Children's Fund

UNDHR- United Nations Declaration of Human Rights

UNDP- United Nations Development Programme

UNECA- United Nations Economic Commission for Africa

UNESCO- United Nations Educational, Scientific and Cultural Organizations

UNFPA- United Nations Population Fund

USAID- United Nations Agency for International Development

WOZA- Women for Zimbabwe Association

ZACH- Zimbabwe Association of Church Related Hospitals

ZANU PF- Zimbabwe African National Union Patriotic Front

ZAOGA- Zimbabwe Assemblies of God

ZDHS- Zimbabwe Demographic and Health Survey

ZIMTA- Zimbabwe Teachers Association

ZINATHA- Zimbabwe National Traditional Healers Association

ZNFPC- Zimbabwe National Family Planning Council

ZWLA- Zimbabwe Women's Lawyers Association

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.0 Introduction

Although there has been significant progress in reducing maternal death, as evidenced by 44% decline in maternal mortality recorded between 1990 to 2015, the maternal mortality is still unacceptably high (WHO, 2017). Globally, there has been a growing concern about the unacceptably high maternal mortality, and it is estimated that in 2017 approximately 810 women died every day from pregnancy- or childbirth-related complications around the world (WHO, 2017). The same report further highlighted that in 2017, an estimate of 295 000 women died during and after pregnancy and childbirth. In the face of high maternal mortality, the adoption and implementation of international norms on maternal health becomes a topical issue. Moreover, it has been observed that Sub-Saharan countries still have high maternal mortality rates not only because of pregnancy complications that cannot be treated, but also because of ideological and social factors which contradict the international norms related to maternal health. Thus, improving maternal health is one of the thirteen targets for the Sustainable Development Goal 3 (SDG-3) on health adopted by the international community in 2015 (WHO, 2017). This is the background against which the study was conducted with the aim of examining how countries in Southern Africa have adopted and implemented the international norms on maternal health. This chapter presents the, the aim and rationale of study, research questions, the theoretical framework, framework of analysis and research methods as well as the thesis outline.

1.1.1 Background to the study

In her keynote address, Dr. Nafis Sadik, the former Executive Director of the United Nations Population Fund, highlighted that women's health, including sexual and reproductive health has finally been recognized as a human right. She noted that the health of women does not only depend on appropriate health care, but also on the socio- ideological environment that surround women within their communities (Sadik, 2014). The provision of basic maternal health care is an investment for every country because in African context, it is women who are traditionally expected to carry the load of raising and nurturing children. Therefore, a high percentage of

maternal mortality would result in children having impaired development due to the absence of parental guidance and support from their mothers. In this regard, there are numerous international norms that most African states have adopted as a demonstration of commitment to the International community that they are indeed committed to curbing maternal mortality rates in African countries. The current trend "the Right to Maternal Health", under the umbrella of the "Right to Health" is increasingly featuring prominently in the discussions pertaining to maternal health. The international community has made amends towards assistance in the implementation of policies and programmes aimed at increasing access to maternal healthcare. These have been widely made available to governments, especially in the developing world (UNFPA, 2016). However, it has been observed that Sub-Saharan countries still have high maternal mortality rates not only because of pregnancy complications that cannot be treated, but also ideological and social practices and beliefs which do not recognise the value of saving women's life. In other words, the Sub-Saharan African countries still have to make the decision that women's lives are worth saving through the wide scale roll out of these international maternal health international norms. In this study, the focus will be on the influence of culture and religion on the acceptance and active appropriation of international maternal health norms and practices in the SADC region. In an ideal world, all states in the International Community would contribute to the formulation of International norms aimed at curbing maternal deaths. Within the idealistic framework that is inclusive of all states, all states would easily implement International health policies based on their confidence and understanding that the innate cultures and beliefs of their people were considered and incorporated in the formulation of the International norms. However, the realistic formation of international norms can be characterized by unbalanced power relations between developing and developed countries, that often leads to situations whereby Western countries are the ones who lead the way in how International norms are formulated (Maluleke, 2012). As a result, developing countries are habitually coerced to commit themselves to International norms that contradict the fundamental cultural and religious beliefs of their people, specifically regarding international norms pertaining to maternal healthcare provision (Maluleke, 2012). In this study, culture is understood as the ideas, customs and social behaviour of a group of people in society, while religion is understood as a particular system of faith or worship in one's belief of a supreme being.

According to Ahmed and Deng (1990), the underlying views of the drafters of the declaration of human rights were relatively homogeneous; with the states represented being primarily Western states, reflecting traditional Western perspectives on rights. The authors further argue

that in the 1960s, many new countries of Africa and Asia had become members of the United Nations, and their outlook on International problems and human rights differed from those of the West (Ahmed and Deng: 1990). In addition, political and ideological confrontations from the cold war divided the West and the Eastern European countries more profoundly than during the period when the declaration was drafted (Ahmed and Deng: 1990).

Therefore, the solution to universal acceptance and cohesion in the implementation of the Universal Declaration of Human Rights would be if the International Community provided a platform for regions that have previously excluded in the formulation of the Universal Declaration of Human Rights to express and contribute their own perspective on the concept of Human Rights, that is influenced by their religious and cultural beliefs.

The benefits of including the views of the previously marginalized regions (mainly Africa & the Eastern region), would be the more acceptance and less resistance of the Universal Declaration of Human Rights by certain religious and cultural communities in the African region. This study will therefore explore this phenomenon with specific interest on the implementation of International Instruments aimed to curb Maternal Mortality in African countries.

1.2 Aim and Objectives of Study

1.2.1 Aim of study

The study aims to draw from the cases of Botswana, South Africa and Zimbabwe to examine whether the right to maternal health care has been realized in Southern Africa through cascading of international norms related to maternal health. In general, the study focuses on how cultural and religious ideologies influence the adoption and implementation of international maternal healthcare norms as encapsulated by International Organizations, governments and individual women in the selected Southern African countries.

In particular this study focuses on the important role played by the international community as a catalyst in encouraging states and their populations to recognize good maternal health as a human right.

1.2.2 Objectives of study

1. To identify the international/regional treaties and conventions pertaining to maternal healthcare that have been signed by Botswana, South Africa and Zimbabwe.

2. To assess how the international norms on maternal health have been translated into practice at a national level.

3. To examine the extent to which the translation and the implementation of these policies and practices regarding maternal healthcare in these three countries have been affected by various traditional cultural and religious practices related to pregnancy and childbirth.

4. To recommend possible ways of ensuring that the international norms on maternal health are successfully cascaded to the grassroots level.

1.2.3 RESEARCH QUESTIONS

In examining the above-mentioned fundamental issues pertaining to maternal healthcare in the Southern Africa region, this research addresses the following research questions namely:

1. What international/regional treaties and conventions pertaining to maternal healthcare have been signed by Botswana, South Africa and Zimbabwe?
2. How have the international norms on maternal health been translated into practice at a national level?
3. To what extent has the translation as well as the implementation of these policies and practices regarding maternal healthcare in these three countries been affected by various traditional cultural and religious practices related to pregnancy and childbirth?
4. How can the international norms on maternal health be successfully cascaded to grassroots level?

1.3 Rationale of Study

The rationale for the conducting and assessment of the adoption and implementation of the international norms on maternal health is manifold as it touches on several aspects such as women's rights and sexual health, gender and socio- cultural and religious ideologies.

1.3.1 Bridging the gap in literature

The reason why this study is important is that despite the existence of several studies on public health issues (such as clinical dimensions involved in HIV and AIDS, non-communicable diseases), there is limited research that focuses on the policy dimensions of public health. In particular, there is a dearth in literature which addresses maternal health care in the context of sub Saharan Africa with a particular focus on how to resolve the conflict between culture and traditional norms versus international norms on maternal health. In this context pregnancy is regarded as "a rite of passage" that involves bringing a life into the world (Cote-Arsehault et al, 2009). It has been observed that in the African region, governments, religious sectors and cultural groups often have different ideas about the provision of reproductive health care. In situations where international norms are decided upon by representatives of states at various international, regional or local fora, the ideas of marginalized groups, in this case women, are often not heard in such discussions, to such an extent that decisions are made by their governments without their input. For example, a study done on a community health project for a South Asian population in Greater Manchester revealed that health professionals who work in community-based approaches in reducing health inequalities, often lack the cultural awareness needed to win the trust of marginalized community members. This ends up negatively affecting the partnership between health professionals and the marginalised such as the rural lay persons in the implementation of rural based health programs (Bandesha, 2005). As a result, the marginalized groups sometimes end up rejecting the national health care services provided by their government because they are in contradiction with their specific culture and/or religious beliefs. In such cases, cascading international norms pertaining to maternal health becomes problematic. Thus, the study finds significance in examining those factors that inhibit the cascading of international norms on maternal health to grassroots level.

1.3.2 Highlighting Maternal health as a priority

The importance of conducting this research further stems from the fact that ever since the emergence of the HIV and AIDS pandemic in Southern Africa during the mid-80s, a lot of medical and social science research has been focused on the pandemic because of its high prevalence within the Southern African region. However, the focus on HIV and AIDS research has led to the neglect of other medical issues such as diabetes, heart disease and maternal mortality. Many Southern African countries have failed to meet their Millennium Declaration target of curbing Maternal Mortality rate by at least 5% every year until 2015 (Vandermourtele, 2007). One of the reasons why the countries struggle to meet the target is because, their governments are yet to realize maternal mortality as a critical medical issue that needs undivided attention, research, and potentially its own international funding mechanism, in the same way HIV and AIDS pandemic has had. However, it has been observed that in most African countries, there is not enough financing and sustainability of the health sector in general and of reproductive health in particular (Rogo et al., 2006). Sustainability in reproductive health in this regard refers to accessible legal safe abortion, the examining of the social determinants of pregnancy amongst the younger generations, as well as the linking of sexual and reproductive health rights (SRHR) with HIV (Rogo et al., 2006). In this case, it is important to recognize how sexual and reproductive ill health and HIV do share root causes that include poverty, gender inequality, and social segregation of marginal groups (Heard,2016). According to Rogo, Oucho and Mwalalli (2006), one of the reasons behind African countries' on-going battle with curbing maternal mortality rates is because most countries in the region have not adequately addressed maternal health within national policy and programmes. Therefore, in this regard, the rationale of the study is premised on highlighting maternal mortality as a critical health issue that deserves prioritisation in terms of resources, legal and policy provisions.

1.3.3 Determining the progress in compliance with international norms

Understanding different international and regional treaties and conventions related to maternal healthcare that the three countries in South African are signatories to, helps in assessing the progress that these countries have made in complying with those international norms. Moreover, the study will also provide insight into various ways that different countries in the regions have cascaded the norms to their intended destination.

Another significance of this study lies in highlighting how the cultural and religious ideologies have affected the implementation of those norms, the study provides an in-enriching insight into those religious and cultural practices and beliefs that oppose women's health. In addition, understanding those factors will equip policy makers, health workers and other social actors with requisite understanding of how to deal with issues of maternal health in those societies.

Finally, in the light of the above, the study therefore, finds significance in bridging the existing knowledge gap on factors affecting the adoption and implementation of international norms on maternal health in the context of Southern Africa. In addition, the study is expected to make the much-needed contribution to the issue of maternal health by evaluating how societal variables impacts on the cascading of international norms from the international/ regional arena to the domestic grassroots level. In addition, Sikkink and Finnemaore (1998), highlighted that the issue of norm internalization is not a well-researched area in the social sciences because norm internalization is not usually the centrepiece for political debate and as a result is ignored by political scientists. This study aims to fill in this specific research gap in the area of maternal healthcare provision within the Southern African context.

1.4 Theoretical framework

In tackling the research questions, this study employs a social constructivism approach. This approach was considered as an ideal approach to explore the influence culture and religion in the implementation of maternal health policies as the approach examines the extent to which state interaction is conceptualised by identities, interests and values of individual states overtime (Robinson et al., 2009). Unlike the popular International Relations theories such as realism and liberalism that are substantive theories, social constructivism is rather an approach that examines the "relationship between agents and structures", and the extent to which human consciousness plays a role in influencing international life (Barnette, 2014). *Björkdahl (2002) added that research* interest in social constructivism has increased owing to the emergence of certain analytical and empirical limitations of conventional theories that have been commonly used in the field of International Relations, such as neoliberalism and neorealism. The author further highlighted that the conventional theories failed to adequately capture the influence of ideas, values and norms on the identities and interests of actors. On the contrary, social constructivism claim to seize the middle ground by providing an alternative understanding

resulting in the creation of new theoretical insights regarding the influence of norms. In this context, social constructivism considers how the cultural environment plays a role in how people understand and interpret international norms. In international relations, concepts such as “Development, Human Rights, and Sovereignty” are prominent concepts in the field that can be open to different meanings by various kinds of people who are influenced by their cultural backgrounds.

According to social constructivists, international institutions such as the World Health Organization have both regulative and constitutive functions. In issues pertaining to maternal health, international norms such as the Beijing Platform for Action, the Millennium Development Goals, Sustainable Development Goals, and the Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW) can be considered to have regulative functions. However, it becomes a challenge to implement at a national level in most African countries, specifically when there is a dispute of policies between the UN and the African Union, and states that embrace both common law and customary law. This dual legal system can have conflicting views on issues of life due to cultural and ideological differences. In consideration of constructivism and global change, the international community operates in such a way that within the midst of a ‘diversity of models’ existing in the international community, some models gain more prominence and popularity over others (Barnette, 2014). As a result, the international community reaches a point where there is “conformity and divergence around a single model”, which will be considered to be the standard that every state should abide by. For example, the international standard of the Universal Declaration of Human Rights is more slanted towards the western normative ideas of what international human rights should look like. In this case, one often finds that African countries tend to sign International Human Rights norms not particularly because they believe in these norms, but because they want to gain acceptance, legitimacy and prominence in the international community (Barnett, 2014).

In international relations, countries normally have corporate identities that create their basic state roles such as physical security, stability, recognition by others and economic development (Robinson et al, 2009). A corporate identity is the way in which a country defines itself or has established its ‘brand’ within the international community. For example, South Africa established itself as a country that respects human rights and liberal democracy during the Mandela Presidency after 1994. The issue with most African countries is that they often feel

powerless in formulating and maintaining their own independent identities within the space of international community because a lot of them hold a view that influential international organizations such as the UN are predominantly controlled by the wealthier countries of the West. Moreover, most African countries are reliant on the financial assistance from the developed nations in order to fund some of their most crucial problems such as the controlling of the HIV and AIDS pandemic, conflict resolutions and many other issues (Akwagyiram, 2013). Therefore, most African countries tend to formulate their corporate identities in accordance to their perceived expectations of the developed countries that financially invest in their national development plans. It has been observed that when health policies are being deliberated and agreed upon at United Nations level, most African countries face challenges in implementation of those policies due to the national challenges of integration, particularly in the identifying and evaluating strategies and criteria for integrating traditional medicine into their national and primary health care (WHO:2014). It is for this reason that some African countries only partially ratify instruments such as the CEDAW.

Robinson (2009) shades some light on how African countries find themselves in a difficult dilemma of integrating traditional medicine with the national health care system. This is so because, at the international level, they would be under pressure to comply and conform to international norms, and on the other hand, at a local level, they are expected to embrace their heritage and traditional healing methods. Robinson (2009) further argues that there are lower levels of nationalism amongst citizens of African states because they are relatively young compared to their European counterparts. The author further states that the ability of African people to formulate their identity along in accordance to the state rather than ethnic lines is to a large extent dependent on the Human Development Index of the country (Robinson, 2009). In countries where there is equal distribution of state resources amongst the population, all citizens of the country will be more likely to identify with the state rather than with their specific ethnic groups (Robinson 2009). Also, countries that are culturally diverse are least likely to have higher levels of nationalism than more homogenous states (Robinson, 2009). It is in this regard that the cascading effect of international norms on maternal health can be interrupted as African states tend to be more culturally diverse in comparison to other states in the world.

In her study, Robinson (2009) also discovered that citizens are more likely to identify with the state, in countries where more citizens are employed in the formal sector, have higher levels of education, and the country which is urbanized. However, this is not the case with most African

countries, as most African citizens tend to identify more with their specific ethnic groups rather than with the identity of their nation state or its policies. With regards to the use of maternal healthcare services, it means the more a country has people employed in the formal sector, the more they are educated and therefore enabled to critically evaluate the different healthcare options offered to them. They can either choose official allopathic medicine, alternative medicine such as traditional healing, or complementary healthcare options. In reference to the topic on maternal health as an international human right in the Southern African region, it can be observed that this identification with one's ethnic groups rather than the national identity of their country, makes people oblivious to the country's mainstream allopathic policies on maternal health.

1.5 FRAMEWORK OF ANALYSIS

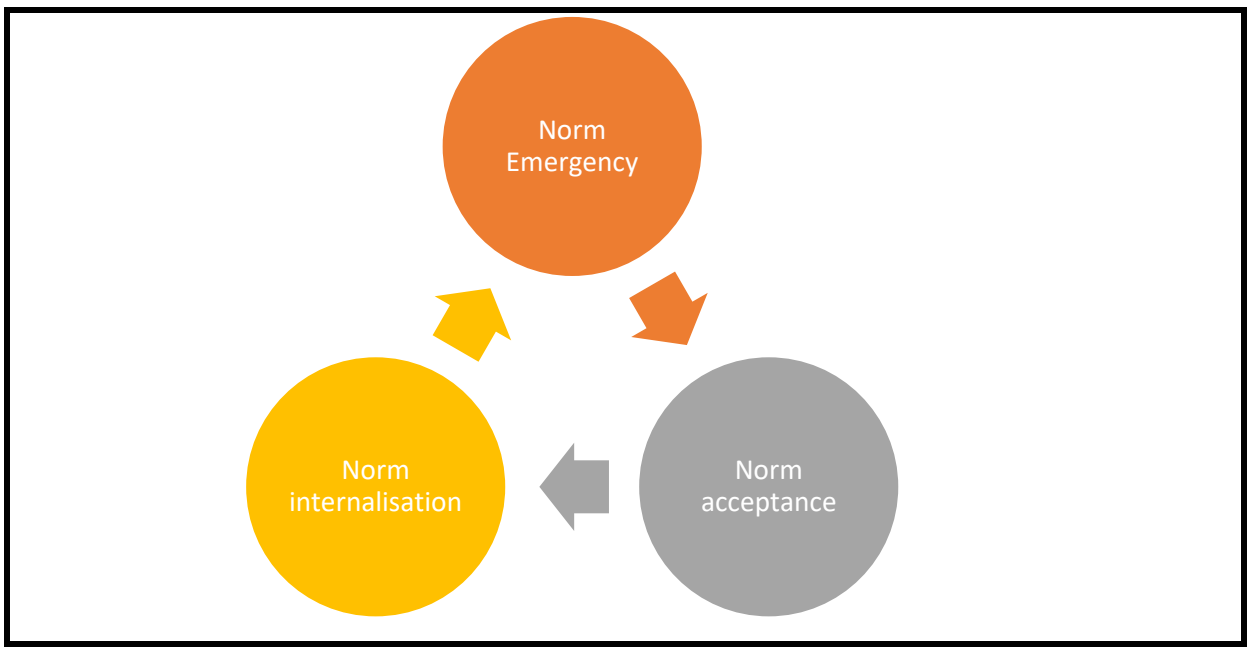
The study applied Sikkink and Finnemore (1998) construct of norm evolution to structure the discussion and analysis regarding norm creation and implementation. A norm can be defined as a: "standard of appropriate behaviour for actors with a given identity" (Sikkink and Finnemore, 1998). Axelrod, 1986 cited in *Björkdahl (2002)* gave a comprehensive definition of norms as general prescriptions of behaviour which regulate intentions and effects. Finnermore and Sikkink (1998) further argue that some of the key aspects to take into account when studying norm creation and norm implementation include; the origins of the norms, the mechanisms by which the norms exercise influence, and the conditions by which the norms will be influential in world politics. The authors further argue that one of the areas that will always remain a challenge is the connection between domestic and international norms due to the fact that many international norms began as domestic norms and became international through the efforts of entrepreneurs and/or ambassadors who advocated for the norms to be placed within the international arena. In addition, several scholars attribute the origins of international norms to domestic norms and they highlight how domestic norms become international through the efforts of actors of various kinds. Thus, domestic norms may spread to the international level. Hence the challenge would set in when those parts of the world that were not advocates of the international norms feel that they have to adopt a certain behaviour that is foreign to them and not part of who they are as a people. In this way, international norms are always in a position where they have to work their influence through the filter of domestic structures and domestic norms, which can of course produce important variations in compliance and interpretation of these norms (Sikkink and Finnemore,1998). Another

phenomenon that tends to happen in local settings is a process by which domestic norm entrepreneurs would advocate a minority position use of international norms in order to strengthen their position in domestic debates (Voeten, 2014). In the African context however, there are cases where the international norms do overlap with regional and domestic norms, particularly in those countries where common law and customary law are both recognized. It is in this regard that norm cascading becomes a challenge.

1.5.1 Norm Cycle

In their argument, Sikkink and Finnemore (1998) describe the norm cycle which operate in three stages namely, norm emergence, norm acceptance and internalization of the norms by countries.

Figure 4. Norm Cycle



1.5.1.1 Norm Emergence

Norm emergence occurs when norm entrepreneurs make an attempt to convince a number of states (norm leaders) to embrace the new norms. Most of the international norms pertaining to maternal health such as the Abuja Declaration (2001), the Beijing Platform for Action (1995) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979) emerged during the period when many African countries were still settling into their newly found independence and hence were not in a position of being norm entrepreneurs within the international community yet. Effectively, they were not able to fully

engage in discussions around the suitability of these norms for local context and they did not have the capacity to implement these.

1.5.1.2 Norm acceptance

The second stage in norm cycle is norm acceptance which involves norm cascading from the global level to the grassroots level. It entails norm leaders making attempts to socialize other states to become norm followers, thus advocating for norm acceptance. It has been observed that at this stage where the norm "cascades" through the rest of the states' population, the cascading of those norms is facilitated by a combination of situations, such as pressure to conform, the desire to enhance international legitimation, and the desire of most state leaders to enhance their self-esteem (Sikkink and Finnermore, 1998). With regards to international norms pertaining to maternal health, it was found that most African countries are signatories, thus, committing themselves to international norms established in these instruments especially because this would make them appear to be diligent, capable members of the international community despite the newness of their states and the significant challenges to their sovereignty in other areas.

1.4.1.3 Norm Internalisation

The far end of norm cascade is characterized by norm internalization where norms acquire a taken for granted quality within states and are no longer a matter of public debate (Sikkink and Finnermore,1998) .For an example, few people today discuss whether women should be able to vote or not. Some of the ways in which states can internalize international norms include; enlisting prominent spokespeople in the country to talk about the norms, building coalitions between the government, International Organizations and Non-Governmental Organizations in order to establish campaigns that will popularize the norm, building trust between the government and other opinion leaders in the small communities, as well as using the global media (Martinsson 2011). With regards to maternal healthcare provision in Africa, though literature alludes to the fact that the international norms pertaining to maternal healthcare have still not yet reached the far end of norm cascade in most parts of the African region. This is evidenced by the existence of wide debates on what is considered to be the best care for expectant mothers, particularly amongst several social institutions such as the professional health sector, the religious groups, as well as the cultural groups (Martinsson, 2011). One weakness that has mitigated against the internationalization of international norms on maternal health in particular, has been identified as the domestic actors' failure to

communicate information from the bottom-up perspective in which community leaders such as religious and cultural leaders are involved in making the norm popular among their people (Martinsson, 2011). In Southern African countries that have weak civil society groups such as in Botswana, research has found that it has taken a long time for some maternal heath international norms to be internalized. This is due to the fact that it is usually only when there is an active civil society or NGOs that bypass the state and directly seek out international allies to try and bring pressure onto their state from the outside, that the state being more actively involved in formulating campaigns that will popularize the international norms (Martinsson, 2011). Further, Voeten (2014) argues that signing a convention does not really guarantee that states will adopt or abide by the norm especially if it has negative domestic social, economic or political implications. Thus, this study purports to ascertain progress made by maternal health care norms in the Southern African region in reaching the completion of Finnemore and Sikkink's defined norm life cycle.

1.6 Research Method

The research methodology in this study was intended to test the social constructivism theory in its examination of the influence of culture and religion in the cascading of International norms pertaining to maternal health. Constructivists thinkers hold a view that knowledge is socially constructed because of their perception that people consume knowledge in an interactive way that builds on what a person already knows (McLeod 2019). In this way, constructivist thinkers believe that the environment in which people are socialised influences the ways in which they think about the information they receive and how they apply it in their everyday lives (McLeod 2019). Therefore, social constructivism argues that people have a distinct view about issues, that is based on the knowledge that they already have and the values that they hold (McLeod 2019). Under this consideration, the research method that was applied in this study is qualitative content analysis that comprises of qualitative in-depth interviews, focus group discussions, document analysis and thematic analysis. The study utilised a comparative case study design that focused on three case studies on maternal health in Botswana, South Africa and Zimbabwe. This methodology has been adopted to explore the extent to which norm cascade of maternal health as an international human right in Southern Africa has occurred.

The study applied a comparative case study design, which applies the logic of comparison by implying that a social phenomenon can be understood better when it is "compared to two or

more meaningfully contrasting cases or situations" (Bryman 2012, P.70). Through the comparison, the researcher showed that the cascading of International norms that speak to the issue of maternal health within the Southern African context can be better understood by doing a comparison between a middle income countries (in which one has an unequal healthcare system), and a country that has not yet reached middle income status and facing unstable economic and political instability. Under such differing circumstances, the religious and cultural sectors would have various positive and negative ways in which they affect the cascading of International norms pertaining to maternal health, and hence the comparative case study design was best suitable to apply in this study. The advantages of this study design is that it enabled the researcher to be able to scrutinize the similarities, differences and patterns in which the three countries implemented the CEDAW, Beijing Platform for Action/ UN Conference on women, and the MDG/SDGs in the three countries in which the findings of the cases were themed upon. Some of the challenges encountered in this comparative case study design however is that collecting data took longer and was more expensive, with different currencies used in the three countries. In the case of Zimbabwe, there were some provinces that were using the Rand as the main currency, while other provinces would be used the Dollar as the main currency at the time of data collection. One also had to be mindful and sensitive to the different cultural and national contexts when collecting data and presenting information about the three countries.

Because of the nature of the study to examine the extent to which culture and religion have an influence on the cascading of International norms pertaining to maternal health, qualitative research methods were chosen in the collection of data. This is because qualitative research methods are useful in providing depth and detail using interviews, it is also reliable in terms of gathering people's attitudes, feelings and behaviours about the subject being studied (Bryman, 2012).

In the study, the researcher opted to select samples in each country according to which area had the highest level of maternal deaths and which area had the lowest cases of maternal deaths. After these areas were identified in each of the countries, the researcher sought information on which religious institutions and which cultural groups dominated in each of the sampled areas in the three countries. After which, representatives from the most dominant religious groups and cultural groups were selected for focus group interviews and qualitative in-depth interviews within the areas with the highest levels of maternal mortality rates and the areas with the lowest maternal mortality rates in each of the countries. In this way, the qualitative in-

depth interviews helped the researcher to better understand the beliefs, attitudes and values of the people living in areas with the highest levels of maternal mortality rates, and areas with the lowest maternal mortality rates in the three case study selections.

As a means to strengthen the reliability of the collection of data from the focus groups and the qualitative in-depth interviews, the researcher included a document analysis method of data collection which was utilised by studying the religious doctrines and published texts on the dominant population groups in the areas with the highest maternal mortal rates and the areas with the lowest maternal mortality rates. The studying of the published documents of the religious documents helped in providing a stable reading of the underlying principles of the religious and cultural groups being studied, and thus helped in ensuring that the information that is collected from the focus group discussions and the in-depth interviews is valid and can be replicated by any other researcher who might have an interest in conducting a similar study. In addressing issues pertaining to ensuring validity of the study, the triangulation of data from multiple sources such as interviews, focus group discussions, document analysis and thematic analysis assisted in ensuring the validity of the study (Adams and Adams 2006). In the case of interviews, the researcher's ability to study and observe other communication cues such as participant body language and tone of voice enabled the researcher to be able to make a judgement on the validity of the information collected from both interviews and focus group discussions (Ekanakaye, 2015). In addition, the researcher aimed to counter the threats to the validity and the reliability of the study through asking probing questions during the interviews, asking questions in an inverse way, and also seeking alternative explanations to what appears to be the research results (Ekanakaye 2015).

In looking at the sampling, the study used multiple study sources that included semi-structured in-depth interviews, focus group discussions, and documentary evidence. In the semi-structured in depth interviews, a purposive sampling of official sources such as medical doctors, midwives, traditional healers/birth attendants, cultural and religious leaders were interviewed as expert sources in order to get insight on their ways of incorporating International norms pertaining to maternal health within their professions. In terms of medical practitioners, the researcher selected these professionals from hospitals that recorded the highest levels of institutional maternal deaths and lowest levels of institutional maternal deaths in the three countries from within a 10-year period of 2005-2014. In terms of traditional healers, traditional birth attendants, religious leaders and cultural experts, the researcher selected the interviewees according to religious institutions with higher numbers of membership from within the villages

that recorded the highest levels of maternal deaths and the lowest levels of maternal deaths in the three countries. Such religious institutions included the Zion Christian Church, Apostolic Faith Mission Church, Spiritual Healing Church, Seventh Day Adventist Church, the Catholic Church, International Pentecostal Church, Gudare Ngwane Church amongst others. In some cases, a snowball effect was applied in the interview method of data collection whereby a spiritual healer would identify names of other healers they know that predominantly provide maternal services such as abortion, and thus the researcher would follow that lead. For Marshall and Rossman, the purpose of qualitative in-depth interviews is that they reveal the respondent's meaning perspective, in such a way that respects how the respondent frames and structures their responses (Marshall and Rossman, 1995). It can also be argued that the main reason for conducting qualitative interviews is to understand the beliefs, attitudes, values and motivations that propels individuals to interpret social events in particular ways (Bower and Gaskell, 2000). One advantage of conducting qualitative in-depth interviews is that it provides opportunity for large amounts of data to be collected within a short period of time as a wide variety of information will be collected across several subjects (Marshall and Rossman, 1995). The qualitative in-depth interviews were also undertaken to identify the extent to which higher educated women and lower educated are likely to follow cultural and church doctrine without questioning it.

In some cases, statistical records from the central statistics offices were studied in order to assist in identifying the average, mean and continence intervals of the phenomenon being studied. When choosing case selection of comparative studies in social science research, it is important to consider selecting principles such as "maximizing variance, minimizing error variance, and controlling the extraneous variance' (Burnham et al, 2008). Experimental variance in this comparative case selection was ensured by choosing to study women of different education levels, age groups, socio-economic levels, and cultural and church denominations within Botswana, South Africa and Zimbabwe.

With regards to focus group discussions, the participants selected included women in childbearing age, relatives who have lost a family member to maternal death, and caregivers of women who have recently given birth such as grandmothers, mothers in law, and the mothers of women who have recently given birth. In the focus group interviews, the inclusion of participants such as caregivers of pregnant women and women who have recently given birth was in consideration of the fact that in most Southern African countries, mothers or mothers in law of pregnant women are the ones who usually take care of the pregnant and women who

have recently given birth. Therefore, it is highly likely that the mothers or mothers in law are the ones who encourage women to adhere to the cultural and religious methods of maternal care. The interviewing of care givers of pregnant women and women who have recently given birth was important in the sourcing of cultural and religious factors that can potentially have an influence on maternal health care provision of women within the three countries. The interviewing of caregivers was also important because the effectiveness of the implementation of International Instruments depends, in part of the ability of countries to understand the cultural dynamics of the communities in which these International Instruments are supposed to be implemented.

The researcher facilitated at least two interviews (in groups of 6) in the area with the highest recorded maternal death and the area with the lowest recorded maternal death within each country. The information that was gathered through medical doctors, midwives, traditional healers/birth attendants, religious leaders and cultural experts was triangulated with the information from the focus group categories and document records in order to improve the validity of the study (McKinnan, 1988). The selection of the focus group participants planned through the assistance of persons working at the central statistics offices that work with the recording of maternal mortality cases, and birth and death registration departments, as well as offices responsible for the registrations of religious and cultural institutions in the countries.

Also to mitigate in issues concerning the reliability of information gained from these official sources, the researcher also studied documents such as national maternal health reports, church doctrines of the most attended religious institutions within areas with highest mortality rates and lowest mortality rates within the three countries, and the country reports of how each country performed in the international norms pertaining to maternal health that were used as themes in the study, as well as country constitutions. Document analysis was also helpful in the enquiry about written rules, procedures, instructions and the communications that occur in the organisations that were part of the study (Hall and Hall 1995). Other documents studied included documents that speak on the countries' GDP and the Human Development Index, as such information was helpful in identifying the economic growth of each country & the implications of the economic growth on maternal health policy implementation. The information of the Human Development Index assisted in identifying the distribution of each country's economic wealth, and the terms and conditions in which the governments committed themselves to signing and ratifying International treaties and conventions concerning maternal

health care provision, and how those measures infiltrated at grassroots level, specifically when traditional healers and church practices were concerned.

In terms of analysis and reporting, thematic analysis was applied as it "allows a lot of flexibility in the interpretation of data", and it allowed the researcher to approach large data sets more easily by sorting them into broad themes (Caulifield, 2020, 1). In this study, the themes were divided according to the international norms being studied that included the CEDAW, The Beijing Platform for Action/UN Conference on Women, and the MDGs/SDGs. These broad themes were further studied accorder to smaller sub-themes such as 'distrust of experts', 'misinformation', 'uncertainty/ alternative' and so on. In this way, one could say that the codes involved included factors such as; distrust of experts, acknowledgement of disparities in providing maternal healthcare, influence of access to education, financial opportunities & the link between women's maternal health experiences (Caulifield, 2020). In this case, a deductive approach was used in the reporting and analysis of data whereby the researcher came to the data with preconceived constructivism inspired themes that were expected to be reflected in the application of Finnermore and Sikkink's norm cycle analytical framework (Caulifield, 2020).

In terms of the ethical considerations in the study, the researcher chose to conduct interviews in a way that did not subject the participants in harm's way by conducting the interviews in places that were familiar to the participants such as their place of occupation (hospitals, clinics, their places of worship, local kgotla and their homes). Means to respect the dignity of the participants was ensured through using pseudo names in the final report instead of the participant real names. Full verbal consent was obtained from the participants before the interviews were conducted, as well as consent to record the interview conversations. The protection of the confidentiality of the research data was prioritised through making sure that the researcher was the only one conducting and transcribing the interviews, and that all tapes and notebooks with collected data was kept in a safe place that only the researcher had access to. Honesty and transparency in the data collection process was ensured through providing all research participants with participation information sheets that provided the participants with information on the purpose of the study.

Limitations of the study

Drawing from the researcher's experience, it can be argued that the limitations of conducting research in the selected case studies is that the governments of the countries (specifically Botswana and Zimbabwe) were not research friendly. Southern African government departments tend to withhold information as they fear that the research results will expose their governance methods instead of considering research findings as a tool that might provide them with insights on how to solve problems in society. The researcher struggled a lot with acquiring a research permit from the Botswana Ministry of Health as the research office at the ministry took long to review the research permit application and when the research permit application was finally reviewed, the researcher discovered that the main persons that were in the panel that reviewed the research permit application did not really have a background in the field of International Relations or its research methods which compromised the way in which the research permit application was processed.

In the case of Zimbabwe, the researcher experienced difficulties to interview some professionals as there was a lot of fear about speaking up about issues within the communities. At the time, the researcher discovered that the government censors' officials in a way, thus people become fearful to speak up about certain issues.

Also, some unlicensed traditional healers tended to be reluctant to answer certain questions as they feared that the interviews would expose them and jeopardise their livelihood.

From a methodological point of view, the limitations emanated from the fact that qualitative in-depth interviews tended to be time consuming and expensive to implement (travelling, scheduling appointments) can take a toll on the researcher as it consumes a lot of energy and resources which can jeopardise the way in which a person analyses information when they have to work within a specific time. Other limitations are that when one gathers information from government sites, one can come across information that is misleading as government sites tend to package information in a way that protects the states perceived national interests. When examining different country reports, the researcher found that the ways in which some progress reports were reported (particularly on the Zimbabwe MDGs) were reported in a way that protected the state without necessarily holding it accountable. In this case, maybe surveys could have been used to enhance the research methods.

1.6.1 Rationale for Case Study Approach and Selection

In this thesis, case studies were used as a research design in which the research questions were to be answered. The case study was selected due to its efficiency in achieving an in-depth understanding of the social phenomenon. In this research, the purpose of case study research would not be to generalize study results to large populations, but it would be more towards whether the theoretical proposition of constructivism captures the variations in interpretations of international norms pertaining to maternal health, through the application of Finnermore and Sikkink's norm cycle analytical framework (Ekanayake, 2015).

According to Yin (1994), case studies help us to make an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially in situations where the boundaries between phenomenon and context are not obvious (in Woodside, 2010). In other words, case studies design enabled the researcher to identify the extent to which people's choices to comply or not comply to maternal health policies are influenced by their own agency. It also enabled the researcher to determine the extent to which these decisions are influenced by the concepts that shape the value systems in their communities, districts/provinces, and nationality. This research entailed studying communities within the selected countries in order to discover the prevailing perceptions about maternal health within those communities. It also focused on the prevailing systems that determine the concepts in which these health policies are utilized by women of different cultures and religions in those different countries. This ultimately speaks to the extent to which variables assist or impede the cascade of this norm. Therefore, in this context a case study was deemed as efficient in determining the attitudes, perceptions, and beliefs of participants that are being examined in the study (Stake, 2005).

According to Santrock who is a developmental psychologist, human beings have schemas, which are pre-existing mental concepts or frameworks that help them to organize and interpret information (Sandtrock, 2003). In this case, schemas from prior encounters with the environment influence the way in which people encode, make inferences about, and retrieve information (Sandtrock, 2003). This affirms Woodside's argument that thinking consists of about 5% conscious thinking-which can be understood as an individual's *agency*, and approximately 95% sub-conscious thinking in which culture and religious teachings formulate the concepts in which people make sense of maternal health care policies (Woodside, 2010). Consequently, people have only a limited access to their own thinking processes, not to

mention the thinking processes of others (Woodside, 2010). In this context, case studies were found useful in identifying the interactions between different groups in society, interactions between a state as well as the international community, and the dominant views that form the framework in which national and international health policies are formulated. Thus, this assisted the researcher to chart the movement of the norm from its emergence to its cascade and finally to ascertain whether it ever achieves internalization. In addition, a case study was chosen because it allowed for critical analysis of the interplay within and between these different levels that assist or prevent implementation. Case studies also helped the researcher identify the processes that determine how health policies are perceived and interpreted by the citizens of a country (Woodside, 2010). Therefore, case studies were useful in allowing the researcher to deal with "the subtleties and intricacies of complex social situations and offering a more valuable and unique insight" on how citizens of three Southern African countries respond to maternal health care policies (Descombe,2007). Botswana, South Africa and Zimbabwe have been selected as the three case studies that are going to be studied in this study.

1.6.1.1 Case study one – Botswana

Botswana was chosen because it is one of the middle-income countries in Southern Africa which is perceived to be doing well in terms of development as measured by the human development index as well as democracy (World Bank, 2019). In spite of all these accomplishments, the country still has fluctuating maternal mortality rates. The Republic of Botswana used to be one of the poorest countries in the world when it got its independence 45 years ago (Worldbank, 2019). However, the discovery of diamonds has transformed the economy of the country like the proverbial "from rags to riches", thus it has moved from being labelled one of the poorest countries to achieving highest economic growths in the world (World Bank, 2019). This has resulted in Botswana being declared a middle-income country in 2009 (IMF, 2010). According to the National Development Plan 9, Botswana has made a lot of positive advances in developmental areas concerning the expansion of health services and facilities around the country (Gaolathe, 2003). However, the country is still battling increasing levels of mortality rates. According to Central Statistics Botswana, the Maternal Mortality Ratio for 2005-2009 decreased between 2005 and 2006, but increased annually from 2006 until 2007, and had a slight decrease between 2007 and 2009 (Mbinganyi, 2011). These statistics do show that Botswana as a country is making an effort to curb the rate of maternal deaths although the effort it's not adequate to effect a significant change. This study therefore sought to establish whether the challenges of maternal deaths in Botswana has to do with the problem of

norm translation from the international through the state to communities who may have different beliefs and values around pregnancy and childbirth than the one advocated by national health agencies.

1.5.1.2 Case Study Two - South Africa

The second case study that was used is South Africa. South Africa has been chosen because just like Botswana, South Africa is a middle-income country which has a rapidly growing economy with a GDP per capita of USD 3000 (World Bank, 2013). The South African public health care system is largely tax funded and provides care for 85 % of the population (Young 2016; Gilbert et al., 2007). A well-entrenched private health care sector provides for other 15% of the population (Young, 2016). Due to the structural transformation of the public health system, necessitated by inequitable provision on the part of the apartheid government, more health facilities have been built and renovated. These health care facilities are being made to be freely available to pregnant women, young children, people living with disabilities, and prison inmates who primarily rely on the public primary health care system (Young 2016). However, despite the advanced economic development of South Africa, there is still an unacceptably high maternal mortality rate in South Africa (Maternal and Child Health Draft Policy, 2014). According to the United Nations International Children's Fund (UNICEF), the recorded maternal mortality ratio of South Africa in the years of 2006-2010 was 400 per 100, 000 births (UNICEF, 2012).

South Africa's high HIV prevalence rate further poses unique challenges in ensuring a safe, health pregnancy and birth for HIV positive women as well as preventing mother to child transmission at or after the birth. In particular this would involve ensuring that pregnancy and birth does not compromise the mothers' immune systems and that whatever antiretroviral treatment (ARVs) a mother may be on, remains effective (Bodipe, 2012). For Helen Rees, who is the Executive Director of the Wits Reproductive Health and HIV Research Institute, there is now an increase in maternal mortality rates when there should be a progressive decrease in maternal mortality rates as South Africa rapidly develops as a country (Bodipe, 2012). She further mentions that some of the causes of the increase in maternal mortality in South Africa are due to HIV infection amongst pregnant women in South Africa (Bodipe, 2012).

1.6.1 3 Case Study Three – Zimbabwe

The third case study that was used in this thesis was that of Zimbabwe. The reason for selecting Zimbabwe was because maternal mortality is a huge cause of concern in Zimbabwe, especially with reference to the reports by Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS) which revealed high maternal mortality ratio of 725 deaths per 100 000 live births in the 2007 (UNFPA, 2011). Like Botswana, the direct causes of maternal mortality in Zimbabwe are pregnancy induced hypertension, postpartum haemorrhage, puerperal sepsis, malaria and obstructed labour. A study by ZMPA revealed that in 2007, HIV emerged as the leading indirect cause of maternal mortality by being the cause of 25% of maternal (UNFPA, 2011).

Much of Zimbabwe's drastic increase in maternal mortality can be attributed to the current state of economic and political upheaval in the country. According to one Viyeyarasa, the Zimbabwe government built maternity wings and even went to the extent of abolishing maternity fees shortly after the country gained independence in 1980 (Viyeyarasa, 2011). However, health standards have decreased drastically because of the brain drain of qualified midwives and doctors that have fled the country because of unfavourable economic and political conditions (Viyeyarasa, 2011). The migration has led to overstretching of a few trained staff remaining in Zimbabwe who could not cope with the demand of obstetric services. Consequently, patients experienced complications that eventually made them loose confidence in modern medicine and rely more on traditional birth attendants. In addition, in cases of suspected birth defects or in life and death situations, the authority of two medical practitioners is required for a termination of the pregnancy but may be impossible to obtain in urgent situations because of shortage of doctors. These barriers have created a black market of 70,000 unsafe abortions every year, a situation that is perpetuated by the fact that abortions are also not legal, as according to the UNICEF data released in 2005 (Viyeyarasa, 2011). According to Sparks (2004), a dual maternal health care system has always existed in Zimbabwe whereby one system consisted of formally trained nurses and midwives which was not accessible to many of the citizens. On the other hand, another system consisted of traditional birth attendants in which health care was provided by lay healers in the villages that incorporated traditional health practices and beliefs (Spark,s 2004). Traditional birth attendants have been formally recognized by the Zimbabwean Ministry of Health since 1982, in which they have been offered pilot training courses as a means to upgrade their midwifery skills. However, maternal mortality rates still remain high in Zimbabwe, in spite of these initiatives. In this regard, Sparks (2004) argues that the traditional society in Zimbabwe, which is both patriarchal and

patrilineal, has implications on maternal health as well. For example, there have been numerous cases in which women were advised not to have any more children by their physician, but their husbands insisted that the women fall pregnant once again (Sparks, 2004). Therefore, the selection of Zimbabwe as a case study examined the extent to which religion and culture influence the way women in Zimbabwe understand and make use of the health systems provided to them by the state and the traditional birth attendants.

1.6.2 Motivation for selecting the three cases

The above three case studies were used to explore the extent to which the state takes tradition and religion into account when ratifying international norms concerning maternal health, formulating and implementing national health policies, and to what extent does religion and culture influence the way women in these countries understand and make use of the health systems provided to them by the state. Economically and politically these countries are extremely disparate. Botswana is a stable democracy with a strong economy. Its government has been able to provide the population with good public health care. South Africa also has a fairly stable democracy and a fast-growing economy that allows it to have material accessibility to all the necessary equipment and infrastructural adjustment needed to improve medical facilities in post-modern society. However, we cannot say the same for Zimbabwe, as the country is politically and economically unstable. Any progress made in advancing access to healthcare since Zimbabwe's independence has largely been eclipsed by the nationalization policies of the Mugabe government, coupled with poor governance and corruption.

Despite these fundamental differences, all three countries are struggling to make progress in decreasing maternal mortality rates. Consequently, this thesis investigates the position of each country guided by Finnemore and Sikkink's norm evolution model, in terms of translating international norms on maternal health into domestic policy and practice. As discussed above, this model identifies numerous impediments at domestic level. Thus, the study sought to identify in each case study how the convergence of specific domestic issues and actors' impact on the realisation of maternal health norms as well as the contribution they are making to increased maternal mortality in each of these countries. Furthermore, by establishing a clear picture of these factors, the study was able to propose / recommend possible solutions to each of these.

1.7 THESIS OUTLINE

Chapter one presented the introduction and objectives and rationale of study as well as the research methods. Chapter two presented the literature pertaining to maternal health. Chapter three chartered the emergence of the norm of maternal health as a human right. Chapters four, five and six presented respective case studies as outlined above. In those three chapters, the study incorporated the levels of norm cascade and norm implementation to analyse the progress being made in the three case studies towards realizing the norm of maternal health at the domestic level in these three countries. In the final chapter (seven), the researcher compared and contrasted the findings of each of the case studies as well as providing general suggestions for ways in which international and domestic actors could assist in achieving the final step of norm internalisation in each case.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Literature review provided a discussion in the context of what is already known about the state of maternal health in Southern African countries. The literature review identifies maternal health as one of the top six global health problems, in which global networks seem to lack proper coordination and adequate representation of the persons involved and affected by maternal health. Thus, the literature review began the discussion by exploring maternal health issues faced by both the developed countries and the developing countries, maternal health issues in the Sub Saharan African region, as well as maternal health issues in Southern Africa. In the African context, the literature review argues that the prioritisation of maternal health issues varies across different African countries as most developing countries are grappling with a lot of political and economic issues and have limited resources to deal with all of these issues. Unsurprisingly, it is always the poor and the marginalised that mostly experience the worst health status and access to services for optimum maternal heath, and therefore maldistribution of health care in Southern Africa is identified as one of the indirect causes of maternal deaths in the region. The second part of the literature review explored the issue of maternal health norms, the literature review also discussed the patient level determinants of maternal health outcomes such as the influence of religion and cultural practices in the Southern African region.

2.1 A Global Overview of Maternal Health

According to the United Nations Population Fund, there has been a decline in worldwide maternal mortality rates, although there is room for more improvement in curbing maternal death rates- particularly in impoverished communities such as the African continent and South Asia (2017). By the year 2017, maternal mortality rates in developing countries stood at 462 per 100 000 live births in comparison to 11 maternal deaths per 100 000 live births in the developed countries (WHO, 2017). The general causes of these maternal death range from severe haemorrhage, complications from unsafe abortion, hypertensive disorders of pregnancy, as well as obstructed labour (WHO, 2017).

One of the ways which the international community has used to measure progress on maternal mortality issues across the world has been through examining the country level targets of the Millennium Development Goal 5, that aims to reduce the maternal mortality ratio (MMR). Specifically target 5A, that sought to reduce the maternal mortality ratio by three quarters, between 1990 and 2015 (Broek and Falconer, 2011). Studies show that less than 40% of the countries in the world have a complete civil registration system that can clearly attribute the cause of death, " which is necessary for the accurate measurement of maternal mortality" (WHO, 2014; Mgawadere et al, 2017).

According to the World Health Organisation's Maternal Mortality Ratio (MMR), maternal deaths per 100 000 live births), there is approximately 295 000 estimated number of maternal deaths in the Global region, with an "estimated 415 maternal deaths per 100 000 live births" occurring in developing regions and only 2 300 of the deaths occurring in the developed regions (WHO 2019;p34). The global MMR in 2017 was estimated at 295 000 (UI 270 000 to 340 000) (WHO, 2019). Out of the 40 countries with the highest MMR in 2019, South Sudan was estimated to have the highest number of MMR, which is estimated at 1150, followed by Chad (1140) and Sierra Leone (2210) (WHO, 2019). Some of the other countries with the higher numbers of maternal deaths in the Sub-Saharan African region include: Central African Republic (829); Somalia (829); Burundi (544) ; South Sudan (1150); Cote d'Ivoire (617); Guinea (576); Liberia (661) ; Niger (509); Cameroon (529) ; Guinea-Bissau (667); Mali (562); and Nigeria with 917 (WHO,2019).

2.2 Factors affecting women's health

The World Health Organization (2009) argued that in order to find efficient ways to best cater for women's health issues, it is important to acknowledge that the lives of women are shaped by factors that are: epidemiological, demographic, social as well as cultural (WHO, 2009). Although this argument was advanced by the WHO ten years ago, that argument is still relevant even in 2019. The cultural factors in this case include the religiously and culturally induced gender inequalities that affect women's health. In many countries, behavioural and other social norms determine the conduct and laws that perpetuate the subjugation of women (WHO 2009: Marx et al, 2018). Consequently, the unequal power relations and gendered norms and values lead to "differential access to and control over health resources, both within families and beyond" (WHO,2009: Marx et al., 2018). Gender inequalities also led to unequal distribution

of resources, such as income, education, health care, nutrition and political voice, which will alternately cause poor health and related well-being among women (Towns, 2010).

2.2.1 Education

With regards to education and job security, both the WHO (2009) and Towns (2010) state that it is important that women are granted the opportunity to engage fully in primary school and beyond as this is not only beneficial to the women themselves, but also beneficial for the survival, growth and development of their children. However, statistics recorded by the World Health Organization reveal that despite the impressive gains in female enrolment in primary education between 2000 and 2006 across the world, 55 % of girls can be counted within the out of school population (WHO, 2009). These "socio economic and gender-based inequalities that women face is played out in the access to and use of health-care services" (WHO, 2009). In these cases, it was found that it is the poorest women that are least likely to use health-care services because of complex reasons such as: unavailable or in accessible services., women not being able to find affordable transport, socio-cultural norms that often limit women's mobility, and interaction with the health system (WHO, 2015).

2.2.2 Developed versus the Developing World

The countries situated within Central Eastern Europe as well as the Commonwealth of Independent States have been identified as the states with the lowest cases of maternal deaths in the entire world, with the Sub-Saharan African region being reported to have the highest cases of maternal deaths in the entire world. By the year 2009, maternal mortality rates had been reduced by half in Eastern Europe (UNFPA, 2017). One of the most effective cost-effective ways of reducing maternal mortality has been through 'smart economics' as well as effective family planning, in which teenagers are taught from a young age about different ways of family planning methods and how to access them (UNFPA, 2017). Furthermore, Eastern Europe still felt that although they have halved maternal mortality rates by 2009, the fact that every day a woman dies due to pregnancy related complications means that one life lost is still "one too many" and states therefore have to do their best to totally eradicate maternal deaths in the region (UNFPA, 2017). In this regard, the population groups that have been identified as most vulnerable to maternal deaths in Eastern Europe include impoverished women, teenage girls as well as "women living in remote rural areas" in Europe (UNFPA, 2017). In the case of young women in Eastern Europe, most maternal deaths within this age group are associated with illegal abortions.

2.2.3 Abortion and maternal death in developed countries

According to Zeitlin et al (2013), most countries that consider abortions to be illegal are more likely to have higher cases of maternal deaths that are linked to illegal abortions. With the case of Eastern Europe, most countries have legalised abortions in which the abortion rates are considered to be lower than other developed countries such as North America and the Oceania (Zeitlin et al 2013). It has been observed that higher cases of abortions experienced within Eastern Europe, are usually characterised by inaccessibility to family planning methods (Zeitlin et al 2013). Some of the other reasons that have associated with unsafe abortions in Eastern Europe include new legislative barriers that make abortion more difficult, the unequal distribution of abortion services in Eastern Europe, as well as the increased of abortion costs (Zeitlin et al., 2013). Even though this region has been perceived to be a stronghold of liberal abortion laws, women living in countries such as Russia experience restrictions when they attempt to access abortion clinics as the clinics are often forced to give dubious warnings regarding abortions (Parfitt, 2011). Women are often told that having an abortion would increase their chances of getting cancer and infertility. In countries such as Poland, abortion has only been allowed in situations where a woman is raped, when a foetus is malformed, or when the pregnancy is a risk to the woman's life (Sifferlin, 2019). The restriction on abortion laws has prompted Polish Women to draft the "Save Women" law that would make it possible for women to legally have abortions during their first 12 weeks of pregnancy (Kcpura, 2016).

In a study conducted by Zordo and Mishtal (2010) on "*Physicians and abortions: Provisional, political participations and conflicts on the ground-the cases of Brazil and Poland',* it was found that in addition to lack of abortion rights and the non-engagement of physicians in the discourse on abortion rights in the political space, "poor links with women's rights groups as well as a lack of political unity within the medical community" increases the likelihood of women, particularly young women dying from illegal abortions in Poland (Zordo and Mishtal 2010). The study examined the extent to which the strong influence of the catholic church on Polish and Brazil politics have an influence on the sexual and reproductive rights in the two countries. With regards to Poland, the study refers back to the collapse of the communist regime in Poland in 1993, in which the Catholic influenced government took charge and instigated a ban of the abortion rights that were previously granted since 1956 (Zordo and Mishtal, 2010). It can be argued that the influence of the catholic church in governance in this case has institutionally influenced the implementation of international norms pertaining to reproductive

in the case of Poland. This differs from the cases in this study whereby the countries in the case comparative case study selection do not have governments that are institutionally influenced by a religious organisation, but the health seeking behaviour of women and girls in reproductive age are being influenced by their religious and cultural ideologies that they subscribe to within their immediate communities or villages. Under the polish government, women who had an interest in abortion were required to acquire permission from four physicians (Zordo and Mishtal, 2010). In addition, they introduced the conscience clause law that discouraged doctors from freely granting permission letters to women who desired to have an abortion (Zordo and Mishtal, 2010). However, the study found that the freezing of doctors' wages in the post-communist Polish government fuelled the mushrooming of private practices as a means of supplementing income from their public practice jobs (Zordo and Mishtal, 2010). Moreover, it was also established that doctors would often conduct abortions in those private practices at much higher rates without fully applying the conscience clause required by the law (Zordo and Mishtal, 2010). As a result, the fertility rates dropped drastically from 2.1 in 1989 to about 1.26 in 2008 which indicated that women did find ways of preventing births despite the existence of the conscience clause, abortion ban and the non-support of contraceptive use by the catholic government (Zordo and Mishtal, 2010). However, only wealthier women could afford those abortion services as these kinds of services were only easily accessible among the private practices in Poland, whose cost was too high for ordinary women.

2.2.4 Impact of religion on sexual and reproductive health

Zordo and Mishtal's (2010) study described above is important because it delves into the issue of the impact of religious (particularly catholic) influence on sexual and reproductive health policies i

n developed countries. When observing this issue from a global maternal health network perspective, it is evident that the Catholic church is a widely respected religious body amongst most western countries due to the fact that it is the largest Christian group in Europe. Therefore, the church tends to influence policy making to some extent in some European countries such as Poland. Furthermore, the influence of the Catholic church has even extended to the UN where the Catholic Holy See is reported to have tried to influence the United Nations to change its stance regarding abortion rights. In an effort to influence UN decision about abortion rights, one of the permanent observers of the Catholic Holy See, Archbishop Ivan Jurkovic is reported to have written a letter to the Economic and Social Council (ECOSOC) expressing the churches dissatisfaction with the Sexual and Reproductive Rights that make provision for free

abortion rights (Watkins, 2017). In response, the UN argued that the Catholic stance on abortion rights amounts to "psychological torture" on women to such an extent that this particular stance leads desperate women to choose to have abortion in dangerous ways that could be detrimental to their health (Bedard, 2014). In comparison to case studies selected in this study, one finds that there tends to be less engagement between the church and the state about issues pertaining to sexual and reproductive health. As result, religious institutions in the countries involved in the study can negatively or positively influence the translation and implementation of international norms pertaining to sexual and reproductive health, without any institution regulating whether the religious institutions are not disrupting effective cascading of the international norms or not, as it was the case in the case of the Catholic church and the UN. Although the UN holds opposing opinion to the Catholic church, there are some European states that receive large amounts of funding from the Catholic church. As a result, the church would have heavy influence on the cascading of international maternal health norms and policy implementing measures in those states.

Although, Zordo and Mishtal (2010)'s study was insightful in highlighting how the church influenced abortion laws and policy in Poland and Brazil, however, the study only showcased the influence of this one particular church through examining how the church influenced abortion policy without necessarily examining the ways in which the doctrine of the church influenced women's decision making in issues pertaining to their sexual and reproductive health. In the same vein, Thornton (1985) argues that societal differential views on abortion are generally determined by cultural conflicts in a modern world. The class conflicts are often divided according to the class stratification in which different classes are prone to follow churches that hold a particular doctrine on abortion. In this case, the Zordo and Mishtal (2010) study could have been further strengthened if it had explored doctrinal influences of the church on women's decision making on issues pertaining to sexual and reproductive health. The study could have been further enhanced if it had explored the influence of other religious influences apart from the views of the Catholic church. Such views could have explored the influence of other churches such as the Polish Orthodox Church, the Polish Reformed Church, and the United Methodist Church.

Another worrisome issue about the Zordo and Mishtal (2010) study is that the study does a comparison of the implementation of abortion laws between two countries (Brazil and Poland), although the interviews in these countries were conducted during different time frames. The data collection in Brazil was conducted in 2009 and consisted with semi-structured interviews,

whereas the data collection in Poland was conducted from 2002-2007 and only consisted of semi-structured interviews. The use of the semi structured interviews was advantageous because as much as the interviewers used some predetermined questions to guide the interview conversation, the interviewers were also flexible enough to allow for the participants to fully express themselves by providing space for the participant to talk more about an issue that is important to them but might not necessarily be within the scope of the interview guide. In this way, the interview allows the conversation to be a two-way process between the interviewer and the participant (Keller, 2017). However, conducting interviews at different time frames between Poland and Brazil is problematic because the method does not cater for other factors that could have affected maternal death rates besides the catholic influence of abortion laws and policies between the countries. In this case, while the Polish interviews that were conducted between 2002-2007 could have fully explored the issue of the catholic influence on abortion laws that could have ultimately contributed to the rise in maternal deaths in Poland, the maternal deaths in Brazil could have also been influenced by other factors such as economic reasons as the interviews were conducted in 2009 which is right after the 2008 economic crunch was identified as a challenge in the international community. In this regard, the fact that the interviews were conducted during different timeframes does not provide a standardised platform to be able to do a comparative analysis of the study. Another concerning issue about the methodology utilised in the Zordo and Mishtal (2010) study is that only semi-structured interviews were used as a method of collecting data in Brazil, whereas semi-structured interviews and survey were used to collect data in Poland. This notion presents an unbalanced ground in collecting data because Brazil does not get to benefit from the advantages of using surveys like Poland. Hence it was going to be more helpful if the study had standardised its data collection method amongst case studies to allow for a balanced comparative study.

The ways in which this study differ in this regard is that this study did not only just explore religious influence on issues pertaining to sexual and reproductive health, but it also explored structural factors that disrupt the cascading of international health norms in Southern African countries such as Botswana, South Africa and Zimbabwe. The study also found it essential to focus on case studies that are located within the same region in Africa as regional bodies such as the Southern African Development Community often have protocol and set intentions on how they are plan to tackle maternal mortality rates. For example, the sexual and reproductive health strategy for the SADC region 2006- 2015 that seeks to harmonise policies, guidelines, and protocols for the provision of sexual and reproductive services in the SADC region (SADC, 2007).

2.2.5 Migrants and maternal health care

One of the contributory factors in the rising levels of maternal deaths in some regions in the developed world has been identified as increasing levels of migrations by people from the developing countries to the developed countries (WHO, 2016). As a result, the health policies in the developed countries are often not clear on how their public health service providers can best assist pregnant foreign women in their countries (WHO, 2016). In relation to this, Sergent and Larchanche (2011), argue that migrants generally reside in living conditions that place their health at risk. It has been observed that migrants' chances of being at risk are varied across different features of migrant populations that include "gender, ethnicity, class and legal status" (Sergent and Larchanche, 2011). With regards to access to sexual and reproductive healthcare, it was found that host governments often have a negative attitude towards fertility amongst migrant population groups as they fear further increases in the number of migrants in their country might possibly increase more numbers of immigrants than citizens in their country (Fair et al, 2020). As result, migrant populations are least likely to have support systems in their host countries regarding their sexual and reproductive health care. In relation to this, the European Union has noted the increase in the feminization of migration together with the family reunification policies among EU member states calls for a specific consideration of migrant sexual and reproductive health as an issue concerning human rights (Machado et al, 2009). However, some EU countries have raised concerns about the "capacity of the EU's social and health policies to deal with newcomers' groups" (migrants) in this regard (Machado et al., 2009).

In their report on immigrant maternal and child healthcare in the European Union, Machado et al. (2009) further highlight that the under usage of contraceptive methods is prevalent among migrant populations in Europe (2009), which tends to increase their likelihood of being victims of maternal mortality as family planning generally contributes to the reduction of maternal mortality rates when used effectively (Stover and Ross, 2014). In addition, immigration status can be closely associated with maternal mortality in this part of the world due to the fact that the current regulation and legislation among EU member states does not necessarily ensure that immigrants have access to healthcare but is on the contrary restrictive towards immigrants, specifically undocumented immigrants (Fernandes et al., 2009). For example, the UK and Germany have health policies that stipulate that undocumented immigrants can only access healthcare in situations classified as 'special circumstances. In this case, undocumented

migrant women would access the healthcare services when they really have to access the medical care or when there is an accident, of which immigration officers would use the situation as an opportunity to arrest the undocumented immigrant women (Fernandes et al., 2009). As a result, most undocumented immigrant women would opt to not access healthcare services as a means to avoid the likelihood of being arrested and undocumented. Therefore, it is essential that the individual countries within the EU adopt a much more humanist approach with regards to providing healthcare services to both documented and undocumented migrants.

Other factors that places migrants at higher risk of maternal mortality in the EU includes the issue of cultural barriers and access. In this regard, Machado et al. (2009) argue that EU countries need to recognise the diversity of cultures of all peoples living in their countries as this would assist maintaining good relationships and a level of understanding between the patient and the public health systems. The authors further argue that there is no adequate research that provides insight as to how the various immigrant cultures within Europe understand and make sense of the maternal health policies in Europe, as well as how their existing cultures manage the pregnancy phase in a woman's life. This aspect of Machado et al. (2009) report relates with the current research study on the extent to which religion and culture have an influence on the provision of maternal healthcare services to women. However, Machado et al. (2009)'s report described above could have been enhanced if it had included an insight on the immigrant women's voice on their experience of maternal healthcare service in the EU.

2.2.6 Maternal deaths in United States of America

Apart from the EU, another region that tends to have an increasing number of maternal death rates is the United States of America. According to Linda Robinson (2016) who is an American Peace Corp medic and qualified midwife who has served in both developing and developed countries, maternal mortality rates in the USA has tripled since the 1980s. Some of the contributors of rising maternal deaths that she identified in the USA is the high concentration of the capitalist way of providing healthcare services in which women are manipulated into having Caesarean sections that they do not need (Robinson, 2016). In relation to this, the WHO has stated that between 6 and 15% of caesarean sections are unnecessary with the USA having an increased number of unnecessary Caesarean sections that are at 34% (Robinson 2016). This has been identified as contributory to the rising maternal deaths in the USA as the women are

more likely to experience blood clots and infections when they have caesarean sections than when they have vaginal births (Robinson, 2016).

Another contributor issue to the increase of maternal deaths in the US is the fact that women living in rural America have to travel longer distances to access maternal healthcare services, of which most of these rural women are Native American women (Robinson, 2016). This situation has been exacerbated by the fact that the health insurance reimbursement system has changed overtime in the US, whereby maternity care has become more costly and rural hospitals that generally have low volumes have made business decisions to pull out from low density areas, and thus leaving rural hospitals in understaffed conditions (Robinson, 2016).

According to Tavernise who is a columnist in the New York Times, the United States is one of the developed countries that has alarming levels of maternal mortality rates, which are highest in areas such as the District of Columbia, Texas, New Jersey, Georgia and Arkansas (2017). In addition, it has been found that the maternal death rates are highest among the black women living in these areas. Some of the overall observations about the causes of the rising maternal mortality rates in the US are attributed to the lack of preparation or protocols by most hospitals to effectively manage potentially fatal complications of pregnancy cases.

In a 2011 study entitled *'Maternal mortality in Columbia in 2011: A two level Ecological Study'*, in which the study examined the extent to which socioeconomic variables at municipal and departmental levels can have an impact on maternal mortality levels, it was found that the high numbers of maternal mortality rates in the district of Columbia was closely associated with the prevalent multidimensional poverty within that particular area (Cardenas et al, 2012). In this particular study, the multidimensional poverty level was identified as the independent variable in the study, whereas other variables such as "the overall fertility rates in the area, the percentage of the local rural population, the level of health insurance coverage in the area, and the transparency index" were considered as possible other measures of the social and economic characteristics at municipal and departmental levels (Cardenas et al, 2012).

In as much as the study mentioned above used a statistical analysis that is usually effective in "quantifying a huge range of phenomena", the statistical analysis also has blind spots that can ultimately distort the study findings if not managed properly. Some of these disadvantages of statistical analysis is sampling error which can be misleading in cases when researchers collect data using procedures that are faulty (Robinson, 2017). Another disadvantage of statistical

analysis is that it can lead to “unjustified conclusions about causal relationships” between variables. For example, statistical analysis cannot effectively explain the correlation between the overall fertility rate and the percentage of the local rural population. In this case, there could be higher fertility rates among black teenage girls in the district of Columbia because of unstable family structures or because they could generally be the highest population in the district or municipality. Such blurry lines in the correlation of variables can most probably be only cleared when in-depth interviews are conducted with some representatives of the population being studied. In this way, statistical analysis does not seem to provide “simplified answers to questions that are complex” (Robinson, 2017). In their study, Cardenas et al (2012) argue that they did not need ethical approval as their study was based on publicly available data and not necessarily information at an individual level in the form of interviews. The disadvantage of their study design is that disregards other patient driven influencers in increased maternal mortality rates such as how religion and culture affect the women’s approach to sexual and reproductive health.

In a Texas study on the increasing levels of maternal mortality rates in the USA, MacDornan et al (2016) argue that the increased levels of maternal mortality rates in recent years can be attributed to the delay in including a pregnancy question in the standard death certificate in most US states. In their study, the authors refer to the issue of the pregnancy related question in death certificates which was only included in 2003 but adopted by US states at different years, thus creating a situation where it becomes difficult to identify a trend analysis of maternal deaths causes across US states at different times (MacDornan et al, 2016). They further argue that other possible contributors to unnoticed increased US maternal mortality rates is due to the fact that the United States generally allocates insufficient funding towards issues pertaining to maternal mortality rates, of which has led to less research outputs on particular maternal mortality rates in the U.S (MacDornan et al, 2016). With the case of Texas that was also identified as a state with increased levels of maternal mortality rates in the above discussed Cardenas et al 2012 study, the MacDornan et al (2016) argues that Texas only included the pregnancy question in death certificates in the year 2006. After this adjustment in the death certificate questions, there was only a modest increase of maternal mortality rates in Texas during the years of 2006-2010, which was from a rate of 17.7 % in 2000 to 18.6% by 2010 (MacDornan et al, 2016). There was however an unexplainable doubling of maternal mortality rate in Texas during the years of 2011-2012 (MacDornan et al, 2016). In this case, the authors could not find the correlation of the doubling of maternal death rates within 2011-2012 with the added pregnancy question in death certificates as Texas made adjustments to

their death certificates in 2006 while the sudden surge of maternal mortality rates was in the 2011-2012 period.

In their methodology, MacDornan et al (2016) used a trend analysis in which they made a comparison of maternal mortality rates by groups states with similar characteristics that had included the pregnancy question in their death certificates, and grouping together states with similar characteristics that had not yet included the pregnancy question in their death certificates and then thereafter made the comparison between the two (MacDornan et al, 2017). However, their methodology could not really explain the sudden doubling of maternal mortality rates in Texas during the years of 2011-2012. One of the ways in which this particular study could have explained the sudden increase in maternal mortality rates in Texas is through studying the socio-economic conditions of different populations in Texas in order to find in-depth information on how different ethnicities or race access maternal healthcare services or find access to information pertaining to sexual and reproductive health. Although the authors argue that the sudden increase in maternal mortality rates in Texas can be attributed to the closure of many women's health clinics in Texas in 2008, the study did not really conduct interviews with physicians, medical examiners and women in reproductive years as a means to find out the trends in which Texas women use women's clinics in this particular US state.

2.2.7 Medicalisation of maternal mortality

Based on the reviewed studies on maternal mortality, it can be observed that most of the studies tend to be physician focused rather than patient focused or the balance between the two. In this case, most of the studies focus on the cause of maternal mortality rates in relation to how physicians administer or not administer maternal healthcare services to pregnant women rather than how the pregnant women choose to view the value of maternal healthcare services provided. Hence, there is tendency of looking at maternal mortality as a mere medical issue (medicalization) without considering the social cultural and ideological factors that determine women's maternal health seeking behaviour. According to Ballard and Elson (2005), the concept of medicalization refers to the "extension of medicine's jurisdiction over erstwhile 'normal' life events and experiences". In relation to maternal health, medicalisation refers to regarding pregnancy as a health condition that needs to be managed by physicians instead of regarding pregnancy as a normal rite of passage that most women experience in their lifetime. It has been observed that when the issue of pregnancy is, medicalised, there is a tendency to only seek physician related causes of maternal mortality rates. However, another school of

thought view maternal heath as a normal rite of passage for most women in the world, in that way, it allows researchers to look at other possible factors of maternal mortality other than medical such as religion, culture, ethnicity and race.

According to Ballard and Elson (2006), in the current post modern era that increasingly shows doubts in established authority structures, many sociologists of health and illness argue that the ways in which people consume healthcare in the modern day tends to resist medicalisation to a certain extent. For example, people are increasingly drawn to alternative healthcare providers such as homeopathy, Chinese medicine and traditional medicine. Ballard and Elson's argument are linked to Foucault's views on postmodernity in which he considered modern societies to be too preoccupied with healthism that considered health as a problem and the medicalised way of dealing with disease and ailments (Crawford,1980). The Foucauldian perspective portrays modernity as not necessarily an era in history, but as more of an attitude or frame of mind that was constantly criticising the ways in which assumptions were formulated by those that stood in the higher levels of society (Moore, 1995). In a postmodern attitude however, there is much more space for a variety of perspectives in the social sphere, which then ultimately denies that enlightenment is the ultimate point of view (Moore, 1995). In this case, knowledge does not necessarily mean power, but it rather comes as a result of power as it is ultimately those in powerful; positions in society that package and bring content to what the world would consider knowledge. For instance, people in powerful positions in publishing houses tend to be the ones that decide on agenda setting of research output as researchers have to align themselves to the themes of their journals in order to get a chance to be published by their publishing houses.

In tracing the conceptualisation of knowledge in the health environment, Freidson (1970) argued that the doctors situated in developed countries such as the United States in the mid-twentieth century were the ones who played dominant roles as norm entrepreneurs in issues pertaining to health. Therefore, how health is defined in international bodies such as the World Health Organisation (WHO), and how health should be managed and regulated is through the perspectives of the developed countries. This developed countries' way of understanding 'health' is characterised by the medicalisation of everyday lives in which the rites of passage that women go through such as pregnancy, childbirth or menopause are now considered to be medical conditions that should be clinically managed. The feminists in this regard argue that medicalisation is a way of controlling and managing women's bodies that has been proven to have both advantages and disadvantages for women (Costa et al, 2006). The advantages of

medicalisation for women is that the medical pharmaceutical products and technologies allows women to control when to have children, the spacing of their pregnancies as well as whether to have pain free childbirth or not (Ballard and Elston, 2005). The disadvantage however is that, capitalism has infiltrated into the health sector in such a way the pharmaceutical industry stands to have massive economic gains from the medicalisation of women's experiences of pregnancy, childbirth or menopause that only "sustains their dominant positions in society" which may not necessarily be good for women after all (Ballard and Elston, 2005). For example, Robinson (2016) who is an experienced midwife in both developed and developing countries has argued that the rise in maternal mortality rates in the US can be attributed to the system forcing them to having repeated caesarean section even when they do not necessarily need it. In this regard, she argues that almost 34% of deliveries by caesarean sections were not necessary, and they place women at risk of "blood clots, chronic pain and death" only because the healthcare system has been invaded by capitalist worldviews (Robinson, 2016). For Williams and Calnan (1996), the increasing levels of healthcare costs in developed countries such as the US have led ordinary people to start scrutinising the 'value for money' in some aspects of the allopathic healthcare sector and thus resulting in the "oscillation between medicalisation of many aspects of everyday life" (Ballard and Elston, 2005).

2.2.8 The collective approach to maternal health

In considering the comparison of maternal health care provision in the developed countries versus the developing countries, it was found that the medicalisation of maternal health care that is most prevalent in developed countries has not fully cascaded in the developing countries, more specifically within the African continent (Gilbert et al, 2002). In some African societies, specifically the ones in the remotest rural areas, western medicine is associated with colonialism that is perceived to be indifferent or hostile to local indigenous cultures (Gilbert et al, 2002). In this case, we find that there is a coexistence of the Western 'individualistic' maternal healthcare approach that is considered to be western and located in the official healthcare system, as well as the 'collectivist' maternal healthcare approach that tends to be more informal and administered by religious leaders, traditional healers as well as traditional birth attendants that are located in the local communities in African states (Gilbert et al, 2002). The collectivist approach will thus in this case emphasizes that people's differences in values and their attitudes to health has an influence on their pregnancy behaviour, and on the

conditions on which they choose to seek medical care at various stages of their pregnancy (Gilbert et al., 2002).

2.2.9 Birthing Experience and maternal health

A study by Mensah et al. (2014) on birthing by Ghanaian women reveals that the birthing experience has a personal meaning to every woman, a personal meaning that can be influenced by the women's cultural and religious background. According to Clarke (1988), the pregnancy and birthing process in Western countries such as the United States is likely to consist of more drug prescriptions, diagnostic tests and caesarean sections than in the African context that is more inclined to be less medicalised. In their particular study, Mensah et al. (2014) argue that there is indeed little research that has been conducted to find out on how birthing experiences of women in Africa can influence their decisions of where to give birth and what health care service to use in their subsequent pregnancies. They argue that the birthing experience is often associated with 'pain', of which various cultures have different ways of understanding and managing this pain (Mensah et al.,2014). In their study, Mensah et al. (2014), use semi-structured interviews as a means to garner an in-depth understanding of the experiences of women that delivered within a hospital setting in Accra, Ghana.

In the African understanding of maternal health, the Mensah et al. (2014) study reveals that childbirth is not widely viewed as a medical event in the African context. It is still largely considered to be a sacred event that has cultural and religious meanings to the women that go through it. In reflection to her birthing experience in a hospital setting, one of the Mensah et al. (2014) interviewees stated that:

> "Having lots of children is very difficult. It is a miracle that one comes out alive. Only God can save your life at that time (birth). It is hard, many women die" (Anda in Mensah et al interviews, 2014).

There is a gap in scholarly material which address the influence of religious doctrine on the implementation of International Maternal health norms in the African context, especially in cases where the birth experience is linked to religious beliefs. This is highlighted by Ballard and Elston's (2006), previous argument that in the twenty-first century, it is vital to consider the Foucauldian postmodern attitude to maternal health that does not necessarily medicalise maternal health. Thus, calling for negotiating the meanings of maternal health, and creating room from actors from various parts of the world to influence norm entrepreneurship and implementation of maternal health norms at International spaces such as the World Health Assembly.

In light of the recognition of the significance of traditional medicine to African patients, the World Health Assembly passed a resolution in 1977, in which it sought for the training and development of research that relates to traditional healing in Africa (Gilbert et al, 2002). Following which, the World Health Assembly called for introduction of the Health for All (HFA) principles that would advocate for the inclusion of both western and some useful aspects of the traditional health sector within the national health systems in Africa (Gilbert et al, 2002). Although most African countries have tried to incorporate both Western and African traditional health ways of healing within their national health systems, there have been challenges in creating a platform where both sectors can operate freely and work hand in hand in providing effective healthcare provision for patients living in Africa (Gilbert et al, 2002). For Arazeem. (2011) the allopathic healthcare sector in Africa has a Western hegemonic mentality, in which there tends to be a mistrust of traditional medicine as western medicine practitioners on the continent have a general belief that traditional medicine "defies scientific procedures in terms of objectivity, measurement, codification and classification" (Arazeem 2011.p 117). However, the objectification and scientific analysis of traditional medicine is seen as a challenge to the spiritual aspect of traditional medicine as this aspect is not something that is tangible or possible to measure in any way (Arazeem, 2011). Other challenges regarding the utility and validity of traditional healing in Africa are the increase in numbers of fake healers that are not qualified to treat various ailments. Thus, creating growing reasons for authentic traditional medicines to be mistrusted and disrespected in the Twenty-first Century African societies (Arazeem,2011) both by Africans and foreigners.

When reviewing the differences between maternal healthcare provision in developed countries and developing countries, it was revealed that there are some areas such as Poland (EU) , Texas (USA), the District of Columbia (USA), and Arkansas (USA) have experienced increasing levels of maternal mortality rates in these areas. The causes of increased levels of maternal death rates were attributed to the strong influence of the Catholic church that led to strict abortion laws that made it extremely difficult for less wealthy women to have abortions in Poland. In the case of the United States, the increased maternal death rates in states such as Texas were attributed to lack of details on information on maternal associated causes of death in death certificates which ultimately made it difficult to identify the trends of maternal death causes before the situation got worse as in the case of Texas. Other causes of increased maternal deaths in the U.S and Europe were due to the socioeconomic policies that did not really cater for immigrant women in these regions of the world. In reviewing of literature on maternal

deaths in the western world, it was discovered that most of these studies tended to medicalise maternal health care. In contrast African based research studies reviewed recognised the plurality of maternal health care that is prevalent in the postmodern world.

Many of the studies discussed above highlight not only the importance of recognising that apart from the political and economic realities experienced within Africa states, African religion and cultural contexts also play a significant role in determining the type and quality of antenatal care a woman has access . This will in turn impact on maternal mortality either positively or negatively due to the reality that African countries are part of the international community that participate in international platforms such as the World Health Assembly where various international norms were established and adopted. There is need for those norms to be translated in order to be able to cascade in African settings, including in the remotest African communities where traditional and culturally influenced understanding of health may differ from the norm entrepreneurs who oversaw their creation. Therefore, the study specifically focuses on the maternal health goals set by three countries in the Southern African region, it examined how internationally established maternal healthcare norms designed to increase access to maternal health and lower maternal mortality envisaged by MDG 5 and the 2017 WHO Maternal health guidelines. In addition, the study further assesses the extent to which medical pluralism is a feature of countries' efforts to internalise these norms and the consequences of these choices.

2.3 Maternal health in Sub-Saharan Africa

Sub Saharan Africa is one of the poorest regions in the world (Sahn and Younger, 2009). This has been attributed to lack of diversification of economies, poor governance and inequality in the distribution of resources (UNDP, 2017). Most of the times, the people that suffer the most from unequal distribution of resources are the poor people that reside in rural areas in the region. According to Transparency International, which is an international watchdog on corruption, Sub Saharan Africa is regarded as one of the most corrupt places in the world with 6 out of the 10 most corrupt countries in the world being located with the Sub-Saharan African region (Transparency.org 2016).

According Deaton (2016), Sub-Saharan Africa is rated as a region with the lowest levels of health and health-care systems. Despite this low health ratings in the region, health care is not

a primary policy for governments as the region is also grappling with what is considered to be immediate problems such as job creation, improving agriculture and tackling corruption (Deaton: 2016; Brautigam and Knack, 2004). In this case, the confluence of all of these problems creates dilemmas and full attention to health care provision becomes compromised (Deaton, 2016). According to Ezenou (2008), neoliberalism and the age of globalisation has resulted in many governments opting to cut expenditure towards healthcare and other welfare necessities for the average African person, and thus creating circumstances that exacerbate the likelihood of maternal deaths.

For neoliberal economists, the underdevelopment in African countries can be closely attributed to poor resource allocation because of the "state intervention in economic activities and improper pricing policies" (Ezenou, 2008, pg. 6). Consequently, for neoliberalist economists the solution to this problem would be free market economies that would allow market competition, free trade and foreign direct investment (Ezenou, 2008). It has been observed that the free market economic models have resulted in most African governments cutting expenditure on essential services such as healthcare and education, and many organisations retrenching employees. This has resulted in many households being left without disposable income while they are still expected to pay towards their health-care services in the public sector (Ezenou, 2008). As a way of coping with some of these economic challenges, many breadwinners in African families would migrate to either urban areas or other countries, leaving many spouses physically separated and hence increasing the chances of HIV infections. Increased HIV infections and AIDS related deaths place additional burdens on economic production as well as demand for healthcare (Washington DC Institute of Medicine, 2011). For example, Tanzania has experienced more than a million orphaned children" due to AIDS at a time when government expenditure on health was merely US$3.20 per person per annum (Ezenou, 2008). In general, the decreased government spending on health has forced many healthcare professionals from African countries to become economic migrants in Western countries (Ezenou, 2008).

Frumence et al (2013), point out that when the Sub-Saharan African region gained independence from colonial rule, they inherited health sectors that were concentrated in urban areas. Extending the health network to rural areas has been a challenge for many countries in the region. Challenges like inadequate funding, lack of mechanisms to attract human resources to work in rural areas, as well as mismanagement of funds (both locally generated and those granted by central governments) have proved to be substantial obstacles in balancing the rural-

urban divide (Frumence et al, 2013). In addition, the slow process of de-centralizing health systems in Sub Saharan African countries does lead to a top-down approach of health care provision, which has also proven to be problematic. As a result of these conditions, many average Africans (specifically pregnant women) rely on traditional healers and birth attendants for health care either because, they cannot afford to access healthcare in the allopathic sector, or because the healthcare facilities in the allopathic sector are under staffed due to high migration of nurses and midwives. This has left them with the only option of seeking help from the traditional health sector that has been inhibited from reaching its optimum level of development by neo liberal attitudes and ideologies, and thereby indirectly creating conditions where maternal mortality rates would increase (Ezenou, 2008).

Anyanguwe and Mtonga's. (2007) study on the inequities in the global health workforce shares Ezenou's (2008) views that the health sector in developing countries are understaffed and their resources inequitably distributed in such a way that there is a high concentration of the workforce placed in urban areas. Further, there is high migration to developed countries that offer attractive remuneration and working conditions. In recommending solutions to these human resources crises experienced by African countries, Anyanguwe and Mtonga (2007) recommends that African countries should diversify the health forces skillset to include other categories such as "clinical officers, surgical and medical assistants", as well as medical technicians. The study mentions that there is a need for this diversity of skillset in the health sector, specifically when considering the HIV and AIDS pandemic crises that has called the need for "increased testing among the population" in areas that are already understaffed" (Anyanguwe and Mtonga 2007). The shortfall of this study however is that it fails to consider the inclusion of indigenous health care providers in their consideration of the diversification of health care workers, even though about 60% of Sub Saharan people consider indigenous health care as an important aspect of their everyday lives (Ezenou 2008). In this case, unlike Anyanguwe and Mtonga's study, my study shall consider how various traditional and cultural practices relating to pregnancy and childcare edifies, or does not edify to the translation of maternal health international norms that are geared towards the provision of better maternal healthcare services within the Southern African region.

On the issue of the HIV and AIDS pandemic, the study does not consider that the need for frequent testing might not be the only problems experienced by the health care sector, but the issue could be the different ideological viewpoints in which some members of the population might interpret and make sense of the HIV and AIDS pandemic. For instance, some members

of African population groups associate symptoms of HIV and AIDS with ancestral and religious beliefs, and thus creating a need for the inclusion of indigenous healthcare service providers in the discourses and the implementation of healthcare policies. Therefore, Anyanguwe and Mtonga's (2007) study could have been enhanced if it included interviews of both allopathic and indigenous healthcare providers to find out how they both work together in attending to issue of low human resources in the Sub-Saharan healthcare systems. More so with regards to the HIV and AIDS pandemic which have indirect implications on the general maternal health status in Sub-Saharan Africa.

2.3.1 Total Fertility rate and Maternal Mortality in Sub Saharan Africa

In relation to maternal health, Duur and Bream (2004) argue that the Total Fertility Rate (TFR) could have an impact on maternal mortality in sub Saharan Africa. Places when fertility rates are high, complications such as the rupture of the uterus become more common, which has been identified as one of the sources of maternal mortality in developing countries (Duur and Bream 2004; Winikoff 1983). Currently (2015-2020), the Total Fertility Rate in Africa stands at 4.43, whereas that of the world stands at 2.4, which can be attributed to the low use of contraception (UNData, 2019). When contemplating the issue of high fertility rates in the 21st century context, it is important to consider that places with higher fertility rates can also be inclined to less condom use that can also result in higher HIV infection rates. It has been observed that HIV infection can have indirect causes of maternal mortality rates if the progression of the disease is not closely monitored (Velayati et al. 2007). Under such circumstances, it is vital that research studies on high fertility rates in Sub-Saharan African countries should also include new variables such as religion and cultural viewpoints on issues pertaining to sexual and reproductive health care.

2.3.2 Maternal Illiteracy and maternal mortality rates

In line with studies reviewed in the first section of this chapter, Duur and Bream (2004) also identified maternal illiteracy as another factor that causes distortions in maternal mortality rates in Sub-Saharan Africa (2004). Maternal illiteracy as a factor stems from female illiteracy affects the use of antenatal services (Duur and Bream, 2004). According to Burns et al. (2006), the issue of maternal illiteracy in Sub-Saharan Africa can be closely associated with frequent pregnancies because frequent childbirth also means that a woman does not have much control

over her own life, to get an education, and to learn skills she needs to support herself. This is specifically most common among countries that promote child marriage, which is a common cultural practice in most Sub-Saharan African countries (Odisina et al, 2019). Maternal literacy is thus important because education affects the way women use contraception and would therefore affect their Total Fertility Rate. Furthermore, the education of the mother is a strong determinant of the woman's use of prenatal care facilities, which is a factor that has a positive effect maternal survival (Duur and Bream, 2004) and (Faruta, and Salway, 2006). Literacy also affects the choice of delivery, and the skill level of the health care providers that attend to the woman during birth. In this regard, better educated women tend to prefer delivering their children in health institutions where there are skilled personnel, whereas less educated women are prone to prefer to select healthcare personnel that are more traditionally and culturally based (Duur and Bream, 2004).

2.3.3 HIV / AIDS Prevalence and Maternal Mortality

The strong prevalence of the HIV and AIDS epidemic has also been identified as a contributor to maternal deaths within the Sub-Saharan African region (Alvarez et al, 2009). (Buve, 2002) and (Zaba et al, 2013). The HIV-1 infection is the most common in the Sub Saharan African region with traditions and socio-economic developments being one of the factors contributing to the extensive spread of the infection (Buve, 2002). Some of these traditional factors include the subordination of women in mostly rural areas, the impoverishment and decline of social services, rapid urbanization and modernization, as well as wars and conflicts within the region (Buve, 2002). For Lartey (2008) and Sztam et al (2010), HIV infection among women in the Sub Saharan African region has worsened the nutritional profile of many, resulting in poor pregnancy outcomes. Sztam et al. (2010), further argue that nutrition and HIV infection do have a complex and dependent interaction, in which gastrointestinal function and nutritional status are often affected by HIV, its secondary complications, and by therapies administered to treat the disease.

2.3.4 Implementation of Maternal Health policies in Sub Saharan Africa

With regards to the implementation of maternal health policies in the Sub-Saharan African region, many Sub Saharan African countries struggle to stay on track in the reduction of maternal mortality rates (MMR). This has been attributed to weak health policies and guideline;, shortage of human resources and medicines; the stagnancy in public expenditure on health which does not meet 15% Abuja Declaration target, as well as fragmented information

systems (Tumusiime et al., 2012 & Frumence et al., 2013). The authors further argue that in order for MDG5 to be achieved, there needs to be timely national refocusing of health sector policies and commitment to health systems strengthening. Some of the ways in which the implementation of health policies can be improved in the Sub Saharan Africa region include; updating the policies and guidelines that are still in draft form and in-depth analysis of existing policies from time to time (Tumusiime et al, 2012).

2.4 Maternal Health in Southern Africa

The Southern African region is a home to over 238,8 million people that are located within 15 countries in Africa. The region experiences similar developmental challenges as the Sub Saharan African region that are characterized by poverty, illiteracy, unemployment and poor health and living conditions (SADC, 2008). With regards to maternal health, the trends in Southern Africa have not shown real substantial progress (UNICEF 2009) and (MacPherson et al. 2014). The region has been reported to have high rates of Antenatal Care registrations with the first registration being over 90%. However, less than 50% of the women who have registered for antenatal care visit the facilities for the recommended 4 antenatal visits (SADC, 2008). In addition to this, a large proportion of Southern African women deliver their children outside of health facilities. Unexpectedly, some Southern African countries have reported to have high rates of maternal mortality ratios despite having high rates health facility deliveries (SADC, 2008). This has been specifically been the case with regards to Botswana, South Africa and Zimbabwe (SADC 2008).

HIV and AIDS has been identified as one of the major contributory factors to maternal deaths within the Southern African region (MacPherson et al, 2014). Although Southern African countries have made some impressive progress in HIV prevention and treatment of women and children (UNICEF 2008)., the indirect, AIDS-related maternal mortality is reportedly still high in some countries with Swaziland at (67% per cent), South Africa at (60% per cent), Namibia at (59% per cent), and Botswana at (56 per cent) (UNICEF 2008). HIV is likely "to increase maternal deaths through direct (e.g. puerperal infection) or indirect obstetric related deaths such as anaemia, tuberculosis aggravated by pregnancy. HIV progression itself can also be worsened by pregnancy" (George et al., 2002). In previous studies conducted in South Africa, it has been discovered that indirect causes accounted for as many as half of all maternal deaths, and AIDS related illnesses were the second most common causes of maternal deaths (George et al, 2002).

The studies found out that maternal mortality among HIV-infected women in Durban were in large proportion more than that of HIV-negative women. Moreover, mortality risks were largely affiliated with HIV-tuberculosis co infection (George et al, 2002). In relation to the impact of HIV infection on maternal health, McIntyre (2004) argues that the true contribution of HIV /AIDS to maternal mortality is a challenge to measure because the HIV status of pregnant women is not always known, therefore the existing data on the correlation is largely based on estimates. In addition, the inter-related nature of maternal mortality and pregnancy may also not be clear at health service level in Southern Africa, as medical files of patients are often handled by different health workers and managers (McIntyre 2005).

2.4.1 Cultural factors

Some common cultural traditions in Southern Africa have been pinpointed as contributory factors in HIV infection among pregnant women and women in childbearing age in the region (Hardy, 1987). These cultural traditions include the expectation that pregnant women in postpartum period should abstain from sex. This results in their partners justifying having sex with other people during such times and hence increasing risks of HIV infection (McIntyre, 2005). The patriarchal setup of most Southern African communities also contributes to increased HIV infections among women in childbearing age as such communities usually have increased cases of gender discrimination, lower levels of female education, and lower levels of empowerment opportunities for women (Kinney et al.,2010). Consequently, women in patriarchal communities are left disempowered in seeking care, having autonomy to make decisions in important situations such as negotiating condom use, allocating financial resources or soliciting the best health care during the times when they are pregnant (Cohen et al., 2010).

2.4.2 Early HIV Testing and Family planning and Maternal Mortality

As a means of curbing the maternal mortality rates, the Southern African Development Community (SADC) has identified key priority areas to be addressed. These include early HIV testing for pregnant women when they register for Antenatal Care at health facilities, improving and implementing ‘safe motherhood’ and ‘family planning’ policies in hospitals. In addition, establishing youth friendly reproductive health facilities within health care facilities.

The context of the Sexual and Reproductive Health Strategy of SADC has been structured under the framework of the International Conference on Population and Development (ICPD) (1994), the Beijing Platform for Action (1995) and the Millennium Development Declaration (2005). Within the Millennium Development Declaration, the three goals related to

reproductive health matters include reduction of child mortality, improvement of maternal health, and combating of HIV & AIDS, Malaria and other Diseases (UNICEF, 2009). In this regard, these together with the 2017 WHO guidelines on maternal health constitute the international norms whose implementation the study is looking for within the Southern African context in particular how domestic cultural contexts impact on norm cascade and internalisation.

2.4.3 Inequalities in maternal health service provisions

In a study titled *'Inequities in utilization of maternal health interventions in Namibia",* (Zere et al, 2010) postulate that the poor and marginalised population groups are the ones that have the worst health status. The authors also argue that the use of skilled health care service providers is most prevalent in countries with higher levels of human development index (Zere et al., 2010). In their results, the authors identify factors associated with; 'geographical location, mother's education, rural/urban state of residence, and household wealth as some of the determining factors of women's maternal health status (Zere et al., 2010). Even though the study identifies that women who have higher levels of education are more likely to increase their chances of maternal health intervention, it fails to showcase how religious and cultural affiliation together with education level influence a pregnant woman's health status (Zere et al., 2010). In relation to this, Gyimah et al., (2005) state in their study that religion does in fact have an influence on certain aspects of reproductive health in a form of how fertility and the use of contraception should be managed. The authors further argue that they have been little research done on the link between religious belief and the utilization of services, which is an issue that Zere's et al. (2005) study had overlooked. This is the gap that this study intends to fill by examining the extent to which religious and cultural affiliation contribute to how both educated and non-educated women choose to make use of maternal health care services. The study by Zere et al. (2005) also exclusively focuses on the Namibian case study, which is also a country that is part of the Southern African Development Community. This study examines these sentiments across three different Southern African countries in order to gain insight into the trends of the causes of maternal death within the Southern African region.

Satti (2012) contends that in order to best meet the needs of women in childbearing age, it is important to adopt a comprehensive approach in health care that would "incorporate family planning at all levels of care" that would include access to obstetric care, access to ambulances, and that integrate maternity care with HIV and AIDS and tuberculosis care. Their study focuses

on Lesotho, which is a highly mountainous area in which most villages can only be accessible by foot or horseback (Satti et al., 2012). In this case, the authors hold the view that traditional birth attendants should be included in health networks in Lesotho as they could be the only way that the government can reach people who need antenatal care and HIV testing services (Satti et al, 2012). Contrary to the previous studies that have been reviewed above, this study reveals the importance of incorporating traditional birth attendants in the Lesotho health care networks. The study describes how former traditional birth attendants were provided training on how to conduct safe deliveries and were also provided with supplies of safe deliveries (Satti et al., 2012). This particular study has showcased the usefulness of integrating a different healthcare services provider on issues pertaining to maternal health care in such a way that the study results reveal the number of women accessing ANC services increased since traditional birth attendants were made part of the government maternal health care system (Satti et al, 2012). In addition, women who were HIV infected were identified within the first trimester of their pregnancy and thereby decreasing the chances of complications that could be associated with HIV infection later on in their pregnancy. Although the study can be positively credited for including community level African based maternal health care networks in the form of the inclusion of traditional birth attendants, more research on the influence of dominant religious doctrine at community level on how women choose to access healthcare during pregnancy. In addition, further studies should be conducted to establish how dominant religion at community level affects the time to first register for antenatal care, the food nutrition to consume during pregnancy, the decision to conduct medical tests and the decision to have institutionalised or non-institutionalised births. Hence this study explores these gaps through studying the prevalent doctrines of religious institutions regarding to issues pertaining to maternal health. According to Okwaraji et al. (2015) there is a dearth of literature that explores how socio-economic characteristics of women in reproductive age influence the ways in which the women use maternal health care services. These authors argue that most studies on maternal health focus on the availability or non-availability of healthcare institutions and transportation systems, but they rarely examine why some people of other religious groups would opt not use the healthcare services available.

2.5 Literature on Maternal Health Norms

In relation to the Millennium Development Goal 5, Agrawal et al. (2014) argue that international health care service providers and policy makers need to consider that more than

50% of the population in African countries make use of health care services in the private sectors that are inclusive of licensed and unlicensed providers, midwives, pharmacists and traditional healers. According to the authors' observation, locally based private health care services are normally the first line of contact for families that are in need of health care. However, in general little is known about the quality of care, or the fees that are charged within this sector (Agrawal et al., 2014). As the international community and the donor community has been so focused on strengthening the public health care system, investigations of the expanding role played by the private healthcare sector in addressing issues pertaining to maternal health care has been under-investigated (Agrawal, 2014). Consequently Agrawal (2014) argues that it is important for more research to be conducted in the private health care arena, as a means to understand the extent to which it fills in the gaps that the public health sector leaves, why some people prefer to seek private health care instead of public healthcare, and the number of local private health care facilities and the content and quality of care within the local private health care systems. Agrawal and colleagues' findings are supported by Mothupi's (2014) Kenyan study in which the author founded that it was common for Kenyan women to use a combination of western medicine and traditional herbal medicine during their pregnancy. The same study found that the use of herbal medicine was most prevalent among women with low education and skill levels. In addition, some women would not inform their public health care providers that they were using a combination of both public and herbal medicine (Mothupi, 2014). This study also revealed that the use of herbal medicine did in fact have an influence on healthcare seeking behaviour of the pregnant women (Mothupi 2014). The concern about using a combination of western medicine and herbal medicine is that there is not enough evidence to substantiate the safety or efficacy of herbal medicine. Thus, the "injudicious use of herbs or interaction of these herbs with prescribed medications" has in some instances caused some negative effects on the health of pregnant women (John and Shantakumari, 2015). Moreover, the authors state that lack of regulation regarding the prescribing and use of herbal medicine can lead to women taking more dosages than recommended or beneficial (John and Shantakumari 2015). Therefore, there is a need for more studies to be done on issues pertaining to the impact of using a combination of western medicine and traditional medicine during pregnancy, or the impact of exclusive usage of traditional healing remedies during pregnancy as a means to understand how the traditional practices affect the cascading of international norms pertaining to maternal health, particularly at grassroots level. In addition, there is a need for studies to be done on the extent to which traditional healthcare providers understand and translate national policies regarding maternal

healthcare, and if there is little understanding in the traditional sector, governments would have to create campaigns and engage with the traditional and cultural healing sectors a bit more.

2.5.1 Collaboration between traditional / cultural and public / medical health Care providers

From the above articles it is clear that there is need for more investigation into the ways in which actors located in both the public and private healthcare sector seek to address the issue of maternal health. There is also need for further investigation into how traditional and cultural healthcare providers within the Southern African context could collaborate with public health care providers in sharing expertise and providing optimum maternal health care services for pregnant women, Thus, decreasing maternal mortality rates. Exploring these types of partnerships is important as a lot of rural pregnant women cannot afford the service fees in public health care. Thus alternative/herbal medicine functions as an alternative in maternal health care provision. Moreover, patients feel that they can easily connect with herbal health care providers because of shared culture and ideological viewpoints in health (Gilbert et al, 2010). Therefore, the study aims to investigate this issue further by interviewing public health care providers as well as alternative or traditional healthcare providers to understand how both sectors translate and implement international norms pertaining to maternal health. The understanding how the different sectors translate and implement the international norms would assist in identifying some of the stumbling blocks in the effective cascading of the international norms at grassroots levels within the three case studies selected in the study.

2.5.2 Effective International Norm Cascade

For effective norm cascade to happen within a region, there has to be a strong network of actors that promote those international norms across various sectors of society (The Health Foundation, 2014). According Smith and Rodriguez (2016), the prioritization of maternal health as an international norm can be traced from the 1970s, through to the 1990s as a result of increased networks of organizations and individuals committed to reducing maternal deaths. During the 1980s in particular, the feminist women's health movement established a new goal to create a women-centred health system, rather than the existing health system that was often insensitive to women's needs (Tavaana, 2017). It envisaged that, feminist activists would educate themselves about the female body, establish women's clinics as well as publish books on women's health (Tavaana, 2017). Smith and Rodgriguez, (2016) observed that maternal health reached an increased stage of agenda status in the early 2000s, through the establishment

of the Millennium Declaration that included the reduction of maternal deaths as Goal 5. Establishing improved maternal health as an MDG was significant in that it focused on international and domestic attention on the issue. This saw an important increase in government policies and programmes seeking to expand access to maternal health services for all pregnant women and reduce maternal mortality (Smith and Rodriguez, 2016). The same authors argue that maternal health gained attention during this time particularly because of the activism of norm entrepreneurs that advanced women's health rights issues in the form of conventions such as the Convention of Elimination of Discrimination Against Women (CEDAW) (1979), and Decade for Women (1975-85). These sentiments are shared by Smith and Shiffman (2016) who also argue that maternal survival became a global health priority" when the Millennium Declaration was established in the late 90s. However, despite gaining limelight at a global level, as rightly observed by Smith and Rodriguez (2016), it can be argued that the attention paid to maternal health did not take place at an equal pace across the globe. Western countries in general have been far quicker to engage with and internalise international maternal healthcare norms than those in the global South. Moreover, in considering the era in which the activism on women's health became popular in the 1970s and 1980s, it must also be noted that women living in Southern African countries were facing a different type of dynamics and challenges in comparison to the women living in the Western countries (Geiger et al, 2002). In the 1970s and 1980s, most African women were preoccupied with participating liberation struggles in the form of providing food, shelter, clothing to guerrillas (Geiger et al, 2002). At this time, Southern African women were "hailed internationally as women who rose above traditionally subordinate gender positions in order to fight equally with men in the struggles for national African independence" (Geiger et al, 2002: pg.305). In this case, it is important to realise that the role that the African women were playing during the liberation struggles is almost the similar roles that women in western countries were playing during the World War II, and thus by the 1970s and 1980s the feminist movement had already advanced in the West to such an extent that women were advocating for the consideration of women's rights in health policy whilst the African women were still in the earlier stages asserting themselves in the liberation struggles, something that western women had already done in World War II.

In his 2011 address on the Global Strategy for Children's and Women's Health, former UN Secretary General Ban Ki Moon highlighted the importance of cohesiveness and working together by different stakeholders in tackling the MDG 5 and 6 concerning the prevention of children and maternal deaths. He identified the stakeholders as 'governments and policy makers, donor countries and philanthropic institutions, the United Nations and other

Multilateral Organisations, civil society groups, the business community, health workers and their professional associations, and academics and research institutions. This he argued would ensure that all stakeholders were aligned in their approach to addressing the maternal deaths, as well as ensuring that there was no overlapping of policies that would ultimately jeopardise efforts to curb maternal deaths.

In dissecting this issue, studies show a predominance of top down approaches of policy making in the organs of the United Nations such as the WHO, whereby the US and other powerful economies always drive the agenda in a way that favours their cultural values and ways of understanding health. When this happens, representatives of African countries are often intimidated to advocate for the incorporation of ways in which Africans understand health and hence they just opt to sign to oblige by international norms and conventions that are to a certain extent in conflict with their cultural views. Consequently, no cascading effect of international norms and conventions pertaining to maternal health as African countries are challenged to implement the policies at national and community levels in their own soul. It is in this regard that this study aimed to explore the ways in which culture and religion had an influence on the translation, implementation and acceptance of maternal health policies in the Southern African region.

Within the Southern African context, the overlap of policies can ultimately occur when governments pledge and commit to ensure that all pregnant women have access to adequate antenatal care through insuring that they spend at least 15% of their national budget towards healthcare as stipulated in the ICPD. However, it has been observed that although these governments are prepared to spend at least 15% of their budgets on healthcare, the religious and cultural beliefs of the local communities may restrict them from fully accessing the provided ante natal healthcare services. Moreover, their decision cannot challenge, in view of the African Human and People's Rights regional norms which state that all citizens of the continent have a right to practice any religion and cultural practices of their choice.

In the era of the Millennium Development Goals together with the new Sustainable Development Goals, the health networks that drive the maternal health agenda within the African network are mostly donor organisations from western countries (Miers 2011). The negative effects of such a setup is that when a network is set up by donors with minimum input from the local communities, the networks are least likely to be fully accepted by the local communities, whereas "networks that emerge from grassroots" are more likely to be

extensively supported and accommodated by the local communities (John and Shatakumari, 2015). In support to this, Smith and Rodriguez's (2016) study postulates that effective norm cascading is most likely to take place when there are diverse networks within the cause. These diverse networks would in this case include stakeholders such as 'activists, advocates, policy makers, and others "from high- and low-income social status within the international community.

Within the African context, the main stakeholders/participants in maternal health networks include organizations such as; USAID's Maternal and NeoNatal Health Projects, The UK's Department of International Development (ODA) that has largely supported projects in countries such as Nepal and Malawi, UNICEF and UNFPA that have contributed towards creating national programs pertaining to maternal health, as well as the Bill and Melinda Gates Foundation that has contributed to the reduction of maternal mortality rates via "Columbia University and Family Care International" (Campbell 2001). Within this maternal health networks, there tend to be a predominance of western researchers or western funded research on issues pertaining to maternal health in the region. Hence, the need for more maternal health research projects that are conducted in Africa, by Africans and through African funding streams so that more African perspectives can be captured about issues pertaining maternal health care on the continent.

Despite the enthusiasm surrounding the MDGs, Shiffman (2007) argues that the process towards Millennium Development Goal # 5 has been too slow and government commitment generally too low. In the SDG era, the process towards lowering maternal mortality rates would need to include a more multisectoral action, include innovation and research, and enhance more community engagement in the plans to curb maternal mortality rates in the region (Pillay and Barron, 2018). Within the African context, maternal health issues have not experienced extensive attention because African countries are often grappling with issues such as inadequate funds," lack of consensus on intervention strategies", as well as health systems that are not strong enough (Shiffman, 2007). The same author highlighted that to be effective in expanding access to maternal health as well as instituting initiative to lower maternal mortality requires effective local political entrepreneurs that have strong characteristics. These include persistence, excellent abilities to establish coalitions, ability to appeal to the improvement of social values and the ability to influence subordinates to have a strong sense of mission towards the cause (Shiffman, 2007). Thus, it is fundamental to realise that norm cascade and internalising lie within the country itself requiring champions among government, the public

and private healthcare sectors as well as civil society. Without these actors working in partnership to create policies and programmes as well as mobilising the necessary resources international maternal health norms will remain unimplemented and maternal mortality will escalate. Shiffman (2012) also argues that maternal health will only become an issue of priority when there is enough domestic advocacy of it through domestic actors such as "ministries health, parliamentarians, doctors, obstetricians, gynaecologists and health focused nationals that are employed by donor agencies" (Shiffman, 2002). Thus, the author's view norms are irrelevant if they remain at the international level. He also highlights that although international actors may act as norm entrepreneurs it is far more effective if local actors take over control of the process of realising these norms at the domestic level as they should be most sensitive as to how to adapt the norm to suite local cultural contexts enhancing the likelihood of it eventually becoming internalised. It can be argued that in Sub Saharan Africa, this goes beyond merely involving local government and healthcare professionals. Due to the way maternal healthcare is accessed in these regions, traditional birth attendants and cultural experts must be included as they have strong influence on women's maternal health seeking behaviour. Shiffman (2007) does concede that "cultural barriers place a low value on women's rights" and thus need to be addressed but does not include the cultural actors in his study on maternal health.

The effective organisations of networks constituted by international organisations as well as non-governmental organisations are critical in achieving effective maternal health policies. They must be skilled in "securing global agreements, attracting funding, producing policies, developing interventions and generating national commitment to scale up interventions (Shiffman et al, 2015). At times when the global maternal health networks engage in issues pertaining to reducing maternal death rates, actors usually operate from a rationalist point of view in which they participate in normative concerns that are in line with their idealised way of seeing and understanding health (Shiffman et al, 2015). Other authors have found that within the global health networks such as the Global Fund for HIV, TB and Malaria, World Bank and the World Health Organisation, African actors are rarely in favourable positions to assert their agency in issues pertaining to policy direction and agenda setting (Barnes et al, 2015). It has been observed that very few African countries are able to participate in formal structures of global health networks (Barnes et al.,2015). They are however able to participate in informal spaces even though it is only the elite African countries that can extensively participate in these spaces (Barnes et al 2015). In this case, there is a hierarchy of participation whereby the ability to participate is determined by factors such as one's position within government, relationships

to external funders and awareness of informal opportunities for participation" (Barnes et al 2015). For political economists, the actors with the greater financial power in global health networks are most likely to have a much stronger influence in the direction of the economic, political and social developments of the health cause (Browning and Kilmister, 2006). Drawing back to Shiffman et al's (2015) study, the authors state that better outcomes by health networks are more likely to be achieved if there are diverse groups that are part of the network as this will increase the likelihood of a wider representation of population groups.

2.6 Literature on how culture impacts on maternal health

In a Ghanaian study investigating the degree to which traditional healers are included in obstetric care, Aborigo et al (2015) argue that traditional health systems are a first preference for most people living in Ghana, particularly within the rural areas. They found that there was a strong element of trust between the local communities and the traditional leaders due to the shared culture and religious beliefs. The reasons why some people generally preferred traditional leaders than the public health service was because they felt that surgical procedures were overused and that there was a general "lack of confidence in formal maternal health services" (Aborigo et al, 2015). Traditional healers were able to provide treatment for jaundice complications, "prolonged labour; retained placenta; obstructed labour; still births; minor haemorrhage and termination of pregnancies" (Aborigo et al, 2015). However, the traditional healers stated that there were some areas in which they were not able to perform such as blood transfusions or intravenous treatments (Aborigo et al, 2015). Thus, traditional healers could not assist pregnant women with severe haemorrhaging or dehydration as well as women needing advanced obstetric care such as a caesarean section (Aborigo et al, 2015). Realising that there was a limit to the services they could provide during pregnancy and birth, traditional healers displayed an interest in working closely with medical doctors and midwives as they shared a common goal of wanting to provide the best healthcare for women in reproductive ages (Aborigo et al, 2015). Although Ghana has opted for an integrated system of health care which includes the integration of traditional healers within the overall health system, this has not been largely translated from policy into practice (Aborigo et al, 2015). Ghana had established the Traditional Healers Association in which all practicing traditional healers were required to register in the association, but most traditional healers interviewed stated that they had not registered in the association because no one had informed them that this was necessary.

A demographic health survey (2013-2014) of the Kozah District, Northern Togo revealed that women were the principal decision makers in issues pertaining to accessing health care services in only 12% of the cases (Arnold et al., 2016). The same study revealed that male partners had a considerable say in these matters often based on their cultural beliefs. Thus, educating and involving men on maternal health was deemed important. Furthermore, most rural women did not see the need to have earlier access to antenatal care services because of the cultural perception of the meaning of pain. In one interview, a woman is identified to have stated that;

> *"I am not in pain and the belly is not showing, so why should I go to the check up early"* (Arnold et al, 2016).

This study again found that the amount of education attained by women had a significant impact on expanding their agency regarding maternal health choices. Mooney and Loft (1989) comment more generally that one of the reasons why it has been difficult for the African national health care system to implement health policy is because there are fundamental uncertainties about the ways in which people define and understand the term "health problem" (Hunter 2003:21). This is due to the influence of traditional beliefs on people's definition of health problems warranting consultation and treatment by a healthcare professional. Uncertainties can also exist within the allopathic health sector alone apart from the traditional health sector (Robinson 2016). For example, people involved in national health policy formation can have disagreements on how to rate the health status of a population as mentioned earlier in the literature review (Robinson 2016).

Sialubanje et al (2014) researching in the Kalomo district, Zambia also found that the majority of women register for antenatal healthcare services late and many do not use postnatal services that are offered within the allopathic healthcare system. The study also revealed that more than 50% of "women in Zambia did not complete the required four antenatal visits during pregnancy", and over 60% of pregnant women did not access postnatal care (Sialubanje 2014). This is at odds with WHO guidelines that advocate accessing maternal healthcare services from the earlier stages of pregnancy right until after birth. Reasons given by women for this behaviour include; negative attitude of medical staff, an overall negative opinion on the effectiveness of allopathic healthcare services, as well as some "physical and economic barriers" that include having to travel long distances to access allopathic healthcare services and indirect costs involved associated with baby clothes and other requirements (Sialibanje 2014). In concurrence, a study conducted in Ghana by Hill et al (2014) revealed similar results, that many of the allopathic healthcare providers seemed to be disconnected from the culture of the communities in which they serve and as result, patients felt more at ease with the traditional

health care providers as they were more knowledgeable and more aware of their local cultural beliefs and practices. Gilbert et al (2002) concur and argue that the increased cultural complexities within modern societies have led to health care pluralism. They further argue that healthcare pluralism encompasses the coexistence of different medical systems that draw their knowledge from different worldviews. Hill et al. (2014) state that a medical pluralist approach to maternal health would mean including "orthodox/allopathic/professional modern/western sector as well as the folk/alternative /traditional sector" (Gilbert et al, 2002). Kleinman (2003, 58) suggests that is a complex society that a medical pluralist approach would involve identify an overlap between the *allopathic sector itself, as well as the overlap between the allopathic sector* and the *folk sector*.

Abdallah (2015) delves even further to determine the influence of beliefs or normative beliefs on urban women's decision to access free maternal healthcare services as well as where they choose to give birth. This study supports and adds knowledge to many of studies reference in the last two paragraphs Using the theory of planned behaviour the research found that women chose not to access free maternal healthcare services mainly due to "poverty, cultural beliefs, lack of awareness, distance to healthcare services, and shortage of professionals" (Abdallah, 2015). Further it was found that many women from different cultures and religious beliefs regard pregnancy as a spiritual event, and thus sought spiritual advice from traditional healers before they could access the free maternal health care services provided in public health. Moreover, many women chose to use a combination of allopathic, spiritual and the herbal healthcare services during their time of pregnancy.

2.6.1 Religion and maternal health

Related to the issue of religion raised in Abdallah's article, Johnson and Well (2014); Amanze (2006); Oni-Orisan (2015); and Pretorius (2007) all concur that western religious groups have gained exponential traction on the African continent over the last two hundred years. These groups range from the Catholic Church who established missions from colonial times to more modern Pentecostal groups. The values that these groups bring an additional layer to cultural practice and are either hybridised with existing traditional cultural values or supplant them thereby creating new ones. Thus, access and adoption of maternal healthcare facilities are now also influenced by the precepts of various religious ideologies that prescribe gender relations as well as how the issue of health is addressed. Johnson and Wells (2014) trace the increasing

role Catholic nuns came to play in providing maternal healthcare services through missionary services. Consequently, this has entrenched the religion's norms regarding maternal and reproductive health such as a ban on abortion and contraception or negative perceptions of pregnancy out of wedlock. This is significant as Catholicism is the dominant form of Christianity practiced in most African countries. Oni-Orisan (2015) argues that the rapid Pentecostalism in Africa, particularly Nigeria has reached a point of "confrontation with state maternal health programs", whereby by state health care service providers are associated with secularization to such an extent that a large number of women are increasingly giving birth at Pentecostal mission homes that shun biomedicine and opt to use prayer alone to assist women when giving birth.

2.6.2 Medical plurality Approach to maternal healthcare

Finally, Satti et al's (2012) proposed the establishment of a medical pluralist approach to the provision of maternal healthcare in Lesotho and the benefits derived thereof. Lesotho being a mountainous country makes it difficult access healthcare facilities especially those living in rural areas. Most of these people are reliant on horseback services for transportation to healthcare facilities. A desire to provide better access to these services in order to decrease maternal and infant mortality as well as HIV infection has encouraged partnerships between the allopathic and alternative/traditional health sectors. In particular the majority of births took place at home without medically trained attendants. Partners in Health (PIH) and the Lesotho Ministry of Social Welfare (MOHSW) established a pilot programme that provided comprehensive maternal healthcare from "community to the health centre level", in which they gave the traditional birth attendants the responsibility of being community health workers. This established a working relationship between the allopathic health sector and the traditional sector through engaging with them about the complexities of home deliveries, the importance of HIV testing for pregnant mothers, and the importance of record keeping of patient notes (Satti et al, 2012). Traditional birth attendants were also provided with extra skill techniques of delivery as well as given monthly remunerations for working closely with the allopathic health sector. This collaboration of the allopathic and the traditional birth attendants in Lesotho illustrate how dialogue and engagement between the two sectors can in the long run be beneficial to the lives of rural women in Lesotho and build trust, respect and a mutual exchange of knowledge between these two groups. However, the complaint was that the exchange of knowledge was one-sided with allopathic practitioners only wanting to provide traditional birth attendants with conventional knowledge and not necessarily wanting to learn anything from

them. Wilcox et al (2105) state that this inability to conceive of maternal healthcare more holistically, beyond that of a medical issue, actually continues to alienate populations from the conventional or allopathic healthcare sector and limiting their likelihood of using their services. This in turn limits the success of the implementation and internalisation of international maternal healthcare norms.

2.6 Chapter Summary

In conclusion, the literature review has provided a discussion on the context of what is known about the state of maternal health in the developed verses the developing countries, Sub Saharan African region, and the Southern African region. The literature identified maternal health to be among the top six global health problems that lacked proper coordination and adequate representation of all the persons involved and affected. The literature recognised the need to include religion and culture as additional variables in research studies regarding maternal health as health care pluralism. The literature review also revealed that, it is always the poor and the marginalised that mostly experience the worst maternal health status and access and are more inclined to seek care in religious and indigenous settings. Finally, the review of literature also highlighted the state of maternal health norms in the African context and the possible causes of slow norm cascade in developing countries compared to developed countries.

CHAPTER THREE

ANALYTICAL FRAMEWORK

3.0 Introduction

This chapter provides a discussion on the life cycle of maternal health norms as an international human right. The chapter firstly establishes the criteria for selecting norms for specific international instruments. Further, the chapter briefly discusses the emergence of these instruments in relation to their impact on the human rights of women in general or women's maternal or reproductive health. The purpose of this discussion is to narrate the process of norm emergence in relations to women's maternal and reproductive health. Finally, the chapter concludes by presenting the norms that have been selected from these instruments to form the analytical framework which was applied in the three case studies. This was done to determine their progress in realising each maternal and reproductive health norm, as according Finnemore and Sikkink's norm life cycle model. The framework will also be used in the next three chapters to facilitate the analysis of the domestic issues hindering or assisting in moving each norm closer to the final stage of norm internalisation.

3.1 Norms related to maternal and reproductive health

Norms that have come to constitute a framework for maternal health can be derived from a variety of sources and may vary according to the operational perspective of a particular country, organization or researcher as explained by the theory of social constructivism discussed in the introductory chapter. As such the norms outlined in constructing the maternal health framework in this chapter which was then used to interrogate the extent to which these norms have cascaded and had been internalised within the three case studies, may probably differ from other researchers. Thus, in no way does the researcher claim that the norms chosen for inclusion in the framework are inclusive of every norm that may exist relating to maternal health. However, effort has been made to construct the analytical framework from what the researcher deems to be key to international instruments created under the auspices of the United Nations that establish general norms regarding the human rights of women together with those that specifically set norms regarding maternal health. Further, the study's criteria for selection was based on the premise that norms within the international instrument must enjoy widespread acceptance or accession to by the majority of countries constituting the United Nations. Again,

it must be noted that although some of these norms form part of international law, not all norms are legally binding on states. A norm, in general, merely specifies a general standard of behaviour as well as delineating the rights and obligations of states in relation to upholding the norm (Finnermore and Sikkink 1998). Nevertheless, how a state chooses to internalise a norm and interpret its incorporation within its domestic policy framework and context is usually determined by intra state dynamics and actors therein (Finnermore and Sikkink 1998). An additional reason for only selecting international instruments is that Finnemore and Sikkink's (1998) in the model of norm life cycles locate norm emergence at a supra-state or transnational level. The construction of the analytical framework was strongly informed by the universal rights of childbearing women as set out by the White Ribbon Alliance (www.whiteribbonalliance.org/respectfulcare). Based on this criterion the norms chosen for inclusion in this analytical framework have been drawn from:

1. The Universal Declaration of Human Rights, 1948, as executed through the International Covenant on Civil and Political Rights (ICCPR) 1966 and the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1976.
2. The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), 1979.
3. The Millennium Development Goals together with the Sustainable Development Goals.

3.1 The Universal Declaration of Human Rights (UNDHR), 1948, as executed through the International Covenant on Civil and Political Rights (ICCPR) 1966 and the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1976 as platforms for establishing norms relating to women's maternal and reproductive health.

Although the UNDHR forms the foundation of the current international human rights regime, it is not legally binding on member states as it is only a UN Resolution. It is through the ICCPR and the ICESCR that the human rights from the UNDHR have been translated into international law. The Declaration and two Covenants are evidence of the work of various Post-World War Two norm entrepreneurs wanting to establish the respect for human rights as an international norm. Despite being a virtuous cause, the efforts to establish such a global regime has been fraught with difficulties such as . In particular, the type of human rights and the degree to which they are internalised and upheld have largely to date been determined by individual states. However, with emergence of the Responsibility to Protect as an accepted UN norm, the

exclusivity states once exercised over the practice of human rights within their territory has seen some erosion. Further the liberal individualist conception of human rights set out in the UNDHR and the ICCPR often conflict with cultural norms and values present at intra-state level and upheld are simultaneously argued by certain groups to be upheld by the ICESCR.

3.1.1 Norms, culture and religion

When it comes to the norms pertaining to the practice of religion, the international community has stipulated in the 'International Covenant on Economic, Social and Cultural Rights' and the 'International Covenant on Civil and Political Rights' some provisions that address issues pertaining to the discrimination against women's rights, rights of the child, minorities as well religious instruments (OHCHR, 2017). The challenge with the issue of the freedom to practice religion in the African context however is that in the context of globalisation, there is a "confluence of cultures" in a world that has a multicultural ways of living and thus resulting in societies that are filled with "cultural tension, confusion and conflict" as different cultures try to adjust their original cultures to the widening pluralism of cultures that is common in todays globalised world (OHCHR, 2017). In his article about cultural wars, Kellner (1995) argues that the multicultural postmodern world of today is characterised by cultural wars between conservatives, neoliberals and progressives present in most states. In terms of the global health networks, the progressives would be those within the allopathic healthcare sector that aim to bring about universal healthcare coverage that would take into consideration the holistic care of the patient that considers various aspects of a patient's life such as the "social determinants of health, whether the patients have stable and affordable housing, a living wage and well-funded public education" (Tsega 2017:1). The neoliberals, on the other hand believe that social needs can be best met under the conditions of a free market system (Bodenheimer, 2017). Neoliberals no longer focus on the needs of each person individually but argue that the individual needs of each person should be balanced out with the overall needs of the community (Bodenheimer 2017). In this regard, the neoliberal approach to health manifests itself through the ways in which it has convinced parliamentarians that the state involvement is not the best way to manage healthcare provision, but it should be rather left to the private sector that are often characterised by state reduction of social spending towards healthcare and overall welfare activities by the state (McGregor 2001). As a result the state finds itself not being able to intervene when the market forces tend to prioritise profit making over the welfare of the people as has been seen in the effects of structural adjustment programmes within the African setting, where public healthcare services introduced fees payment for consultation and medication by

patients (McGregor, 2001). Moreover, in the twenty-first century healthcare provision, there are voices of the conservatives which come in three strands that include; social conservatives that focus on traditional values, fiscal conservatives that focus on balanced budgets as well as economic conservatives that are more slanted towards a 'laissez-faire economy with minimal government intervention" (Bodenheimer 2017). With regards to women's access to maternal healthcare in the twenty-first century, most social conservatives in African countries would maintain the traditional practices of health care that include the contributions of traditional healers and traditional birth attendants. The cultural wars that Kellner (1995) mentions would result in traditional healers and traditional birth attendants to cling on to their own methods of healing, and in a way resisting interference from the allopathic healthcare providers and the state regulatory bodies. These issues were assessed when considering the extent to which maternal and reproductive health norms have cascaded and internalised within the three case studies. However, the germinal nature of these three instruments should be acknowledged given that their rights identify vis-à-vis women' rights are confirmed and drawn upon by CEDAW: the Beijing Platform of Action, the MDGs and the SDGs.

3.1.2 Norms related to maternal and reproductive health instruments

The following are the key norms from these three instruments relating to maternal and reproductive healthcare that were selected to form part of the analytical framework:

1. All women have the right to be free from harm and ill treatment. (ICCPR, 1966, Article 7)
2. All women have the right to privacy and confidentiality. (ICCPR, 1966, Article 17)
3. All women have the right to be treated with dignity and respect. (ICCPR, 1966, Article 2)
4. All women have the right to equality, freedom from discrimination and equitable care. (ICESCR, 1976, Article 2; ICCPR, 1966, Article 2)
5. All women have the right to liberty, autonomy, self-determination and freedom from coercion. (ICCPR, 1966, Article 9.1 & 18.2; ICESCR, 1976, Article 1)
6. All women have the right to healthcare at the highest attainable level. (UNDHR, 1948, Article 25)
7. All women have the right to information, informed consent and refusal, as well as respect for her choice of companionship during maternity are wherever possible. (ICCPR, Article 7 & 19)

3.2 The Convention on the Elimination of all forms of Discrimination against Women (CEDAW)

CEDAW is an international treaty that was adopted in 1979 by the UN General Assembly to establish pathways for women to enjoy their human rights. The CEDAW international treaty falls under the Economic, Social and Cultural Rights (CESCR) which form part of the Universal Declaration of Human Rights (UNFPA, 2019). The Economic, Social and Cultural Rights have however been second generation rights which are less of a priority in comparison to the civil and political rights (Eide et al, 1995). The ideological and technical nature of the Economic, Social and Cultural Rights has brought complications on these types of rights. As a result, courts and other judiciary bodies have found them to be difficult to implement and monitor in comparison to the civil and political rights that are much easier to implement by judiciary systems (Eide et al.,1995). For the Economic, Social and Political rights to be effectively implemented, the state would need to ensure that it provides adequate welfare for individuals. Moreover, the ideological nature of these rights can be complicated to universalise because what is considered to be justifiable rights in one country may be considered as more aspirational than justifiable (Jung and Hirschl, 2014). Also, for the economic, social and political rights to be taken seriously, the country leadership would need to show commitments to equal income distribution, social integration, and issues concerning solidarity, of which are difficult issues to tackle considering that people hold various ideological and cultural perspectives in the world (Eide et al, 1995). Another school of thought argue that the economic, cultural and political rights are so many to such an extent that it becomes difficult to maintain and monitor them, as a result some countries would allocate most of their budgets towards military maintenance over issues such as education expenditure, which would ultimately lead to decreased enrolments in schools (Overseas Development Institute, 2008). In an African context this can be a challenge as Non-Governmental Organisations who usually play a central role in social justice, fresh thinking and new developments often face resistance from oppressive regimes and hence decreasing the likelihood of proper respect for the economic, social and cultural rights (Eide et al, 1995).

3.2.1 Overlapping of economic, cultural and political rights

Another factor that can complicate the implementation of economic, cultural and political rights is that the rights tend to overlap in certain aspects. For example, the issue of land allocation and redistribution which is usually aimed at rectifying the injustices of the past, the land redistributors tend to use the culturally and religiously influenced patriarchal ideologies

where women are allocated land through land proxies. As result, the redistribution of land ends up reinforcing another form of inequity and dependency on the population group that is on the lower levels of the hierarchy (which is usually women). Hence, the notion of cultural rights tends to be more complex in this regard (Eide, 1995). The same can be said about educational rights where some cultures prioritise male education over female education. As a result, this hinders the prospects of the emancipation of women in their ability to make their own independent decisions regarding important issues concerning their lives (i.e. how to access healthcare, access to education and freedom to be key decision makers in family and social environments).

McChesney (2000), suggested that although some states share the inspiring ideals of human rights in the form of providing optimum welfare towards citizens, there is the depressing reality that most states just do not have strong enforcement mechanisms, police forces and court systems that would sufficiently attend to possible neglects of economic, social and political rights within the domestic spheres of states. When the International Human Rights system largely relies on states voluntary co-operation in the implementation of International Human Rights, states in many parts of Africa become challenged in this area as the tradition of rights discourse on the continent is "underlined by several aspects of local history", (Ibhawoh, 2007, 2). Some of these underlying aspects of local history include colonial legal systems (usually regarded as common law), "contestations over land, press activism, and the nationalist movement" (Ibhawoh, 2007, p2). In this case, these underlying several aspects of local history end up receiving more attention by the African states instead of the recent concerns of universal human rights that the CEDAW falls under (Ibhawoh 2007). For some Africans, international human rights have been perceived as inherently colonial as they are regarded as challenges to the practice of sovereignty in the name of universal standards that have been established by the Western countries (Ibhawoh, 2007).

According to An-Na'im (2003), the issue of universal human rights tends to be both practically important and conceptually problematic because international law assigns states to be responsible for the protection of human rights. Moreover there are only provisions for the law to be applied when the state, state official and institutions abuse the Internationally set human rights, and not necessarily when other actors in a national setting violate human rights (An-Na'im , 2003). The same author highlighted that the principle of International law of national sovereignty that is guided by the UN Charter does not necessarily address the violation of human rights "except through the agency of the state". Within the context of prevention of

maternal deaths, it is important that the expectation to protect human rights should be shifted beyond the state perimeters to be inclusive of partnerships between the state and civil society groups that campaign for reproductive and human rights, health professionals and others. This expected to contribute towards the reduction of maternal deaths (Ray et al, 2012). This is due to the consideration that maternal deaths can be caused by various factors ranging from difficulty accessing healthcare facilities, the cultural factors affecting women perception of the importance of seeking health care during pregnancy, as well as underlying chronic medical conditions that can place them at risk of maternal death (Lowe et al, 2016). Hence, it is essential to have partnerships between the state and civil society groups as this would ensure that the various causes of maternal deaths are tackled at deeper levels.

3.2.3 Key Norms in CEDAW relating to maternal health

The following are the key norms in CEDAW relating to maternal and reproductive healthcare that have been selected to form part of the analytical framework:

1. States must ensure that all women have the right to equality, freedom from discrimination and equitable care. (Article 1, 2, 3 & 5)
2. States must ensure that rural women in particular have the right to access adequate healthcare facilities including information, counselling and family planning services. (Article 14)
3. States 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, including those related to family planning. (Article 12)
4. States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning. (Article 10 & 14)

3.3 The Beijing Platform for Action (1995) together with the UN Fourth Conference on Women

The Beijing platform for action draws its central tenets from the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and both refer back to, support and extend clauses from the UNDHR, ICCPR and ICESCR. It is structured in a way that shows the

joining together of the "political and legal processes to underscore" the central issue of human rights in the struggle of gender equality matters on a global scale (United Nations, 1995).

The following are the key norms relating to maternal and reproductive healthcare that the study has selected to form part of the analytical framework:

1. All women have the right to equality, freedom from discrimination and equitable care. (Article 28)
2. All women have the right to healthcare at the highest attainable level.

3.4 Millennium Development Goal 5 (MDGs) and the Sustainable Development Goal 3 (SDGs)

The establishment of the Millennium Development Goals can be traced to the Millennium Declaration, in which world leaders adopted the Millennium Declaration that was geared towards committing their nations to a new global partnership as a means of reducing extreme poverty (Millennium Project, 2002). In the Millennium Declaration of the year 2000, one of the quantified targets for addressing extreme poverty is improving maternal health, in which there was target 5A that focused on reducing Maternal Mortality Rates by three quarters between 1990 and 2015, and target 5B that focused on reducing achieving by 2015, the Universal Access to Reproductive Health (Millennium Project, 2002).

Some of the noted goals and achievements of the MDG5 included a 45 percent worldwide decrease of the maternal mortality ratio since the year 1990 (MDG Monitor. 2016; WHO, 2015). Also, there has been a notable increase in institutional births occurring at global scale; improvements in the numbers women who register and attend at least for ante natal visits; and increased numbers of 15-24-year-old women who use contraceptive methods (MDGMonitor, 2016).

In examining MDG5 target 1 concerning survival of pregnant women, it was reported that there has been a 45% reduction of maternal mortality rates during the years of 1990-2013, of which the maternal deaths were reduced "from 380 to 210 maternal deaths per 100, 000 live births" (MDGMonitor 2016, 1). However, there are still large numbers of women dying from pregnancy related complications, particularly within the developing region that has 14 more chances of maternal mortality cases in comparison to developed countries (MDGMonitor 2016; Girum and Wassie, 2017). The Sub Saharan and South Asian regions have been identified as areas with highest levels of maternal deaths that amount to 86 percent of the total numbers of

maternal deaths in the world (MDGMonitor 2016). In these cases, haemorrhages, illegal abortions, delivery complications, and high blood pressures have been identified as some of the leading contributors to maternal deaths (MDGMonitor 2016).

In examining MDG5 target 2 concerning the issue of "universal access to reproductive health", the WHO recommended that pregnant women should attend at least four antenatal visits in order to safeguard the health of mother and child (MDGMonitor 2016). During these antenatal visits, the WHO recommended that women should be advised on the proper nutritional guidelines to follow, as well as given guidance on some of warning signs of pregnancy complications to pay attention to during the gestational period (MDGMonitor 2016). However, a wider coverage of ante natal visits in the developing region has been slow (MDGMonitor 2016; WHO, 2015). Regarding the use of contraceptives, it has been noted that numbers of married and women in committed relationships who use methods of contraceptives have "increased from 55 to 64 percent between the years of 1990-2015" (MDGMonitor, 2016). The provision of universal access to education opportunities has positively contributed to curbing instances of teenage pregnancies in which teenage birth rates were reduced from 51 births per 1000 girls to about 51 births per 1000 births during the years of 1990-2015 (MDG Monitor 2016).

In the examination of the global maternal mortality ratio, there has been a 44 percent decrease from "385 to 216 maternal deaths per 100 000 live births", even though the MDG target of 75% reduction by 2015 was not necessarily reached (MDG Monitor 2016, p 2). As such, the Sub Saharan region was identified as the region with the highest numbers of maternal deaths of 546 maternal deaths per 100 000 live births, which is above the average numbers of maternal deaths of "12 maternal deaths per 100 000 live births" in the developed regions (MDG Monitor 2016, p 2).

In the post 2015 MDG era, the issue of maternal mortality is still relevant whereby maternal mortality has been prioritized under the new sustainable development goals (WHO, 2017). To continue focusing on this goal of curbing maternal death rates, the WHO established the "strategies towards the ending prevention maternal mortality (EPMM Strategies, WHO 2015). Under the EPMM, the international community focuses on adopting a human rights approach in its manner of tackling the issue of maternal death rates, through which considerations will be made on how to integrate services and increase consultations with stakeholders across the

board to address the social inequalities leading to unequal access to adequate healthcare in different countries (WHO, 2015).

The set EPMM targets include the reduction of maternal deaths to less than 70% by the year 2030, with countries that are experiencing higher numbers of maternal deaths aiming to reduce their cases of maternal deaths by more than 70 percent by the year 2030 (WHO 2015). Under the EPMM, the social determinants of maternal deaths such as the women's socio-economic status, women's ability to independently access national resources, and political will be considered (WHO 2015). Also for these particular SDG targets to be reached, there has to be an increase in the output and investment in research projects pertaining to maternal deaths, and also notable changes in policy frameworks to make them more focused on issues concerning the integration of services (WHO 2015).

3.5 Key maternal norms advocated in the WHO strategies

The following are the key norms that are advocated in the World Health Organization's strategies towards ending preventable maternal mortality (EPMM) that have been selected to form part of the study's analytical framework:

1. Countries must empower women, girls, families and communities.
2. Countries must within their healthcare sector integrate maternal and newborn care and protect and support the mother-baby relationship
3. Countries must assume ownership, leadership and supportive legal, regulatory and financial mechanisms
4. Countries must apply a human rights framework to ensure that high quality sexual and reproductive, maternal and newborn healthcare is available and accessible to all who need it.
5. Countries must improve metrics, measurement systems and data quality
6. Countries must prioritise adequate resources and effective healthcare financing
7. Countries must address inequities in access to and quality of sexual, reproductive, maternal and newborn healthcare.
8. Countries must ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn healthcare.
9. Countries must address all causes of maternal mortality, reproductive and maternal morbidities and related disabilities.

10. Countries must strengthen their health systems to respond to the needs and priorities of women and girls.
11. Countries must ensure accountability to improve quality of care and equity.

3.6 Final Consolidation of Norms into a Framework for Analysis

In creating the analytical framework that was used to frame the data presentation as well as assess the positions of the countries in terms of internalising international norms on maternal and reproductive health, the study has consolidated all the identified international norms for the international instruments discussed above into a single framework. The study has tried to eliminate duplicate norms as well as merge those that focus on specific issue areas. Further the study has grouped norms under three main questions in order to more coherently structure the analysis in the case study chapters. Thus, the final analytical framework appears below.

1. Does the country apply a human rights framework to ensure that high quality sexual and reproductive, maternal and newborn healthcare is available and accessible to all who need it?

   As such is able to ensure that specifically in relation to their maternal and reproductive health that:

   a. All women have the right to be free from harm and ill treatment.
   b. All women have the right to privacy and confidentiality.
   c. All women have the right to be treated with dignity and respect.
   d. All women have the right to equality, freedom from discrimination, liberty, autonomy, self-determination and freedom from coercion.

2. Is the country addressing inequities in access to and quality of sexual, reproductive, maternal and newborn healthcare?

   As such is the country able to ensure that:

   a. It is taking 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 at the highest attainable level, including those related to family planning.
   b. It is taking appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular access to specific educational information to help to ensure the

health and well-being of families, including information and advice on family planning.

c. All women have the right to information, informed consent and refusal, as well as respect for her choice of companionship during maternity are wherever possible.
d. That rural women in particular have the right to access adequate healthcare facilities including information, counselling and family planning services.
e. That within their healthcare sector countries are integrating maternal and newborn care as well as protecting and supporting the mother-baby relationship.
f. That the country has not only identified but is also endeavouring to address the causes of maternal mortality, reproductive and maternal morbidities and related disabilities among its population.

3. Are there country assumed ownership, leadership and supportive legal, regulatory and financial mechanisms within the area of maternal and reproductive health?
   As such has it:
   a. Improved metrics, measurement systems and data quality on maternal and reproductive health
   b. Prioritise adequate resources and effective healthcare financing
   c. Is accountable to improve quality of care and equity in that it is a) able to measure and report on its progress toward EPMM and b) is held accountable by its citizen and civil society for its progress towards achieving EPMM

Overall, these three questions with their sub-questions should be able to demonstrate governments' commitment to empowering women, girls, families and communities in realising international maternal and reproductive healthcare norms.

The following chapter presents the three case studies where the above analytical framework was employed to allow the researcher to assess the degree to which the cascade of each of the above norms is occurring in each country in relation to the norm life cycle continuum as described by Finnemore and Sikkink. The study also purports to determine whether any of these norms have been internalised or are close to be internalised. Finally, in each case the study will then ascertain what domestic issues are hindering or assisting in moving each norm closer to the final stage of norm internalisation.

CHAPTER FOUR

BOTSWANA CASE STUDY

4.1 Introduction

This chapter presents the findings from the case study of Botswana concerning show international maternal norms cascade in Botswana. Guided by the key research questions, the study assesses (1) the international and regional treaties regarding maternal health that Botswana is signatory to, (2) it looks at whether Botswana has internalised those norms and (3) how those norms have been cascaded to grassroots level.

4.1.1 Locating Botswana in Southern Africa

Botswana is a Southern African country with just about 2 million people that is situated within the South-Western part of the African continent (Victoria Falls Guide, 2018). Economically, the country is middle-income and is regarded as one of the fastest developing economies in the region. In addition, the country has been widely applauded for its positive strides in development as well as its matured democracy. At the time of its independence 53 years ago, Botswana was one of the poorest countries that has somehow managed to transform itself by building a good track record of growth that is supported by good macroeconomic and fiscal management (World Bank, 2018). Henceforth, the country was recognised as a middle-income state in 2009.

Despite these positive strides in economic growth and prudent macroeconomic and fiscal management, Botswana does have pockets of high levels of poverty and inequality that is mostly prevalent in the rural areas, in addition to having 'low human development indicators' (World Bank, 2018). As of 2017, Botswana's Human Development Index (HDI) was recorded to be valued at 0.717-which placed it among the countries in the higher HDI category (UNDP, 2019). These numbers show an increase in HDI from 0.581-0.717 during the period of 1990-2017 (UNDP 2019). However, the country's HDI level of 0.717 is below the average of countries in the higher HDI category (UNDP 2019). It's Gender Development Index (GDI) shows women lagging behind in mean years of schooling, and its Gender Inequality Index (GII) shows 129 women dying in every 100 000 live births from pregnancy related causes of

death, within 65.6% women's participation in the labour market compared to the 78.4% of men's participation in the labour market (UNDP, 2019).

4.2 Findings of the study

4.2.1 Overview of the Findings

The findings revealed that Botswana has developed infrastructure and is recognised for high numbers of institutionalised births of about 96% (Statistics Botswana, 2016). However, the public health system has a bad record keeping system of the details surrounding the causes of maternal deaths. The findings also revealed that some of the causes of maternal deaths in Botswana are due to cases of illegal abortion procedures that are administered by some traditional birth attendants, traditional healers and some religious groups. Results from the study also revealed the existence of a phenomenon of commercialised churches in the country, in which the registrar of societies that registers religious institutions have not been able to keep a good track record of the churches registered and their locations. The problem with this phenomenon and its implications on maternal health issues is that, some of these churches have an influence on the women and girls 'access to maternal health care, as these churches offer healing services in which some discourage women from using methods of contraception and seeking access to obstetric services. The findings also revealed that NGOs that are supposed play an active role in sensitizing the nation about maternal health norms are normally faced with funding challenges, which negatively impacts on their ability to do more advocacy work.

4.3 Findings on international/regional treaties and conventions pertaining to maternal healthcare that have been signed by Botswana

The first research objective of the study sought to establish international/regional treaties and conventions pertaining to maternal healthcare that have been signed by Botswana, South Africa and Zimbabwe. In pursuance to this objective in this chapter, the study looked at the Botswana case to establish the international treaties that the country is signatory to. Findings from the study suggest that Botswana is signatory to a number of treaties such as; CEDAW, Millennium Developmental Goals 5, the Beijing Platform for Action (1995) and the UN Conference on Women.

4.4 Findings on how the international treaties and conventions related to maternal health care are being cascaded to the grassroots and the extent to which they are being internalised in Botswana.

The following section addresses two questions and in pursuance of those questions, the study looked at different norms related to maternal health and it also assessed how those norms were cascaded to the grassroots and internalised as the various factors that affect internalisation of the norms. The study presented the results in this sequence, firstly it looked at each norm related to maternal health through the norm cycle model, and secondly it examined it against the various factors affecting its implementation in Botswana.

4.4.1 Findings on Botswana's stance on CEDAW

An investigation into Botswana's stance on *CEDAW (Article 1, 2,3 & 5),* revealed that women living in the rural areas tend to be lagging behind in the government's efforts to improve women's right to equality, freedom from discrimination and equitable care. The study also found that highly educated people tend to migrate to urban areas in search for better career opportunities and as a result, most rural households are predominantly headed by people with much lower education levels (secondary school level of education). According to the last informal sector survey conducted by the central statistics office, Botswana's rural areas largely comprises of households headed by women with lower levels of education, with most of these women relying on informal businesses as a source of income (Central Statics Office, 2015). The business challenges experienced by these women include; 'non-payment of goods and services supplied on credit to the customers", intense competition from other small business owners selling the same merchandise, as well as a lack of capital to establish a small business (Central Statistics Office, 2007) and (Moffat et al., 2015). According to the Botswana Household's surveys (2015/16), the percentage distribution of poor households by sex of household head show that female headed households are generally poorer than male headed households with (48.5% female vs 51.5% male) in cities and towns, and (57.7 % female vs 42.5 male) in rural areas during the period of 2009 and 2010 (Central Statistics Office, 2018).

During the period of 2015 and 2016, the distribution of poor households by sex of household head was (54.1 % female vs 45.9% male) in cities and towns, and (53.8% female vs 46.2% male) in rural areas (Central Statistics Office, 2018). These statistics indicate that women are lagging behind in economic development in comparison to men within both rural areas and cities and towns.

Politicians and government officials in Botswana state that citizens can boost their businesses by seeking additional funding from institutions such as the Citizen+ Enterprise Development Authority (CEDA), National Development Bank (NDB) and Local Enterprise Authority (LEA). However, women living in Botswana's rural communities are often not familiar with the procedures to follow when seeking funding from such institutions. Furthermore, the documents such as valuation reports, business plans, tax registrations and business infrastructural plans required in the funding application processes by such institutions are usually lengthily and cost a lot of money to acquire which often discourages rural women from pursuing these applications or giving up along the way. Because of the ongoing citizenry criticism of this funding application process, the government is currently considering contingency plans and support systems that can make the funding application processes much easier and accessible, specifically for women and the youth. In this way, women in the rural areas can have better access to funding for their small businesses.

Apart from women who make their family income through informal and small businesses in the rural areas, women and girls living in the rural areas have access to far less favourable education facilities in comparison to women living in urban areas.

4.4.1.1 Level of education and women health

When women do not have access to a good education that equips them with critical thinking skills and enough income of their own to enable them to be the key decision makers in their homes and communities, their chances of accessing the right sexual and reproductive health information is highly reduced (Cornell University, 2018). As a result, they (rural women) end up just following advices of the elderly women in their families and communities regarding issues pertaining to their maternal health. As a consequence, rural women become less able to question the unfavourable and discriminatory patriarchal ways of decision making regarding their sexual and reproductive health.

In patriarchal families and communities, key decisions regarding women's sexual and reproductive health are normally made by the woman's partner and/or the woman's mother in law. In relation to this, Professor Gaaie who is a theology professor at the University of Botswana argued that;

> "…Husbands and mother's in law are usually the key decision makers on maternal health choices in Botswana, specifically the maternal health choices regarding taboo foods to be avoided, where to give birth, traditional health remedies to prescribe to pregnant woman and so on" (Personal Communication in Botswana Interviews, 2015).

In communities where women's level of education is low, the women become less empowered to develop the critical analytical skills needed to evaluate cultural practices that often place them in risk of maternal deaths (Wodon et al, 2018). They tend to rely on religious institutions for every problem they face.

However, religious institutions are limited in their capacity to help solve the broader structural causes of poverty that are associated with lack of political will to bring about equality and discrimination against women in in issues pertaining to economic distribution and access to better education (Miller 2014). In this case, governments have to do more to attend to the structural issues that prevents people from thriving in life so that people become less likely to rely too much on churches/religious institutions that do not have the capacity to solve the structural problems that prevent people from thriving in society.

4.4.1.2 Religion and women' reproduction health

It has been observed that in the 21st century era, people have become more vulnerable to abuse if they lean too much on religious institutions for support. This is more prevalent since the spread of commercialisation of religious institutions that tend to abuse people's religious beliefs, especially women. This has been observed by Mogano, 2017 cited in in Piet (2017), who is an economist and the author of the book '*The end time church'*, that Botswana has become plagued with the influx and mushrooming of foreign churches, in which one finds people being indoctrinated and hypnotized by false prophets.

Similarly, with regards to issues pertaining to maternal health, the study found that commercialised churches can have a negative impact on the state of maternal health as some of these churches such as the ZCC church can discourage women from using family planning methods. It was also revealed in the study that some churches provide illegal abortion services that often occur in unsterilized environments, and some claim to offer healing services that lead some women to abscond from their antenatal and ARV treatment remedies (Botswana Interviews, 2015). All this contribute towards maternal mortality.

In this case, the ability for women to access adequate healthcare services including information, counselling and family planning services *(Article 14)* can be disturbed by some of the commercialised churches that offer healing services. In such cases, the study found that there was an underlying health system war between the progressives and the social conservatives mentioned by Kellner earlier in the analytical framework section.

Upon probing further on the concerns regarding the commercialisation of churches, the Botswana registrar of societies that oversees the registration of churches in the country confirmed that they do have a difficult working relationship with the exceeding number of churches that often register their churches under a particular physical address, only to be found operating in a different physical address which was not listed in their initial registration at the national registrar of societies (Botswana Interviews, 2015).

Furthermore, the registrar of societies also revealed that they also face other problems regarding the mushroomed churches as a church would register their religious organisation, and then a few months later, they find that one or two members of the leadership of a church that is already registered would visit their office to register their own breakaway church that is separate from the church that they have originally been registered under (Botswana Interviews, 2015).

When enquiring further about this issue from some of the religious leaders in Botswana, one of the religious leaders who serves as a traditional healer and a prophet in one of the Zionist churches in Mogoditshane village stated that;

> *"When people go to register a church at the Botswana registrar of societies, they must be asked questions by the officials, especially the ones involved in church splits. Sometimes it is a split about money issues, specifically where family members hold top positions in the church" (Botswana Interviews, 2015).*

It is apparent from the above statement that the Botswana government does not seem to have a set policy to regulate and monitor the registration of religious institutions, and hence it will be unable to identify and hold accountable those churches that might hold religious practices that prevent people from accessing adequate healthcare information and family planning services.

In further highlighting the challenges being brought about by modern churches, one of the interviewees, who is a midwife employed by the Botswana Ministry of Health and who has experience of working in many rural areas in Botswana during the years of 1988 to date argued that;

> *"...most of these old churches that young people don't like going to, are the ones that do teach (eg the Seventh Day Adventist Church (SDA). The problem that I see is these churches that are booming up is that people are now interested in having a lot of finances and getting marriages through churches. People now want material things..." (Botswana Interviews, 2015).*

When further probed about the mushroomed churches that can negatively influence pregnant women to adopt health seeking behaviours that could be detrimental to their health, the interviewee responded to say;

> *"...the problem is that as health care providers we do talk to the community, but people listen to these churches, these churches want money and they want to be popular. The community believe in these things, they believe in miracles, they believe in going to these prophets & that is the problem that we do have. Like my friend, was a professional but believed them when they told her to stop her ARV & hypertension medication." (Botswana Interviews, 2015)*

The statement above shows that in some cases, even educated women are often caught between being progressive thinkers that is influenced by their educational background, and being social conservatives, which is mindset that is influenced by their cultural/religious background and being members of conservative communities.

The researcher had to ask about how women could potentially be a statistic of maternal mortality deaths in Botswana through their choice of seeking maternal health counsel from spiritual healing churches and traditional healers in 21st century. In response to that one of the interviewees, who is a traditional healer and church prophet stated that:

> *"...In traditional healing, they are good healers and they are also bad healers. When someone comes to me, I'm like the professional who uses tools in the hospital. When they come, and I pray, I can tell them that they will give birth to a boy. If their child is going to be handicapped, I can also tell them. I can see it in my prayers just like they could tell with many in the bible. The holy spirit senses others" (, Botswana Interviews).*

A religious leader from a faith-based organisation argued that the healing remedies offered by healing churches do work and are solutions to health solutions, however problems arise when people seeking health counsel become too desperate and start to seek healing counsel from different churches or different traditional healers. His argument is captured in the following extract from the interview where he stated that;

"...But when they (pregnant women) get scared of symptoms they are experiencing; they go to different healers and as result those medications begin to clash. They are not going to work together. Other healers take chances, they are not qualified healers who have gone through the training process. You see in our profession, there are about seven different kinds of healers. Some are called Masedi, some called sangomas, some called Mangwadi, some called Ntshonkonane's that can also be found in Zimbabwe. The Masedi's and Ntshonkonane's can work together, but the Sangoma's can only work alone. So when you seek medical counsel from all these different types of healers then you are most likely to experience problems and potentially die as we are not all meant to work together and we give different dosages in the medication that we give to our patients, which can clash if you mix all these medications together" (Botswana Interviews, 2015).

When asked about whether some women seek abortion services from healing churches and traditional healers as an alternative consideration that abortion is rendered an illegal practice in Botswana, one of the interviewees, who is also a practising traditional healer admitted that;

"...Churches do help women abort. They do it, both traditional healers and churches. They are some herbs that when you give to pregnant women, they can lose the baby like for example the Tony 'G' Herb. It is yellow in colour. We have been warned about them. The church people also do it. At churches, we have a group, and a division. The way to solve these problems is at the registrar of societies and associations, they should arrange for all of us to meet at the lekgotla (tribal court), the committees, they must involve all the stakeholders with integrity, so we can tackle the issues. Sometimes we healers from healing churches give them an overdose then tell them to go to hospital when it goes bad. Sometimes we use the medications that sterilise cats" (Botswana Interviews, 2015).

On the other hand, a practicing midwife, confirmed that the issue of abortion is a problem as captured in the following extract from the interview.

> ***"...****they (those who offer abortion services) are known as abortionists & they use all sorts of terrible things. We as health care providers see that something was done when we examine. I think it would be better if abortion was legalized so that these things can be done properly. The problem is that these young girls don't want to use family planning & plan for their pregnancy, but they are not doing that. Most of these abortions are during month end because that is when they have money to do it or when the boyfriends have money to fund it. They fall pregnant & abort, after three-four months they do it again. It's very rare that it done because of cervical incompetency or the womb can't carry the child, it's very rare." (Botswana Interviews, 2015).*

The statements above reveal that women's access to adequate information, counselling and family planning services is often caught in between the progressive versus the social conservative mindset of viewing sexual and reproductive health. It also shows that progressive medical practitioners such as midwives are often caught in between these two mindsets themselves. The statements also reveal that the mushrooming of churches in Botswana has fuelled illegal abortion services by those churches and moreover, these churches are contradicting overall government approach to the issue of sexual and reproductive health by advising them to adopt contradictory sexual and sexual reproductive health services.

The situations described above showcase that in Botswana, there is poor communication and lack of collaboration between the registrar of societies and religious institutions, as well as inadequate communication between government officials and traditional healers [both licensed and unlicensed] about how to safeguard women during pregnancy. The study also suggests that there is lack of consensus as to what procedure to follow in cases where women have unplanned pregnancies and wish to terminate the pregnancies. It is also apparent from the findings that most young women in Botswana do not have sufficient information about how to use family planning and contraceptives. It is also clear that average women in general have not yet developed the capacity to be the key decision makers regarding their own sexual and reproductive health. The study also revealed that the women tend to make decisions according

to the rules of their churches and the church leaders that has advised them not use contraception in some cases, of which can place women at high risk of dying during pregnancy.

Under these situations, it is expected that the Non-Governmental Organisations such as *Gender Links Botswana* and *Emang Basadi (Department of Women)* should be able to play a pivotal role in teaching women at grassroots level about their sexual and reproductive health rights and how to become key decision makers in issues pertaining to their health, seem to have failed.

The researcher had to interview representatives from Non- Governmental Organisations to understand what they were doing to ensure that women were adequately informed about their sexual and reproductive health at grassroots level.
A representative from these NGO organisations argued that they are having problems with reaching out to the broader communities in the rural areas because they are usually accused by the communities of ridiculing roles of women in Botswana society as according to set culture and religious laws that the local communities abide . This could be an indication of the existence of a strong hold of the social conservative views in the country. This is illustrated by the outcome from the interview with a former employee of one of the NGOs whose mandate is women empowerment. Her response is captured in the following quotation below:

> *"…I once organised meetings for women at the local kgotla in one of the villages. The purpose of the meetings was to teach rural woman about their anatomy and different methods of contraceptives so that they can begin to think about how to select contraceptive methods that would be most suitable for them and how to spot signs of cervical cancer situations. However, most of the women that attended that meeting felt like I was insulting them by talking about anatomy issues, specifically considering that I was much younger than them in age and hence most chose to not receive my message with some even leaving the gathering before the meetings were scheduled to finish..." (Botswana Interviews, 2015)*

Since most people in Botswana have a high trust in the government and view the government in high regard, the impact of NGOs specialising in women empowerment could be strengthened if the government publicly supported such NGOs. However, the government regards NGOs such as gender links as organisations that are led by angry leftist women and thus the relationship is operationally difficult between the government and these organisations. As such, the NGO recommendations on issues pertaining to gender equality are normally not taken seriously by government departments, which often causes them to experience challenges in securing funding and hence limiting their possibilities of doing adequate advocacy work regarding mobilising the country to ensure that all women have the right to equality, freedom from discrimination and equitable care.

4.4.3 Findings on Botswana government stance on abortion right

A documentary review of abortion laws in Botswana, shows that that until 1991, abortion was governed by the provisions of the Penal Code of Botswana, enacted in 1964 and modelled on the Offences Against the Person Act 1861 (United Kingdom). No exceptions were expressed to a general prohibition on the performance of abortions, although under the general criminal principles of necessity, an abortion was allowed if performed in order to save the pregnant woman's life. Persons who performed abortions and women who consented to them were subject to imprisonment under this law.

In the 1980s however, there were requests from members of the medical profession regarding the need for the re-evaluation of the abortion law. The Botswana government began drafting a bill to adjust the abortion law, which it sent to Parliament in 1990. The Government's action was based on its concern for the health of women, as evidenced by high rates of maternal mortality and morbidity. Some 3,700 women were officially treated for the complications of illegal abortion in 1992; at least 14 per cent of maternal mortality was estimated to result from unsafe abortion; and some 200 deaths per year were attributed to illegally performed abortions. Despite determined opposition, the bill was approved by Parliament and signed by the President of Botswana in October 1991 (Smith 2013).

The new law added language to the Penal Code, in which it set forth exceptions to the general prohibition against the performance of abortions. Under the new adjustments to the penal code, abortion would be allowed in the country under the following conditions: (a) when the medical practitioner carrying out the abortion is satisfied that the pregnancy is the result of rape, defilement, or incest; (b) when the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; and (c) when established evidence shows that there is substantial risk that the child would suffer from or later develop such serious physical or mental abnormality or disease as to be seriously handicapped. The government stipulated that the legal abortion should be carried out within the first sixteen weeks of pregnancy by a registered medical practitioner in a Government hospital or registered private hospital or clinic approved for that purpose, and in the cases of (b) and (c) two practitioners must approve the abortion in writing.

Three decades later after the adjustment of the abortion law however, it is evident that despite the enactment of this legislation, there still exists concerns about the occurrence of unsafe

abortion in Botswana. This is confirmed by a recent report issued by the Botswana Department of Women's Affairs which concluded that bureaucratic delays and "far-flung health clinics" still encouraged illegal backstreet abortions. Although there is no adequate data to support the above, reports indicate that, despite the 1980s adjustment to the abortion law, illegal abortions are still common and extremely risky. Findings from the study shows that these illegal abortions being carried out by some traditional and religious leaders. This is confirmed from the outcome of the interview with a midwife who has worked one of the Village Hospitals and clinics, when she expressed the opinion that it is necessary to relax the abortion laws a bit more because there are still untrained people in Botswana communities that provide abortion services. In her statement, Radikgomo argues that;

> *.... "Others who are performing these procedures use equipment that are not sterile, others do it in places that are not right. Most of the deaths were related to these kinds of abortions. According to me personally as a midwife, I think it would be good to legalise it. But as a Christian and Pastor's wife, I don't believe in it [abortion]. In our clinics we even stopped doing pregnancy tests because they would come for them to confirm pregnancy, and then go to do the abortion" (Moruakgomo, Botswana Interviews).*

It is apparent from the above findings that although the abortion laws were adjusted in the 1980s to allow abortions to be carried out under certain conditions, these adjustments did not extensively solve the problem of illegal abortions. It has been observed that women who seek these services face discrimination by public health care providers due to lack of clear procedures to be followed in obtaining permission for abortion. Moreover, it has also been observed that some physicians have an uncooperative attitude towards women who want to seek justification to have an abortion. In addition, the government law is not very clear on what constitutes "acceptable evidence" that a pregnancy is the result of rape, defilement and incest (Smith, 2013). The Botswana judiciary bodies have also failed to address the legal situation of minors seeking an abortion, in addition to there being a scarcity of approved places where abortions can be legally performed, there is a shortage of medical practitioners to perform abortions, and the difficulty of access experienced by many rural women in Botswana communities (Smith, 2013,pp 4). In this case, there seems to be a need for the amendment of the law, including the replacement of the two-physician approval requirement with a one-physician requirement, and the provision of more accessible, safe and adequate facilities for the performance of abortion (Department of Women Affairs, 2013).

In order to bring about a positive change in the controversial issue of abortion laws, the family law in Botswana needs to delve deeper into the broader complexities and intricacies that surround the conditions of how some women and young girls fall pregnant as at the moment

law enforcement agencies and government officers still assume that all women have control over how and when they fall pregnant. For example, one minister of presidential affairs has previously quoted ridiculing women who have unplanned pregnancies in his statement that:

"...getting pregnant is a personal choice and the law [on abortion] should not be amended just to encourage irresponsible behaviour. And having sex is a choice as such if both partners choose to not take precautions, then they have made a choice" (in Sokari, 2005)

The ignorant attitude by higher government officials on the complexities of unplanned pregnancies are counterproductive to any attempts made towards reducing maternal deaths in Botswana. This is highlighted by the coordinator of maternal mortality reduction initiative in the Ministry of Health, who argued that about 22 percent of maternal deaths in 2014 Botswana were due to abortion cases compared to the previous five years, thus making abortion the leading cause of maternal deaths in the country (Sinvula in Botswana Gazette, 2015).

The arguments stated above, therefore show that in order to eliminate discrimination against women on a basis of access to health care services related to family planning *(Article 12)*, the government needs to consider being more flexible in abortion laws. In addition, there is need to improve their record systems of religious institutions so that they can have better data capturing of religious institutions operating in the country and the operations of these religious institutions in matters pertaining to sexual and reproductive health. In addition to this, the government needs to consider creating platforms for the public health, religious and cultural sectors to engage and collaborate on issues pertaining to maternal health.

4.4.4 Botswana and the Beijing Platform for Action (1995) and the UN Conference on Women

The study found that the Botswana government has made some legislative and institutional adjustments to comply to the norm on the right to equality; freedom from discrimination and equitable care (*Article 28)*. However, these adjustments have been mostly focused on training government departments and the private sector employees to adopt equitable gender policies in their workplace, but not necessarily creating policies and programs that would encourage gender equality at grassroots level. The training of government officials on gender equality policies varied across different government departments with some departments being well advanced and other departments still lagging in gender equality policy implementation.

The study also found that in the Department of Health specifically, some midwives were not aware of the national policies established by the government regarding gender equality or equitable health care, particularly with regards to the maternal health care policies and country targets (Personal communication in Botswana Interviews, 2015). This is highlighted by the outcome from interviews with midwives in which most midwives stated that because of their healthcare facilities being understaffed and having heavy workloads, they tend to focus most of their attention on being clinicians as they do not have enough time to learn more about Botswana's policy towards maternal healthcare and country targets (Personal Communication in Botswana Interviews, 2015). The study found that their lack of sound knowledge about policies pertaining to maternal health does have negative implications on the public health institutions ability to provide equitable maternal healthcare services. The study also found that lack of in-depth appreciation of country's policies and targets regarding maternal healthcare, resulted in most midwives failing to appreciate why it was important to correctly fill in the maternal death report forms that are available in all public health maternity wards. This is evidenced by, one midwife who stated in her interview that filling in the maternal death form was not a priority for her during days when the maternity clinic was full as all the patients needed her attention during labour. It is apparent from the above that the midwife's lack of knowledge about the country's policies and/or targets regarding maternal health causes her to fail to recognise that neglecting to fill in maternal death forms in cases of maternal death in her ward can in itself increase maternal deaths in the country. This is because there would not be available information captured on the trends of maternal deaths within her own health facility (interviews, 2015). Thus, it becomes difficult for the country to plan how to meet the maternal mortality targets if they are not constantly updated about the developing trends and patterns of maternal deaths in their healthcare facilities. Furthermore, the lack of enough data on the trends on maternal deaths also prevents researchers from conducting research studies on these developed trends of maternal deaths.

In the case of Botswana, the study found that although the country might have set policies towards curbing maternal deaths, the inadequate knowledge of these policies by some public health clinicians can prevent effective implementation of these policies which takes the country steps back.

Although some midwives (public health allopathic healthcare practitioners) displayed lack of knowledge about the country's policies and targets regarding maternal healthcare, the study also found that the traditional and religious health care providers also did not have much knowledge on Botswana's policies and targets equitable maternal healthcare. This was brought

to the fore during an interview with one of the traditional healers when asked about his knowledge about international norms such as the Beijing Platform for Action and Millennium Development Goals relating to maternal health, his response is captured in the quotation below:

> *"…I have heard of such policies informally from other people in my field of practice. It is just that we as traditional healers do not really share information. A lot of us in this sector are not educated and we are also arrogant and step on each other. It delays our progress and effectiveness in society. At times we are assigned mentors to teach us certain skills as traditional healers as traditional healers. But when the mentee qualifies from learning from their mentor, they then want to step on their mentor so that they can appear to be the best on the field. Hence, we tend to hide some information from one another such as the information about those Beijing policies that you are mentioning (Botswana Interviews, 2015).*

In another interview with a religious leader, serving as a pastor and traditional healer further confirmed the general lack of knowledge about the international norms and government policy on gender equality, this is highlighted in the following extract;

"Botswana is selfish because they rarely call us to teach us about some of these policies. They will sometimes call & speak to us about it after 10 years. We need committees where they teach us about these so-called policies. Now you can tell me whether that shows us whether they love us or don't love us. Sometimes they call & advise just a few people. You should rather call a meeting with traditional healers & prophets & teach us 1,2, 3" (Botswana Interviews, 2016)

The statements by the two spiritual healers above show that in addition to clinicians in the public health sector not knowing much about Botswana's policies and targets regarding the country's strategies to provide effective maternal healthcare, the traditional healers also do not have extensive knowledge about the government's policies and targets regarding maternal healthcare. This lack of knowledge of policies by clinicians in the allopathic sector as well as the traditional and religious healers could be due to the fact that in its Beijing Platform for action implementation processes, the Botswana government tends to focus more on institutionalisation in a form of establishing the Department of Gender Affairs, signing the SADC gender protocol and making some legislative and policy changes in the institution to stipulate that the government does agree with the values of gender equality. However, inferring from the outcome of the interviews with both traditional healers and clinicians, the government needs to do more in implementation in terms of teaching the public health officials about the country's goals, targets and policies about maternal healthcare provision so that the clinicians can see the value of why it is important to fill in the maternal death forms in cases of maternal deaths in their healthcare facilities. The government also needs to do more to establish dialogue between the government (medical and clinical personnel) and traditional healers on issues pertaining to maternal health policies, goals, strategies and targets. Although the government-through the Gender Affairs department has in the past created a platform for the Non-

Governmental Organisations (NGO) and Civil Based Organisations (CBO) forums to meet and establish think tanks on how to better "women's service provision projects" in meetings that were held every quarter throughout the year, the full impact of this activity was not experienced by people living in the rural areas. This is because most NGOs in Botswana are concentrated in Gaborone (Capital City), and hence the grassroots views and experiences of the gender issues occurring in rural areas would not really be captured as their representatives would not usually be part of the quarterly meetings organised by the Department of Gender Affairs in the city (Europa.eu ,2018).

With regards to the Civil Based Organisations, the study found that these organisations are normally registered as "Development Trusts' that are funded by the Botswana Community Based Organisations Network (Bocobonet). These CBOs are usually small organisations that are located within the remote rural areas (Europa.eu, 2018). Although they are situated in the rural areas where most people at grassroots level reside, the CBOs are however disadvantaged by the fact that Bocobonet (their dominant funder) has experienced financial challenges over the years and in some instances even stopped operating as a non-state actor (Europa.eu, 2018). In Botswana, organisations such as Bocobonet normally depend on government spending, and the funds are limited as the government does not have a diversified income, but rather relies on mining revenue (Europa.eu 2018). Over the years, as HIV prevalence increased in Botswana during the 90s, the government developed a habit of predominantly providing funds to HIV and AIDS related NGOs and CBOs, leaving NGOs and CBOs that focus on other matters such as gender equality with little resources to work with . Thus, the lack of funding experienced by the CBOs hinder the cascading of information on the right to maternal healthcare to people at grassroots level. In addition, it also limits government bodies from getting information about the traditional & religious healers understanding and implementation processes of policies pertaining to healthcare provision for pregnant women in the rural areas. Hence more needs to be done to be done to assist NGOs and CBOs with diversified funding mechanisms that would enable them to reach out to rural areas and hold the state accountable for implementing some of the policies pertaining to maternal health access.

Through effective partnerships and strong maternal healthcare networks, historical challenges regarding maternal healthcare such as changes in abortion laws, culturally and religiously influenced methods of antenatal care and childbirth can be addressed as coalitions of women's organisations, health and legal professionals, members of parliament, policy makers would be working together towards achieving a common goal of reducing cases of maternal deaths in a country (Ray et al, 2012).Also, for the economic, social and political rights to be taken

seriously, the Botswana state leadership would need to show commitments to social integration, and issues concerning solidarity, of which can be difficult issues to tackle considering that people hold various ideological and cultural perspectives in the country (Eide et al, 1995).

4.4.5 Botswana and the Development Goal 5 (MDGs) and the Sustainable Development Goal 3 (SDGs)

At the beginning of the implementation of the Millennium Development Goal 5, Botswana had set a target to reduce maternal deaths by three quarters between the years of 1990 and 2015 (UNDP 2015). In the years from 1990-2015, there was a sharp decrease of 60% in maternal deaths, with the numbers decreasing from 326 to only 135 maternal deaths per 100 000 live births (UNDP 2015). However, these numbers were reversed from 2006 in which maternal deaths increased to up to 163 per 100 000- live births by the year 2011, hence Botswana did not reach its global target of curbing maternal deaths to 82 per 100 000 by the year 2015 (UNDP, 2015).

According to the Botswana National Development Plan 10 mid-term review (2009-2016), Botswana has achieved some developmental milestones in ensuring that 95% of pregnant women deliver their children in health care facilities, there has been a less than 3% mother to child HIV transmission, more than 95% of those needing to be on Ante-Retroviral Therapy (ARV) are on treatment and new infections of HIV have been reduced (UNDP 2010). However, there are still challenges of high maternal mortality rates, HIV and AIDS prevalence is still high with many not being aware of their HIV status, there is inadequate provision of quality health care services, and there is no adequate participation and ownership of programmes by community members (UNDP,2010).

In addition to the above listed challenges, Botswana has shortfalls in data capturing where information is not consistently monitored and evaluated or stored in reliable databases. For instance, a midwife in Kgatleng District stated in her interview that;

> *… "The previous forms which were used to fill details of the causes of patient maternal mortality did not provide enough options to fill in the finer details of what really caused the maternal death of a patient. The government then revised the structure of the forms, but they were revised in such a way that it would require a lot of time to fill in patient details of the deceased woman. Now in most of our maternity clinics and some hospitals, especially rural ones, we are understaffed which does not really grant us adequate time to write detailed patient notes when a woman dies from childbirth to be honest. Therefore, usually the midwifes do not write the full details of the case in patient notes purely because of time constraints" (2015)*

Inadequate maternal deaths audits not only prohibit the availability of in-depth information about the cause of maternal death, but it will also assist in identifying possible behavioural factors that influence decisions made by pregnant women that could possibly be affecting the pregnant women's maternal health.

In further stressing the behavioural factors influencing decisions made by pregnant women one of the midwives, highlighted during interview that;

"…Some of us healthcare workers do try to talk to the community, but people listen to these churches, these churches want money and they want to be popular. The community believe in these things, they believe in miracles, they believe in going to these prophets & that is the problem that we do have; Like my friend, was a professional but believed them they told her to stop ARV & hypertension medication"(Botswana Interviews, 2015)

The study's review of Botswana's data capturing methods shows that the country does not record data on the 1% non-institutional births. Other than the information that most of the non-institutionalized births happen in Ghanzi district, the government has not done much to record the details of these births or studied how many of these births have led to maternal deaths. The study established that most of these non-institutionalized births in Ghanzi District are among the Khoi San communities that rely on their alternative medicinal practices for their health care needs. Of the 95% of the births occurring in health care facilities, the leading cause of maternal deaths was due to genital tract and pelvic infections during abortion procedures, followed by ectopic or molar pregnancies, then diseases of the circulatory system being the next major cause of maternal deaths (Statistics Botswana, 2016). Of the maternal deaths occurring in health care facilities, the deaths are generally attributed to substandard care and poor decisions and referral decisions not being made at the right time (UNDP, 2013).

In some cases, however, women are referred on time but are influenced not to give birth at the referral hospitals. For instance, one of the interviewees who is a midwife in the public health sector argued that;

> *… "I am a trained professional in nursing and midwifery and both my daughters are fairly well-educated women with degrees from the University of Botswana. But when my eldest daughter was pregnant, her doctor advised her to move closer to a referral hospital when she is close to give birth because she had high chances of having a complicated delivery. My daughter went to her church where one of the visiting pastors told her that she will have a normal delivery after praying for her. My daughter then decided to not move closer to the referral hospital as her doctor had advised her because she believed the pastor had healed her from whatever was wrong with her. She however had complications at the time of the birth of her child and we had to quickly drive her to the nearest referral hospital. We were very lucky that she did not lose her life, nor the baby's (2015).*

It can be seen from the above interview extract, that the mushrooming of churches has introduced new dynamics to pregnancy care and response to pregnancy complications by the ways in which religious leaders can influence women to perceive their pregnancy complications in ways that differ from the public health way. Therefore, it is important that the Ministry of health makes attempts to facilitate communication between the health department and other social institutions (such as churches) that often have their own healing remedies to maternal health issues. Otherwise they will always be conflicting ways of dealing with pregnancy complications in Botswana.

With abortion being the leading cause of maternal deaths as highlighted in the 2016 data at the Botswana Statistics office, this is confirmed by an interview with one of the midwives in the public health sector who highlighted that the abortions are usually prevalent among young people in which she argues that;

… "I have noticed that these women get pregnant at an early age; there is a lot of peer pressure. They know about the methods of prevention, but they still indulge in unprotected sex. They do what their friends influence them to do. They know about HIV, but they never test" (2015).

It is apparent from the above responses that, in order to curb unplanned pregnancies among young people, more needs to be done to diversify the ways in which family planning services are available to young people in ways that complement their education level. In this regard, it can be stated that women with less education are less than likely to use family planning centres and maternal health services across the board. In rural areas where there is more likelihood of women with less education, there are generally increased possibilities of these women opting to not use maternal and family planning services. Another factor that can cause less utilization of family planning services in rural areas is that cultural beliefs seem to be much more intense in rural communities. In Botswana culture, it is expected that women be subservient to males in society (Palattiyl et al, 2003). The society in such communities expects men to be the ones that control sexual relations within intimate partnerships, and it is in this regard that the "men end up being in charge of making decisions on contraception, and on whether or not to use the condom" (Palattiyl et al, 2003; p 64). In defence of the Botswana government, the Botswana National Policy on culture does acknowledge that women and girls tend to bear the brunt of the effects of cultural stereotypes, attitudes, indirect and direct marginalisation in decision making processes both in the public sphere and within family settings (Botswana Ministry of Labour and Home Affairs; 2001). The government further states that there is evidence that the co-existence of both common and customary law makes it challenging to solve the gender inequality issue as these different types of laws to tend to overlap and contradict each other

from time to time (Botswana Ministry of Labour and Home Affairs, 2001). To resolve the problem, the Botswana government proposes that some of the cultural beliefs and practices need to be re-evaluated in such a way that would allow the promotion of cultural values, norms and practices at family level that would promote gender equality between the two different sexes (Botswana Ministry of Labour and Home Affairs, 2001). However, very little has been done to challenge some of these cultural practices and thus more women engage in unprotected sex, even though they are not equipped to deal with the after-effects of unprotected sex and thus leading many to want to undergo abortion procedures.

Other factors that might lead to increased cases of abortion in Botswana are religious teachings that discourage members from using family planning. This is highlighted in an interview one of the members Zion Christian Church and housewife, when she expressed the opinion that

> *"The problem with my church is that it is not allowed to use family planning, but the issue is that one will have many children and then do what with them? It is said by the pastors that you are killing a child if you are using family planning. Many women are using family planning despite the church's beliefs because they cannot manage many children. I went to insert the IUD after I fell pregnant with my first child" (Botswana Interviews 2015).*

On the other hand, one of the religious leaders who serve as a prophet and a traditional healer, expressed the opinion that Botswana women should sometimes learn to defy the doctrines of their religious and cultural institutions in which he states that;

> *"…Women are the ones who fall pregnant, so they should make their own decisions. It is their body. It is my wish for women to stand up and make their own decisions. Even with pastors, you must question these things. Some of our churches do say that women should not make their own decisions in issues concerning sexual and reproductive health and that they should not use family planning methods (Botswana Interviews 2015).*

The statements above indicate that for a woman in Botswana to reach a point of attempting to abort their pregnancy, there are a range of factors such as peer pressure and church beliefs that discourage family planning which can be contributory to many unplanned pregnancies, abortions and subsequently maternal deaths. However, due to less data capturing of the factors influencing how women choose to use family planning, the government has not been able to establish strategies of how to engage with religious leaders about encouraging women to make use of family planning so that they don't have unplanned pregnancies that might propel them to attempt to do abortions. In addition, most of the data captured on the finer intricacies of maternal deaths are more focused institutional maternal deaths and thus more needs to be done to capture information on maternal deaths that occur in non-institutionalised births. There also

needs to be an improvement on capturing data on how women choose their family planning methods and the social factors influencing their decisions on family planning. Therefore, Botswana needs to improve their maternal health metrics, measurement systems and data quality in this regard. In this case, I argue that Botswana has not addressed all extensive causes of maternal mortality, reproductive and maternal morbidities and targets.

In examining Botswana's bottleneck score card which looks into the points of congestion in the addressing of maternal mortality in the country, I found that issues such as organisational and management factors, the lack of recognition of the seriousness of the pregnant woman's condition, and lack of proper equipment in the smaller healthcare facilities in the country (Madzimbamuto et al, 2014). Therefore, Botswana needs to make some changes towards strengthening the supply chain management and ensuring adequate supplies and equipment in hospitals, strengthen the communication in referral systems, and empower the communities to continue care of pregnant women in between the household and healthcare facilities (UNDP, 2013). Also, the Botswana government must address services that address adolescent sexual and reproductive health (UNDP, 2013).

With regards to strengthening the supply chain, one finds that like in most countries in the developing world, Botswana does not produce its own medical drugs and supplies but rather imports the drugs and medical supplies through the government owned medical store (BNDP, 2002). According to the Botswana National Drug Policy, the Botswana Ministry of Health has showed commitment towards National Drug supply by forming partnerships with the Ministry of Local Government, the Ministry of Finance and Development Planning, the private sector and Non-Governmental Organisations that will collectively "plan, budget, and secure sufficient funding" for the nationwide availability of drugs, including the nutritional drugs required by women to maintain a healthy pregnancy (BNDP, 2002). Furthermore, the Ministry of Health has planned to ensure that there is access to quality drugs by requiring that drugs be only be "prescribed in generic names unless where it is justifiable for specific brands to be used" (BNDP, 2002, 18). In as much as there is availability of drugs and funding for drugs in the country, there are cases where essential drugs are not consumed by pregnant women who have registered for ante-natal care as I identified in Mrs Mogorosi's interview who is midwife, in which she stated that some women die from hypertension complications during pregnancy or shortly after birth because;

"…It is standard practice that we provide pregnant women with some medication or supplements during pregnancy. However, the women tend to not disclose information. She will take the medication from the clinic even though she will know that she will not drink it at home because of church doctrine. She can just take the medication & then not take it at home We give them information that it's going to help

with their hemoglobin, but usually they will take them [medication] & then put them aside and then they come during labor with a very low HB they do not even open. She takes & then throws them away [the medication]" (Botswana Interviews, 2015).

Mrs. Seitshiro who also practices as midwife in public health shared similar statements as Mrs. Mogorosi above in which she stated that:

"…It is standard practice to prescribe some medications during pregnancy. Though in my experience, I do have a problem with them coming to register for ANC very late in their pregnancy, as that gives you little time to take blood, the CD4 count, especially the ones who are HIV positive, sometimes the test kits are not there. There is this program-Option B5 where a pregnant woman who is HIV positive must go on the PMTC Program". (Botswana Interviews, 2015)

Some of the overlooked contributory factors of women's decision to register late for ante natal care is that in the African context, it is usually the mother in law or elderly women in the pregnant woman's life that make the crucial decisions about how a pregnant woman should carry herself during the gestation period, of which the mother's in law are more prone to rely on cultural and/or alternative medicinal care than the allopathic medicinal (Gaaie, 2015). In Tswana culture, the woman is supposed to keep her pregnancy a secret in the earlier stages of her pregnancy and avoid publicizing information about her pregnancy because it is culturally believed that a woman can be easily bewitched by jealous members of the community if she discloses that she is carrying a child. It is often feared that if a woman discloses her pregnancy early, she is most likely to give birth to carry malformed fetus and give birth to a child that has physical or mental impairment (Gaaie, 2015; Kgoadikgoadi, 2012). Hence, some women prefer to keep their pregnancy a secret and register late for ante natal care. When the elderly women in the pregnant woman's life are the ones making the key decisions regarding their pregnancy, they are most likely to advise pregnant women to consult with herbalists or spiritual healers as most negative physical symptoms are usually presumed to be as result of malicious actions of some members in the community (Kgoadikgoadi, 2012).

In the general prescriptions of drugs, the Botswana National Drug Policy states that the Ministry of Health should work closely with traditional healers and should have a database of the indigenous medicinal plants and the dosages, uses and methods of identification (BNDP, 2005). However, on the contrary the study found that there has not been enough communication between Botswana traditional healers and the allopathic health sector. This is evidenced by the outcome from the interview with one of the leaders from one of the religious organizations who practices as a prophet when he argued that the healing remedies offered by healing churches do work and are solutions to health solutions. However, they pointed that the

problems arise when people seeking health counsel become too desperate and start to seek healing counsel from different churches or different traditional healers as the medications are bound to clash resulting in patients dying. This is highlighted in the following extract from the interview which has been captured as follows:

> *"...But when they (pregnant women) get scared of symptoms they are experiencing; they go to different healers and as result those medications begin to clash. They are not going to work together. Other healers take chances, they are not qualified healers who have gone through the training process. You see in our profession, there are about seven different kinds of healers. Some are some called Masedi, some called sangomas, some called Mangwadi, some called Ntshonkonane's that can also be found in Zimbabwe. The Masedi's and Ntshonkonane's can work together, but the Sangoma's can only work alone. So when you seek medical counsel from all these different types of healers then you are most likely to experience problems and potentially die as we are not all meant to work together and we give different dosages in the medication that we give to our patients, which can clash if you mix all these medications together" (Botswana Interviews, 2015)*

When further probed about whether some women seek abortion services from healing churches and traditional healers as an alternative consideration that abortion is rendered an illegal practice in Botswana, the respondent gave the following response:

> "...Churches do help women abort. They do it, both traditional healers and churches. They are some herbs that when you give to pregnant women, they can lose the baby like for example the Tony 'G' Herb. It is yellow in colour. We have been warned about them. The church people also do it. At churches, we have a group, and a division. ... Sometimes we healers from healing churches give them an overdose then tell them to go to hospital when it goes bad. Sometimes we use the medications that sterilise cats" (Botswana Interviews, 2015).

The statements above show that although the Botswana National Drug Policy stipulates that the Ministry of Health should work together with traditional healers and should keep a database of the drugs being prescribed in the traditional healthcare sector, the reality is that the Botswana registrar of societies does not even have a reliable database of registered societies from which to track down the healers in religious sectors. It also came out from the study that most religious and traditional healers have never engaged with the Ministry of Health about policies pertaining to maternal healthcare or possible collaborative efforts. In addition, it was also revealed in the study that some medicines clash with medicines of other traditional healers which can be detrimental to the patient. Moreover, some traditional healers who participated in the study admitted that women in the community have approached them about abortion services which they are capable of administrating. These findings confirm the existence of relationship between the maternal deaths and illegal abortion cases.

The study also established that most maternal deaths caused by the circulatory system ailments result from failure by pregnant women to take medications prescribed from public health facilities (Personal communication in Botswana interviews, 2015). Moreover, late registration

for Ante Natal care was found to be contributory factor to maternal mortality due to insufficient time to administer the HIV treatment regimes. Therefore, more needs to be done in terms of engaging with traditional healers and cultural leaders on issues pertaining to maternal healthcare.

According to the Botswana government's *Vision 2036* agenda, Botswana shall be an equitable country that provides equal opportunities and prosperity will be widely shared in ways that leave no one behind (Statsbots, 2018). Also, the *Vision 2036* agenda will ensure that all people are free to practice their religious and cultural beliefs and all men and women will be given equal opportunities to actively participate in the economy (StatsBots, 2018).

With regards to the empowering of women, the sustainable development goal 5 advocates for the eradication of discrimination of women in access to economic resources, education and their sexual and reproductive rights. In Botswana, the government has established policies such as the 2008 National Draft report on education in Botswana as a way of accommodating the girl child.

In its draft report, it is noted that the revised National Policy on Education (RNPE) advocates for the integration of contemporary issues such as HIV and AIDS, gender awareness, population and family life education, and life skills in the school curriculums (UNESCO, 2008). The draft report is in line with the new WHO strategies towards ending preventable maternal mortality (EPMM) that call for shift of a system that focuses on emergency care to a system that accommodates more supportive care that responds to women's holistic needs during pregnancy (WHO 2015). In this new shift, government's focus on ensuring that all girls have access to education would contribute towards eradicating maternal mortalities as the more educated the women and girls are, the more they will be equipped to make well informed decisions regarding their sexual and reproductive health.

For the government to effectively implement the national policy on education, various actors (such as family, religious, cultural bodies) involved in the schoolgirls 'lives would need to work collectively as a network in order to ensure that young girls receive and assimilate the integrated education that encompasses contemporary issues such as HIV and AIDS, gender awareness, population and family life education (UNESCO, 2008: UNICEF, 2012).

The study of the case of Botswana, revealed that although there has been increased enrolment of girls in Botswana schools the girls struggle to proceed to higher levels of education due to societal ills such as widespread violence against women, the reality of girls having to shoulder

the brunt of the HIV and AIDS pandemic that often leads to a large orphan population and increased household responsibilities for girls (UNICEF, 2012). The study also revealed that although statistics reveal good numbers of enrolment of girls in schools, these girls face challenges at home as the culturally and religiously influenced gender roles can lead to higher absenteeism at school that deprives their chances of thriving in schools due to increased expectations and responsibilities in maintaining the households at home. Therefore, it can be observed that Botswana might have the right educational policies that recognise the importance of an integrated education system that would support girl child education 'but the implementation of these policies is still a challenge. This could be attributed to lack of collaborative efforts and strong network between the education system, families, cultural and religious bodies in order to break the societal norms and gender role expectations that prevent girls from reaching higher levels of education.

In relation to this, a 2016 PEPFAR gender analysis report in Botswana revealed that in 2014, the mean years of schooling among females was 8.7 years, as compared with 9.7 years among males. The report also revealed that there were fewer females (73.6%) with secondary education in comparison with the men (77.9%). The men were found to have higher numbers in workforce participation (81.6%) than women (71.9%) (PEPFAR 2016). Because of the influence of religion and culture, as well as patriarchy, the education for girls has had little impact in the advancement of girls' decision processes. In concurrency with the above, the study found that girls have been traditionally raised to believe that they should always be subservient to men, while boys are socialised to believe that they have power and control over girls and women. Hence the girls grow up believing that their natural sphere of influence is inside the home, whereas power and decision making belongs to men and the boys, including the decisions pertaining to their sexual and reproductive health.

Apart from the deeply entrenched gender roles that negatively affect girls' chances of pursuing education to the highest levels, the study also found that the government systems in the rural areas do not provide adequate support for women and girls to be economically independent. In the early 1980s, the government's rural development strictly referred to infrastructural development and improvement of social services. In the current millennial setting of rural areas in Botswana, there are more urbanised features such as "access to road networks, a minimum of a primary school and a health facility, a kgotla (customary court), a mobile phone network access and a connection to the electricity grid" (Moepeng, 2013:1). However, like in most rural settings in Southern Africa, people must migrate to the cities in order to get access to tertiary education and access to white collar jobs after they have graduated at tertiary level

(Moepeng,2013) and (UNDP,2016). Consequently, this could explain why the study found that most rural households are headed by women with secondary education as their highest level of education. According to the last informal sector survey conducted by the central statistics office , the majority of women with lower levels of education in rural areas rely on informal businesses as a source of income, that often experience challenges such as 'non-payment of goods and services supplied on credit to the customers", intense competition from other small business owners selling the same merchandise, as well as a lack of capital to establish a small business (Central Statistics Office, 2007; Moffat et al., 2015).

Most policies and other government aided support structures for small business enterprises have been criticised for not providing support structures that would empower women to make their informal businesses more profitable. In terms of supporting small businesses, the government has been more focused on empowering villagers involved in cattle farming and some aspects of commercial farming, of which are sectors that culturally dominated by men (Klaven et al 2009).

As such, the study found that as much as women dominate the informal business sector, their mainstream businesses are predominantly concentrated on businesses such as tuckshops, mobile airtime retailing, and sewing which are not extensively profitable or supported by government village development structures compared to cattle farming and commercial farming that are predominantly dominated by men. In relation to this, Maropeng (2015) argues that Botswana has a poverty rate of 44.8 percent, which is regarded to be too a high rate for a middle-income country. In the same vein, Maropeng (2013) observed that although rural development and poverty eradication are important aspects of Botswana's government policies, these policies are not effectively identifying problems faced in the rural areas, nor are they appropriately targeting efforts that could help solve poverty problems within the rural areas, specifically where rural women's' economic empowerment is concerned. This is consistent with the findings of the study which revealed that that when rural women only have access to lower levels of education are not economically empowered, they become more inclined to not make well informed decisions regarding their sexual and reproductive health. Moreover, there are most unlikely to question cultural and religious beliefs that could be harmful to their maternal health.

Thus, village development agendas would have to be structured in such a way that would create an enabling environment for women to succeed economically. Some of the ways of creating this enabling environment for village development would be improving the quality of facilities in rural schools to similar levels as the ones of government schools situated in the urban areas.

This is in consideration of the fact that for one to be able to attain higher education in Botswana, they would need to be able to access the government loans for tertiary education which are normally allocated according to excellent senior secondary school results (Maropeng, 2013).

Therefore, the school facilities in the rural areas needs to be improved to such an extent that would enable to place rural high school students in favourable positions to also be able to compete for government aided loans towards their tertiary education. In addition to the improvement of facilities in rural schools, there should be Non-Profit Organisations that would serve as mentorship structure that would help train teenagers in rural areas towards planning for their educational and career goals.

Access to Knowledge on sexual health

In relation to access to knowledge on sexual and reproductive health, the study found that some of the ways in which the government sought to empower women and girls in respect to the human rights framework is to provide information and access to a variety of contraceptive methods, as a means to promote better sexual and reproductive health and thus curbing possibilities of escalating maternal mortality rates. According to Melles (2009), maternal death risk is higher among young teenage mothers in Botswana due to their undeveloped bodies. The same author highlighted that teenage girls are more likely to consult with illegal abortionist as abortion is deemed illegal in the country, and there are most at risk of contracting HIV that can possibly cause complications in their pregnancy.

4.4.5.1 Promotion of youth reproduction health

The study found that some of the ways in which the government attempts to adopt a human rights approach in reducing maternal deaths among adolescents is through the sexual and reproductive health policy for the youth population (13-29 years), in which the government provides youth friendly services in most public health clinics where the youth are provided with sexual and reproductive health services by younger health worker that the youth can easily relate with. The youth friendly services are structured in a way that allows privacy for the youth to feel comfortable and dignified when seeking information regarding their sexual and reproductive health (Melles, 2009). Also, the government resorted to using alternative media in a form of pamphlets to educate the youth more about how to care for their sexual and reproductive health (Melles, 2009).

4.4.5.2 Gender and sexual health awareness

The study also found that in Botswana there are programs that are aimed at helping young people lead healthier sexual lives. Examples of these programs include; the *Basha Lesedi (Youth are the Light)* programme that is funded by the US Centre for Disease Control and Prevention (CDC), as well as the *Social Marketing or Adolescent Health (SMASH) Project* that is funded by USAID. These programmes are aimed at facilitating dialogues on reproductive and sexual health through a radio call in show, youth clubs in schools, peer education and the previously mentioned youth friendly clinics (Melle, 2009). The study found that although all these programmes that are geared towards assisting the youth with matters of their sexual and reproductive health, the youth are still not completely protected because most sexual and reproductive health programmes in Botswana are not gender sensitive. In concurrence, UNFPA (2019) highlighted that the programmes that are not specifically created to target men, and programmes not delivered in areas that are easily accessible to men such as their work place, local kgotla meetings, and at non-working hours where men would be available. The study found that the patriarchal nature of the society where men (who do not frequently access sexual and reproductive health information) are usually the main decision makers, expose women and girls to harmful sexual practices. Some of the practices have been identified as incest, coerced inter-generational sexual practices and gender-based violence general population of men have not been taught how to be responsible in issues pertaining to sexual and reproductive health. Thus, it can be seen that the challenge with the implementation of the human rights framework in ensuring high quality sexual and reproductive healthcare services in Botswana is that not all stakeholders are included in the health networks, specifically stakeholders that involve the participation of men in issues pertaining to sexual and reproductive health.

It is recommended that other traditional healers and cultural leaders, as crucial stakeholders, should be included in the health network as they have an influence on the people's decision on applying sexual and reproductive health knowledge in their lives. According to the Human Rights Watch (2013), it is common practice for tradition to be used as an excuse to abuse people's human rights that have been stipulated in the Universal Declaration of Human Rights and the Vienna Declaration. The study found that in Botswana, traditional and religious beliefs play a crucial role in determining women's decision to comply with the recommended antenatal visits during pregnancy. In further reinforcing this argument, one of the respondents, who has practiced as a nurse and midwife in both urban and rural areas in Botswana argued that a higher educational level and a schooling system that teaches critical thinking skills would equip young women with the skills needed to evaluate problematic traditional and religious practices and

make wiser choices regarding their sexual and reproductive health. The interviewee argued that:

> *"…My main worry is the mindset. You know with the mindset, once it's been twisted, it's very difficult to untwist it. Now they go around house to house to make more people to join their church, so such its dangerous for mankind. For me, WHO I think they should even get to them, involve them so that they can understand about these health policies because it's very difficult to change people's mindset. Maybe they should bind them; maybe we should have clauses that prevent people from abusing others' human right. Because these are human beings, so whatever stand I take, somebody can try to convince me otherwise, but if there is a clause that protects me then I'm covered" (Botswana Interviews, 2015).*

She further stated that:

> *"…You will get somebody seeking a letter of permission to travel from a midwife because they need to travel to a church conference. But the problem we have is with the Jehovah's Witness because they don't allow blood transfusions which can cause problems in pregnancy & delivery..." (Botswana Interviews, 2015).*

In concurrency, another respondent who is also a midwife who has practiced in both rural and urban public hospitals shared the same viewpoint, in which she argued that

> *"…We give prep talks, flyer, information that they can read at home but some of them are reluctant to read. We are so rooted as Batswana, they are so many foods that we are reluctant to eat culturally but they could benefit us a lot, I don't know whether we have been brainwashed because we advise, but they won't listen. For example, the rupture of the membrane, if it ruptures before they interpret it as because they didn't follow certain things culturally & it's difficult to convince them otherwise…" (Botswana Interviews, 2015)*

The statements above showcase that although there are actors such as the Botswana government, UNESCO and PEPFAR that have been working towards effective human rights framework approach to implementing policies pertaining to sexual and reproductive health care, there are other important actors in the religious and cultural sector that have a strong influence on people's decision-making processes. It is worrisome to note that the cultural and religious actors are not necessarily engaged with the health networks as revealed by the midwives' statements above. Therefore, this could be reason why the effort to implement the human rights framework in sexual and reproductive healthcare services, as well as the maternal healthcare services has been failing. Hence in this case, there seems to be inadequate wider community participation and weak ownership of programmes that are geared towards better access to sexual and reproductive healthcare. Another challenge in the adoption of the human rights framework in the Botswana context is the issue of the restrictive abortion laws that have not necessarily stopped women from accessing illegal abortionists in the country.

4.5 Conclusion

In sum, the findings of the Botswana case revealed that in terms of the norm cascading of CEDAW norms from an administrative point of view, the government has made the environment conducive for NGOs in global health networks to operate in the country as a way of showing their commitment to the legitimisation of the CEDAW principles of women's empowerment. However, from a practical point of view, some government officials believe that women empowerment NGOs such as *genderlinks* are too leftist and contradict the women's cultural role in society. Institutionalisation can be identified as the dominant mechanism in the cascading of CEDAW norms whereby, the government's establishment of the youth friendly services in public clinics has provided the youth with a desire to learn more about how to care for their sexual and reproductive health and family planning. However, institutionalization has failed in rural women's lack of access to business development information and institutions and in the registrar of society's failure to control the institutionalisation of mushroomed commercialised churches with problematic doctrines that prevent women from adhering to antenatal care or practicing effective methods of family planning. In terms of the norm internalisation of CEDAW, the legislature continues to make amendments to the constitutions so that discrimination against women can be curbed. However, the overlap between common law and customary law defeats the purposes.

In terms of the cascading of the Beijing Platform for Action norms, Botswana government is one of the key actors in the cascading of these norms whereby Government established the Women's Affairs Department in the year 1997, which was renamed to the Gender Affairs Department that would be inclusive of gender issues affecting men (BotswanaGenderAffairsDeaprtment:2014).The Gender Affairs was also decentralised to cover extensive areas within Botswana which included; "Francistown & Ghanzi (2000), Maun and Tsabong (2004), Serowe and Kasane (2007), and Kanye &Selibe-Phikwe (2008) (Botswana Gender Affairs Department: 2014). In the constitution, The Government of Botswana made some legislative changes during the period of between 1995 and 2009, to make them more gender sensitive (BotswanaGenderAffairsDepartment.2014). Some of these laws include the Abolition of Marital Power Act (2004), Domestic Violence Act (2008), and the Children Act (2009) that was established in accordance to human rights (BotswanaGenderAffairsDepartment,2014).

Non-governmental organisations and Civil Society Organisations such as the Botswana National Productivity Centre, The Institute of Developmental Network, the Botswana Council of Women, Genderlinks Botswana, Botswana Council of NGOs (Bocongo), and the University of Botswana have made some provisions to contribute towards matters pertaining to women's empowerment issues, although they do grapple with funding issues. Like in the case of the CEDAW norms, institutionalisation is the dominant mechanism in the cascading of the Beijing Platform for Action norms. In the internalisation of these norms, Botswana's application of laws pertaining to the Beijing Platform for Action can be hindered by the fact that laws overlap with other international covenants such as the International Covenant on Economic, Social and Cultural Rights. There also tends to be an overlap within the country's dual legal system that recognises and practices both common and customary law. Also, the prevalence of the urban institutional approach to implementing the Beijing Platform for Action policies has marginalised other actors such as traditional healers, religious healers from extensively participating in the network, although much of the population choose to consult with these marginalised actors within their rural areas.

In issues pertaining to the MDGs and SDGs, it was found that in the cascading of the norms, mothers in law and elderly women in the pregnant woman's life tend to be the key decision makers regarding the pregnancy and are more inclined to rely on herbalist rather than allopathic healthcare system. Hence, one finds that women tend to register late for ante natal care. There is also less civil society activism that would sensitize communities to crucial policies regarding maternal healthcare. In terms of the internalisation of these norms, the study found that there are policies & guidelines such as the National Sexual and Reproductive healthcare programme, Policy Guideline and service standards of Sexual and Reproductive Health Programme, and Adolescent Sexual and Reproductive Health Implementation Strategy. However, these policies do not extensively provide guidelines on how to handle issues pertaining to culture and religion in the administration of maternal healthcare services in Botswana.

CHAPTER FIVE

Findings from the case study of South Africa

5.0 Introduction

This chapter presents the findings from the case study of South Africa concerning international maternal norms cascade in South Africa. Guided by the key research questions, the study assesses (1) the international and regional treaties regarding maternal health that South Africa is signatory to, (2) it looks at whether South Africa has internalised those norms and (3) how those norms have been cascaded to grassroots level.

5.1 Locating South Africa in the Southern Africa

South Africa is a Southern African country on the Southernmost tip of the African continent with just about 56.72 Million population size (Worldometers, 2019). Economically, South Africa is regarded as a middle-income and is the second largest economy on the African continent with a GDP of 349,4 billion USD (2017) (World Bank, 2018). Apart from being the second largest economy in the African region, South Africa has been regarded as the gateway to Africa and recognised as an emerging middle power state in the region, through which has afforded it to be a member of prestigious regional cooperation's' such as IBSA and BRICS (European Commission, 2018). Since the end of the apartheid era, the South African government has increased spending on social services and has had a stable macro-economic outlook (European Commission, 2018). However, the country has also experienced deep social inequalities, poverty and high youth unemployment (European Commission, 2018). The deep inequalities in South Africa have been evident in the health sector, whereby a small number of the South African population can afford private healthcare and most of the citizens are either reliant on the public healthcare system, traditional medicine or a combination of both.

The public health care system in South Africa is largely tax funded and provides care for 85 % of the population. The more well-entrenched private health care sector provides healthcare services for the other 15% of the population (Health Care as a Democratic Right in South Africa, pg6). After apartheid, more health facilities have been built and renovated, with health care being made to be freely available to pregnant women, young children, people living with disabilities, and prison inmates who primarily rely on the public primary health care system (Health Care as a Democratic Right in South Africa: pg 6). Despite the construction of more

health facilities and the advanced economic development of South Africa in comparison to other African countries, there is still an unacceptably high maternal mortality rate in the country (Maternal and Child Health Draft Policy –SA: PG 7). According to the United Nations International Children's Fund (UNICEF), the recorded maternal mortality ratio of South Africa in the years of 2006-2010 was 400 per 100, 000 births of which the country did not reach its maternal mortality rates target goals in 2015 (UNICEF, 2012).

For Helen Rees, who is the Executive Director of the Wits Reproductive Health and HIV Research Institute, there is now an increase in maternal mortality rates when there should be a progressive decrease in maternal mortality rates as South Africa rapidly develops as a country (Bodipe, 2012). She further mentioned that some of the causes of the increased maternal mortalities in South Africa are due to HIV infection amongst pregnant women in South Africa (Bodipe, 2012).

In the South African case, the HIV factor in maternal mortality rates was compounded by broader political issues regarding the methods of fighting the HIV and AIDS pandemic in South Africa. During the two terms of the Mbeki administration, the official response of the South African government on HIV was rather a controversial issue whereby the government was "accused of HIV denialism and being seen to be resistant to providing anti-retroviral therapy in the treatment of AIDS" (Rohleder et al:2005:p7). For a number of years, the South African government was not convinced that there is a need to roll out ARV treatment to persons infected with HIV and AIDS, and as a result, there were conservative estimates that more than 330,000 people lost their lives and 35 000 babies were born with HIV because of the lack of implementation of ARV treatment during the Mbeki administration (Hashain 2004). However, the 2012-2016 National Strategic Plan for HIV, STIs and TB now considers the AIDS epidemic as a Human Rights issue, in which it is mandatory for the South African government to provide ARV treatment for all South Africans that have been diagnosed with HIV (Info. Gov. 2012).

In this 2012-2016 South African National Strategic Plan for HIV, STIs and TB, young girls who have dropped out of school before matriculating and people from low socio-economic groups were identified as some of the key populations that have a high risk of HIV infection in South Africa. For Johnson and Budlender (2002), there are many misconceptions in Africa about the ways in which HIV and AIDS is transmitted and cured (Johnson and Budlender,2002). These misconceptions are predominantly identified in rural areas and among the unemployed population, in which most black women are identified (Johnson and Budlender, 2002). In consideration of Robinson's (2009) views that members of poorer ethnic groups are least likely to identify with the state on allopathic healthcare being the best suitable

healthcare provision for them, I find that women living in rural parts of South Africa are more likely to trust and have more confidence in the health care provision offered by the traditional healers in their villages than the public health maternal healthcare offered by the Department of health, or even use the combination of the two which can have useful or detrimental effects on their maternal health as I identified in the Botswana case study.

5.2.1 Overview of the findings on the case study of South Africa

The findings in this chapter reveal that in comparison to Botswana, South Africa has a history of the apartheid regime that led to situations of unequal wealth distribution, unequal access to healthcare and education facilities, and increased levels of violence which still prevails today. After the country became democratic in 1994, the ruling party vowed to rectify some of the past injustices. However, in the post-apartheid South Africa, the women and girls rights to equality, freedom of discrimination and equitable care is threatened by factors such as maladministration in the health care facilities, corruption, cultural and religious norms that are discriminatory against women, insufficiently managed HIV and AIDS infections during pregnancy and the stigma attached to abortion procedures. The study found that in comparison to Botswana, the South African civil society organisations are more active. This is evidenced by how organisations such as *genderlinks*, *Treatment Action Campaign* and *Sonke Gender Justice* have been playing an active role in sensitizing the South African citizenry about women's right to healthcare in the highest attainable level and the need for the government to address inequities in access to and quality of sexual, reproductive, maternal and newborn care amongst other issues.

5.3 Findings on international/regional treaties and conventions pertaining to maternal healthcare that have been signed by South Africa

The first research objective of the study sought to establish international/regional treaties and conventions pertaining to maternal healthcare that have been signed by Botswana, South Africa and Zimbabwe. In pursuance to this objective in this chapter, the researcher looked at South Africa case to establish the international treaties that the country is signatory to. Findings from the study suggest that South Africa is a signatory to a number of treaties such as; CEDAW, Millennium Developmental Goals 5, the Beijing Platform for Action (1995) and the UN Conference on Women.

5.4 Findings on how the international treaties and conventions related to maternal health care are being cascaded to the grassroots and the extent to which they are being internalised in South Africa.

The following section addresses two questions and in pursuance of those questions, the study looked at different norms related to maternal health and it also assessed how those norms were cascaded to the grassroots and internalised as the various factors that affect internalisation of the norms. The study presented the results in this sequence, firstly it looked at each norm related to maternal health through the norm cycle model, and secondly it examined it against the various factors affecting its implementation in South Africa.

5.4.1 South Africa and the CEDAW

An investigation into South Africa's stance on *CEDAW (Article 1, 2,3 & 5)*, revealed that just like in the Botswana case study, South African rural women tend to be marginalised in the government's efforts to improve women's right to equality, freedom from discrimination and equitable care. The study further revealed that, women in some rural areas do not have access to good education and health support systems, as well as good transportation systems in comparison to most developed areas in the country (HRSC, 2018). This can be attributed to the previous history of division of the country according to homelands and more developed towns during the apartheid system. In this case, even though the government has added some infrastructure and services in the previous 'homeland areas', access to equitable care is still a problem in most parts of South Africa.

The researcher also observed the overall wellbeing and the status of women in family life in rural South Africa, and found that in South Africa there is a higher number of married women in comparison to the Botswana case, in which these marriages are classified according to three types namely; civil marriages, customary marriages and civil unions (StatsSA 2015:ENCA, 2017). Among these types of marriages, the registration of customary marriages was highest in the KwaZulu Natal Province (48.6%), followed by the Limpopo Province (17.4%) and the Mpumalanga Province at (11.2%) (StatsSA, 2015).

The study also found that customary marriages have become an important and respected tradition within the indigenous black communities as they are considered to be an important aspect of joining two families together, in a manner that is inclusive of customary traditions and rites of passage (StatsSA, 2015). In this type of marriage, polygamous practices are allowed whereby the husband can have more than one wife that can be registered as prescribed "in the recognition of customary marriages Act, 1998 (Stats SA, 2015).

Regarding the issue of customary marriages to maternal health, the study found that the problematic aspect of customary marriage is with the consideration of the *ukuthwala customary practice* that is widely applied in some rural areas in KwaZulu Natal such as in Nongoma and Pongola, as well as in some parts of rural areas in the Eastern Cape. In this practice, the bridegroom along with a couple of friends opt to abduct a young girl that he intends to marry and then keeps her at the intended to be bridegroom's home (Ntlokwana 2016). After abducting the girl, the bridegroom would inform the girl's family about the abduction to prevent them from worrying, and then offer to pay lobola (bride price) to the parents as a symbol of showing intent to marry the girl and to join the two families together (Ntlokwana 2016). Although in the past this practice was generally practiced with the participation of the bridegroom and bride within the same age group in the past years, this practice has evolved over the years with some South African law practitioners arguing that poverty and parental greed has led parents to allow for their young to be married by much older men without the girls consent, in which it often happens that girls as young as 12 years old are married off (Ntlokwana ,2016). In some cases, the young girls are abducted as virgins with no sexual experience, only to be abducted and married off to a man that is HIV positive and approximately 20+ years her senior (Ntlokwana, 2016). In one of the interviews conducted in Pongola village in KwaZulu Natal, Thabisile Mngoma who is an 18-year-old wife that got married through the ukuthwala practice mentioned that:

> *"...I got married to uBaba Mkhize [who is 36 years her senior] when I was 15. I was in grade 9 at the time when I was taken to be his wife. I was scared at first and was worried about missing school, but I eventually got used to be his wife. After the lobola was paid, he did allow me to continue going to school but it eventually became hard for me to continue after I became pregnant and later when I had a small baby to take care of" (South Africa Interviews, 2016).*

Upon my asking about how she felt about having been married through the ukuthwala practice, Thabisile responded to say that:

> *"...I was afraid at first, but I eventually got used to it. I would have loved to stay longer in school but at the same time being married to my husband helped a lot because I am from a poor family. I eat better food now since I got married to my husband and he also helps my family financially when he can, like when my mother was sick" (South Africa Interviews, 2016).*

For Ntlokwana, the ukuthwala practice has become a problem because it has unwritten rules that differ within ethnic groups and tribes in South Africa (2016). In addition, the ukuthwala aspect of customary law is often passed on through word of mouth that often leaves "each tribe, each person, with a distinct view of what constitutes the customary law" to determine how the practice will be applied (Ntlokwana, 2016, p1). In this case, the ukuthwala practice becomes a challenge in the consideration of the issue of the elimination of discrimination against women

and girls as it presents a contradiction in the South African constitution to uphold the universal individual rights as according to the bill of rights on the one hand, versus the maintenance of the traditional practices on the other hand (Ntlokwana, 2016).

5.4.1.1 Poverty and maternal health

The study also found that just like in Botswana, South African women living in impoverished communities need support in getting access to economic opportunities. They are also faced with many incidents of gender-based violence that affects their ability to be the key decision makers in their daily life decisions. The researcher found that in cases where women in the rural areas participate in productive work within the agricultural sector, they tend to be associated with subsistence farming in which they farm for consumption at home, while the men normally specialise in the more commercialised cash crops (Mokgokong, 2010). The subsistent ways of how rural women have been participating in agricultural practices in the South African context is generally perpetuated by the traditional, cultural and social constructions of women's roles as being of a more subordinate position compared to the men. Culturally, women tend to be assigned reproductive and community roles that do not necessarily generate income.

For Edward Webster who is a professor at the Society, Work and Developmental Institute (SWOP), South African women living in rural communities tend to be assigned community roles such as caring for the ill, cooking and washing for family members, in addition to mainly focusing on subsistence income that does not necessarily generate monetary reward (Webster et al, 2010). As a result, rural women are left with limited options to become more financially independent and hence more reliant on the male figures in their lives that ultimately become the key decision makers in important matters regarding the women's livelihood. The author further elaborates that the cultural norm of not considering women's cleaning, caring for the sick, and cooking as a form of work in the home, places women at a disadvantaged position within their homes as they would generally be considered to be playing a community duty role, and not a productive role within their homes. As result, the men [as the ones who participates in the financially remunerated 'work'] are the ones that are regarded to be the rightful key decision makers about important decisions in the home as they are the ones that society perceives to be contributing the most through their financial contributions in the home.

To attend to some of these challenges of financial independence faced by rural women, the South African government has established some funding mechanisms such as the Isivande Women's Fund to provide opportunities for women to participate in the formal economy in South Africa (Cascale and Posel 2010). The Isivande Women's Fund is a Department of Trade

led exclusive fund project that aims to create a funding stream for women's business deals involving start-ups, franchising, as well as business expansion projects (TheDTI, 2018). As much as there are a number of these platforms such as Isivande that seek to help women find access to funding for their potential businesses, several women who were interviewed revealed that they did not know about some of these funding mechanisms and were of the view that they would qualify for the funding. In one interview in Bethel (Mpumalanga), the respondent stated that:

> *"...My husband works in Johannesburg and comes to visit sometimes two times during the year. To sustain my family, I grow mealies in my small garden so that I can sell them to travellers along the road. I also do small trading of scones, sweets and potato crisps along the road and by the school entrances" (South Africa Interviews, 2017)*

When asked whether she thinks her small business has potential to expand, Dlamini responded to say:

> *"...Yes, I do think that my business has the potential to expand because now I wake up in the morning to bake the scones so that I can sell them to the school children by the school children. When I go there, it is not only the school children that buy them but people in the neighbourhoods who buy so that they can eat the scones when drinking their morning tea. It would be nice to get an assistant who can help me with the scone sales so that I can be able to go sell the mealies earlier by the side of road because that has a high market as well. People who travel like to buy the roasted mealies, so it would be nice if I could reach that market much earlier in the day..." (South Africa Interviews, 2017)*

One of the ways in which organisations such as the Industrial Development Community (IDC) [a parastatal that offers funding to South African businesses] can inform women in rural areas about funding mechanisms such as the Isivande Women's Fund is by partnering with media organisations such as community radio stations existing in the rural areas, in which the Industrial Development Community would share information on how women can access funding through institutions such as the IDC. For a long time in the history of South Africa, community radio stations have been used as platforms to "influence public opinion, create consensus," and to strengthen democracy (Bernard 2000, p73). In the post-apartheid era, community radio stations should be used as platforms to inform people living in the rural communities about accessible funding opportunities available for them should they need to start or expand their businesses. The community radio stations can also be used to educate ordinary people in the rural communities about the benefits of gender equality and to share broader information about issues pertaining to family planning and how to evaluate cultural norms that influence family planning behaviour. Furthermore, organisations such as the

Industrial development community can use other alternative means of media such as pamphlets to share information with the rural communities about how they can access funding support for their business ideas.

Besides not being able to access funding knowledge and mentorship on how they can expand or diversify their income within a rural setting, some women living in the rural areas have expressed that they have experienced gender-based violence by their intimate partners. When women are violated, their confidence levels slump which ultimately impacts on their ability to thrive in bringing their income generating ideas into fruition. Women who are violated also have less ability to feel free to express their views on key decisions needed be made within their family setting. According to a Sociology expert on violence against women in South Africa, the culture of violence against women is largely widespread and largely stems from the culturally influenced perceptions that a man is the owner of his family, and therefore ownership gives them an exclusive right to control their family members, of which is "erroneously seen as a form of love for their family" (UNISA 2018, p1). In this case when there is lack of balance in power within a family setting, there is a high likelihood that the person who hold the most power is most likely to abuse the power they have within their family members.

5.4.1.2 Violent legacy of South Africa

In considering how the South African setting has a history of using violence as a way of dealing with problems during the apartheid era, the study also found that South Africa's historical past of violence has somewhat normalised the behaviour of violence as an acceptable way of instilling discipline within a family setting. Hence, South African women living in rural or less developed areas are more likely to have partners that are violent abusers as they are less likely to have platforms to challenge the issue of domestic and sexual violence in their rural communities. Besides the historical consideration of violence having been used as a problem solving mechanism during the apartheid era, other contributory factors of violence against women can be fuelled by frustration men feel regarding social ills such as "unemployment, financial hardships and poverty, alcohol and drug consumption', as well as factors such as immature attitudes and unchallenged negative cultural beliefs (Seabi, 2009).

After the dismantling of the apartheid regime, one finds that the issue of "poverty, social disarray and fragmentation", has indeed contributed to the alarming cases of violence against women within the South African context (Seabi 2009). In relation to this, the researcher found that despite the existence of laws that are meant to dispel and discourage the abuse against

women, the assimilation of these laws has been a challenge as they are incompatible with the cultural framework of the persons that are meant to implement these laws (Seabi 2009). For example, although police stations can issue protection orders for victims of domestic abuse, some male police offices often consider the reports of domestic abuse by women as harmless 'lovers quarrels' and often send the women home without adequate help, or they deflect the issue to the female police officers to address because of their perception that domestic violence is a 'social' issue that can only be addressed by a female police officer (Retrief and Green , 2015). In this case, police response showcases that even law enforcement officers uphold the problematic culturally acceptable gender roles that perpetuate gender-based violence in society (Retief and Green, 2015). In issues pertaining to sexual and reproductive health, the issue of gender-based violence is important to consider because one finds that women who have been abused sexually have been found to be 48% more likely to be infected with HIV compared to women who have not been sexually abused (Mukanangana et al, 2014). In consequence, sexually abused women who contract HIV become more prone to having life threatening pregnancies if their HIV infection is not monitored and managed accordingly.

5.4.1.3 Activists and maternal health

The study found that, as a way of dealing with some of these challenges, South Africa has a numerous number of Non-Governmental Organisations that play an activist role against issues regarding gender-based violence, and matters relating to gender inequality in South Africa. In this case, the culturally induced lack of financial independence and prevalence of gender-based violence threaten South African rural women's right to equality, freedom from discrimination and equitable care.

Regarding policies and programmes aimed at ensuring women's freedom, right to equality and freedom from discrimination, the study found that in the South African context, NGOs and civil society groups such as *Sonke Gender Justice* and *Gender Links* are normally the ones actively striving to change the ways in which women are disadvantaged in South Africa. In comparison to Botswana, the study found that there is a lot more variety of NGOs in South Africa. Also, the South African NGO and civil society sector is a lot more active and have a less challenged platform to promote gender transformation in South African societies (Colvin, 2009). It can be argued that the reason for a much more freer platform for South African NGOs is that unlike Botswana, South Africa is coming from a history of institutional discrimination whereby certain population groups were not afforded the right to live their lives in the ways that they saw fit and applicable to them, of which is a situation that led to the rise of the liberation movements that fought the system so that all groups of South Africans can have

equal rights. It is from this part of South African history that has led to the culture of activism that is strongly encouraged and supported in the South African context.

Through this culture of activism, the study established that NGOs such as the *Sonke Gender Justice* have been doing high impact work in the transformation of mindsets regarding harmful gender stereotypes and the challenging of counterproductive traditionally set gender roles in most parts of South African societies. For an example, the Sonke Gender Justice Network has initiated its 'One man can campaign' through which it provided training and capacity building training kits that were used to train men that include coaches, religious leaders, father's, teachers, ward councillors, and young people about the benefits and importance of the adoption of gender equality attitudes for both men and women in South Africa (Colvin, 2009). The effectiveness of the work of this NGOs is that it partnered with other social institutions such as the Nkandla Hospital in Kwa-Zulu Natal, the South African Police Services (SAPS) in Thoyandou in the Limpopo province, as well as the Siyakhanyisa, Qumbu Community Health Centre and the Qumbu SAPS in the Eastern Cape Province (Colvin, 2009). As result, the partnership with various social institutions enabled the Sonke Gender Justice Organisation to have an impact in some of the furthest rural areas in South Africa.

Another NGO that has made an impact on the quality of life for rural women is the Rural Women's Movement (RWM), which an NGO that was established in 1995 to tackle issues such as women's access to land and the role of women in development issues within the local and national levels (Ngopulse, 2006). In its objective of bettering the lives of rural women, this organisation pays emphasis of; encouraging women to participate at local government, helping rural women to acquire their own piece of land, providing HIV and AIDS training for women and orphans, as well as providing ICT training for women in rural communities (Ngopulse, 2006). In its practice and experience of working with rural women, officials at the Rural Women's Movement have made some observations that because of the deeply entrenched patriarchal values within rural communities, rural women tend to be more shy and somewhat withdrawn when they have to engage in public spaces and meetings compared to the women living in urban areas (Rural Women's Movement, 1995). In consideration of this reality of the demeanour of rural women, it is important that government agencies and private sector institutions [such as ICT companies] make more attempts to reach out to organisations such as the RWM, in order to offer to create more platforms for the organisation to have access to funding agencies, teachings about international norms and the government's agenda regarding matters pertaining to gender equality, so that the organisation can have a greater impact in positively changing the quality of life for women living in the rural areas.

5.4.1.4 Family planning and maternal health

In consideration of women's right to access adequate healthcare facilities including information, counselling and family planning services *(Article 14)*, the study found that it is important to consider how community family planning programmes were structured during the apartheid context, during the post-apartheid context and how culture and religion has an influence in how families choose to make use of family planning methods. During the apartheid era, the aim of the family planning programmes was to control the black population groups while encouraging the white population groups to grow (Ndinda et al, 2017). During this time, the white National Party government was in control of the national government and the most influential financial institutions (Norling 2015). The other racial groups [namely African, coloureds, and Asian] had some restrictions imposed on how they could move around in the country (Norling 2015).

The separationist attitude in governance was to a large extent predominantly felt by the black population who consisted of three thirds of the population of South Africa, as they were restricted to acquiring permits before they could be able to move around the urban areas where most people could find jobs (Norling, 2015). This was an effective family planning method that was strategically established to control the growth of the black population. At this time, the black population that was able to live and secure jobs in the white areas in South Africa gave birth less compared to the black women living in the homelands (Norling 2015). The black population living in urban areas at that time were also prone to give birth later in life and would have longer intervals between the years they gave birth (Norling 2015). Since the homelands [Transkei, Bophuthatswana, Venda, & Ciskei] had nominal independence and were allowed to self-govern from the late 1970s and early 1980s, the African leaders within those homelands were at liberty to decide on the family planning programmes that they would require for their homelands to follow (Norling, 2015). At this same time, there were major concerns that the contraceptive Depo Drovera had cancer causing side effects, through which countries such as the United States decided to stop its domestic sale of the until the year 1992 (Leary, 1992).

Other Southern African countries such as Zimbabwe also banned the use of the contraceptive injection, but South Africa continued to use the drug (Kaler, 1998). Because of the political instability that was filled with suspicion of other races, the homelands leaders perceived the South African government's decision to continue administering this drug as a tactic to get rid of the black population groups in South Africa, and hence most black population groups had a distrust for the national sexual and reproductive health policy (Norling 2015). Since they

[homelands] were considerably independent and self-governing, the leaders of the homelands encouraged people under their rule to not use contraceptives so that the black population can multiply. In this case, the African Communist Newspaper even stated at the time that:

"…The so-called national family planning program is being used to perpetuate white domination and the oppression & exploitation of the black majority." (unsigned 1982, pg 87) in (Norling 2015).

Because of these misconceptions and the black leaders' mistrust in the national sexual and reproductive policy at the time, independent homeland leaders decided to not establish "extensive family planning programmes' within their own communities (Norling, 2015). As a result, the black population living in the homelands maintained the culture of not using contraceptives and the perception that modern contraceptive methods have negative life-threatening side effects.

In the post-apartheid era (post 1994), South Africa discarded the population control type of family planning policies and adopted family planning policies that were more acceptable to the global agenda that "pay emphasis on the link between population and development" (Ndindaet al, 2017). As much as South Africa has shifted towards the global agenda in family planning policies, it has been a challenge for the large part of the black population to adopt this form of family planning strategies (Ndinda et al, 2017). In most rural areas, people are more accustomed to have more children than spacing their pregnancies which is culturally acceptable within this specific communities. In this case, the researcher found that there are overlapping policies and agendas despite the South African government's intentions to aligning itself to the global agenda regarding family planning methods, the South African government is also cognisant of the fact that the over two thirds of the black population in the previously 'homelands' part of the country were oppressed before, and thus the government prefers to let them practice their preferred cultural and religious practices as a means to protect their 'human right' of freedom of expression (Ndinda, 2018). For instance, although South Africa has allowed abortion rights since 1997, abortion is still religiously and culturally regarded as an unacceptable practice within the black community. As a result, most young people choose to secretly have these procedures done at non-licenced facilities because of the fear that the professional bodies (formal abortionists) would inform their families about their unplanned pregnancies and their decision to terminate the pregnancy. In this case, different social categories perceive the offered family planning methods by the government in different ways. Based on the above , it can be argued therefore that , rather than the government focusing on making various family planning methods available to the public, the government should rather study how different population groups perceive family planning so that they use that

information to create campaigns that would change the negative perceptions held regarding the offered family planning methods, and consider ways of how they can make available the family planning methods that best meets the needs of the population groups in the rural areas.

In some of the remotest rural areas in South Africa, the residents have an entrenched cultural beliefs and perceptions regarding methods of family planning and have voiced that they prefer their own cultural ways of family planning. The weaknesses of the cultural methods of family planning however is that it lacks a variety of contraceptive methods, and only pays emphasis on the role of the woman in using that method of family planning, even though women are not entirely the key decision makers in their intimate relationships within these rural settings. For example, the practice of virginity testing [ukuhlolwa] as a method of family planning is based on the belief that the more social structures ensure that young women delay their sexual debut until they get married, the more they would be decreased chances of HIV infections.

The blind spot of this particular family planning method however is that as much as the young women are taught and rewarded for delaying sexual debut, it is socially acceptable for the men to not delay their own sexual debut and therefore there are chances that the young women who have delayed their sexual debut can find themselves in situations where they become infected with venereal diseases such as HIV which can be an indirect cause of maternal deaths if not managed properly.

5.4.1.5 Education

As a means of resolving some of the problems of the overlap of policies where, on one hand, the government wants to align itself with the global standards, and on another hand, it (government) wants to protect the cultural and religious rights of the previously homelands areas in the name of protection of 'human rights'. It is important to realise how good education can be used as a tool to help equip people living in rural areas with the critical analytical skills. It is envisaged that good education would equip them with requisite skills to study the various methods of family planning offered and then choosing the best method that is suitable for them after evaluating their religious and cultural practices. However, the education system in the rural areas appears to be challenged in this regard. In relation to this, it has been reported in the shadow report of the implementation of the CEDAW that there are much fewer women over the age of 20 years with a formal education (CSVR, 2011).

Some of the barriers that prevent women over the age of 20 from accessing formal education include the fact that the no fee policy for schools in impoverished areas tends to only cover central schools, and hence does not extensively include all poor learners (CSVR, 2011). As of

current state, geographical location is used as a yardstick for measuring the poverty levels, in determining whether learners are eligible to pay fees or not. This method has proven to be ineffective as learners who are impoverished can reside in geographical areas that are deemed to be doing well financially (CSVR, 2011). Therefore, it is important that the school's poverty demographics should be used instead of geographical location when considerations are being done on whether to apply the no fee policy or not for the learners (CSVR, 2011).

Furthermore, the government should reconsider placing the responsibility of exempting fees for impoverished learners on the schools and should rather take up this responsibility from government level. It has been observed that, often the poorer schools are expected to "recoup costs from other sources" when they exempt learners from paying fees, which ultimately negatively affects the resources available for the schools to provide quality education that can enable learners to reach a critical thinking mindset (CSVR, 2011). Currently, the government has adopted a policy of free education since December 2017, a decision that was made as a political strategy by one of the contesting factions at the ANC national conference. In this case, the ANC government still needs to examine the ways in which the free education policy will be implemented for deserving students across the country.

Another issue that needs to be considered in support systems for impoverished schools is the issue of the need to have a more standard transportation policy in rural schools because the transportation of rural school children to and from schools is currently not properly managed or funded, which can discourage children living many kilometres from their schools (CSVR, 2011). The situation of the inadequate school transportation system in the rural areas can be specifically more dangerous for female students as they are likely to encounter sexual assault on their way to school, which can lead to unplanned pregnancies or venereal diseases that can indirectly cause maternal deaths [through illegal abortions or HIV induced maternal death] (CSVR, 2011).

5.4.1.6 The effect of Culture and religious ideologies on maternal health

The study found that some women often turn to religious organisations so that they can learn the coping mechanisms of how to deal with their day to day struggles. Thus, they turn to religion as a way of coping with some of the challenges listed such as rights abuses in the family dwelling, inadequate access to quality education, and exclusion from access to social and economic development resources. However, impoverished church going women have also experienced cases of abuse of their religious rights just as it has been the case in the situation

of Botswana. While collecting responses to the women's experiences, the researcher found that most of the women in the rural areas in South Africa tend to associate their health problems with spiritual 'higher powers' such as the ancestors, as some believe that their health and general life challenges are attributed to witchcraft in their area. In this regard, one of the respondents who had lost her sister through maternal death stated that:

> *"...My sister had health challenges a few months before she gave birth. When we took her to our umthandazi [prayer warrior/spiritual healer] at our church, it was revealed that one of her women colleagues at work had put bad stuff in her food that made her feel sick all the time. When she was pregnant and close to her due date, she started to lose her mind and eventually died two weeks after she had her baby. When we went through her health cards after her death, we found that she had tested positive for HIV 3 years before her death. She never told us that she is HIV positive, and I have never seen her drinking medication, so I think maybe the HIV caused her to die after she had her child ..." (South Africa Interviews 2016)*

The quotation above showcases how the prevailing stigma around HIV can delay people from seeking the appropriate health care during pregnancy, which can ultimately contribute to maternal death. Furthermore, the different meanings attached to health symptoms as signified by witchcraft associations described above, shows that institutions such as churches can have an influence on how, where, and when pregnant women choose to seek healthcare services regarding their pregnancies. Consequently, this can also determine whether they will die from the pregnancy or not. It is apparent from this case that, it is important that the international community does not underestimate the influence of religious doctrine on how pregnant women choose to make use of healthcare services available to them.

In consideration of the State taking appropriate measures to eliminate discrimination against women in the field of health care, including those relating to family planning, it was found that amongst the adolescent group, the South African government has made some strides in the availing of access to education for girl learners in South Africa's basic educational sector. However, the government has been challenged with lowering the numbers of teen pregnancies that occur in South African public schools. According to the public interest law centre named Section 27, there was over 99 000 learners who fell pregnant in South Africa in the year 2013 (2017). In addition to this, 473 159 teenage girls between the ages of twelve and nineteen were reportedly not attending school in the year 2014 in which 18% of these girls were not attending school due to issues pertaining to teenage pregnancy (Section 27.2017). In studying the reasons behind the high rates of teenage pregnancy in South Africa, the study found that besides the issue of cultural and religious barriers that cause young women to have negative perceptions regarding the use of contraception, as well as having patriarchal male figures being the key decision makers regarding women sexual and reproductive health, a number of girl learners in

South Africa still fall pregnant because of social ills such as rape, male teachers taking advantage of female learners by coercing them to have sexual relations with them, as well as cases of pregnancy that occurs in traditional practices such as ukuthwala (child marriage) that are still prevalent in provinces such as KwaZulu Natal and the Eastern Cape (Section 27).

Just like in the case of Botswana, patriarchally influenced religious and cultural ways of socialising girl children has led to a society where most women and girls develop less agency to assert themselves on insisting to be the key decision makers in matters concerning their lives, specifically regarding the education and sexual & reproductive issues. The patriarchal nature of socialisation in most South African rural villages often considers women and girls as lower-class citizens that are often 'classified as child bearers and keepers of the home' (Memela, 2017). Within the context of deep economical inequalities, and the traditional rural settings that favour men, there is often a feminization of poverty where women are expected to be the ones who fend for their families without much family income. To deal with these life dynamics, women often seek solace and support from religious institutions. However, there has been some instances where churches have abused some aspects of congregant's human rights when they are operating within their constitutional right to practice freedom of religion. Another example of such cases is with regards to a situation in the Eastern Cape whereby a church named 'Angel Ministries' prevented 18 young people from attending school, of which was an abuse of human rights (Raborife, 2016).

According to Strauss, churches tend to agree with the general concept of human rights as accepted by various parts of the world (2015). However, different parts of the world and different societies (including church environments) tend to differ in their interpretation or the detail of the concept of human rights (Strauss, 2015). In the context of the relationship between the church and the state, the two institutions tend to agree with the central idea of human rights (Strauss, 2015). They however differ in their interpretation of specific rights or the way in which certain rights are formulated (Strauss, 2015). Most South African churches as social institutions tend to refer to the Bill of Rights when arguing a point against other social institutions such as the state, but they however perceive to be abused if other social institutions review them about the bill of rights (Strauss, 2015). This is particularly common when churches are questioned about the status of women in their church as an institution, the church's position

on sexual and reproductive health, as well as about issues concerning sexual orientation and other controversial issues.

5.4.1.7 Abortion and maternal health in South Africa

In situations where the church prevents children from attending school like in the case of the 'Angels Ministries', the South African Department of Social Development can argue that the church has abused the children's human rights by keeping them out of school but at the same time, state organs such as the courts could be accused of 'deciding for the church what its beliefs should be', which can be interpreted as the courts way of using article 9 of the Bill of Rights to be totalitarian, and hence limiting the church from exercising its freedom of religion (Strauss 2015). It is in cognisance of these factors that they should be an engagement between the church, the state, and other actors in women and girls' empowerment networks so that problematic ideological perspectives that negatively affect the implementation of gender equality policies can be ironed out from an ideological perspective, specifically those issues concerning sexual and reproductive health that can possibly cause maternal deaths if implemented incorrectly. Such issues include the Termination of Pregnancy Bill which shall be studied further below:

In 1996, the South African government established and committed to the Choice of Termination of Pregnancy Act in which abortion was legalised to curb maternal deaths linked to sepsis (ECR Unit Working Paper, 2009). The Act was inspired by the ICPD as well as South Africa's wish to establish laws that would positively serve the majority in which women were identified as those that needed their rights to be acknowledged and respected (Mhlanga 2003). However, the expanding religious sector as well 'conservative persuasions' that are being pushed by the growing charismatic Christian Movement has led many people to be against abortion laws, hence abortion is generally stigmatized and associated with shame within the religious community (Mhlanga 2003). In a study done by the HSRC, it was found that those that 'frequently attend church meetings or services' tend to be against pro-choice (Mncwango 2007). On the other hand, those with a higher level of education were reported to be for pro-choice regarding abortion laws (Mcwango, 2007). Ultimately, those with higher levels of education and frequently attended church meetings or services would be most likely to be against abortion laws. This is illustrated in the way in which organisations such as 'doctors for life', 'the Christian Lawyers Association', and 'Africa Christian Action' were actively against abortion laws when the law was approved (Mncwango, 2007).

In current actual practice, the legalization of abortion has not extensively stopped women from choosing to have abortions in safe designated areas as some women (including church attending women) (Berger 2016). Instead, they tend to choose to do abortion procedures at the illegal service providers. For Berger (2016), South African women have not extensively used government abortion health care services because of "poverty, lack of information and services" and the social stigma associated with having an abortion. The legalization of abortion was not effectively communicated with the public to such an extent that women who live in the most rural areas of South Africa did not have access to the extensive information about the costs and the safest place to get these procedures done within the South African health care system (Berger, 2016). For the urban impoverished women, the information that they have been exposed to about abortion has been from the popular flyers posted by illegal abortion service providers, in which they claim to provide pain free abortion at affordable costs (Berger 2016). Even in situations where the women and young girls have access to information about safer ways to have abortion, they are often discouraged from going to these areas because of fear of being stigmatized by the health care service providers, particularly with regards to the adolescent population group (Berger, 2016).

According to the Department of Education, the widespread stigma about adolescent sexuality and unbalanced gender relations prevent open communication between young people and more knowledgeable persons about issues pertaining to sexual and reproductive health (2009). At some point, the South African government established the Adolescent Friendly Clinic Initiative that is meant to offer young people information and service regarding family planning and contraceptive health care services. The negative attitude of health staff working in these health care facilities however discouraged young people from visiting these facilities to seek advice and health care services (Department of Education, 2009) and (South African Department of Health: 2005). As result, unplanned adolescent pregnancies have escalated as well as new HIV infections in this population group, which often places them at risk of maternal mortality considering that many maternal deaths are closely linked to the HIV epidemic in post-apartheid South Africa (Department of Education, 2009).

5.4.1.8 Use of contraceptives

In terms of the use of contraceptives and family planning, one finds that there is a 50.6% of the use of modern contraceptive methods by women in South Africa (UNFPA 2017). The South

African government has made provision of contraceptive health services through the guidance of the 'contraceptive policy of 2001' and 'contraception service delivery guidelines of 2003' which have been revised over recent years as new challenges emerged (UNFPA, 2017). Although there has been over 50% of contraceptive use in South Africa, there has been some challenges in the use of these services, the challenges of which are most prevalent within the very poor and deep rural communities (UNFPA, 2017). In rural KwaZulu Natal province, talking about sex is taboo in traditional Zulu culture and teenagers often receive corporal punishment when they initiate a conversation about sex (Ndinda et al, 2017). Furthermore, the rural area society is still predominantly male dominated with women often feeling compelled to have more children to prove their fertility and worth in their community (Peer et al, 2013). This explains the high numbers of unplanned pregnancies that remain a challenge in these communities, and thus showcasing an unmet need for contraceptive use within rural areas in South Africa (Seutlwadi, 2012).

Other reasons that cause the low use of family planning services in these areas is lack of easy access to the services, as well as limited knowledge and awareness of the value of contraceptive use, which can be exacerbated by the issue of not having enough staff in community health centres within the rural areas, and health facilities that only operate during office hours and therefore not user friendly for working and school going youth (UNFPA, 2017) and (Motswaledi, 2013).

With regards to the elimination of discrimination against women in access to the field of education, the study found that most government schools in South Africa are grappling with challenges such as "low teacher morale, poor quality of education, inadequate sanitation and water in school facilities, and poor mechanisms for inclusive education" for special needs children such as children living with disabilities (UNICEF, 2018). Girl children are more prone to experience "sexual abuse, harassment, exploitation and murder in their schools" (UNICEF 2018). To deal with some of these challenges, the Department of Education formed the *Girls Education Movement (GEM)* policy, through which adolescents and young people at grassroots level work together to impact the lives of girls and boys in a much more positive manner (UNICEF 2018). This programme is supported by the government and UNICEF with its strategic goals including; to improve the quality of education in rural schools, making the school curriculum to be more gender sensitive, involving boys as strategic partners and formulating youth clubs that are geared towards reducing gender-based violence and abolishing harmful practices such as early marriages, which could possibly disrupt a girl child's educational journey (UNICEF 2018). Furthermore, the study found that the active NGO and

civil society sector in South Africa have more mentorship organisations such as the Thope Foundation, the Western Cape Government Youth Development Programme, and the Trasnet teenage health programme amongst others, that have been playing a pivotal role in influencing the delivery of education in ways that accommodate girls 'specific needs. Although the South African civil society and NGO sector is active in this area, these organisations need to do more collaborations with other actors in the communities such as the community leaders, religious and cultural leaders, and parents so that collectively, these actors can work towards debunking the harmful cultural and religious practices that can negatively affect girls access to education, specifically in matters concerning girls 'access to sexual and reproductive healthcare.

5.4.2 South Africa and the Beijing Platform for Action (1995) and the UN Conference on Women

When South Africa committed to the Beijing Platform for Action in February 1996, the then two-year-old democratic South Africa of the time was focused on rebuilding the image of South Africa as a country that values the protection of human rights, and as a country that wants to be a positive participant in the international community after many years of being sanctioned and civil instability during the period of the apartheid regime. In this case, the international community has witnessed South Africa adopting a new constitution, the bill of rights, as well as committing to international instruments such as the Beijing Platform for Action in 1996 (Plaatjie and Huffel, 2011). In his comments about gender equality at national parliament, Nelson Mandela who was the newly elected state president of the time stated that all South Africans had to understand that the country could not experience true freedom "unless women have been emancipated from all forms of oppression" (Plaatjie and Huffel, 2011). It is worth considering that before South Africa became a democratic state in the year 1994, the division of gender in the country was separated across racial lines and hence the new government "tried to turn around the unfortunate inheritance through changing some legislation to fit the pro-gender equality stance by formulating and adopting the new constitution, adopting the bill of rights, the Beijing platform inherited policies and institutions" that perpetuated inequality across race, class and sex (Plaatjie and Huffel,2011, 2). After 1994, however, the full implementation of these laws and policies has not extensively been successful due to various reasons, although South Africa has performed better than Botswana in its implementation of the Beijing Platform for Action in some areas.

5.4.4.1 Advocating for gender equality

Some of the ways in which the South African government aimed to ensure that all women had the right to equality; freedom from discrimination and equitable care was through establishing the Gender Equality Commission (GEC) that would be used as a channel through which the Beijing Platform For Action would be implemented. As a way of achieving some of the Beijing Platform for Actions goals for the country, the GEC partnered with organisations such as *Sonke Gender Justice* whereby *Sonke* was part of the monitoring team at GCE, specifically in addressing issues pertaining to gender-based violence. The monitoring team would also address issues concerning the provision of better services to rural women, women living with HIV and women in low paying jobs such as domestic workers. Furthermore, organisations such as *Genderlinks* and *Media Development and Diversity Agency (MDDA)* contributed by using media to produce content that is geared towards sensitizing the South African public about the importance of ensuring that women's right to equality is realised. In this case, the study found that in comparison to Botswana, South Africa used demonstration more as the dominant mechanism that would sensitize the public about issues concerning women's right to equality in the country. However, due to reality of South Africa having conflicting legal/common and customary systems, the socialisation of the principles of the Beijing platform for action has not been extensive across the country, with some provinces performing better than others. In this regard the study found that one of the driving motives of South Africa's participation in the Beijing Platform for Action is *legitimacy*, whereby South Africa was willing to institutionalise the principles of the Beijing Platform for Action as a means of developing its legitimacy, reputation and esteem as a new democratic state that has risen from being isolated in the international community because of the apartheid regime. However, the overlapping and coexistence of customary norms and common norms has in some instances caused South Africa to experience some legitimacy crises as in the case of Botswana.

According to Finnemore and Sikkink (1998), countries that experience legitimacy crises tend to be more drawn towards signing international norms as they sign to conform and to be included in international relationships. It can be observed that most African countries do not usually have liberal democracies (specifically Sub-Saharan African countries) nor do they have liberal economies, as a result they tend to feel excluded and powerless in their participation in the international community (Ipinyomi, 2016). This feeling of exclusion by African countries has been displayed by their persistent advocating for the reform of international institutions such as the UN, World Bank and the World Trade Organisation. According to Trevor Manuel who is a South African former Minister of Finance, there needs to be stronger north-south relationships between the developed countries and the developing countries, in which African

countries develop a louder voice in international decision, as well as the "reform of international financial governance" and other international organisations (Wall, 2002).

Among most countries in the international community, Africa is usually perceived to be a single entity, without considering the diversity of the continent consisting of a "collection of disparate states and ethnolinguistic groups with varied customs, cultures and philosophies" (Ipinyoni, 2016). Most leaders of African countries have argued that general narratives in the international community define Africa by its colonial history", as well as its current failure" without necessarily considering Africa's pre-colonial ideology and the extent to which it still exists and is still meaningful to the diverse African people (Ipinyoni, 2016). African leaders also argue that countries were not part of the treaty of Westphalia that is one of the important world events regarding state sovereignty (Ipinyoni, 2016). In this case, African countries only alluded to the Westphalian way of living after their decolonialisation, hence their "Wesphalianism was never completely developed" (Ipinyoni, 2016). As a result, African states have become a combination of a colony, sovereign states that have an operational mechanism of a precolonial ideology (Ipinyoni, 2016). It is in this manner that African countries tend to struggle with an identity crisis in the international system whereby African states sign international instruments that are not in line with their cultural ideologies.

5.4.4.2 Civil society

In comparison to Botswana, South Africa has a larger number and more active civil society groups and non-governmental organisations. In addition, South Africa has a public service broadcasting system that provides the platform for civil society organisations to demonstrate in comparison to Botswana that has a government-controlled state broadcasting system that is heavily influenced by the ideologies and the politics of the ruling party. As a result, South African civil society non-governmental organisations and Civil Society Organisations are in a better position to demonstrate their activities of their implementation of the Beijing Platform for Action. However, according to the media uses and gratification perspective' that is audience-centred and concerned with what people do with the media as opposed to what the media does to the people, the South African audience would be not passive in their consumption and interpretation of media content (Pearse, 2014). Instead, the media audience is rather active in how they interpret and integrate media messages into their own lives (Perse, 2014). This means that the demonstration of the Beijing Platform for Action activities by South African civil society groups and non-governmental organisations (through the media) would not necessarily cause the masses to internalise the values of the Beijing Platform for Action as the audience choose to consume media content that aligns with their personal ideologies

(Pearse 2014). Therefore in order to effectively lead the masses to consume media content by CSOs and NGOs that promotes the principles of the Beijing platform for action, social institutions such as churches, schools, family set ups and cultural institutions should do more work to lead the masses to adopt ideologies that are for women equality so that they can be more inclined to consume and follow media programmes that are produced by gender equality organisations such as *'sonke gender justice'* and *'genderlinks'*.

In consideration of norm internalisation of the Beijing Platform for Action in South African, the study established that the Committee for Gender Equality has been active in pursuing draft bills such as family law & marriage legislation reform and the amendments of the traditional leadership act and the act as a means to drive gender equality. However just like in Botswana, South Africa must wrestle with overlapping international covenants such as the International Covenant on Economic, Social and Cultural Rights, as well as the overlap & coexistence of South Africa's pluralistic legal systems that recognise the practices of both common and customary law.

5.4.5 South Africa and the Development Goal 5 (MDGs) and the Sustainable Development Goal 3 (SDGs)

Just like in the case of Botswana, South Africa is one of the countries in the Southern African region that has not been able to meet their set target of reducing their Maternal Mortality Rate Ratio. In comparison to Botswana that had a sharp decline and then an increase from 2010, South Africa has had an increase in maternal deaths to about 311 per 100 000 in 2009, which then declined to 270 per 100 000 by the year 2010 (Stats SA, 2015). It is argued that the government's robust stance on ensuring that all people living with HIV have access to anti-retroviral treatment and several policy and programme changes have been some of the contributory factors to South Africa' sustained decline to maternal deaths that stood at an estimate of 141 per 100 000 in the year 2013 (Stats SA, 2015). However, as much as South Africa has had a sustained decline to maternal deaths, the country was still not able to achieve its 38 per 100 000 maternal deaths by the year 2015 (Stats SA,2015).

5.4.5.1 Power records keeping

Also, similar to the Botswana case study, South Africa does not necessarily conduct a comprehensive accurate measurement of maternal deaths due to the absence of a vital registration systems, "health service records, household surveys and census data" are usually used to estimate maternal mortality rates in the South African context (Graham et al, 2008; Burton 2013). Estimating maternal mortality rates in this manner can be problematic as it can lead to inconsistent population-based estimates that do not conclusively showcase the rate of maternal deaths in South Africa (StatsSA, 2015). Sometimes, the differences and errors that occur in data capturing can lead to discrepancies in maternal death estimates (StatsSA, 2015). When the DHIS is used to capture information on the trends of maternal deaths for example, the information does not become accurate as the DHIS usually captures population data from population deaths that occur within the public healthcare facilities, without necessarily including the deaths that occur in private health institutions as well. Also, the estimates of maternal deaths in South Africa are usually restricted to deaths that occur within the public health facilities without necessarily taking into consideration the deaths that occur outside of the health facilities (just like in the Botswana case) (Burton, 2013). Therefore, there is need for a standard way of capturing data on maternal deaths to have accurate data capturing of the rate of maternal deaths in South Africa.

According to the data capturing of maternal deaths in South Africa, the major causes of maternal deaths in the South African context is non-pregnancy related infections that are normally associated with HIV infection (50%), followed by obstetric haemorrhaging that causes 14 % of maternal deaths, as well as complications of hypertension that is also responsible for 14% of maternal deaths in South Africa (Department of Health, 2013). The issue of the high HIV related infections being the leading cause of maternal death in South Africa is linked to the previous situation whereby former President Thabo Mbeki and former Minister of Health (Dr. Manto Tshabalala Msimang) supported the AIDS denialism ideology that led to many people living with HIV not being able to have access to the Ante- retroviral therapy (TAC, 2016). At the time of the AIDS denialism stance by the South African government, many pregnant women did not have adequate access to the PMTCT programme, which led to an estimated 35, 000 babies being born HIV positive (TAC, 2016). The 35 000 that were born with HIV during the Thabo Mbeki denialism era are now in the age group of procreation stage, and hence many maternal mortality rates being attributed to HIV related infections, in addition to new HIV infections that are most prevalent among young women within the 18-24-year-old age group.

5.4.5.2 Access to Ante retroviral treatment

Although there is a wide access to Ante-retroviral treatment for pregnant women that has been vigorously implemented by the Health Ministry of Dr. Aaron Motsoaledi, HIV related infections amongst pregnant women still remains a factor as there are increasing numbers of teenage pregnancies in the country, in which a lot of the teen mothers attend their first ante natal visits after the 20 week period (2012). Furthermore, a lot of front line workers administering sexual and reproductive health care services at public healthcare facilities are not properly trained on how to maintain the dignity of patients when administrating sexual and reproductive healthcare services, and hence some adolescents opt to not use these services as they are afraid of being ridiculed by nurses when they go to seek sexual and reproductive healthcare services in the public healthcare system. In this way, the study found that although South Africa has good policies on the provision of sexual and reproductive healthcare, cultural dynamics prevent the extensive implementation of these policies.

5.4.5.3 Inadequate knowledge of contraceptive among youth

With regards to the distribution of various methods of contraceptives in South African health care facilities, the South African government argues that contraceptives are freely available in South Africa as per the guidelines stipulated in the National Contraception Clinical Guidelines and the National Contraception and Fertility Policy (South African MDG Country Report 2015). Despite this, South Africa still has a prevalence of unplanned pregnancies, especially amongst the black adolescent population group which can be attributed to the micro factors that maybe be an oversight from by the government.

According to Gurenne et al (2001), South African youth do not have adequate knowledge about reproductive health issues to such an extent that they mostly rely on "friends, siblings, and magazines" for information on issues pertaining to sexual and reproductive health. In some South African cultures, discussions about sexual and reproductive health matters is a taboo (as aforementioned) to such an extent that most parents do not consider it as an essential part of parenting responsibilities. It is also often the case that the parents that are prepared to discuss sexual and reproductive health with their adolescent children do not have the adequate skills to speak with their children about this very important subject (Gurenne et al, 2001).

Young people have also unfortunately been the population segment that is mostly affected by the politics around the morality of using family planning (Gurenne et al, 2001). In this regard, adolescents, specifically black adolescents are less likely to have access to the health systems in South Africa and seem to be more likely to be exposed to the risk of pregnancy and

ultimately also more likely to be infected with the HI Virus (Gurenne et al,2001). This is highly worrisome considering how HIV infection in pregnancy has been one of the contributory factors in increased maternal deaths in South Africa (SA MDG Status Report, 2007).

Young people living in the rural areas often argue that there are limited options of family planning methods in their local clinics, contrarywise, people living in urban areas are more likely to have access to a wide variety of methods of family planning. In addition, decreased levels of the Human Development Index have indirectly led to increased levels of maternal mortality rates, specifically within rural areas as they have the highest levels of poverty, underdeveloped infrastructure and high levels of unemployment, as well as poor access to health care in Southern African countries (Polity,2017). According to the Department of Education, girl children are generally the ones that are most likely to experience disruptions in their high school career due to various factors such as financial issues and family obligations (Department of Health, 2005). The Department of Education (2007)further reports that adolescent girls that face disruptions in their schooling career are therefore more likely to become demotivated to commit to education goals and thus more likely to fall pregnant while they are still teens, which is a situation that also places them at higher risk of HIV infection as teenage pregnancies are rarely planned.

5.4.5.4 Cultural issues on the decision to use family planning

Another issue that is often overlooked is the influence of cultural values, beliefs and norms in one's decision to use family planning and methods of contraception. South African society in general has had a "gradual decline in social mechanisms to ensure that young unmarried men take responsibility for procreating" (SA Department of Health, 2005). This has in turn negatively influenced young men's decision making regarding the timing of first sexual debut as they know that they will be little consequences for them if pregnancy occurs (Bird and Rieker, 2008). In a patriarchal society such as South Africa, women are less likely to have the skills needed to negotiate condom use in intimate relationships, which ultimately leaves men in control of making decisions regarding when and how contraception should be used in a relationship. Therefore, in a society that has minimum consequences for men who procreate outside of wedlock, the men are least likely to choose condom and thus increasing likelihood of unplanned pregnancies and possible HIV infections that ultimately increase chances of maternal mortality rates among adolescent pregnant women. Adolescents living in rural areas are in this case disadvantaged as they often experience the tension between the traditional roles concerning fertility versus the "social responsibility associated with education and economic

success (Department of Education, 2005). Because of the social pressure, young women and women living in rural areas end up being more drawn to the traditional expectations and beliefs which tend to be against their best interests with regards to their reproductive health. In a 2005 study on rural women in KwaZulu Natal, Maharaj and Cleland founded that there was low condom use by couples within the rural parts of the province, including among the couples that were living with HIV (2005). The study found out that the men in the province usually resisted the use condoms, often using cultural norms to not use condoms and other methods of contraception (Maharaj and Cleland 2005). The less educated couples living in rural parts of KwaZulu Natal had an 8% and 11% level of condom use among men and women, whereas the more educated couples living in urban areas had a 29 to 34 % likelihood of using condoms (Maharaj and Cleland, 2005). The study also founded that women living in rural areas have less chances of discussing condom use, in comparison to the women living in urban parts of KwaZulu Natal (28% vs. 80%) (Maharaj and Cleland, 2005).

According to Peltzer (2008), one of the ways in which maternal mortality rates can be curbed in South Africa is through integrating family planning, HIV management and treatment. Now, most public health messages regarding HIV have been putting emphasis on the use of condoms and messages that are aimed to discourage people living with HIV from having more children (Peltzer, 2008). The dangers of this approach are that; it does not appeal to HIV positive people who still have a desire to have more children, and thus they opt to disregard condom use as they perceive it to be a barrier that would prevent them from falling pregnant. In this case, it becomes essential that public health messages are packaged in a way that would show HIV positive couples' safer ways of conceiving, as well as showing them ways to maintain condom use to avoid HIV re-infection.

With specific consideration of adolescent reproductive health, it is important for the department of health to consider the various needs and challenges of adolescents in different population groups, to be able to effectively meet their sexual and reproductive health needs. The Department of Health should also consider disseminating more information about the principle of gender equality, that is enshrined in the 1996 Constitution of the Republic of South Africa, as well as the more information about the 1996 Choice of Termination of Pregnancy Act that was established to provide safer ways for women and young women of South to have abortions. The Department of Health should also address issue of the negative staff attitudes to provide more favourable environments for the youth to access sexual and reproductive health care in public health care facilities. In the rural areas, the government needs to provide a range of

contraceptive methods for the youth to choose from. For instance, in some rural parts of South Africa, there are restricted IUD provisions since there is lack of suitable facilities and staff members trained to conduct IUD insertions. Furthermore, emergency contraceptive should not be a contraceptive method that is only easily accessible to adolescents living in urban areas but should also be accessible to the youth living in the rural areas as well. Also, the Department of Health and the Department of Arts and Culture should work together to find ways to address the cultural beliefs and practices that inhibit wider use of sexual and reproductive health care. In this regard, the Arts and Culture Departments need to formulate targeted campaigns that would include men in issues to sexual and reproductive health. The Department of Education should also address the issue of adolescent pregnancy by creating environments that would allow children from impoverished families to cope with the academic career, as well as working with the broader community to address the cultural gender role expectations as it has been proven that young women who are doing well at school are least likely to stop going to school and least likely to fall pregnant during their schooling career. Also, within this same population group (black adolescents), there are increased levels of illegal abortions despite the legalisation of abortion in South Africa since 1996.

In as much as abortion has been legal in South Africa since 1996, the Department of Health has reported that between 52% and 58% of the estimated abortions in South Africa, 260 000 of the abortions have been conducted illegally (2018). One of the factors that make illegal abortion more appealing in comparison to the much safer abortion procedures that occur in healthcare facilities is that to a large extent, the religiously and culturally influenced ideologies have led many South African communities (and the broader Southern African communities) to stigmatise those women and girls that are known to have gone through abortion procedure (MarieStopes, 2016). According to Maxaile, the 1996 Choice on Pregnancy Act is a codified law that has not really caught up with the popular attitudes of the people of South Africa (1998). The Choice on Pregnancy Act is a law that has been formulated under the individualistic enlightenment inspired ideologies that challenged existing conceptions that were rooted in traditional worldviews that were dominated by Christianity (Maxaile, 1998). The 1996 Choice on Pregnancy Act is in this regard a Euro-Western inspired Act that values individuality whereby people have individual freedoms to make their own choices without necessarily being influenced by the state, church or traditionalist entities in society (Manxaile ,1998). In this case, the Act is in contradiction to many popular churches in the South Africa such as the Catholic, the Protestant, as well as the African Independent Churches that regard abortion as a "destruction of germinating life" that they regard as killing a human being (Manxaile 1998). For the African Independent Churches in particular, abortion is regarded as a disruption of the

ancestral plans and the individualistic notion of the Choice on Pregnancy Act is regarded as a selfish act which contradicts African's communitarian culture and hence decisions regarding sexual and reproduction health are usually preferred to be made by various family members of the woman in reproductive age (Manxaile, 1998). It is in this context that abortion is largely stigmatised and hence many women wanting to have an abortion opt to do the procedure illegally to maintain privacy and protection from social shame (Manxaile, 1998). These religious and cultural aspects of abortion tend to prevent the norm internalisation of the Choice on Pregnancy Act and hence increasing the likelihood of maternal deaths. In South Africa, it has been observed that even though women and girls are not comfortable with having abortion procedures conducted at healthcare facilities, several middle-class young women from neighbouring Botswana do cross the borders to terminate pregnancies in neighbouring South African hospitals and clinics (News 24). Therefore, Botswana's stance of illegalising abortion and South Africa's stance of legalising abortions do not necessarily stop women and girls from terminating pregnancies (whether legally or illegally).

Despite the fact that the culturally and religiously influenced ideologies have maintained the stigmatization of abortion procedures in both South Africa and Botswana, the MDG acceleration programmes that were formed through partnerships between the two countries and UNDP and AU, the MDG acceleration programmes have predominantly focused on the clinical causes of maternal deaths without necessarily prioritising the inclusion of cultural and religious opinion leaders in the maternal health networks, as a means to have more dialogue that would eventually lead to the societal de-stigmatisation of abortions that could potentially save lives of women who choose to terminate pregnancies in illegal facilities that endanger their lives. The inclusion of the African Independent Churches in the health networks would be specifically important because unlike the mainline churches, the African Independent Churches continue to be in the periphery of discussions in most political debates as they have not really "produced a system of thought" that debates health issues within the academic and systematic platforms, even though they have large followers in many African societies (Manxaile, 1998).

5.4.5.5 Doctor and nurse failure to follow procedures

Other factors that have contributed to maternal deaths in South Africa include the common challenges of doctors and midwives not following essential protocols of providing health care services to pregnant women, some district hospitals not having bloods for transfusions, poor antenatal care and late presentation of pregnant women at health care facilities, as well as inadequate transport to health care facilities, specifically within the rural areas (South African

MDG Midterm Country Report, 2007). According to the Human Rights Watch, ill treatment of pregnant women by health care service providers in public health care institutions have been a hidden contributory factor in increasing maternal death rates (2011). For instance, women in Dora Ngiza Hospital in the Eastern Cape have argued that nurses often physically and verbally abuse them, they are often told to return home without being examined while they are in labour, and the nurses also ignore them when they call for help when they are in pain (Human Rights Watch,2011). The situation is further exacerbated by the lack of proper procedures to hold maternal health care service providers accountable in the public health care system, as well as the lack of mechanisms to monitor the performance of health care service providers in public maternity wards (Human Rights Watch,2011). In some incidents, the hospital management defends their behaviour of non-performing nurses, often with some justifying the behaviour by stating that nurses are harsh towards patients to make patients comply with hospital procedures and that women would often appreciate this treatment after they have delivered their babies (Human Rights Watch, 2011).

5.4.5.6 Administrative factors affecting maternal death

Furthermore, the Human Rights Watch have reported that several public hospitals in South Africa are experiencing administrative and financial management problems, which can be attributed to the "lack of separation of political and management responsibilities that would allow senior hospital managers to intensely focus on service delivery (2011). The unfortunate factor about maternal deaths in South Africa is that, unlike in other African countries where pregnant women die from not having access to ante natal care or public health care institutions, in South Africa most women who die from maternal issues have actually been to health care institutions at some point in their pregnancy. This may suggest that some of the deaths could have been prevented (Human Rights Watch, 2011). In comparison to Botswana, one finds that while Botswana pubic hospitals are faced with the need to supply more obstetric services in their public health care facilities, South Africa's public healthcare facilities are faced with administration and financial management problems. In South Africa there is great disparities between the public health and the private health systems, through which only about 40% of the total healthcare expenditure in the country is allocated to the public healthcare system that serves about 86% of the population (Mabaso et al., 2014).

5.4.5.7 Private and public health sectors

In the South African context, the private health sector was introduced into the country in 1889, to attend to the health needs of white mine workers (Coovadia et al, 2009). The membership in these specific medical schemes were purely reserved for the white population until the late 1970s and were mainly stimulated by corporate capital that also has a strong influence in "political economy of the South African health System" (Coovadia et al, 2009; Benator 2013). In the 1980s, the private health care systems expanded as the International System adopted more privatisation policies (Coovadia et al, 2009; Benator 2013). As result, more doctors and specialists migrated to the private sector as they offered better working conditions and paid substantially better than the public health sector (Coovadia et al, 2009).The financial deregulation, privatisation and deregulation in the International Community during the 1970s led global health to divert into two health paths, whereby one pursued the advancement of medical practices that would benefit the top 20% of wealthier people (private health sector), and the other was "characterised by impediments to economic for a poor majority, deterioration in their living conditions and the curtailment of public health services" (Benator, 2013,p1).

In the South African context, the apartheid regime maintained the effects of both the private and the public health sector (Benator, 2013). In 1994, the new democratic government did make some positive changes in healthcare administration and legislation, as well as improving the living conditions of many previously disadvantaged people (Benator, 2013). However, the continuation of slow economic growth, some free market policies, "rapid urbanisation, migration, corruption and poor management of public services" by the post-apartheid government has left many South Africans in impoverished positions (Benator, 2013).

5.4.5.8 Neo Pentecostalism

The unfortunate socio-economic challenges are some of the reasons that propel many South Africans to follow the neo-Pentecostalism movement, that promise miraculous healing, deliverance and success to its followers (Kgathe, 2017).Unlike the classical Pentecostalism that believes in the baptism of the holy spirit and the gifts of the spirit, neo Pentecostalism is a new Christian movement that believes in miraculous healing, deliverance and prosperity ministry that often "revolves around charismatic personalities" (Kgathe, 2017). In many cases, the neo-Pentecostalism leaders are often dissenters from mainline churches who often choose not to be associated with established denominations or the South African council of churches in which they offer alternatives to life challenges such as "sickness, joblessness and poverty" (Kgathe,

2017, p2). The movement often uses material objects such as anointing oil, blessed water, bracelets and stickers that are perceived to be infused with spiritual power (Kgathe, 2017). However, the problematic issue about the neo Pentecostalism movement is that it seems to be anti-intellectualism, whereby most of the leaders in this movement have not been enrolled in proper theological training that adequately prepares them for full time ministry in which they can be taught about "doctrinal values and administrative duties" of the leaders in Ministry (Kgathe, 2017). As result, one finds that some religious leaders in the Pentecostal movement tend to abuse the religious rights of followers, where in cases of maternal health, the lack of financial means leads some followers to rely more on the counsel of these spiritual healers in matters regarding their pregnancy as it saves them health costs. The problematic issue about the reliance on the healers in the Pentecostalism movement however is that there has been some cases where they have led many families to remove their children from the formal education system, of which can affect the women and girls ability to make proper decisions regarding issues pertaining to family planning & contraceptive use, nutrition during pregnancy, as well as when to register for ante natal care which can have an influence on increasing maternal death rates in certain parts of South Africa.

Although neo Pentecostalism movement can have an influence on health issues in society. They are not necessarily active formal members in the maternal health networks within the country or regionally. The realisation of the impact that these movement can have on the lives of struggling ordinary South Africans is only just been realised, with organisations such as the Cultural, Religious and Linguistic Committees (CRL) only just recently started a debate on how these movements can be regulated to ensure that the religious rights of vulnerable people are mot abused. In this way, there needs to be more research in this area to direct policy and regulation going forward.

5.4.5.9 Institutionalisation of MDGs

The study established that, in relation to cascading of the Millennium Development Goals in Southern Africa, institutionalisation has been the key dominant mechanism in MDG 5 where the government established laws and policies that were aimed at facilitating South Africa's accomplishment of the MDG 5 target. However, this institutionalisation focused more on the macro level than on the micro Level of addressing issues that can curb maternal deaths. For example, regarding the issue of access to sexual and reproductive healthcare services, the

government addressed the issue at a Macro level by adopting a rights-based approach to reproductive health care in South Africa, in which it is expressed in the form of promoting information on sexual health services. However, the government could also address the situation more from a micro cultural level where, more studies are done on the socio-cultural & religious determinants that prevent women & girls from accessing and processing information on sexual and reproductive health are explored a bit more. In this way, there could be more micro level actors included in maternal health networks in the country. In addition, the study also found that just like in the Botswana case study, South Africa was assisted by UNDP in its acceleration framework. Other actors involved in the maternal health networks included the African Union which partnered with the South African government to formulate the campaign for accelerated reduction of maternal and child mortality in Africa (CARMMA), as well as the Action Campaign fought against the state sponsored AIDS denialist stance that deprived many pregnant women from accessing anti-retroviral treatment. However, the internalization of maternal health norms has not been fully enforced in the international community. The study revealed that the South African state had adopted the abstract form of the Millennium Declaration, but at the same time issues of poor administration in public health care facilities, poor service delivery and corruption led people to seek solace in institutions such as neo Pentecostalism in which some of these institutions undermine education and health rights that are essential in curbing maternal deaths. In context South Africa needs to expand its maternal health networks to include men as decision makers in matters pertaining to sexual and reproductive health, as well as include and promote dialogue with cultural leaders and leaders of neo Pentecostal churches.

5.4.5.10 South African Health system - Maladministration

A study of the Sustainable Development Goal 3 that aims to produce positive health outcomes for all by the year 2030, revealed that South Africa is still grappling with challenges such as; poor administration and financial management matters in some government hospitals, insufficient community buy in the use of contraception and some of the conflicting ways in which cultural values, beliefs and norms determine health outcomes. Also, the South African government is still battling with bringing into effect the National Health Insurance that aims provide a high standard of health care for the over 80% of the South African population that cannot afford to seek health care from the private sector.

An examination of the issue of the National Health Insurance, revealed that the roots of this problem derive from the structure of the health care system in the apartheid era that was set up

in an unequal way, whereby the wealthier and more privileged racial group had access to better health care service than the other racial groups, that were regarded to be of a lesser value than the whit e minority population group. After the passing of the 1913 Land Act, there was a high need for the supply of black workers in South African mines and other industries, a situation in which epidemics such as Tuberculosis, silicosis and Sexually Transmitted Diseases were allowed to develop without being properly checked among the black population (Jobson, 2015). The controlling of this epidemic became a challenge amongst the black population when one considers that there was differential funding of the different healthcare systems that were divided according to race, and in which created inequality in access to healthcare, in access to health care training, and in the conditions of healthcare workers (Jobson, 2015). At the time of World War II, there was a heightened need for the South African government to increase staff in healthcare and training of more doctors and nurses. After the increased of medical staff however, the South African government at the time placed the new trainees in "curative and hospital care in urban areas to meet the health needs of the white population" (Jobson, 2015). In this case, the homelands areas were left with healthcare facilities that did not have enough staff and thus some would rely on the traditional medicine offered by traditional doctors in their homelands.

It is in this apartheid era that the private health sector was established in the country around the year of 1889, specifically to attend to the health needs of white mine workers (Coovadia et al, 2009). The membership in these specific medical schemes were purely reserved for the white population until the late 1970s and were mainly stimulated by corporate capital that also has a strong influence in "political economy of the South African health System" (Coovadia et al, 2009). In the 1980s, the private health care systems expanded as the International System adopted more privatisation policies (Coovadia et al, 2009). As a result, more doctors and specialists migrated to the private sector as they were offered better working conditions and paid substantially better than the public health sector (Coovadia et al, 2009).

After 1994, the new South African government decided to amend some of South African health care policies to enable health care services to be more accessible by all population groups, and to provide better health care services and standards in the previously disadvantaged Bantustans. In so doing, some of the new health policies that were introduced by the South African Government included the adoption of the new constitution that enshrined principles of human dignity, equality and freedom for all races living in South Africa (ECR Unit Working Paper, 2009) and (Coovadia et al., 2009) . This new constitution indicates the inclusion of economic

and social rights in Section 27 (1), and generally speak to the provision of accessible health care services, provision of sufficient food and water by the government, as well as providing social security to all people of South Africa, irrespective of what race they are (ECR Unit Working Paper, 2009). However, the study found that implementation of more inclusive health policies of the post-apartheid era is still lacking in some parts of the new democratic South Africa as some public healthcare facilities experience misadministration and mismanagement of funds, corruption and low staff morale that leads some medical staff to treat patients unprofessionally.

The misadministration problems reported in post-apartheid South Africa include doctors and midwives not following essential protocols of providing health care services to pregnant women, some district hospitals not having bloods for transfusions, poor antenatal care and late presentation of pregnant women at health care facilities, as well as inadequate transport to health care facilities, specifically within the rural areas such as the Eastern Cape Karoo area(South African MDG Midtern Country Report: 2007) and (Frost et al, 2017). According to the Human Rights Watch, ill treatment of pregnant women by health care service providers in public health care institutions have been a hidden contributory fact in maternal death rates in the South African post-apartheid era. For instance, women in Dora Ngiza Hospital in the Eastern Cape have argued that nurses often physically and verbally abuse them, they are often told to return home without being examined while they are in labour , and the nurses also ignore them when they call for help when they are in pain (Human Rights Watch, 2011) and (Frost et al., 2017). The situation is further exacerbated by the lack of proper channels to hold maternal health care service providers accountable in the public health care system, as well as the lack of mechanisms to monitor the performance of health care service providers in public maternity wards (Human Rights Watch,2011). In some incidents, the hospital management defends the behaviour of non-performing nurses, often with some justifying the behaviour by stating that nurses are harsh towards patients as a means to make patients comply with hospital procedures and that women would often appreciate this treatment after they have delivered their babies (Human Rights Watch, 2011) .

The administrative and financial management problems experienced in most public hospitals in South Africa in the post-apartheid era can be attributed to the “lack of separation of political and management responsibilities that would allow senior hospital managers to insanely focus on service delivery (2011). The unfortunate thing about maternal deaths in South Africa is that unlike in other African countries where pregnant women die from not having access to ante

natal care or public health care institutions, most women who die from maternal issues have actually been to health care institutions at some point in their pregnancy, meaning that " some of the deaths could have actually been prevented" (Human Rights Watch, 2011).

Another unfortunate thing about the management of maternal mortality in post-apartheid South Africa is that just like Botswana, South Africa does not keep reliable track records of maternal deaths (Human Rights Watch,2011) and (MDG Country Report, 2007). The government also does not regularly update population data on antenatal prevalence (south African MDG Country Report,2015).

The culmination of the misadministration problems in the public hospital sector has had a negative impact of the patient experience of maternal health care in South Africa, and hence it can be argued that some South African public healthcare facilities do not adhere to human rights approach that is expected to include non-discrimination and accountability as required by the WHO's strategies towards ending preventable maternal mortality (EPMM).

In the Strategies set towards ending preventable maternal mortality, it is required that various health care service providers at community and national level should consider effective interdisciplinary teamwork and integration across facilities and community settings (WHO, 2015). In African context, this means healthcare providers such as the allopathic health care sector and the alternative healthcare sector should consider having conversations and working together towards finding prevailing health problems such as maternal and infant mortality, HIV and AIDS, Tuberculosis, abortion. In the South African context, the study found that the two health sectors have made some strides to work together, although there is still a lot of opportunity for improvement.

The study also established that the National Department of Health has taken active initiative to be accommodative to alternative medical practices through establishing the directorate of traditional medicine within the Department of health, "as well as the enactment of the Traditional Health Practitioners Act (22 of 2007), in which the traditional health council was formulated (Moshabela and Zuma 2016, p2). The traditional Health Practitioners Act and the traditional health council have created a platform where deliberations can be held about their preferred methods of healing, as well to allow possible ways to bridge the gap between the allopathic medicine and traditional medicine. However, the traditional practitioners hold the view that most literature portrays them in negative light, specifically with regards to the

controversies regarding treatment care for people living with HIV, and issues pertaining to sexual and reproductive health (Moshabela and Zuma, 2016). In this case, there remains mistrust between allopathic and traditional healthcare providers.

The study found that the plurality of cultures and medical pluralism in the South African context creates a struggle to find common ground to work together. Therefore, it results in a delay in achieving optimum healthcare in this regard as "belief systems impact directly on how pregnant women understand health and respond to illness" (Walker et al, 2003).

5.5 Conclusions

In conclusion, the findings in this chapter revealed that socialisation is one of the dominant mechanism in the cascading of CEDAW norms in South Africa, in which civil society groups and NGOs have played an active role in changing perceptions about the role of women in society and the strengthening of women in decision making processes. Despite challenges such as maladministration in health care facilities, corruption and discriminatory cultural and religious norms, measures to eliminate discrimination against women in the field of healthcare has been put in place. In terms of norms pertaining to the Beijing Platform for Action, the findings revealed that South Africa has been pursuing draft bills such as family law & marriage legislation reform and amendments of the traditional leadership act and the customary act. However, just like in Botswana, there has been an overlap between the Beijing Platform for Action and the International Covenant on Economic, Social and Cultural Rights as well as within the country's pluralistic legal system. There are more professional actors in comparison to Botswana that include a diversity of NGOs and CSOs advocating for the Beijing Platform for Action. However, the institutional approach of making traditional and cultural leaders to sign agreements that promote gender equality has led to marginalisation of traditional and cultural leaders. This marginalisation of traditional leaders had been attributed to the top down approach which discourage more dialogues with them about the significance of gender equality and how they can adopt gender equality principles without necessarily losing their religious or cultural essence. This is problematic, as much of the South African population still consult them (traditional and cultural leaders). The findings also revealed that like Botswana, South Africa also predominantly implements the Beijing platform for action from an institutionalisation point of view. However, its plural legal system can be a hindrance to how ordinary citizens can internalise the Beijing Platform for Action principles. In this way, people at grassroots level are hindered from developing a habitual internalisation of the Beijing

platform for action. In the case of MDG5 and SDG3, the findings revealed that although there are established policies and laws that are geared towards curbing maternal deaths, these laws and policies do not extensively help with the internalization of maternal health as a human right as human rights are under-enforced in the international community. The state has adopted the abstract form of the Millennium Declaration, but at the same time, issues of poor administration in public health care facilities, poor service delivery and corruption leads people to seek solace in institutions such as neo Pentecostalism in which some of these institutions undermine education and health rights that are essential in curbing maternal deaths.

Chapter Six

CASE STUDY OF ZIMBABWE

6.0 Introduction

This chapter presents the findings from the case study of Zimbabwe concerning international maternal norms cascade in South Africa. Guided by the key research questions, the study assesses (1) the international and regional treaties regarding maternal health that Zimbabwe is signatory to, (2) it looks at whether Zimbabwe has internalised those norms and (3) how those norms have been cascaded to grassroots levels as well as the factors affecting internalisation of those norms

5.1 Locating Zimbabwe in Southern Africa

Zimbabwe is a landlocked Southern African country that is in the South Eastern part of the African continent (Nations Online, 2019). It has a population size of about 16,53 million (2017) with an economy largely driven by its agricultural produce and the mining sector (World Bank, 2019;African Development Bank, 2019). In comparison to Botswana and South Africa, Zimbabwe's economic growth has been declining due to the former President Robert Mugabe's protectionist economic policies. During the 1980s after the country gained independence, the president enacted some economic policy changes that included; increasing the tariffs on imports, introducing a licensing system for new investors that discriminated against private sector companies, as well as increasing the minimum wage which made it difficult for private sector enterprise owners to hire more staff in their organisations (Hanke, 2013).

The economy could still cope during this period as it was well diversified at the time. In the 1990s, international institutions such as the IMF began to put more pressure on the Zimbabwean government to liberalise its protectionist economic policies, as well as insisting that the government manage its spending well (Brett, 2005). Hence, Zimbabwe entered the Structural Adjustment Programme (SAPs) in 1991. In its decision to enter the agreements, the government of Zimbabwe was intending to accelerate the process of its GDP growth (Mavunzi, 20111). At this stage, Zimbabwe had increased its expenditure in the public sector by 60% since the 80s, that was directed towards its health care and education sectors (Hanke 2013). It was in this period that the country's GDP decreased so drastically to such an extent that the 1999 Zimbabwe GDP was far much lower than it had been at the beginning of that century in

1990 (Umraw, 2017). The social implications of the structural adjustment agreements resulted in the reduction of expenditure in health, which led to an increase in prices of healthcare services that ordinary people had access to. Furthermore, the private health sector was not receiving subsidies from the government and could therefore there was no incentive for private hospitals to operate in rural areas which resulted in inequalities in healthcare provision (Mavunzi, 2011). Other social implications of the SAP agreements included; the abandonment of public health programmes, reduced maintenance of health infrastructure, and reduced funding in drug supply and equipment (Mavunzi, 2011). In this way, the Zimbabwean healthcare sector was negatively affected by the structural adjustment programme agreements in comparison to Botswana and South Africa that did not enter the agreements.

In the 2000s, Zimbabwe's economy continued to drastically decline, in addition to 165,000 inflation by beginning of 2008 and about 95% unemployment rate by the year 2009 due to the government's appropriation of white farms (Hanke, 2013). In this case, the government's policies resulted in the country having debt that is over 200% of the GDP which was against the SADC recommended GDP-debt ratio of not more that 60%. There was also currency shortages, foreign companies and investors leaving the country, as well as skilled workers leaving to seek better economic opportunities in the diaspora (Hanke 2013). After President Emerson Mnangagwa became president in November 2017, many were hopeful that the economic situation would get better. However, it is taking too long to improve the unpleasant economic situation, which has left many citizens impatient. In terms of the country's Gender Development Index (GDI), the country records are extremely low (0.924) with a 74.8% poverty rates, with maternal mortality rates that are far greater than in the cases of Botswana and South Africa (UNDP 2019).

6.2 Findings of the study

6.2.1 Overview of findings

Findings in this chapter revealed that although Zimbabwe has signed the CEDAW, the Beijing Platform for Action, the Millennium Development Goal 5 and Sustainable development goals as an indication of its commitment towards the welfare of women and girls on issues of maternal health, not much change has been experienced. This is so because the country battles with implementing the policy and law changes that it has made in the constitution in this regard. Some of the factors preventing implementation include the declining economy, the co-existence and overlapping policies in common and customary law, the bad relationships between the government and other actors in the health care network such as NGOs, as well

excluding traditional birth attendants, in the healthcare networks. The findings also showcase how providing a good education can help women make well informed decisions regarding their maternal health and childcare.

6.3 Findings on the international treaties and conventions that Zimbabwe is a signatory to

The first research objective of the study sought to establish international/regional treaties and conventions pertaining to maternal healthcare that have been signed by Botswana, South Africa and Zimbabwe. In pursuance to this objective in this chapter, the researcher looked at Zimbabwe case to establish the international treaties that the country is signatory to. Findings from the study suggest that Zimbabwe is a signatory to a number of treaties such as; CEDAW, Millennium Developmental Goals 5, the Beijing Platform for Action (1995) and the UN Conference on Women.

6.4 Findings on how the international treaties and conventions related to maternal health care are being cascaded to the grassroots and the extent to which they are being internalised in Zimbabwe.

The following section addresses two questions and in pursuance of those questions, the study looked at different norms related to maternal health and it also assessed how those norms were cascaded to the grassroots and internalised as the various factors that affect internalisation of the norms. Study presented the results in this sequence, firstly it looked at each norm related to maternal health through the norm cycle model, and secondly it examined it against the various factors affecting its implementation in Zimbabwe.

6.4.1 Findings on Zimbabwe and the CEDAW

Findings revealed that, as a way of addressing issues pertaining to discrimination against women in the country, Zimbabwe has signed numerous International Conventions and agreements supporting gender equality such as; the SADC Declaration on gender and development, the Universal Declaration of Human Rights, the SADC addendum on the Prevention and Eradication of Violence against women and children, the Convention on Civil and Political Rights as well as the CEDAW agreement amongst others. After its independence in 1980, the Zimbabwe legislation was changed to accommodate women's' right to equality, especially in relation to land ownership. Furthermore, the Zimbabwean government established the Ministry of Community Development and Women's Affairs as an entity that would focus

on mobilising government entities to eradicate all the laws that perpetuated the discrimination against women.

As much as Zimbabwe signed up to international and regional conventions and agreements in support of gender equality initiatives, the implementation of the adjustments made in the constitution to accommodate gender equality has been a challenge, specifically in the area of land ownership as land in rural areas is normally allocated by predominantly patriarchal; traditional leadership. When the Zimbabwean government implemented the land reform programme under President's Mugabe's protectionist policies in the early 2000s, the constitution was amended to legitimise the acquisition of farmland that had been previously owned by white famers (Chitsike: 2003; Weidele 2017). The plan for the land reform was to "subdivide" the land into small and medium scale sizes for the majority black population groups that was to be used for agricultural purposes. The land reform projects in Zimbabwe were practically motivated by political and racial reasons, rather than for economic advancement of the previously disadvantaged black population in Zimbabwe (Chitsike, 2003; Weidele, 2017).

6.4.1.1 Marginalised women and Land Issues

At this time when the acquisition of land was being carried out, Zimbabwean women living in the rural areas were marginalised with traditional leaders being reluctant to grant them land as traditional structures of power were applied through which women could only get access to land through their "husbands, male relatives, and social networks" (Weidele, 2017). At this time, the majority of women living in the rural communities were poor and too illiterate to be able to go through the bureaucratic processes of acquiring land (Mgugu,2007). As a result, most women found themselves in situations where their husbands would register the land entirely in their own names. Thus, leaving women with the only option of accessing the land through the male registrations by their husbands or other male family members (Weidele, 2017). In this case, the study found that women living in rural Botswana and Zimbabwe have relatable experiences because whilst women in Botswana have better chances of accessing a piece of land in comparison to Zimbabwean women, the Botswana women often do not know how to access funding to commercially develop the land acquired from the government. Hence both groups of women face similar challenges of being unable to extensively use their land to free themselves from poverty.

In the case of Zimbabwe, the study found that although it is no longer a government requirement for married people to apply for the land as a couple as it now allows for people to apply as individuals which presents them with opportunity to start their own agricultural projects and become more financially independent. However, the cultural and religious socialisation in some parts of the country influences women to opt to acquire land in a form of a joint partnership with their husbands. Normally in such cases the husband will be the one in charge of the paperwork involved in the registration of the land which would often end in them registering the land in their name only (Weidele, 2018). Although, there are some pockets of Non-Governmental Organisations such as *Women and Land in Zimbabwe* that have played a crucial role in empowering rural women by lobbying for women's groups to be granted land to create community nutrition gardens, conservation farming, goat and poultry rearing, as well as offering self-help study groups that teaches rural women about their constitutional rights as offered in the latest 2013 constitution, in addition to teaching women about financing mechanisms that they can use to commercially fund the land that they have been granted by the traditional leaders (Mawoyo, 2015).

Through the training that the women have received from the *Women and Land* in Zimbabwe NGO, women have developed leadership skills that have enabled them to take up other leadership positions in other societal structures such as; the "social development associations, church organising committees and chief councils" (Mawoyo, 2015). However, this organisation has only been able to reach one ward in eight districts in Zimbabwe and needing more resources and support to be able to reach more districts around the country (Mawoyo 2015).

With regards to the married educated women, they often do not experience similar land acquisition challenges as the rural uneducated women as they are more knowledgeable of the processes involved and are actively involved in the bureaucratic processes of land acquisition, as well as in the "operations and management" decisions involved in the partnership of land ownership with their husbands (World Bank, 2017).In this regard, the acquisition of higher levels of education becomes an essential tool in helping married women to become more assertive in their day to day life decisions, including key decisions such as land acquisition and operations and management of their farming areas.

In some cases, some women are not educated, but are married to husbands who are educated and willing to be fair by registering acquired land in both themselves and their spouse's names,

and thus proving that education is also essential in propelling the men to be more gender sensitive and to be fair towards their wives when they make key decisions regarding family land ownership (Toro, 2016). Educated men are also more likely to ensure that their marriages are officiated under the Civil Marriage Act and that their customary marriages are registered, which establishes a platform for their spouses to be protected in cases when they become widowed. In this case, the most vulnerable groups of women in the population are women with lower levels of education and married to men who also have lower levels of education belonging to fundamentalist religious and cultural groups.

6.4.1.2 Girl child education and maternal health

In terms of the elimination of discrimination against women in the area of equal rights with men in the field of education, the study established that when Zimbabwe gained independence in 1980, it aspired to make education accessible to all as revealed in the Zimbabwe Education Act (UNESCO, 2013). However, the declining economic conditions overtime have strained government expenditure to such an extent that the government could no longer afford to offer universal access to education to all Zimbabweans (UNICEF 2018). To cope with the financial pressures, the government has resolved to requiring students to pay school fees, even if it is just a minimum fee that would allow schools to be able to pay for some of the operational costs in running the schools. According to UNICEF, children that have been mostly affected by the government inability to provide free education are orphans, those living in remote rural areas, those from low socio- economic backgrounds, as well as those living with disabilities (UNICEF, 2017). The lack of access to education has negatively affected women and girl's decision-making abilities regarding their sexual and reproductive health. This is illustrated by one of the interviewees in the focus groups that was conducted in Chiredzi in which the interviewee stated that:

> *"…In issues concerning maternal health, I left school when I was 14 years and therefore did not know the details about the importance of antenatal visits, screening of other diseases like cancer of the cervix, breast, and family planning methods. As time went by, I would observe that more women were dying from giving birth in my church, and women were having complications from undiagnosed diseases that were later found to be relating to cancers of the womanhood and other health complications. These scenarios made me to start having questions about some of beliefs in the church as the church had guidelines on how we should use family planning" (Zimbabwe Interviews, 2015).*

In relation to this, a member of the Zimbabwe Teachers Association (ZIMTA) has argued that the development levy fees that pupils are expected to pay in addition to minimum school fees

has also been an impediment to possibilities of all children having access to education as many development levies are unaffordable for most parents (Sithole, 2009). Other costs involved include the high costs of uniforms and books that the parents of many learners living in the rural areas cannot afford to pay (Sithole, 2009). The education dynamics that the country has been experiencing is an unfortunate outcome considering that the Zimbabwe Education Act stipulates that all children have a right to access education. Also, the fact that there is no legislation in place to ensure that parents keep their children in school is another factor that reduces the chances of universal access to education for Zimbabwean children.

This issue of access to education is especially felt by the girl children because oftentimes in financially challenging times, families opt to invest more on the education of boys than on the education for boys. The preference for the prioritization of male education is religiously and culturally influenced as for instance, a religious leader in Gutu stated in the interviews that:

> "…Biblical views help us in decision making regarding family matters and life. Just like the father is the head of the family as Christ is the head of the church. So, women are there to submit to the husband or male leaders of their family on each decision pertaining to family life" (Zimbabwe Interviews, 2015).

According to the Education Policy and Data Centre in Zimbabwe, almost 45% of the female youth that were attending school at secondary level were out of school in comparison to the 37% of the male youth that were recorded to be out of school (EPDC 2014). In this case, the dropout rate of girl children is generally higher than that of the boy children in Zimbabwe as has been observed by the United Nations organisations such as UNICEF, UNESCO (OHCHR). To solve the problem, non-governmental organisations such as the Campaign for Female Education (CAMFED), have been established to enable girl children to have access to education and to stay there longer in the education system (OHCHR, 2013).

As their contribution towards facilitating education access for girl children, the Zimbabwean government also contributed by launching a National Girls' Education Strategic Plan in 2006, in which the Strategic plan report highlighted widespread labour migration as one of the contributory factors that cause girl children to drop out from schools. It was found that when parents migrate to neighbouring countries in search for better economic opportunities, it is often the older girl children that are placed in the position of looking after their younger siblings. In some cases, the children are left under the care of other extended family members whose supervisory role maybe be limited. At such times, the extended family members tend to deny the children remittances sent to them by their parents. Such situation may increase stress levels amongst school going children and inevitably causing them to be distracted at school

and eventually dropping out. Girl children living with extended family members also often experience sexual abuse by some of the family members that leads to teen pregnancy that subsequently compromises their schooling attendance and health. Also, vulnerable Zimbabwean girls (especially older teens) tend to experience exploitation in neighbouring countries, where they are tricked to accept exploitative employment arrangements in countries such as South Africa and Botswana. They will be making a little bit of money that makes them even more alienated from the core reasons why they took these menial jobs (saving money to pay education fees) (Sithole 2009).

Some religious beliefs and cultural practices compromise the education opportunities for girl children in Zimbabwe, especially among children who are orphans or who are left under the guardianship of extended family members when their parents emigrate outside Zimbabwe to seek better economic opportunities. In traditional Shona culture, it is the responsibility of the extended family members to take over parental care of orphans once their parents are deceased (Nyamukapa 2005). Nowadays, extended family members do not want to take up these roles because the challenging economic hardships make it difficult for anyone to take in someone else's child (Nyamukapa 2005). Also, contemporary pressures such as work-related migration and resettlement leading to dispersed family members lead to the breakdown of the extended family structure, and thus increasing the chances of orphan children being left without guardians. In some Pentecostal churches such as the Zimbabwe Assemblies of God, Africa (ZAOGA), emphasis is placed on nuclear families rather than extended family structures, thus most members of such religious institutions are often desensitized from taking guardianship responsibility of the children of a deceased family member (Maxwell, 1998).

Other religious influences stem from churches such as the Apostolic Sect whereby it is common practice to have Nocturnal religious practices in which night prayers and meetings that often lead to young girls being often married off to older male members of this sect (UNESCO, 2011). Consequently, the girls are not only exposed to higher chances of falling pregnant at a young age, but they make them vulnerable to HIV virus infection as they are married off to men that are much older than them (UNESCO, 2011).

6.4.1.3 Access to Sexual and reproductive health and maternal health

In terms of Zimbabwe's position on sexual and reproductive health, it can be argued that the country has been lagging behind in the implementation of policies geared towards enabling

access to adequate healthcare facilities. This has been mainly due to the repercussions of the declining economic stature, the after-effects of the hostile political situation in 2008, as well as the economic sanctions that led to the migration of most people in the productive age among the Zimbabwe population. In this regard, the public health care system was badly affected as public hospitals were hit by budget cuts during the economic sanctions. During this period, many skilled health care providers opted to migrate to other countries in search of a better life. It is worth noting that while some churches have indeed negatively affected implementation of policy efforts to empower women through providing them better access to education and sexual and reproductive healthcare, some churches have indeed been knowledgeable about the CEDAW and showed willingness to contribute towards the full implementation of the access to adequate healthcare policies in the country. For example, one of the participants in the focus group stated that:

> *"…My church [Seventh Day Adventist Church] does act as a supportive mechanism in our daily lives as women by empowering and supporting our advancement by including us in their health-related programmes like training us as village health workers. There are also projects like poultry keeping and some nutritional gardens that the church encourages us to be a part of" (Zimbabwe Interviews, 2015).*

In concurrence to the above a pastor in the Seventh Day Adventist Church mentioned that:

> *"…We do agree with some of the treaties like that of empowering women and their advancement. We have programmes for them where we invite experts on such matters to equip them with new developments. In our church, we don't support oppression but encourage submission as written in the scriptures, so we take our work in accordance with these treaties and the bible as well" (Zimbabwe Interviews, 2015)*

The statement above showcases that just like in South Africa where different social institutions (including the church) interpreted the bill of rights in different ways, one finds that a variety of churches also have different ways of interpreting constitutional rights, of which can be negative and positive. In fact, some churches have assisted in education and health care provision in the country, which was most needed when the government was hard hit by the economic crunch and could therefore not implement some policies regarding education and health care. For example, the Presbyterian church has a history of having established schools in Zimbabwe, in which "it turned most of the schools over to the government" after the country gained independence and opting to only oversee one school (Presbyterian Mission 2016). At the time that the Zimbabwean government was going through economic sanctions, some churches opted to take over some schools. This was not widely positively received by the Zimbabwean community though, as the missionary education has been historically associated with colonialism in the country, and churches have been considered to "lack proper consultation when they run schools, tend to have policy inconsistencies, as well as fail to meet some

expectations" when they did take over some schools during the economic sanctions in the country (Kawadza 2015, p 1). Another way in which the church is assisting in the provision of health care services in Zimbabwe is through the Zimbabwe Association of Church Related Hospitals, which is a registered private voluntary organisation that has facilitated the partnership between "the head of the Christian denominations (HOCD), the ministry of health and child care (MOHCC), as well as other health care providers and service providers" (ZACH, 2018p1).

6.4.1.4 Religious institutions and maternal health

In the Zimbabwe Association of Church Related Hospitals, various churches with different doctrines have collaborated because of the shared interest of wanting to establish a medical arm of Zimbabwe churches that aims to assist the government in providing effective health care services to the people of Zimbabwe (ZACH, 2018p1). The organisations currently have a church membership that has made an impact in a 130 hospitals and clinics in Zimbabwe (ZACH, 2018, p1). Some of their contributions that have been made by this organisation include contributing towards the sourcing of drugs from pharmaceutical companies in situations where the government, private hospitals and mission hospitals are unable to because of financial reasons, especially within those health facilities that served the marginalised people in the Zimbabwean rural communities (Chitimbiri, 2016). With regards to matters pertaining to family planning, ZACH has contributed through reaching out to people at grassroots level and teaching them about the advantages of family planning in the form of child spacing, the economic implications of having more unplanned children, as well as showing them the "social, health, and economic advantages" of child spacing (Chitimbiri, 2016). Some of the effects of the mandate of the Zimbabwe Association of Church related hospitals were revealed in the focus groups, through which some of the respondents stated that:

> *"...Our church doctrine supports maternal health care because it builds hospitals and clinics. We have hospitals which train health care workers specifically nurses and village health workers. We conduct health-based programmes that are geared towards fighting HIV and AIDS which is a sentiment that has been expanded to include maternal and child health services. Also, we have delivery services, counselling during pregnancy, nutrition which help to decrease the likelihood of death during pregnancy" (Zimbabwe Interviews, 2015)*

The statements above showcase that although there have been religious institutions that hold religious doctrines that can increase maternal deaths, there are many religious institutions that are knowledgeable about the CEDAW and willing to collaborate with the government to provide more equitable health care. Therefore, it is important that religious institutions become

part of the International health networks as more engagement with them can facilitate the cascading of education and health policies.

6.4.1.6 Economic and political factors affecting the delivery of maternal health care

At the time of the economic sanctions, the hyperinflation in Zimbabwe reached about 231 Million Dollars more specifically in 2008, forcing the government to abandon the Zimbabwean Dollar (Biti, 2015). As a result, many public hospitals and schools were understaffed with limited resources. In the health sector, many pregnant women were more susceptible to being victims of maternal deaths, more specifically the women that needed caesarean section and those that needed access to ARV drugs. There has subsequently been the provision of the transition fund to breathe life into the Zimbabwean health system through a collaboration between the Zimbabwean government, the International Donor Community and the European Union after the lifting of some of the sanctions and the coalition government in post 2008, although some repercussions are taking time to be brought back to normal again. For instance, many children lost their parents to the HIV virus because of shortage of medical supplies or poor access to proper nutrition, which has resulted in the mushrooming of many child headed households and children that were being raised by their grandparents that struggled to pay for their education and health services.

The Zimbabwean government initially had plans to do collaborative work with local and International NGOS to attend to the HIV and AIDS health care services (Zimbabwe ICPD Report, 1999). The collaboration would include NGOs such as the US Agency for International Development (USAID) and the NGO Development Project that was established to strengthen NGO response capability in HIV and AIDS prevention and control (Zimbabwe ICPD Report,1999). However, the economic collapse as well as the unfavourable political situation resulted in a lot of the International NGOs pulling out of the country. At the time when such NGOs left the country, the HIV infection rate in the country was comparable to its neighbouring countries, but the death toll was a bit higher compared to that of the neighbouring countries. This is due to the government being unable to finance the HIV treatment drugs in public hospitals, a situation which was exacerbated by the primary health care budget cuts from the economic sanctions. During this period, patients were given HIV and TB treatments based on what is available in the pharmacy at the time, not on what kind of treatment was best for their health condition, which contributed to cases of drug resistant HIV and TB (Sithole, 2009). In other cases where people could access adequate HIV treatment, the treatment was not effective because they were not able to use the treatment with adequate nutrition. The financial crisis in the country will therefore continue to affect the implementation process of health

policies due to limitations in budget allocations on both the government of Zimbabwe and the reduction in donor funding available for official developmental assistance (UNFPA, 2011).

A study Zimbabwe's health programmes from as far back as 1999, shows that the government did have good intentions to provide adequate and diversified sexual and reproductive health care services through the family planning strategy (1997-2002). This would be done through working with both local and International NGOs such as *the Advance Africa Programme* that was co funded by USAID. The program aimed at decentralising the centres which enabled access to family planning methods (MSH, 2004). Under this program, the NGOs assisted with procuring fuel (especially during the fuel crisis), for the relevant Zimbabwe National Family Planning Council (ZNFPC) to travel to the district sites to provide supervision and support (MSH 2004). The procuring of fuel in this case also assisted with providing an enabling environment for the linkages between organisations implementation of family planning and organisations specialising in HIV programming, and thus leading to a coordination of efforts between all stakeholders in reproductive health and HIV & AIDS prevention and management (MSH 2004). Furthermore, the advance Africa project also hired a management information systems (MIS) specialist that would provide technical support to the Zimbabwe National Family Planning Council in a form of generating a requisite program data the Zimbabwe Africa Program can use to formulate suitable strategies on how to best assist the Zimbabwean population in sexual and reproductive health issues (MSH, 2004).

Despite all these collaborations, the researcher found that the maternal mortality ratio has increased more than threefold "from 283 deaths per 100,000 live births in 1994 to 960 deaths per 100,000 in 2010/ 2011 and 443/100 000 in 2015 which is still relatively high (USAID 2014). The coalition government and some developmental partners have been trying to help Zimbabwe recover from the problems in the public health system. However, the problem of malnutrition in the country has also exacerbated most attempts to curb child and maternal deaths and contributing to reduced outcomes in education (USAID, 2014).

6.4.1.7 Cultural factors affecting women's access to maternal care

In relation to women's right to access to information, counselling and family planning services, the study found that healthcare facilities do provide information. However, certain areas have deeply traditional patriarchal systems and ways of interpreting information, which can propel the women in these areas to develop the unwillingness to engage with the information provided in the healthcare facilities as it is perceived to be against their traditional and/or religious

beliefs. This is showcased by the interview with one of the church leaders from Zaka District in Masvingo, which is one of the areas with the lowest levels of contraceptive use, who stated in response to the question on the appropriate level of education a woman should have before starting a family by stating that;

> *"...We do not agree with some of these values that are encouraged by this cedaw policy because in our church doctrine, the man is the head of the family and the decision maker. We don't follow and are not guided by these treaties but the holy spirit. He [the holy spirit] is our consultant on any issues through our gifted and anointed prophets" (Zimbabwe Interviews, 2015).*

These views were similarly shared by a traditional birth attendant from within the same area who argued that;

> "...we don't agree with the International/regional treaties and conventions agreements because everything they say is against our church beliefs pertaining to maternal health and human rights. We only agree with the African Charter as it is at least cognisant of our cultural beliefs and allows us to practice them" (Zimbabwe Interviews, 2015)

Upon my asking about the appropriate age they think it is okay for a woman to get married and start a family, one of the church leaders stated that;

> *"...14 years is the appropriate age. Education is not important for a woman, the appropriate level of education is grade 7 where we know that a woman is supposed to read and write, but the man should go ahead and get more education as he is the head of the family that should be able to have a wider understanding of things and to provide" (Zimbabwe interviews, 2015)*

The interviewee further argued that;

> *"...Out of all these treaties and conventions that you have just mentioned, we mostly agree with the African charter because we are benefiting from some of the aspects of it eg..the freedom of conscience allows for the protection and free practice of religion shall be guaranteed and that the family should be the national unit and the basis of society" (Zimbabwe Interviews, 2015)*

6.4.1.8 Marriage system and maternal health

An examination of the 2014 Zimstat statistical report shows that trends of marriages in the country are that most marriage partners have wider age gaps with women getting married at much younger ages [between 15-24] compared to the men in the country (HRW, 2015). The study found that a significant number of such marriages are in a form of child marriages that are facilitated by religious and cultural fundamentalists, particularly in religious denominations that combine the Christian faith with cultural practices. In the year 2014, there was a high rise of adolescent fertility which increased from "115 births per 1,000 women aged 15-19 years in 2010/11 to 120 per 1,000 women by the year 2014" (Banda,2014, pg. 6). These figures also

identify the trends of child marriage within this period. In these kinds of areas where child marriage was rife, there would also be low levels of the use of contraceptives amongst the younger women, of which can be attributed to the fact that wider age differences amongst spouses makes it difficult for women to assert themselves about issues concerning methods of contraception and family planning (Banda, 2018). In a focus group discussion in Shamva village in Mashonaland Central that had the highest percentage of married women between the ages of 20-22 who got married during their adolescent years, one of the participants who belonged to the Johane Masowe religious sect stated that;

> *"…Men should always be considered to take up leading roles, first class roles especially in decision making because our cultural beliefs teach us morals by giving the man authority in areas of decision making such as how many children we should have in the family" (Zimbabwe Interviews, 2015).*

In addition, the fact that child marriages occur in rural areas and are usually religiously and culturally facilitated, the women in such communities often have a negative perception about the use of family planning, which is similar to the black population's distrust of modern contraceptives during the apartheid era in the South African case study. To a certain extent, the negative perceptions of contraceptive use is deeply entrenched in the subconscious cultural values to such an extent that some prominent government officials have publicly shared these worldviews in public platforms. For example, Tobaiwa Mudede, who has served as the Registrar-General for the Robert Mugabe government has on public platforms warned women against using methods of contraception as he regarded them as cancer causing agents, which is a similar perception that was widely help by South African leaders of the Bantustan areas during the apartheid era (Banda, 2018).

For the key persons[policy makers, doctors, midwives, NGOs] working closely with issues pertaining to contraceptive use and family planning in Zimbabwe, some of the key problems that have been identified in sexual and reproductive health issues in Zimbabwe is that there is no satisfactory integration of family planning services. According to Dr. Parirenyatwa who has served as a minister in the Ministry of Health and Child Welfare, Zimbabwe has a high literacy rate of 96% (Population Census, 2012), and a good dissemination of information about the use of family planning methods, but there is still lots of people who choose not to use family planning. This is normally because of deeply entrenched religious and cultural beliefs that prevent the use of family planning methods (Zimbabwean Government, 2016). In relation to this, a traditional birth attendant from Zaka District in Masvingo stated that:

"...We feel isolated and since we are marginalised and not recognised when it comes to national health policies. We are really left out in terms of policy" (Zimbabwe interviews, 2015)

Upon my asking about his views on the implications of maternal health treaties and conventions on their profession of being traditional birth attendants, the interviewee responded to say that;

".. Our Culture is invaded through some of these treaties and conventions. There is too much freedom which leads to disrespect and conflicts when it comes to family matters and community. People need to understand that we are a product of a cultural system in a community and we are there to protect culture from being invaded by other cultures, we are however at least thankful for the African Charter of People's Rights which gives us the freedom to our cultural beliefs. This charter allows us to protect maternal deaths by letting us practice it though we are not recognised since modern medicine" (Zimbabwe Interviews, 2015).

Another traditional birth attendant from Chitungwiza, which is a small town in the outskirts of Harare that has been identified as one of the areas with the highest intake of contraceptive use argued that;

> *"...People are told that we are useless in life. Infact they are only instilled with fear that once we help them deliver there are great chances that they will die. I have helped over 500 women to deliver but not a single woman died during childbirth at my place" (Zimbabwe Interviews, 2015).*

In one of the focus group discussions in Zaka district, one of the participants argued that it is not all churches that have a negative influence in the ways that methods of family planning are used or not, as some churches are cognisant of the International Treaties and Conventions pertaining to maternal health and are prepared to have those policies guide them. In this discussion, the interviewee argued that;

> *"...Our church doctrine goes in line with the national health policies and it encourages us to visit experts on those matters. These sentiments are good and are improving matters concerning maternal heal" (Zimbabwe interviews, 2015).*

However, another participant in the focus group disagreed with the above statement as she argued that;

> *"...White garment churches do not allow us to visit hospitals regarding anything to do with maternal health. The elders in our church believe that our doctrines are being directed by the holy spirit and some elders who have been religiously trained to attend to issues concerning maternal health" (Zimbabwe interviews, 2015)*

The statements above showcase a similar trend identified in the cases of Botswana and South Africa in the sense that, although the governments of these countries are willing to sign and make constitutional commitments to abide by the CEDAW convention, the governments ruling in these countries should strive to engage with the religious and cultural communities. This is so because religious and cultural institutions are within the proximity to the population and the members of the community are also have a closer relationship with those institutions. More so

in the rural areas where cultural and religious values are strongly used as a moral compass to guide behaviour in everyday lives. The need to include the traditional birth attendants and religious leaders within the health networks relates with the constructivism ways of understanding International Relations. In this regard, constructivist thinkers in international relations do not see facts as reflective of objective material reality, but rather choose to see facts as subjective, ideational reality that are shaped by one's social structure and norms. In other words, constructivist understanding is that our concepts and language help create our reality (Barkin, 2005).

In understanding of constructivism within the context of maternal health, it is important to note that health policies that are aimed to ensure adequate maternal health in the international community can be viewed as threatening to the social identity of persons belonging to marginal religious and cultural sectors that may have peculiar doctoral interpretations of health and healing. The concept of identity in this regard refers to the understandings people hold about who they are and what is meaningful to them (Cambridge dictionary,2018). This can be identified in the ways in which people in the rural Zimbabwean communities identify strongly with the prevailing cultural and religious identities within their specific communities. Other examples of social identities can include gender, nationality or ethnicity, and social class amongst others. In this case, the constructivist approach helps researcher with understanding that some of the social conditions deemed to be social problems can be further analysed as moral discourses which employ different types of rhetoric's (Barkin, 2005). In relation to this study, it can be argued that values and norms vary enormously across nations. These values may be contradictory even within one state, society, or community. Therefore, the key issue that should be considered in this study is to explore whose values and norms are upheld or excluded when states commit themselves to treaties and conventions, particularly the ones concerning maternal health care.

6.4.1.9 Legal systems affecting maternal health

In sum, the study found that even though the constitution addresses discrimination in section 23 of the constitution, it speaks to discrimination that occurs within public agencies but does not necessarily address the gender discrimination faced by women within the domestic spaces. The study also found that the Zimbabwean government could do more work in establishing policies that are structured in a way that decentralises power, to allow more participatory platforms in decision making situations. The government could also do more in terms of reforming marriage laws to create platforms where women can also be enabled to make key decisions within their private lives. The study also found that the key motive of Zimbabwean's

government to sign the CEDAW could have been driven by esteem and the need to fit in the structures of the International Community. However, it is evident that Zimbabwe has not necessarily extensively domesticated the CEDAW principles within national laws as can be seen in how child marriage is still acceptable in certain parts of Zimbabwe, and how discriminatory marriage laws still prevail. The study also noted that socialisation has been used as a dominant mechanism of the cascading of CEDAW in Zimbabwe, thus it is used by civil society organisations in their strategies of teaching people living in the rural communities about family planning methods. However, the institutionalisation of the convention still needs work as the government has not done much to incorporate the issue of discrimination against women within the constitution. More Institutionalisation could also occur if the government reviewed some of the marriage laws that are discriminatory towards women. The study also found that, contrary to South Africa, there have been no extensive demonstrations to promote the implementation of the CEDAW due to the reality that Zimbabwe is a deeply patriarchal country that has been under an authoritarian regime over a long period of time. It has been especially difficult for women activists to organise demonstrations because violence is often used to silence activists, which often includes women activists being labelled, assaulted and sexually violated for "attempting to behave like men" as its often interpreted by those against the women's movement in Zimbabwe.

6.4.9.10 Civil society and norm cascade

With regards to the internalisation of the CEDAW in Zimbabwe, the study found that the key actors involved have been the civil society organisations such as the Zimbabwe Women's Lawyers Association (ZWLA), who have been advocating for the amendment of the constitution so that it can be specific and inclusive of discrimination against women and not just consider discrimination on the basis of public relations. This organisation has also called for the legislation in Zimbabwe to be seen through gender lens, and not just consider the law from the perspective of men. However, it would be difficult for Zimbabwe's widespread population to develop the habit of internalising the CEDAW expectations because over 67% of the Zimbabwean population resides in rural areas that are deeply entrenched with patriarchal and cultural ways of living, of which are not constantly evaluated overtime.

The study also established that it is also difficult for the Zimbabwean population to extensively implement the CEDAW policies on women's health because the economic challenges in the country have caused brain drain of medical doctors and midwives in the country. This has left people living in the rural areas with the option of relying on traditional healers and religious

leaders for medical attention through which these professionals draw their knowledge from cultural and religious perspectives.

6.4.2 Zimbabwe and the Beijing Platform for Action (1995) and the UN Conference on Women

Results from the case study of Zimbabwe revealed that the country is committed to the Beijing platform for Action of 1995, in which it established the Ministry of Women's Affairs, Gender and Community Development so that the ministry could exclusively oversee the coordination of gender programmes in the country (Chipaziwa, 2012). It is under this specific ministry that the Zimbabwean government created a gender forum that was partially coordinated by UN Women to create a platform where stakeholders such as non-governmental organisations, civil society groups, UN Women and the Ministry of Women's Affairs, Gender and Community Development can come together and discuss implementation strategies that would resolve the challenges faced by women in Zimbabwe. The Zimbabwean government also appointed gender focal persons in each Ministry that would ensure that the Ministries adopt gender mainstreaming mechanisms in their everyday lives.

6.4.2.2 Institutionalisation of the Beijing platform of action

Under the Ministry of Women's Affairs, Gender and Community Development, the Zimbabwean government formed a National Action Plan (NAP) in which it planned to establish institutional mechanisms for the advancement of women, as well as women and HIV (UNECA,2014). However, the implementation processes of the National Action Plan would eventually get compromised by the fact that the country started to experience intense pressure from the IMF to control its spending, in addition to the series of droughts that the country was experiencing at the time (the Academic Agent, 2019). As Zimbabwe's economic crises increased into the late 90s and 2000s, the country started operating on survival mode whereby the ruling ZANU PF government was distrustful of civil society and foreign funded NGOs, became more protective towards its sovereignty with the president [Robert Mugabe] spreading the rhetoric about how the UN is led by imperialist countries that want to capture African countries. Therefore in the case of Zimbabwe, the implementation of the Beijing Platform for Action was happening when the country was operating under the economic survival mode and under cultural wars where the president perceived International Organisations as Imperialists and his perception of African countries as countries that should fight to maintain their sovereignty and maintenance of their cultural heritage.

In its implementation of the Beijing Platform for Action, Zimbabwe's dominant mechanism of the Beijing Platform for Action norm cascading is institutionalisation just like in the cases of Botswana & South Africa. However, unlike in South Africa where the Committee for Gender Equality focused more on getting religious and cultural representatives to sign agreements that challenged traditional norms that violated women's human rights, the Zimbabwean government rather changed some aspects of the constitution to accommodate the Beijing platform for action as well as made some legislative changes that are presumed to be promoting gender equality in Zimbabwe. However, there is little dialogue between religious & traditional sectors and other actors in the gender forum. This situation arose as a result of overlapping laws and the lack of synergy between the constitution and the laws that the authoritarian government established to silence its political opponents. Examples of such laws include the Access to information and Protection of Privacy Act (AIPPA) and the proposal of the Non-Governmental Organisation Bill (NGO Bill). These laws have stifled the everyday function ability of non-governmental organisations and the civil society organisations that promoted a diversity of representation of women in Zimbabwe. The repression of the civil society groups eventually led to the formation of Women for Zimbabwe Organisation (WOZA), that would hold peaceful protests and would encourage women to stand up for their rights. This happened specifically at a time when the government would use violence intimidations against civil society organisations that were advocating for the protection of human rights in the country (Masengu, 2010).

6.4.2.3 Legal systems affecting maternal health

With regards to the legislature, the Zimbabwean government made some changes such as adding the quota provisions for women's representation in parliament within the constitution, as well as changing the age of marriage set at minimum age for 18years for both males and females. In addition, it also made changes in the administration of Estates Amendment Act (1997), that would protect the rights of widows and female children (UNECA,2014). However, the Zimbabwean society and institutions are so deeply entrenched with patriarchy as aforementioned, which makes it extremely challenging to effectively implement the positive changes in the legislature (UNECA, 2014). The cultural attitudes that do not value the contribution of women in leadership has led to less women taking up leadership roles as for example in the political sector that is made up of male dominated political parties, thus leaving women with little influence within the Zimbabwean public sphere (UNECA, 2014). Furthermore, the antagonistic relationship between the authoritarian government and civil

society groups limits effective dialogue between various actors in the network, which makes even platforms such as the gender forum ineffective as not everyone can freely participate without fear. During data gathering for this study, most organisations would decline to participate as they feared repercussions if they said something that would be perceived to be a negative statement against the present regime.

6.4.2.4 Political and leadership factors

In comparison to Botswana and South Africa that have more active liberal democracies, Zimbabwe can be classified as a country that is under transition from an authoritarian regime towards a more democratic regime of governance. Zimbabwe's transition began in September 2008 when former President Robert Mugabe, Morgan Tsvangirai of the Movement of Democratic Change (MDC-T), and Arthur Mutambara of the smaller MDC-M faction signed the Global Political Agreement (GPA) (Lee, 2011). All three parties did not consider the signing of the GPA as the best option of resolving their political disagreements, but it was however considered as the solution that would prevent the political squabble to reaching the worst-case scenario (Lee, 2011). The implication of this decision on the relationship between the government and civil society organisations is that the government (Mugabe regime) mistrusted most non-governmental and civil society organisations, specifically in consideration of the fact that most of the civil society organisations were receiving provision from international donors, through which the authoritarian regime interpreted as treachery and thus imposed laws that made it difficult for civil society and non-governmental organisations to freely operate in Zimbabwe. Ultimately, this meant that the civil society sector was less able to challenge the status quo on various social institutions upheld the women's right to equality, freedom from discrimination and equitable care. An example of some of these dynamics experienced by civil society and non-governmental organisations is with regards to the proposal to require all NGOs to be registered and to limit the amount of funding received by all Civil Society Organisations that were involved in issues pertaining to democratic governance (Lee 2011). Although this bill did not pass in parliament, its proposal led to many NGOs and CSOs to close and leave the country to operate online in the diaspora, which ultimately caused them to be least effective in connecting with people at grassroots level who do not have access to the internet.

In comparison to Botswana that has the least active civil society organisations, Zimbabwe's civil society sector used to be more like South Africa as their civil society community used to be 'large, diverse, and active' during the time when the country was transitioning from colonialism (Lee, 2011). However, the difference between the South African Civil Society

community and the Zimbabwean civil society organisation is that the Zimbabwean civil society community tends to be more politically affiliated with the various political parties nowadays, because of the nature of the government which is authoritative. It has been observed that most population groups in the country end up joining those civil societies because they want the regime change from authoritarian towards being more democratic in its nature and practice. As a result, the main mandate of the civil society organisations tends to get sidetracked by the political dynamics that the civil society is involved in. This has led to a situation whereby different civil society organisations become overly sensitive to their organisational turf and tend to defend their sovereignty. Thus, it has resulted in thwarting of platforms for collaborations and working together with other actors towards a common purpose as each organisation wants to do their own thing in their own way (Lee, 2011). Under such circumstances, gender forums become least effective as stakeholders tend to prioritise the protection of their sovereignty over collaborating with other stakeholders in the network.

In addition, the civil society community in Zimbabwe has been negatively affected by the declining economic conditions in the country, where large numbers of skilled professionals working in civil society organisations emigrated from the country [like most skilled professionals], and thus leaving most civil society organisational suffering from the loss of human capital (Lee, 2011). Another phenomenon is that during the time when Zimbabwe was hardly hit by economic sanctions against former President Mugabe's authoritarian regime, several civil society organisations were receiving lots of funding from various actors in the International Community. However, such civil society organisations would suffer from a 'founders' syndrome', whereby the first leader of the civil society organisation would utilise the funds for the civil society organisation towards their own personal use, without necessarily accounting or being audited by anyone on how they use the civil society funds (Lee, 2011). In this case, the implementation of the good Beijing Platform for Action policies and programmes in Zimbabwe have been compromised by the economic crises, the authoritarian regime that has only recently started to transition after Emerson Mnangagwa's presidency, and thus the strive to ensure that all women have the right to equality; freedom from discrimination and equitable care has been comprised in this regard.

6.4.2.6. Internalisation of the Beijing Platform of action

In examining the motives behind Zimbabwe's signing the Beijing Platform for Action, the study found that like Botswana and South Africa, Zimbabwe was willing to institutionalise and adopt laws that are in support of the Beijing platform for Action as a way of developing its *legitimacy*, *reputation* and *esteem* as an active player in the International Community. Another

motive was that the country wanted to participate in the activities in the International Community after it gained independence in 1980. However, the difference between Zimbabwe and the other case studies is that President Mugabe openly had perceptions of the International Community as an imperialistic entity, in which he argued that;

"We reject attempts to prescribe new rights that are contrary to our values, norms, traditions and beliefs" (Mugabe, UN General assembly speech 2015).

Therefore, cultural norms that are against women's International norms are not extensively challenged because of this ideology of preserving African cultural norms. For the leadership of the Zimbabwean state, wealthier countries in the International Community had 'anointed themselves as the prefects of the International Community", in which there are double standards in how International Rights should be implemented (Mugabe, UN General Assembly, 2015). Therefore, in their implementation of the Beijing Platform of Action, the Zimbabwean Government changed some laws in support of gender equality. The implementation of these laws was however disrupted by the overall support of the deeply patriarchal Zimbabwean society and Institutions that was often unchallenged. Also, the squabbles between the authoritative regime and CSOs created much active & diverse participation in the national gender forum.

Institutionalisation has been the dominant mechanism in the implementation of the Beijing Platform for Action in Zimbabwe whereby the government adopted gender focal persons in each government Ministry to ensure gender equality is incorporated in Ministry operations. The Zimbabwean government also put in place the National Gender Machinery that would attend to issues pertaining to gender equality. In addition, the government amending some laws to accommodate issues pertaining to gender equality. However, the demonstrations of civil society as a way of putting pressure on social institutions to implement Beijing platform for action policies and programmes are limited. This was due to ruling party's drive to closely monitor most civil society organisations that were deemed to be affiliated with various political parties in the country and funded by International donors that are perceived to be wanting to impose political influence in the country. In this case, even though the government has amended some laws to accommodate gender equality, most of the population at grassroots level are not aware of these legislative amendments.

In terms of the norm internalisation of the Beijing Platform for Action in Zimbabwe, the study found that the law has been the key actor in this regard, where the quota provisions for women's representation in parliament, change of marriage set at minimum age of 18 for both males and females, as well as the changes in the administration of the Estates Amendment Act are some

of the legislative changes by the Zimbabwean government to accommodate the principles of the Beijing Platform for Action. However, there has been an overlap between the constitution and the law as other laws such as the Private Voluntary Organisations Act, the Access to information & protection of privacy act (AIPPA), as well as the Non-Governmental Organisation Bill have disturbed the daily operations of the civil society organisations, hence even though there has been some legislative changes towards gender equality, the majority of people at grassroots level are unaware of these changes. Also, because of the nature of the authoritative regime that prevailed in the country for a long period of time, government officials have been the key actors in the maternal health network. Other actors such as the civil society communities have been closely monitored due to their close associations with opposition parties and from being funded by foreign donors. As the authoritarian government perceives the International community as dominated by imperialists, Zimbabwean authorities have been less challenging to traditionally held cultural and religious norms. In comparison to Botswana and South Africa, Zimbabwe has been less conforming as there is no diversity of actors in the network and the ideology held by the authoritative government that is still in transition.

Like Botswana and South Africa, Zimbabwe also predominantly implements the Beijing platform for action from an institutionalisation point of view. However, its dual legal system can be a hindrance to how ordinary citizens can internalise the Beijing Platform for Action principles. In this way, people at grassroots level are hindered from developing a habitual internalisation of the Beijing platform for action.

6.4.3 Zimbabwe and the Development Goal 5 (MDGs) and the Sustainable Development Goal 3 (SDGs)

Zimbabwe's first progress report on the MDGS revealed that there has been increasing numbers of maternal mortality rates in the country, which can be attributed to the spread of the HIV and AIDS epidemic (MDG status report 2004). The country's heath sector was also badly hit by a lack of resources, declining numbers of trained staff, and a shortage of obstetric equipment as Zimbabwe was facing economic sanctions from the economic sanctions and the low numbers of direct foreign investments (MDG status report 2004). By the time of the second status report in 2010, Zimbabwe the country's economic situation had deteriorated to such an extent that there was a deep brain drain as most skilled professionals opted to immigrate to other foreign countries such as South Africa and the United Kingdom (MDG status report, 2010). At this point, the maternal mortality rates had worsened significantly to an estimated

725 per 100 000 live births which was far from their MDG target of 71 deaths per 100 000 live births (MDG Status Report 2010) and (Zimbabwe Human Rights Forum 2016). According to Zimstat's 2015 Demographic and Health Survey, Zimbabwe's maternal mortality rate was 651 per 100 000 live birth births (Banya, 2019). It is important to note that in the case of Zimbabwe, there has been incidents of inconsistent record keeping of maternal mortality issues which has led to institutions such as the Zimbabwe National Statistics Agency (Zimstat) using estimates to come up with data (Banya 2019). According to Zimstat's 2015 Zimbabwe Demographic and Health Survey (ZDHS), there has also been less than 50% of children's birth's being registered, leaving just a third of children with birth certificates in the country (Banya, 2019).

6.4.3.1 Factors fuelling maternal mortality

Due to the inconsistencies in Zimbabwe's record keeping on child and maternal mortality rates, the country has not been in a good position to address all causes of maternal mortality, reproductive and maternal morbidities and related disabilities in the country. However, it has been estimated that some of the contributing factors to the increased maternal mortality rates is the requirement for the poor to pay for medical fees during the years of high unemployment rates, hyperinflation, and the world economic recession (MDG Status Report, 2010).

The HIV /AIDS pandemic has had indirect negative implications for maternal health due to the shortage of drugs, shortage of medical personnel to administer the drugs, lack of reliable transport for patients to collect drugs from health care facilities, as well as inadequate nutrition that is needed by pregnant HIV positive women (MDG Development Goals 2010). In one study of the impact of the HIV and AIDS on general community health, one of the respondents argued that:

> *"...We struggle to raise money to get Kombi fare (mini-bus/taxi) to the hospital, it's so discouraging to get there and be told that ARVs are out of stock try next week Tuesday" (Machingura 2010).*

As more people experienced transport issues as a barrier to getting access to ARV treatment, they would opt to use alternative medications such as the ones offered by local faith leaders and traditional leaders within their local areas (Machingura 2010). Also, some of the working-class Zimbabweans complained that the ARV treatment had adverse side effects such as fatigue and liver function, so they rather opted to use either medicine from prophets and traditional leaders or use Tinanche Chinese medicine which they perceived to have less intense side effects comparison to the ARVs (Machingura 2010). Apart from the side effects of the medications, the shortage of foreign currency that is needed to import ARV's has led to shortage of supply

of the drugs. At the time of conducting of interviews, the country did have the funds that has been accumulated from the AIDS levy to purchase the drugs, however the shortage of foreign currency was the stumbling block that prevented the more purchase of the drugs.

From a policy perspective, the country adopted the Zimbabwe National Policy on HIV and AIDS in 1999, in which it valued the collaborations between the Zimbabwean government and International agencies/organisations as a means to support the national efforts in the fight against the pandemic (Zimbabwe National Policy on HIV/AIDS, 1999). In my view, the collaboration should have also included persons from traditional and religious leadership is essential as people living in the rural communities normally consult with them for medical treatment, including maternal health care services and contraceptive use.

6.4.3.2 Use of Contraception

In Zimbabwe, traditional methods of contraception are most prevalent among the older women in the 40-49 years age groups (Clements and Madise 2004). In most cases, a woman's decision on how to use contraceptives is usually influenced by the environment in which she resides. For a communitarian woman living in the rural areas, she is more likely to be attached to her "immediate family, neighbourhood cliques and community organisations" that find traditional methods of contraceptives more appealing than the modern contraceptives (Jaravaza,2013). Some of the traditional methods of contraception include herbs, rhythm, withdrawal methods, holy water and oil, as well as continual breastfeeding (Jaravaza 2013). The communities where they were many members belonging to the apostolic sect were more likely to use traditional methods of contraception as the church has an ideology that is against "the use of pills and other modern contraceptive methods" (Jaravaza 2013). In my interviewing of a member of the apostolic sect and a traditional healer, their church does not allow members to seek medical care in the allopathic health care facilities because;

"…As traditional attendants we do not allow us to go to the clinics and hospitals because we do not want to mix modern medicine with our traditional medicine. That would confuse things" (Zimbabwe Interviews, 2015).

Upon being asked about whether they are familiar with the Millennium Declaration and whether they subscribe to its targets, the same interviewee commented to say that:

"…We subscribe to it to a lesser degree because in our traditional belief, we don't believe or agree with the Millennium Development Goals because we are not benefiting anything from it. Our government is only improving hospitals and clinics, us traditional birth attendants are given nothing

from the government to improve our services pertaining to maternal health care" (Zimbabwe Interviews, 2015).

In some rural communities in Mutasa District of Manicaland province, there is a widespread fear of the side effects of the modern contraceptive methods, in which it is believed that these methods make women to have frail children and they may cause women to give birth to deformed children (Jaravaza 2013). These beliefs also apply to maternal healthcare access whereby a midwife in Chitungwiza argued that;

"…Power relations & family and community influence impact negatively as our community is not well versed in health matters like giving oxytocin which usually complicates the obstetric emergencies" (Zimbabwe Interviews, 2015)

For the traditional practitioners, some aspects of modern gynaecology are perceived as an invasion of the local culture. For instance, a traditional birth attendant in Shrurugwi stated that:

"… My views on the national sexual and reproductive healthcare policy of Zimbabwe is not fair because they don't consider us as proper birth attendants because they say we are not doing the proper way (Zimbabwe Interviews, 2015)

Her sentiments were shared by, a religious prophetess attendant in Gweru who argued that:

"…We also fight with the government because it is always against our church practices as for example, they say we don't value the importance of maternal health because we don't want our children to be immunised and pregnant women will give birth on the church grounds (mitumba) not at the hospital or clinic but we have trained birth attendants amongst our church members"(Zimbabwe Interviews, 2015)

Ngwenya further stated that;

"… We are totally against the Millennium Development Goals because we are not benefiting from it in any way, they are only trying to improve the maternal care in the hospitals and clinics and us we are not using those facilities, the government is not encouraging women to give birth in our presence. They are discouraging women to come to us for the deliveries, yet we know how to help them deliver babies at affordable prices" (Zimbabwe Interviews, 2015)

The chairperson of ZINATHA (Zimbabwe National Traditional Healers Association) in Masvingo province who also serves as a traditional birth attendant argued that;

"…As traditional or cultural representatives we don't agree with some of the international instruments since they are violating and causing havoc in a traditional setup. Those issues of human rights lead to disrespect. We are there to protect our culture from being invaded in the name of international treaties & conventions. An example is that Beijing Conference, it created problems in our society and country. Women now see themselves as being equal to men which is not part of our culture" (Zimbabwe Interviews, 2015)

During some of the conversations in the focus group discussions, some women stated that they prefer to consult with religious and traditional birth attendants because they are much physically closer to where they reside, and the costs are much lower. The women stated that in rural areas the clinics and hospitals are far away, and the nurses and doctors are very few with unreliable transport system. Furthermore, the lack of good communication systems and poor road networks prohibits them from being able to call the ambulance on time, and hence the traditional birth attendants are more reliable maternal health service providers for them (Zimbabwe Interviews, 2015).

The Zimbabwe National Policy on HIV and AIDS also stated that it is important for adolescents to have access to methods of contraception and treatment to Sexually Transmitted Infections. Also, the policy acknowledged that culture does prohibit young people from being knowledgeable about issues pertaining to sexual and reproductive health. This is because culture tends to promote an attitude of "female ignorance of sexual matters as a sign of sexual purity" (Zimbabwe National Policy on HIV/AIDS).

6.4.3.3 The effect of poverty on maternal health

According to the UNFPA, Zimbabwe has a high adolescent fertility rate that is highest among women who only have a primary school level of education, as well as among young women living in the rural areas (UNFPA 2010). One of the ways in which adolescent pregnancy can be curbed is to make amends to keep girls in the schooling system for longer and at the same time strengthening education on sexual and reproductive health to empower young people to make more informed decisions on issues pertaining to sexual and reproductive health (UNFPA). However, when a country is in a bad economic state, it becomes extremely challenging to keep girls in the schooling system due to the ripple effects of poverty in most working-class households, as well as lack of financial resources for the Ministry of Education to make the schooling environment more favourable for all students to thrive. For instance, some of the schools in Zimbabwe "do not have adequate sanitation, health facilities, and schooling equipment's such as desks, chairs and books" (Murisa, 2004). At a household front, it is quite common for girl children to opt to leave in the streets when the living conditions at home become too burdensome and too traumatic to bear. For instance, a 19-year-old living in the outskirts of Harare chose to leave home at the time when her mother was terminally ill with full blown AIDS, leaving behind her sickly mother and two younger siblings. When interviewed about why she decided to leave home, she responded as follows:

"Mother is always sick. I was afraid that one day I will come back home and find her dead. The situation was just too unbearable, so I decided to leave in the streets" (Retrieved from Xoliswa's Sithole's Zimbabwe's forgotten children documentary, 2010)

When questioned about her sexual and reproductive health, the admitted that she is sexually active. However, she also mentions that she and her 21-year-old boyfriend use condoms inconsistently. The lack of access to education by young women in Zimbabwe does increase the likelihood of maternal deaths in Zimbabwe. According to a midwife in Chitungwiza;

"...An educated woman has power over her sexuality and is able to be assertive. She can choose how many children to have at what age and knows about contraceptives and the maternal healthcare that she deserves" (Zimbabwe Interviews, 2015).

A midwife in Chinhoyi shared similar views with Hlabangane in her arguments that:

"...An increase in the female literacy rate was found to be associated with the decline of a number of children a woman has. Women's autonomy is seen through knowledge (exposure to the modern world), decision making, interaction with the wider social circles, emotional autonomy, self-reliance and control over economic resources. Education tends to increase the age of first marriage thereby decreasing the number of years that can be devoted to childbearing" (Zimbabwe Interviews, 2015).

6.4.3.4 HIV/ AIDS Orphans and maternal health

Situations similar to the destitute experience described above are very common amongst many young people in Zimbabwe during the times that the country was experiencing the most intense economic challenges. The economy was characterised by hyperinflation, sanctions that restricted donor funding coming into the country, and government not having enough revenue due to marked reduction of tourists visits to the country. The government found itself in a situation where it could not afford a lot of HIV medications. As a result, a lot of people living with HIV developed full blown AIDS and died, leaving behind their children without reliable care givers. According to Pufall et al (2014), children who have parents with HIV in Zimbabwe have a lot of challenges with paying for school fees due to a loss of income from sick or deceased parents. At the individual level, children who have deceased fathers are more likely to drop out of school due to lack of funds (Case et al, 2005). On the other hand, the children who have lost their mother are more likely to not "enrol in school, delay school attendance", get lower grades at school as well as having higher chances of being in a lower grade for their age at school (Case et al, 2005). Furthermore, some of the children who have lost their parents to the HIV and AIDS epidemic are often living with HIV themselves (Pufall, 2014), and thus the key priority for such families would be the day to day survival with the need to maintain going to school being one of the least priorities for the families.

To make modern contraceptive methods appealing to all population groups, it is important for the Ministry of Health to broaden engagement with members of the community, to understand and to have a discussion with the community about their concerns regarding modern methods of contraception and how these concerns can be addressed. The Ministry of health also needs to diversify their interest and knowledge about the traditional methods of contraception so that they can get to understand and engage with members of the community from their way of understanding the world, specifically during the tough economic climate when public health facilities are less likely to have a wide variety of methods of contraception or adequate members of staff who can administer the modern methods of contraception. It is also important for the Ministry of Health to have community engagement regarding methods of contraception so that they can also address the cultural pressures that may inhibit members of the community from using modern contraceptive methods (Zimbabwe MDG Progress Report 2012).

6.4.3.5 Wellness focused approach

In the extended Zimbabwe National HIV & AIDS Strategic Plan (ZNASP) of 2015-2020, Zimbabwe attempts to adhere to the Strategies toward ending preventable maternal mortality (EPMM) through adopting a more wellness centred approach and people focused plan to reducing maternal mortality rates. In so doing, the Zimbabwean government plans to focus on social and behaviour change communication, that design messages to specific population groups through mass media, interactive materials and interpersonal communications in a form of home visits (Government of Zimbabwe, 2015). The government acknowledges that the challenges experienced in this programme are inadequate community volunteers that would help the programme to "address the social and cultural factors that influence behaviour" (Government of Zimbabwe, 2015). One of the ways in which the government can increase volunteers would be through partnering with civil society organisations that focus on women empowerment and human rights issues. However, the Zimbabwean government has a history of being antagonistic towards civil society groups in the country, which in the end, inhibit the cascading of maternal health norms as these norms need a multisectoral health network to work together in the country's implementation strategies.

6.4.3.6 The relationship between NGOs and the government and its effect on maternal health

At a global level, there are not enough influential actors in the maternal health networks that would be the voice for the ordinary African people. Moreover, it has been observed that there are several factors that prevent NGOs from being effective voices of the common African people within the International Global Maternal Health Networks. Some of these factors

include bad relationships between an African state and NGOs which often lead the state to impose restrictions on the operations of the NGO (News 24: 2017).

It has been found that the bad relations between NGOs and African states stem from how NGOs originally emerged and found a niche in African countries. NGOs emerged in Africa for the first time during the pre-colonial era where they would provide welfare services such as education and healthcare to population groups that were side lined by the state (Hofisi and Hofisi. 2013). Examples of such organisations such as missionary based organisations that would often volunteer to provide free education, healthcare and shelter to poorer members of society in most rural parts of African countries (Hofisi and Hofisi, 2013).

When African countries gained their independence, some African governments would often be sceptical of the true intentions of these NGOs which were normally from former colony countries (Hofisi and Hofisi, 2013). In this regard, African countries would often consider NGOs to be a threat to their sovereignty instead of being a potential partner in solving some of the social ills in African societies, which was most prevalent in African countries that had authoritative one-party states. To deal with the perceived threat, the African state often resorts to tight regulations and monitoring of the operations of NGOs and hence stifling the potential for NGOs capabilities of reaching greater heights in achieving their mandates in the African country (Hofisi and Hofisi ,2013). For example, statist regimes such as in the state of Zimbabwe under former President Mugabe have a history of oppressing NGO activities as they perceive them to be tools that are used by the West to try to undermine the regime in power (Hofisi and Hofisi 2013). In this case, the study found that African based NGOs is spent most of their energy on trying to survive in hostile communities. Instead of applying it in working hand in hand with the government to establish an agenda that would ensure that the most common members of society have access to essential services such as health care services. Even in cases of social democratic regimes such as Botswana and South where there is little negative interference of NGO daily operations by the state, these NGOs often face challenges of human resources as most local graduates with degrees prefer to work with government as they offer more permanent contracts than the temporarily contracts that are often offered by NGOS (Hofisi and Hofisi, 2013). The negative repercussions of this is that the NGOs end up hiring expatriates and less local staff members with more knowledge and have experience of the intricacies of the local culture and religions that influence social behaviour. Thus, the local people who are supposed to assist the NGOs establish ways of better connecting with the community as a means to establish better ways of identifying some of the root causes of social

ills such as the indirect culturally and religiously influenced causes of maternal deaths in the local African community, may not be willing to take a contract based employment which is the norm in NGOs (Hofisi and Hofisi, 2013).

MORE OF RECOMMENDATIONS

Some of the ways in which there could be an improvement of relations between NGOs and African states is for NGOs to establish ways of creating a favourable political context in which they can be able to work in collaboration with the state to implement some of the International norms pertaining to health (Asad and Kay, 2014). One of the ways in NGOS can do that is through working with local chiefs as a way of identifying with and connecting with cultural values and the ordinary people that are mostly affected by maternal mortality rates in African societies (Asad and Kay, 2014). After establishing connections with the local chiefs, the NGO would be in a favourable position to help local communities to reconceptualise issues such as maternal health as an issue that pertains to human rights and hence redirecting the frame adaptation of maternal health issues in local African communities (Asad and Kay, 2014). Furthermore, the NGOs together with the local chiefs would thus be better placed to collaborate with the government to establish the strategies that the government have adopted to reach their goals regarding the treaties and conventions that they have committed to concerning maternal health. NGOs can also further establish trust with the African states by assisting the states with crucial factors in development planning such as how to use technology better to reach the local communities regarding maternal health issues, NGOs could also provide the African state with access and introduction to other multilateral political institutions and thus assisting in the further building of more alliances, networks and more inclusion of African voices in the International Global Health Networks (Asad and Kay, 2014). Furthermore, NGOs can establish alliances with other NGOs in order to create opportunities to connect with the local populations and to pass their message across.

6.4.3.6 Barriers to international Norm cascade

Other factors that prevent the norm cascading of international maternal health norms through Private Public Partnerships (PPPs) is the lack of political will in the country from which the PPP is operating. In this regard, a private public partnership is most likely to achieve its goals if the political environment in which they are operating is in support of their cause. In addition, the PPPs need to have common objectives and mechanisms in which they would apply to

ensure that the country abides by the maternal health norms that they have ratified and signatories to (Sturchio et al. 2017). In Zimbabwe for instance, there has been a slow uptake of public private partnerships during the Mugabe regime because of investors having a perception that it would be high political risk to attempt to invest in Zimbabwe (Zinyama and Nhema 2015; Nishtan 2004). The country is still currently in transition from the Mugabe regime and the nation is still yet to see how the new government will broaden its relations with Civil Society Organisation. Furthermore, the unclear legal policy frameworks and the currency crises in the country are also contributors of the slow uptake of public private partnerships in Zimbabwe (Zinyama and Nhema, 2015).

Above all the challenges listed above regarding the role playing of different actors in the international community about maternal health issues, the study found that the Faith Based Organisations as social institutions is not extensively involved in the global health networks. This is despite the fact that large numbers of ordinary people in African countries have begun to seek medical care from their local Faith Based Organisations in the 21st century. The involvement of Faith Based Organisations in global health networks can be traced back to the 18th and 19th centuries whereby mission societies would provide healthcare to African countries (Kagawa et al. 2012). In this regard, it is essential that Faith Based Organisations become more included in the International and National Health Networks to ensure more accountability to improve quality of care and equity in maternal health provision.

6.4.3.7 The government effort in strengthening health systems to meet the needs of women and girls

In terms of strengthening the health systems to respond to the needs and priorities of women and girls, the Zimbabwean government has attempted to coordinate and manage a multisectoral national response in order to include the hard to reach communities. However, the challenge is that the dire economic situation has led many citizens of the country to emigrate to other countries for economic opportunities. For the Zimbabwean citizens who emigrate as informal workers, they usually live under conditions that are inhumane and abusive to their human rights as they, more specifically when they are illegal immigrants in the host country. Therefore, the government needs to attend to its economic and currency situation so that informal worker Zimbabwean citizens who have emigrated can return and be able to access multisectoral national response on sexual and reproductive health that the Zimbabwean government has selected as a strategy in its Extended National and AIDS strategic plan of 2015-2020.

An examination of Zimbabwe's performance in the implementation of MDG5 and sustainable development goal 3, the study found that the key actors in the cascading of these norms is the

Zimbabwean government when it formed supportive programmes geared towards the reduction of maternal deaths in Zimbabwe. The programmes include the Health Transition Fund of 2011-2015 that was a partnership between the government, the UN and the Donor Community in which the funds were targeted towards improving HIV and reproductive health rights initiatives (UNDP 2015). The government also partnered with UNFPA to establish the maternity waiting homes project, as well as partnered with the European Union and UNFPA, whereby the EU granted the UNFPA US$13 Million that would help support Zimbabwe's Ministry of Health, Child Welfare in their efforts to accelerate Maternal Health targets (UNFPA 2013). UNFPA further assisted with the funding it received to develop projects that are aimed towards the improvement of women's access to sexual and reproductive health services as well as HIV prevention. UNFPA also assisted with the improvement of maternal waiting homes to improve institutionalised births (UNFPA 2013). The study also found that although there are some religious institutions that have problematic doctrines that fuel maternal mortality in the country, there were are some religious institutions that have been working with the government to improve the quality of health care in Zimbabwean hospitals. Examples of such religious institutions include the *Zimbabwe Association of Church Related Hospitals (ZACH)* that formed a strategic partnership with the government, in which it assisted with the running of programmes relating to maternal health. The *Free Presbyterian Church of Scotland* also assisted by forming and operating the Mbama Mission Hospital that offers maternal health care services in the remote village situated in Nkayi District in Matabeleland. *The United Methodist Church* also contributed by forming and operating the Mtshabezi Mission Hospital that offers maternal healthcare services in Bulawayo. From the alternative medicine sector, the study found that *the Zimbabwe National Traditional Healers Association (Zinatha)* has contributed by facilitating the training of traditional birth attendants that were awarded certificated and registered under Zinatha. As much as these actors are contributing towards the implementation of MDG5 and the sustainable development goal 3, the study found that the lack of coordination amongst these actors has negatively affected the implementation of these norms, in addition to some other actors such as the civil society organisations that have a history of having a bad relationship with the organisation.

6.4.3.8 Factors inhibiting norm cascade (MDGs)

The case study of Zimbabwe, revealed that the extensive cascading of the norms was also inhibited by the lack of socialisation of these norms among the broader communities in Zimbabwe. This is illustrated by how the disconnect between the state that directs the implementation of the MDGs and religious institutions that offer spiritual healing as well as

cultural leaders has led to little socialisation of ordinary citizens about the modern contraceptive methods. The remotest rural areas are the hardest hit, where consulting with traditional birth attendants and religious healers is the most cost-effective way of acquiring maternal health care. The study revealed that similar to the case of South Africa, Zimbabwe needs to do more to reach the male population about family planning issues considering that they are the key decision makers in issues pertaining to sexual and reproductive health in a patriarchal society. The study also found that similar to the cases of Botswana and Zimbabwe, institutionalisation has been the dominant mechanism in the norm cascading of MDG5 and sustainable development goal 3, where the government established policies in support of maternal health, and partnered with organisations such as the UNFPA, Mission Churches and external funders in the implementation of these policies and strategic plans. However, other actors such as traditional birth attendants and leaders of some African Independent churches felt that they were excluded from the health networks even though they had been providing maternal health services at much reasonable prices in some of the remotest rural areas. The researcher also found that contrary to South Africa, in Zimbabwe, the cascading of MDG5 and sustainable development 3 could also not be extensively implemented through demonstrations as the dominant mechanism, where civil society organisations such as the TAC could demonstrate against the government regarding its AIDS policies. The Government of Zimbabwe therefore needs to remove some restrictions such as "the freedom of assembly and expression" to allow civil society organisations to really show demonstrations of the need to positive change regarding maternal health issues (Zimbabwe Human Rights Forum, 2016).

In terms of the internalisation of MDG5 and sustainable development goal 3, the study revealed that the law was the key actor whereby the Zimbabwean government established certain laws & policies that were geared towards the implementation of MDG5 and sustainable development goal 3. Some of these laws include Section 76 of the constitution that allows for the right to access to basic healthcare services, although the decrease in budget allocations in health care facilities has made implementation of this right difficult (Zimbabwe Human Rights Forum, 2018). The constitution also stipulates that all persons should have access to emergency medical treatment in all health facilities (Zimbabwe Human Rights Forum, 2018). Another way in which the norms were internalised is through the National AIDS policy of 1999, and the extended Zimbabwe National HIV and AIDS strategic Plan of 2015-2020 through which the government aims to adopt a more people centred approach when dealing with sexual and reproductive health issues in the country (UNDP, 2015). Other actors involved in the norm internalisation include key professions involved in the maternal health networks in Zimbabwe

such as the state, certain UN organs, donors from western countries such as Ireland, Britain, Sweden and the US, Mission health care facilities that are predominantly funded by foreign donors, and some doctors and midwifes in the government health care system. The study also found that norm internalisation could be enhanced if Civil society organisations could be allowed more freedom to demonstrate. In that way, there could be dialogue among all maternal health care service providers and cultural norms that that are detrimental to women's maternal health can be challenged a bit more so that the general population can know more about the MDGs and SDGs and begin to formulate the habit of internalizing these norms.

6.5 Chapter summary

This chapter presented the findings of the study on the case study of Zimbabwe, the following chapter presents the analysis, discussion and recommendations of the study.

CHAPTER SEVEN

ANALYSIS, DISCUSSION AND RECOMMENDATIONS OF THE STUDY

7.0 Introduction

In this chapter, the discussion focuses on comparing the similarities and differences among the three cases, thus Botswana, South Africa and Zimbabwe in their way of translating the CEDAW, Beijing Platform for Action/UN Conference on women and the MDG5/SDG3 norms. A comparative evaluation was also made on which country is making progress in each indicator and the reasons for this. Thereafter, the discussion examines which of the three countries is making progress across the indicators/norms.

7.1 Common Factors inhibiting the norm cascade of CEDAW among the three countries

In comparison of the similarities and the differences between Botswana, South Africa and Zimbabwe on their implementation of the CEDAW, it can be argued that the case studies have similar factors that disrupt successful cascading of this norm such as; (i) patriarchy, (ii) the overlapping of policies-particularly with regards to common law versus customary law, (iii) Institutionalization being the only dominant mechanism in the implementation of the CEDAW, (iv) signing of international agreements that they don't believe in by African countries, (v) and rural women being predominantly marginalized in the areas of access to education, and access to healthcare and some negative cultural and religious influences affecting their ability to be the key decision makers in issues pertaining to their sexual and reproductive health. In addition, it was also found that lack of diverse actors in health networks in these countries slows the norm cascading of the CEDAW. In this case, it can be argued that these similarities remain constant with the only difference being the degree to which these factors occur in the three countries. As much as there are these similarities, there are also differences in the ways in which the norm cascades within the three countries, which will also be discussed and evaluated below.

7.1.1 African countries signing International Agreements that are not aligned to their innate cultural norms.

When the CEDAW norms were at the norm entrepreneurship phase around the 1970s, African countries were still settling in their new positions of being independent states within the international community. At this stage, African countries were newly established in power to be able to be in a position where they can be norm entrepreneurs in the formulation of the CEDAW. In this case, African countries simply joined the CEDAW by signing the agreement, without necessarily being part of the discussions when the CEDAW norms were established. At the time of the CEDAW convention, Botswana's democracy was only 13 years old, South Africa was still under the apartheid regime and Zimbabwe had not yet gained its Independence. Thus, one can argue that South Africa and Zimbabwe were still experiencing legitimacy crises in the international community while Botswana was still finding its feet as a sovereign country in the international Community. This finding also concurs with Finnemore and Sikkink (1998), who argue that countries that experience legitimacy crises tend to be more drawn towards signing international norms not necessarily because they innately believe in the norms, but because they want to fit in the international community. An examination of the relationship between African countries and the international community around human rights issues, shows that African countries often concerned about protecting their states' sovereign rights. Like Eastern countries, African countries have argued that Universal Human Rights that guide the Conventions such as the CEDAW were formed under the individualistic norm principles of the developed western countries. They advocate for the need for reformation of UN institutions to accommodate the voices of African states more. These are some of the dynamics that are the root causes of the problems associated with the duality of common law and customary law that can sometimes be a stumbling block in international norm cascading in the African context.

7.1.2 The conflict of Policies (Common versus Customary Law)

Under the principles of common law, there is more emphasis on the human rights culture based on individual rights. On the other hand, customary law considers human rights on the basis of belonging to a cultural group without prioritizing individuality. In this case, the communitarian aspect of customary law does not blend well with the individualistic principles of human rights. This may mean that, with regards to maternal healthcare provision, the health seeking behaviours can be influenced by other people in the woman's life instead of the woman being the key decision maker in what healthcare options she would follow as expected by the individualistic principles of common law.

Among most countries in the International Community, Africa is usually mistakenly perceived as a single one entity, without considering that the continent consists of a "collection of disparate states and ethno linguistic groups with varied customs, cultures and philosophies" (Ipinyoni 2016:p26). Most leaders of African countries have argued that the general conversations in the International Community define Africa by its colonial history", as well as its current failure" without necessarily considering Africa's pre-colonial ideology and the extent to which it still exists and is still meaningful to the diverse African people (Ipinyoni 2016). African leaders also argue that countries were not part of the treaty of Westphalia that is one of the important world events regarding state sovereignty (Ipinyoni 2016). In this case, African countries only alluded to the Westphalia way of living after their decolonialisation, hence their "Wesphalianism was never completely developed" (Ipinyoni 2016). As a result, African states have become a combination of a colony and a sovereign state that have an operational mechanism of a precolonial ideology (Ipinyoni 2016). It is in this manner that there is often an overlap of policies when International norms have to be implemented in the African context. In this case, one can argue that African countries tend to struggle with an identity crisis in the International community whereby African states sign International Instruments that are not in line with their innate cultural ideologies.

7.1.3 The Entrenchment of Patriarchy in African Communities

Another factor that tends to disrupt effective cascading of international norms in the African context is the deep entrenchment of patriarchy in African countries. Within the patriarchal traditional culture that dominates most Southern African rural communities, the key decisions pertaining to women's sexual and reproductive health are usually influenced by men and elderly women in society, and not the woman in the reproductive age herself as an individual. Despite men being influential key decision makers in women's sexual and reproductive health, the study argue that several sexual and reproductive health campaigns are not structured to accommodate the male population. Therefore, the norm cascading of maternal health norms can be greatly influenced by the health seeking behaviors of the women in African societies. Patriarchy also have an influential role in women's access to education and which people are placed in positions of being key decision makers in society.

7.1.4. Unequal access to education and decision making

In terms of women's *access to education*, the study found that in all three countries, women living in rural areas are marginalized in comparison to women living in urban areas. In the case of Botswana, the government has made some strides in universal access to education for both boys and girls. However at secondary school level, there are not enough support structures such as mentorship that can assist girls in their planning towards achieving a tertiary level education, as well as broader information in the local libraries about the opportunities that are available for them after high school completion. As such, girl children's decision-making concerning reproduction health becomes more vulnerable to the influences of patriarchal cultural and religious factors. It has been observed that as a result of that, many women in most rural households only have high school as their highest level of education which is insufficient in the development of the critical analytical skills needed to challenge some of the problematic religious and cultural believes regarding issues pertaining to sexual and reproductive health.

7.1.4.1 Botswana Access to education and decision making

In the Botswana case however, the fact that most women in the rural communities have a secondary level education and are living in communities that adhere to customary norms that favour men and elderly women being the key decision makers in women's sexual and reproductive health, pregnancy and infant care, ultimately means that women are not equipped enough to be able to be the key decision makers regarding their sexual and reproductive and childcare. In this case, maternal health networks in Botswana need to be active and expanded and diversified to allow more dialogue between community leaders, patients in the community, the allopathic healthcare providers and traditional & religious healthcare providers in the African context. In such maternal health networks, it would also be essential for the government to consider Max Weber's three stratification structures namely political power, economic means and the women's social status when considering ways of equipping women to be the key decision makers regarding issues pertaining to their sexual and reproductive health (Dlamini, 2016). The women's economic means can be strengthened by facilitating rural women's access to credit and making higher levels of education accessible to women through improving the rural areas education facilities and facilitating more channels for more women to get information about pursuing higher levels of education. Women's social status can be elevated through convincing leadership in rural communities to make gender equality a priority.

7.1.4.2 South Africa access to education and decision making

Like Botswana, South Africa's rural women tend to be left out of the government efforts to improve the right to equality, freedom from discrimination and equitable care. Because of the previous societal set up where rural areas were not having advanced social institutions such as schools and hospitals, South African rural women do not have good access to education facilities, some areas in provinces such as the Eastern Cape and KwaZulu Natal do not have good transportation systems, of which can expose young women to sexual abuse. Another issue that prevents access to education for rural women is the issue of child marriage in the form of the practice of *ukuthwala* that is prevalent in South Africa and Zimbabwe. This practice exposes girls to early school dropouts, teenage pregnancy and vulnerability to HIV infections because of the power dynamics involved in marriages between teenage girls and much older marriage partners.

7.1.4.3 Zimbabwe access to education and decision making

The study concludes that in the case of Zimbabwe, the declining economic conditions in the country has led the government to resort to requiring all learners to pay school fees, in which orphans, people living in the remotest rural areas, and people living with disabilities have been the most affected. Due to the declining socio-economic conditions in the country, some families have resorted to taking their children out of school, and this has also been exacerbated by the fact that there is no legislation that compels parents to keep their children in the schooling system. In this case, one can be concluded that lack of access to education does have an impact on the girls' decision-making capabilities in Zimbabwe. It can also be concluded that women living in South African rural communities have similar access to education challenges as women in Zimbabwe that include, low teacher morale, poor quality of education and bad transportation systems, although South African rural areas experiences to a lesser degree compared to the Zimbabwean case.

Decision making

In terms of women being the *decision makers* in matters pertaining to their sexual and reproductive health, the study concludes that owing to lack of access to education by women in rural communities, women are often placed in positions where they do not know how to navigate their way in the processes of applying for funding to start profitable businesses or the higher education levels that can place them in positions of financial independence. As a result, women end up being financially dependent on the male figures in their lives. As a consequence, these male figures end up being the key decision makers in issues affecting the women's lives,

including decisions pertaining to their sexual and reproductive health. In this case, it can be concluded that some rural women and Botswana and South Africa shared these similar experiences, where in the Botswana case, it was established that although women have access to land ownership, they do not have the skills of how to commercially use the land to be able to profit from it. Furthermore, Botswana women living in the rural communities tended to mainly rely on informal business trading and they do not know how to approach funding institutions such as LEA to help them to grow their businesses further. Similarly, in the South African, it can be concluded that rural women rely on subsistence farming and need more support and education on how they can bridge from subsistence farming to commercial farming that can pave way for them to have more financial independence.

7.2 Differences (Women empowerment support groups, the influence of religious institutions, health networks)

The study established that in comparison to Botswana, South Africa and Zimbabwe do more to empower women in the rural communities through organizations such as the *Isivande Women's Fund* and *Women and Land Zimbabwe* that have created funding streams for women's small business start-ups and business expansion projects. These organisations are helping women's groups to acquire pieces of land to create community nutrition gardens, conservation, as well as providing platforms for women to create self-help group that taught women leadership skills and educating the women about their constitutional rights.

The study found that when women experience social ills such as poverty, they have a tendency to seek refuge in religious institutions. Although religious institutions are good in providing motivational and encouraging messages when one is facing personal afflictions in life, they are not equipped with how to solve some of the societal structural issues that contribute to the afflictions of women in Southern African communities. In the 21st Century, there has been a rise of Pentecostalism and the commercialization of religion whereby churches provide healing services and sometimes abortion services as in the case of Botswana in which some of the abortion services provided created health complications for the women involved.

In some cases, some apostolic churches contribute to the problem of maternal deaths through advocating for child marriage that leads to teenage pregnancies and places the young girls at risk of being infected with HIV. In this case, one can argue that both Botswana and South Africa are still grappling with how to regulate religious institutions as a means prevent abuse of religious rights. In the case of Botswana, it was found that, this situation is exacerbated by

the inability of the Botswana Registrar of Societies to keep a track record of how many churches are operating in the country and where they can be found. Although abortion is deemed as illegal in Botswana, some of religious healers interviewed stated that they offer abortion services. These are similar dynamics experienced in the South African context whereby some churches do provide healing services, with incidents of women being sexually abused in religious churches and some churches persuading their members to take their children off schools in the Eastern Cape. Under these unfortunate circumstances the South African CRL Commission is still deliberating on how best to regulate religious institutions and how to protect citizen religious rights, which is more or less the similar dynamics experienced in the Botswana case study on how to best ensure that religious institutions protect the human rights of their members. According to the chairperson of the Cultural, Religious and Linguistic Commission (CRL Commission), most professionals such as doctors and lawyers have councils and societies that regulate and hold them accountable for delivering services in a professional and ethical manner (2018). However, in the case of religious leaders in South Africa, there is less regulatory bodies within this sector which can place vulnerable groups of people such as women at risk of being harmed and ill-treated within these institution (Mkhwanazi-Xaluva 2018). In this era of the rise of commercialised churches that offer services such as healing and offerings of micro solutions to poverty, one finds that women are often exposed to sexual abuse within the religious institutions which makes them prone to illegal abortions and HIV infections. This can have ripple effects of placing women at risk of maternal death. It is in this regard that there needs to be more engaging dialogue between the public health sector, the law enforcement sector, and cultural and religious fraternities about issues that affect women's sexual and reproductive health. In this way, the freedom of women from harm and ill treatment regarded their sexual and reproductive care will be improved.

7.2.2 Zimbabwean churches being a positive influence in the CEDAW implementation

Unlike in the cases of Botswana and South Africa however, it can be concluded that in the Zimbabwean case, some churches positively contribute to the implementation of the CEDAW objectives in the country. Examples of such churches include the Presbyterian, the Seventh Day Adventist Church and the Zimbabwean Association of Church related hospitals. These religious institutions that have played an active role in creating health related programs that trained village workers, assisting in the establishment of schools and providing funding to run the schools. In addition, they were involved in sourcing contraceptives, as well as helping in

the sourcing of drugs from pharmaceutical companies in situations where the government could not afford to do so under strenuous economic conditions in the country.

In light of these factors affecting women and girls' access to education, business funding to acquire financial independence and being taken advantage of by commercialized religious institutions, it can be concluded that there is needs for a diversity of stakeholders in health networks, as a means of adopting a more people centred approach to administering healthcare services in Southern Africa. In this case, it can be concluded that the relationship between maternal health stakeholders such as the government, religious and cultural leaders, NGOs and Civil Society Groups can affect the norm cascading of the CEDAW principles. For effective cascading of CEDAW norms, there needs to be a healthy environment for women empowerment NGOs to be able to operate in the rural communities as a means of cultivating awareness and discussions about women's rights in access to healthcare and educational opportunities needed by women to become their best selves.

7.2.3 Lack of diversity of stakeholders in health networks

The study concluded that when women empowerment NGOs are active in the rural areas, conformity to the societal norms that jeopardize women's access to equal rights, the procedural rules and the power of fundamentalist traditionalists and religious leaders will be questioned as there will be active debates on rights of women in a liberal democracy. As a result, an active civil society comprising of families, schools, churches, non-governmental organizations and communications media will be influenced to evaluate the extent to which the prevailing societal norms are discriminatory against women. From the interviews conducted on this issue in Botswana, it was revealed that there is a deep disconnect between actors in civil society (families, schools, churches, NGOs, communications media, allopathic medicine, alternative medicine). The allopathic medicine and alternative medicine rarely meeting as trusted healthcare professionals to have discussions about how they can collectively come together to bring solutions about how they can provide the best healthcare that ensures that the health and wellbeing of families in the Botswana society.

This lack of coming together by the two arms of the profession ultimately leads to the contradictory and overlapping of information and advice on family planning and how a women should take care of themselves during pregnancy, Hence, often it has been observed that women can be prescribed antenatal supplements by the doctors and midwives and the traditional healers and/or spiritual healers on the other hand informs them to throw away the nutritional supplements. In this case, the visibility of women empowerment NGOs in rural

areas will influence civil society to evaluate problematic societal norms, and thus establishing an environment where a dense maternal health network can be formed within the communities. This network will ultimately enable a much stronger social capital to be formed in these communities, and hence facilitating the norm cascading of maternal healthcare norms in rural communities. When there is diversity and strong social capital in the maternal health networks, there would be community engagement that is socially beneficial and inclusive in nature (Fluker, 2009). The inclusivity in the social capital would therefore allow for the challenge of the dominant power dynamics that prevent equal access to quality of sexual and reproductive healthcare through their ideologies.

In the case of Botswana, the country does not have a history of an active civil society which minimizes the impact that civil society organizations can make. Also, Botswana civil society groups have a tendency to rely on single funding streams which causes them to experience financial problems, hence limiting their chances of doing greater work in mobilizing the country to ensure that all women have the right to equality, freedom from discrimination and equitable care.

South African and Zimbabwe however both have a history of an active civil society groups and have a more diversity of civil society in comparison to Botswana. However, both countries experience some limitations in their civil society groups, in which South African civil society groups experience funding problems and Zimbabwean civil society groups becoming more practically focused on political affiliations instead of the mandate of eliminating the discrimination against women. The declining economic conditions in Zimbabwe resulted in most founders of civil societies spending the organizations funds towards their personal needs instead of the fulfilling the organization's mandates. In addition to some repressive laws against civil society organizations and some foreign funders pulling out of the civil society organizations and NGOs because of repressive regulatory laws in the country.

7.3. Who is making more progress in the CEDAW Indicator?

In sum, it can be concluded that out of the three countries, Botswana is making more progress in providing more equitable access to healthcare and better school transportation systems. In addition, it was also found that Botswana have fewer intensive influencers such as polygamy and child marriage that makes young girls more susceptible to teenage pregnancies, sexual violence and HIV infection that can contribute towards cases of increased maternal deaths. South Africa is making more progress in having a more active civil society groups such as the *Sonke Gender Justice*, *Genderlinks* and women development and mentorship programs such

as the *Rural Women's Development*. Also, the fact that South Africa has a public service broadcaster through the SABC creates a platform for civil society organizations and NGOs to hold society accountable on issues pertaining to discrimination against women and children. On the contrary, the Botswana and Zimbabwe state broadcasting can be limiting in that regard. It can also be concluded that Zimbabwe is making more progress in the areas of church and government partnerships where some churches have played an active role in helping the country meet some of its CEDAW expectations. Zimbabwe is also making more progress in educating women about their constitutional rights and leadership training through institutions such as *Women and Land Zimbabwe*.

7.4 Beijing Platform for Action (1995) and the UN Conference on Women

In their implementation of their commitments to the Beijing Platform for Action, the three countries have a similarity of making some legislative and institutional changes to accommodate women's right to equality, freedom from discrimination and equitable care. In addition, all three countries established small government departments to exclusively deal with gender related matters, in which Botswana formed the *Department of Women's Affairs,* South Africa forming the *Gender Equality Commission*, and Zimbabwe establishing the *Ministry of Women's Affairs, Gender and Community Development.* In this case, it can be concluded that Institutionalization has been the dominant mechanism of implementing the Beijing Platform for Action across all three countries.

7.4.1 Similarities (Legislative Changes, Establishing Departments to exclusively coordinate gender issues, Top down approach in coordinating gender issues)

Although the three countries showed commitment towards the implementation of the Beijing Platform for Action principles through making some legislative changes and establishing departments that would exclusively focus on the gender related issues, the cascading of the Beijing Platform for Action commitments mainly occurs at the International bodies and government department level. Little progress was made in cascading of the Beijing commitments to the grassroots levels. In the case of South Africa and Zimbabwe, it can be concluded that the two countries both have a top down approach in their implementation of their Beijing Platform for Action policies and programs. For Example, the South African *Gender Equality Commission* has made some religious and cultural healers to sign agreements

that they will cease to conduct practices (such as *ukuthwala* and *female virginal testing*) that are deemed discriminatory towards women's individual rights, but do not necessarily have extensive dialogues with the religious and traditional healers about the importance of gender equality for humanity, or the importance of respecting women's human rights as individuals in accordance to the International standards. In this case, South Africa is practicing a top-down approach in its implementation of the Beijing commitments in this regard. In the case of Zimbabwe, can also be concluded that the country has also adopted a top-down approach in its implementation of its Beijing commitments because as much as there has been some constitutional and legislative changes to accommodate issues pertaining to gender equality, one finds that the lack of synergy between the constitutional laws and the repressive laws such as AIPPA and proposal of the Non-Governmental Organization Bill (NGO Bill) creates the top-down approach atmosphere as it prevents more open dialogues between actors on health networks.

In comparison to Botswana and South Africa, Zimbabwe has created some quota systems in the representation of women in government. However, patriarchy in the Zimbabwean society is deeply entrenched, which makes the women's journey to achieve political aspirations extremely challenging, and hence few women show interest in pursuing a career in politics. Moreover, when there are less women advocating for women's issues in these political platforms, the oppressive and patriarchal power dynamics remain in the day to day functions of social institutions.

7.4.1.2 Differences (Partnerships within gender departments, inclusion of traditional and religious leaders in the conversations, gender focal persons)

In looking at the differences across the three countries in their implementation of the Beijing Platform for Actions commitments, it can be concluded that through the *Gender Equality Commission*, South Africa has worked quite effectively with other actors in health networks to reach their mandates of advocating for issues pertaining to elimination of discrimination against women and gender equality. For example, the *Gender Equality Commission* has previously partnered with Non-Governmental Organizations such as *Sonke Gender Justice,* specifically regarding issues pertaining to gender-based violence where *Sonke Gender Justice* was part of the monitoring team at the *Gender Equality Commission.* South Africa also showed to be doing better in partnerships compared to the other two countries through the way in which the NGO *Genderlinks* partnered with the *Media Development Diversity Agency (MDDA)* to establish ways in which to use the media to sensitize people at grassroots level about issues pertaining to gender equality and the individual human rights of women in the South African

society. In this case, it can be concluded that South Africa has been better at using demonstrations in its cascading of the Beijing Platform for Action Principles compared to the cases of Botswana and Zimbabwe.

In comparison to Zimbabwe where leaders of some religious organizations and public health officials were knowledgeable about the country's targets and policies regarding issues pertaining to the Beijing Platform for Action and even in some cases working together with the government to meet these targets, it can be concluded that Botswana needs to do more in educating its public health officials about the country's goals, targets and policies regarding issues pertaining to maternal healthcare. Also, like in the case of South Africa, the Botswana government could do more to create platforms for dialogue between the government, traditional healers, cultural healers and other actors in its health networks, of which would be particularly useful in addressing issues concerning illegal abortion.

In comparison to Botswana and South Africa, Zimbabwe has done better in appointing gender focal persons in each government ministry as a means to ensure that every ministry adopts gender mainstreaming mechanisms in their daily operations, as well as in its establishment of the *National Action Plan* that was geared towards establishing institutional mechanisms for the advancement of women. However, the extensive implementations of some of these initiatives by Zimbabwe have been compromised by the declining economic and political conditions in the country.

7.4.1.3 Who is making more progress in the Beijing Platform for Action/ UN Conference on women Indicator?

In sum, it can be concluded that in comparison to the other two countries, South Africa is making much better progress in using demonstrations in the norm cascading of the Beijing Platform for Action. They are doing it through having a more active civil society groups that form collaborative partnerships with other actors in health networks such as media agencies and men's NGOs as a means to sensitize people at grassroots level about issues pertaining to the Beijing Platform for Action and the UN Women Conference.

In comparison to Botswana and South Africa, it can be concluded that Zimbabwe has made better progress in adopting the quota system in parliament and appointing gender focal persons in each of its ministries. However, these initiatives by Zimbabwe have been compromised by the declining economic and political conditions, as well as the deep entrenchment of patriarchal ideologies in the Zimbabwean society that negatively influence women's decisions on whether to pursue a career in politics.

7.5 The Development Goal 5 (MDGs) and the Sustainable Development Goal 3 (SDGs)

In the analysis of the three countries 'progress on the MDG5 and SDG3, it can be concluded that all three countries share a similarity of having HIV prevalence as a stumbling block in their efforts to lower maternal mortality rates in their countries. In the South African case, although there has been tremendous progress in ensuring a widespread access to ARV treatment, health complications related to HIV infection are still the leading causes of maternal mortality rates in the country. However, new HIV infections remain a problem, particularly amongst teenagers where teenage pregnancy is still a major problem. The situation is similar in the case of Botswana whereby the government has administered a more robust approach towards the fight against HIV and AIDS has been both a blessing and a curse. It is a blessing because now the provision of ARV health care services has become more widely accessible and thus the epidemic is no longer a feared death threat. At the same time, in the midst of the problem of youth unemployment that promotes the culture of intergenerational relationships and transactional sex, young women in Botswana tend to be most fearful of falling pregnant than they are of getting infected with HIV. In this case, it can be argued that while the government response to the HIV epidemic has decreased HIV related deaths amongst the population, the HIV infection rate remains a problem. Other similarities in the translation of MDG5/SDG3 include shortfalls in data capturing, and a lack of different methods of contraception in the rural areas. The differences in the countries' translation of the MDG5/SDG3 include gender-based violence, ill treatment from medical staff, and, economic and political decisions.

7.5.1 Similarities -HIV Prevalence being a stumbling block in efforts to lower maternal mortality rates

In the situation of Zimbabwe, it can be concluded that the traditional practice of some African traditional and religious organizations to marry off adolescent girls before they turn 18, compromises the girls' individual rights under the customary and religious practices. Under such conditions, the girls are left with little room for them to state their views regarding issues affecting them within their marriage, which often affects their health seeking behaviour (Dickson and Louis 2018). Furthermore, the inability for adolescent brides to have a voice in

matters affecting their marriage makes them more vulnerable to being infected with HIV as their much older husbands are at liberty to have sexual relations with other people outside the marriage who could be living with HIV, and then subsequently infecting their younger wives with the virus (Dickson and Louis, 2018). In this case, adolescent brides become prone to maternal deaths linked to HIV infection, in addition to pregnancy complication associated with their young age. Zimbabwe is also affected by the problem of not having enough community health workers to work on issues pertaining to HIV, moreover some citizens do not like the side effects of ARV treatments, especially when they have to take the treatment under malnourished conditions. As a result, they opt to alternative traditional medicine to manage their HIV chronic condition. Additionally, there has been a problem of shortage of drugs and the medicinal personnel to administer the drugs within public hospitals in the country.

7.5.1.1 Shortfalls in data capturing

Another similarity amongst the three countries is that they have shortfalls in data capturing of maternal and child mortality rates, which creates inconsistency in the monitoring and evaluation. All three countries also needed to make some improvements in ensuring that there is more diversity of methods of contraception in the rural areas to provide options for this population of women. Also, all three countries need to create campaigns that are focused on the male audience, as a means of including them in issues pertaining to sexual and reproductive health, since they are the key decision makers in sexual relations. Within the patriarchal traditional culture that dominates most Southern African communities, the key decisions pertaining to women's sexual and reproductive health are usually influenced by men and not women. Despite men being influential key decision makers in women's sexual and reproductive health, it has been found that several sexual and reproductive health campaigns are not structured to accommodate the male population. Therefore, men must be more included in the conversations, in the delivery room, in preconception and post-partum care and so on for improved health seeking behaviour.

7.5.1.2 The need for an intersectional approach in administering maternal healthcare services

Amongst the three countries, it can be concluded that they have similarities of having a dual legal system such as the customary and common law principles that promote some harmful practices against women and girl children such as the *ukuthwala* practice in South Africa,

churches such as the *ZCC* influencing women against the use of contraceptives in Botswana, and the *Apostolic sect* marrying off girls at a tender age and also influencing women against the use of methods of contraception in Zimbabwe. As well as the lack of diversity of actors in health networks that are operating in the country.

One way in which this national maternal health networks can be strengthened would be through creating an environment where CSOs and NGOs advocating for gender equality can thrive and free to operate so that they can mobilize and advocate for matters pertaining to gender equality as according to the MDG5 and SDG3 norms. Another way of strengthening the health network would be to not make the allopathic medical sector the dominant actor in the nation's maternal health networks towards, and rather adopt a more intersectional approach in the way that the national maternal health network is set up. Through the intersectional approach of maternal health network, actors such as the allopathic health sector doctors and midwives, CSOs and NGOs, religious healers, traditional healers and leaders, and traditional birth attends will have a more equal relationship where everyone will be able to have dialogue, will be able to question and reach collective resolutions about maternal health issues, which will assist in debunking some of the confidentiality and privacy issues that indirectly influence illegal abortions and late ANC registrations that can contribute to the increase in maternal deaths. The intersectional approach in the nation's maternal health network would therefore create a more dynamic interaction between the women as individuals and the institutional factors involved in women's decision-making processes regarding their sexual and reproductive health. This will therefore assist in integrating the individual with various institutional standards regarding matters pertaining to their sexual and reproductive health (Hancock 2007). As the intersectional approach becomes more adopted in the countries' communities, the women and girls' political power, economic means and the social status will therefore become elevated in society, which will ultimately increase the respect for their International human right to be treated with dignity and respect, and allow for acceptance of their right to equality, freedom from discrimination, liberty and freedom from coercion their decision making regarding matters pertaining to their sexual and reproductive health.

Another similarity is between Botswana and South Africa, whereby even though South Africa is prochoice through the*1996 Choice of Pregnancy Act* and Botswana is prolife through the *Penal Code (Amendment) Bill/ the abortion bill*, one finds that the unsafe illegal abortions are still prevalent in both countries. The reasons why some women and girls opt for illegal abortion (even though its legalized in South African law) in the two countries are culturally and religiously influenced and include; fear of being dishonoured and shamed by family, friends and immediate community members and being pregnant because of being raped or incest.

It can be concluded that in terms of abortion, women in Botswana are vulnerable because illegal abortion procedures are conducted by some traditional birth attendants and religious leaders. Moreover, the registrar of societies does not keep a good track record of such organisations. Thus, in this regard, women's right to be free from harm and ill treatment is also compromised in this regard.

Thus, there is more need for maternal health networks to be expanded in Botswana, to allow extensive dialogues and discussions on the broader socio-cultural factors that affect women's health rights and how to collectively find solutions to some of these obstacles to women's health rights. The inclusion of the traditional healers should not only be the government's efforts alone, but the Association of traditional healers should also take the initiative to introduce themselves in maternal health networks. By so doing, traditional healers would be bringing themselves to spaces where they could be involved in research studies that allow them to tell their stories and experiences within spaces of a body of published work. Additionally, when the traditional healers take the initiative to participate in maternal health networks their indigenous knowledge can be more familiarized in the higher global health networks and hence paving the way for them to eventually be some of the norm entrepreneurs in issues pertaining to maternal health at the World Health Assembly for example. In this way, the traditional healers would be somewhat contributing towards meeting the strong need for extensive research on the policy dimensions of maternal health care provision that would focus on how to resolve the conflicts between culture and traditional norms versus international norms on maternal health.

In the South African case, women and girls choose to have unsafe illegal abortion because of reasons including the stigma they experience from staff at public health care facilities that provide safe abortion services and unplanned pregnancies affiliated with their experience of gender-based violence.

7.5.2 Differences-(gender-based violence, ill treatment from medical staff, and ill-treatment of medical staff, economic and political decisions)

The study concludes that women and girls in South Africa are often subjected to unfriendly and ill treatment from medical staff that often scare them away from using these facilities as well as the long ques and health care facilities that are unclean. These challenges can be attributed to the lack of adequate training of how to best administer safe abortion services, whereby some doctors and nurses allow their religious and cultural beliefs to influence the way they treat patients seeking abortion services. On the issue of gender-based violence, South Africa has extensive incidents of gender-based violence against women in which it is indicated

in chapter 12 of the National Development Plan (NDP) that the country has a disturbingly high levels of gender-based violence incidents (StatsSA, 2018). In the 2016/17 Victims of Crime Statistical Victims Report, it was revealed that 250 out of 100 000 are more likely to be victims of sexual violence compared to the cases of 100 out of 100 000 men being more likely to be victims of sexual violence (StatsSA, 2018). It can be argued that some of the major causes of the high prevalence of gender-based violence against women in South African is attributed to societal attitudes, through which it is generally acceptable for men to be violent against women in South Africa (StatsSA, 2018).

Furthermore, high alcohol consumption is also linked to the gender-based violence incidents in the country, as well as HIV infections that is most prevalent amongst women between the 16 -25 years (SoulCityInstitute, 2015). When women are in intimate relationships where they are exposed to gender-based violence, they are least likely to have the confidence to communicate their rights, negotiate condom use, or have influence in the key decisions regarding their sexual and reproductive health within that relationship. Also, women who regularly experience gender-based violence are least likely to have autonomy or more influence in decisions concerning their sexual and reproductive health, of which places them at risk of HIV infections, unwanted pregnancies which can lead to illegal or unsafe abortions (UNFPA 2019). According to the report on crime against women in South Africa, it was revealed that even though the general crime rate in South Africa decreased during the 2013/14 and 2016/17 years, the violent crime (specifically sexual crime) against women in South has continued to rise during the years of 2015/16 and 2016/17 (StatsSA, 2018). In this same report, it was revealed that South African women have had unpleasant experiences with the police and have lost trust in the national police system, and thus least likely to report their experiences of gender-based violence to the police (StatsSA, 2018).

The South African parliamentary committee has recognised the prevailing problem of the poor solving of gender-based violence cases by the South African Police Service (SAPS) (Molepo 2019). As a result, they recommended that the SAPS increase their family violence and child protection units, employ more specialist investigative officers to handle cases pertaining to gender-based violence. They also ensure that all South African police stations are supplied with rape kits with officers that know how to use the rape kits and handle sexual violence crime reports in a more sensitive manner (Molepo 2019). The parliamentary committee also recognises that the root causes of gender-based violence cases are much more complicated and intertwined with other social ills such as “alcohol and substance abuse, declining economy, poverty and unemployment”. Thus, the situation calls for multisectoral approach and collaboration with law enforcement officers to end these social ills that fuel gender-based

violence in the country (Molepo, 2019). While the South African Police Services is still grappling with how to improve their ways of better solving gender-based violence cases and building their weakened trust by women on their ability to adequately solve gender-based violence cases, many women continue to seek help for their gender-based violence experiences in other social institutions such as churches. However, women can still be exposed to harm and ill treatment within the religious institutions as well.

In the case of Zimbabwe, another difference that can be identified in comparison to Botswana and Zimbabwe is that its government's efforts to attend to issues pertaining to reducing maternal death rates are often compromised by the country's declining economic and political conditions. On the issue of declining political conditions, the Zimbabwean government needs to take more measures to decentralise power and be more open to adopting bottom up and human rights approaches of governance. Currently, health care workers work under strenuous conditions, with minimum pay and inconsistent supply of resources. Under the current Mnangagwa administration, some health workers who criticize the way the government administers policies are being silenced by being abducted and tortured, which maintains an environment of fear that disables anyone from holding the government accountable, including civil society groups. Therefore, the current Zanu PF government should be less draconian and focus more on rebuilding the focus on human rights in its approach to rebuilding the nation.

Once there are visible results that the Zimbabwean government does take into consideration issues pertaining to human rights violations, the International community will lift off some of the sanctions against the country. Moreover, the civil society groups would be freer to hold the government accountable, there would more foreign direct investment in the country which would facilitate any measures to adopt a more human rights approach that would help the country achieve its sustainable development goals pertaining to maternal health.

In comparison to South Africa where pregnant women experienced ill treatment from some healthcare professionals in public healthcare facilities, it can be argued that in the Zimbabwean case, it is actually the medical professionals who receive ill treatment from the government. The ill treatment come in the form of inconsistent and poor pay, placing them in situations where they have to work without adequate medical supplies and equipment (including water & electricity in some hospitals), and making them to work in fear because of the top down bureaucratic way that government facilities are structured. This ultimately demotivate the few medical professionals remaining in the country, thereby hindering their service delivery. The above findings could the reason why in Zimbabwe, seeking healthcare from traditional and

religious healthcare providers can be more reliable than seeking healthcare services from the public healthcare facilities.

7.5.3 Who is making more progress in the MDG5/ SDG3 Indicator?

In the evaluation of the three countries, the results show that Botswana is making most progress in the prevention of Mother to Child HIV transmissions and provision of a more equitable access to healthcare facilities. It means pregnant women and girls are least likely to experience ill treatment from healthcare professionals. South Africa is making most progress in the use of demonstration through having NGOs and Civil Society groups that are more at liberty to practice their mandate of advocating for women's and girl's health rights in comparison to a much more authoritative Zimbabwe. South Africa has also made most progress in involving men in issues pertaining to women and girls 'sexual and reproductive rights through organisations such as the *Sonke Gender Justice*. South Africa has also made most progress in working together with the media to bring awareness to issues affecting women and girls' sexual and reproductive health. Although Zimbabwe is still struggling because of its unfavourable economic and political environment, there has been some good partnerships between the government and some religious institutions that have helped to improve healthcare and access to sexual and reproductive health information for the Zimbabwean population.

7.6 Which Norm is making more/less progress?

In the analysis of the International Norms discussed above, it is impossible to conclude that pinpointing a single norm as the best performing among other because the Beijing Platform for Action/UN Conference on Women and the MDG5 & SDG3 norms emanate from the CEDAW. CEDAW was created with the intention of establishing a good standard of how to upkeep women's human rights in the community.

Although the equality between men and women remains uneven, it can be concluded that through the Beijing Platform for Action, the legal rights of women's rights have been improved (UNWomen 2019). However, the implementation of these legal rights remains challenged, particularly within the African context where there is the overlap /duality of common law that emphasizes on individual human rights, and the customary law that predominantly considers human rights within the context of group rights. This overlap in the duality between common law and customary law ultimately leads to the contradictory and overlapping of information

and advice on matters concerning maternal health such as family planning and how a woman should take care of themselves during pregnancy which can jeopardize the countries' targets to curb maternal deaths. For example, a woman can be prescribed antenatal supplements by the doctors and midwives and the traditional healers and/or spiritual healers on the other hand inform them to throw away the nutritional supplements. The study identified the complications of the co-existence of the duality between common law and customary law in the way that in the spaces of traditional medicine and religious practice. Thus the ensuring the protection of pregnant women's right to equality, freedom from discrimination, liberty, autonomy, self-determination and freedom from coercion remains a challenge because traditional religious ideologies are much more communitarian in nature, and hence emphasis on group self-determination is more likely to be prioritized than individual liberties.

7.7 RECOMMENDATIONS OF THE STUDY

In view of the challenges revealed in the study, the following recommendations are proposed as a way of addressing those challenges

7.7.1 Diversification of health networks

The study revealed that countries in Southern Africa were experiencing challenges with implementation of the women rights related to maternal health, it is therefore recommended that governments in those respective countries should ensure that stakeholders in healthcare networks are diversified in a way that enable different kinds of healthcare providers to have dialogues about matters affecting women and girls sexual and reproductive health in Southern Africa. In concurrence Fluker (2009) advance that when there is diversity and strong social capital in the maternal health networks, there would be community engagement that is socially beneficial and inclusive in nature. The inclusivity in the social capital would therefore allow for the challenge of the dominant power dynamics that prevent equal access to quality of sexual and reproductive healthcare through their ideologies. In the case of Botswana for example, the social capital in the maternal health networks would even be stronger if doctors and midwives are brave enough to voice their concerns about spiritual healers and religious groups that perform illegal abortion services and discourage women from registering for ante natal care much earlier and taking pregnancy supplements. The social capital could also be stronger if the traditional healers would be brave enough to voice their concerns about being undermined by the allopathic health sectors and the government not engaging with them enough about policies and programmes pertaining to maternal health so that they could also feel included. The social capital in the maternal health network could be further strengthened if the religious leadership would be brave enough to voice their concerns about the registrar of societies not doing enough monitoring and evaluation of the registration of churches as these fuels' rivalries in the religious community and placing the lives of the community in danger. Furthermore, the social capital can be strengthened if women's empowerment NGOs could be more robust in their activist role and if they could get support from both the allopathic and the traditional sector. In this way, the political leadership in the country would move away from seeing women empowerment organizations as a threat to culture preservation and hence be willing to work much more with these NGOs and allocate them funding to reach more rural areas in the country.

7.7.2 Cultivate Free Dialogue among Actors

Studies show that when all these actors in the maternal health networks are free to have dialogues about their concerns, the dominant systems will be challenged and thus allowing opportunity to diffuse the power on the society leadership ideologies about the best way to

provide healthcare services for pregnant women and babies. As result, all women (including rural women), would be in much better position to have access to the right information, informed consent and refusal, as well as respect for how they wish to manage their pregnancy and who they would like to be their leading companions during their journey in pregnancy. When the social capital is dense and all actors freely express their concerns and dispel the dominant power systems, women will get better access to adequate healthcare facilities including information, counselling and family planning services. In addition, traditional healers/birth attendants, religious healers, NGOs, and doctors and midwives would be in the same maternal health networks and hence in better synergy about maternal healthcare. This will ultimately open pathways for women to have better access to adequate healthcare facilities including information, counselling and family planning services. It is therefore recommended that governments should encourage open dialogue.

7.7.3 Extensive dialogue between government, traditional and religious healers

Findings from the study suggest that, when it comes to maternal health, women in Southern African countries consult both allopathic and traditional health care providers. It is therefore recommended that there should be extensive dialogue between the government and traditional and religious leaders, to enable the government to ensure that the health care provision provided by the traditional and religious healers is the best healthcare that is of the highest attainable level and that is best suitable for their maternal health needs.

7.7.4 Traditional healers should take the initiative to be included in the health networks

In view of the findings of the study which revealed lack of diverse stakeholders in maternal health networks, it is recommended that stakeholders such as the traditional healers should take the initiative to introduce themselves in the healthcare networks, rather than wait for the healthcare networks to include them. Some of the ways in which the traditional and religious leaders could introduce themselves in the networks would be through using media strategies in mainstream media. For example, Traditional Healers Associations could familiarize themselves with mainstream news values, form relations with influential journalists so that they can be able to work together to disseminate contextual information to the public about the practice of traditional and religious healing (Manning, 2001). Traditional and religious healers could also adopt a human-interest angle in disseminating contextual information about their health practices through inviting journalists to interview them about their healing remedies, and to film them when they attend to maternal healthcare issues so that other stakeholders can

understand their profession a bit better. Once there is understanding, the doors will be open for both the allopathic and the alternative health sector to have dialogue about those issues of illegal abortions, conflicting drug remedies, best ways to provide sexual and reproductive health, gender equality, policies in the country and some of the problematic cultural and religious values that have negative affect the providing of adequate sexual and reproductive healthcare. Once there are such open doors for dialogues, possibilities would be open for traditional and religious healers to also find themselves in positions where they can form part of the norm entrepreneurs of health norms in International platforms. In this way, there can be more inclusion of a bottom up approach in the provision of maternal and child healthcare provision that is extremely needed in the world targets of meeting the sustainable development goals.

7.7.5 MDG5 and SDGs to focus on factors influencing the health seeking behaviour of women

It can be argued that some of the reasons that prevented the three countries from achieving their MDG5 target is that most of the maternal health concerns under the MDGs were focused on issues around clinical concerns such as improving hospital transport routes, staffing in the health care facilities and improving obstetric care in health care facilities. However, the MDGs were not extensively focused on factors influencing health seeking behaviours of women in reproductive age. In this case, it can be argued that the MDG5 did not consider how issues such as women's access to education, their individual economic status, cultural and religious beliefs influence the ways in which they choose to access maternal health care and how their health seeking behaviours can be detrimental or not detrimental to the women's access to adequate maternal healthcare services. The MDG5 was also weak in the area of integrating maternal healthcare services and adopting a more people's approach to providing maternal health care services, which one is hoping will be rectified during the Sustainable Development Goal era. Currently in South Africa for instance, the government is still strategizing and considering ways in which it can accommodate the Sustainable Development Goal Strategic Framework of integrating the provision of maternal healthcare services and under 5 children maternal healthcare services. In the country's National Strategic Plan for the campaign of accelerated reduction of maternal and child mortality rates (CARMMA), the report states that AIDS related deaths are the leading causes of deaths among children under 5 years but it does not provide ways in which maternal health and child healthcare provision can be integrated as a means to protect the lives of both mother and child. In this case, some of the ways in which South Africa can integrate maternal and child health services is by allocating funding and encouraging researchers to do more studies on how South Africa can adopt integration measures that are

specific and fitting to the South African population and social context, and adopting group care models where community based women's groups of pregnant women are established and provide a platform for women to share their pregnancy experiences, with experts in maternal and child health, educationalists, cultural and religious bodies also using the platform to reach a wider population of women at the same time (Langer et al, 2015). Well organized community women's groups can also assist the department of health in records keeping and measurements of problems affecting pregnant women in South African communities (Langer et al, 2015). In this case, South Africa would be able to on a case by case basis, be able to identify and measure the causes of maternal mortality, reproductive and maternal morbidities and related disabilities among specific South African communities.

7.7.6 Improving maternal health record keeping

One of the ways in which the states in the Southern African region can help public health institutions in keeping records of maternal death forms up to date is through addressing staff shortages in some maternal health facilities by hiring records officers that would assist with some of the administrative operations of maternal health facilities. According to the WHO, countries that have succeeded at lowering their cases of maternal deaths have done so due to attending three factors that include; policy makers that establish effective policies that would effectively solve the problem and successful implementation of these policies, the provision of effective emergency care in healthcare facilities, as well as adequate and widespread geographical access to the financial resources needed to curb maternal deaths (Ray et al, 2012).

7.7.7 Encourage the cultural and religious leaders to participate

It is recommended that the CGE should adopt a less top-down approach on the matter so that religious and cultural can internalise and buy into the overall vision of the Beijing Platform for action a bit more. In turn they would be more willing to convince the masses at grassroots level about the importance of Beijing platform for action and then subsequently it would become much easier for the communities to internalise the international instruments.

7.7.8 Encourage men to participate

In this way South Africa needs to expand its maternal health networks to include men as decision makers in matters pertaining to sexual and reproductive health, as well as include and promote dialogue with cultural leaders and leaders of neo Pentecostal churches.

7.8 Recommendations for Further Studies

In consideration of the recommendations for further studies, the researcher argues that more comparative studies should be done on this subject matter as countries deal with challenges in different ways so we can all learn from one another. For instance, in the case of Zimbabwe, the researcher learned that because Zimbabwe citizens have lost trust in their government, other social institutions and a civil society stepped in to save the day. For example, some Zimbabwean churches and civil society groups are contributing a lot the provision of health care and education in Zimbabwe in comparison to civil society and churches in Botswana and South Africa.

In future studies, one can maybe not just focus on qualitative in-depth interviews and focus groups that are much more time consuming, but maybe incorporate the use of surveys a bit more. Surveys in this case can help in accessing a larger pool of data in the subject matter.
Other recommendations for further studies should focus more how to build relationships between the allopathic healthcare and alternative healthcare practices. Such collaborations would be useful in exploring more dynamics of maternal health in Southern African countries. An example of this could be a study on how tribalism impacts health care financing in Southern African countries.

Successful integration would need for health workers to be trained on how to deliver integrated maternal health services (Jongh et al, 2016). In a country that is currently facing deep economic challenges such as Zimbabwe however, training health workers can introduce additional costs in a health system that is already hardly hit by shortages of medical supplies and large numbers of professional medical professional migrating to other countries. The training of medical professionals would also imply that medical facilities in a country that is already understaffed would have additional tasks in their job descriptions, which can affect staff morale as they are doing more work and underpaid in comparison to health workers in other countries. Therefore, there needs to be more research projects done to provide insight on how integration can be successfully done in countries that are low budgeted such as Southern African countries.

In conclusion, this study managed to address the study objectives of exploring how the International norms on maternal health have been translated into practice at national levels in the three case studies. The study also managed to address the objective of examining the extent

to which the translation and the implementation of the established international treaties and conventions pertaining to maternal health care have been signed by Botswana, South Africa and Zimbabwe, and how the three countries have been affected by various traditional, cultural and religious practices related to pregnancy and childbirth. In addition, the study managed to recommend possible ways of ensuring that the International norms on maternal health care can be successfully cascaded to the grassroots level.

In this study, the research question of how the international norms on maternal health have been translated into practice at a national level was adequately addressed, through which the researcher identified the duality of customary law and common law, the lack of diversity in maternal health networks, access to education, and compromised funding in civil society groups as some of the stumbling blocks preventing successful cascading of maternal health norms in the Southern African perspective. The study also adequately suggested ways in which international norms on maternal health can be successful cascading to the grassroots level and provided some recommendations for further studies relating to this particular research theme.

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APPENDICES

Appendices

Appendix A

Interview guide for maternal health national policy makers, International Organization decision makers such as the WHO and UNDP

International/ regional treaties and conventions pertaining to maternal healthcare

What general government policies that can positively or negatively influence maternal health care in the country?

What were the conditions of signing and ratifying international/regional treaties pertaining to maternal healthcare?

How does the national health plan incorporate these agreements?

What is the impact of the economic recession on the extent to which Botswana, South Africa and Zimbabwe as individual countries could fulfill their commitments of maternal health?

How does the South African Development Community as a regional organization plan to curb maternal deaths in the region and how do Botswana and Zimbabwe adhere to the plans of SADC on this issue?

What were the objectives that countries, NGOs and IOs wanted to achieve through treaties and conventions regarding maternal health?

To what extent does the International Community (WHO) consider cultural and religious understanding of health & illness when formulating International policies concerning maternal health?

Can National Maternal Health Systems and Global Maternal Health Surveillance be compatible?

How are non-state actors (profit & non-profit private sector) of health information treated by the WHO and your state?

Appendix B

Interview guide for medical doctors and midwives

Factors that might influence women's perceptions on maternal health care policies

What is the influence of the African Charter's Human and People's rights in the translation of government policy that you implement in your practice/clinic?

What do you think is the average education level of women in childbearing age in your country of occupation?

Do you think women's education level affects their perceptions of maternal healthcare policies?

How does modern allopathic medicine and alternative medicine partner in matters pertaining to maternal healthcare?

Have you incorporated any religious & cultural practices in your practice of allopathic maternal healthcare?

Staff who have culture practices and religion-is it difficult for them to carry mainstream medical practice?

How do power relations in the family & community influence impact on maternal health-give an example?

Appendix C

Interview guide for traditional birth attendants, church leaders, and local chiefs within various villages of Botswana and Zimbabwe

Doctrinal and cultural guidelines on maternal health

How does your religion view the birth of a new child into the world?

To what extent does the government incorporate your religious/cultural beliefs within the national health care policies?

To what extent do your religious sect/ cultural group agree with the International/regional treaties and convention agreement in matters concerning maternal health?

To what extent do your religious sect/cultural group agree with the Millennium Development Goals?

What does Articles 8 and 18 the African Charter of human and people's rights on people's right to have freedom of conscience, religious and cultural beliefs mean to you and your church, and to what extent does this charter allow you to protect women from dying due to childbirth?

Gender dynamics in the religious and cultural groups

What age or level of education is appropriate for women in your congregation or cultural group to complete school?

What age is appropriate for women in your congregation/ cultural group to get married and start a family?

What is your church/cultural group's view on the national sexual and reproductive healthcare policy of your country?

In your view, does the national health plan include or exclude the religious practices of your congregation pertaining to maternal health care?

Appendix D

Interview guides for focus groups (pregnant women and partners) belonging to the various religious and cultural groups within Botswana, South Africa and Zimbabwe rural areas

Perceptions on professional maternal health care

What is the extent to which the state acts as a supportive mechanism in the maternal health care needs of women?

Does the professional maternal health care provided take into consideration your religious and cultural beliefs-where is the link between the two?

Perceptions on religious and cultural maternal health care

What is the extent to which cultural and religious institutions act as supportive mechanism in your daily lives as women?

How long have you been belonging to your religious group and to what extent has it impacted on your decision making processes regarding family life?

To what extent has your education level enhanced or negatively affected your spiritual/cultural life and how you view maternal health

What does the doctrine of your church say about maternal health care, and to what extent do you believe in these sentiments?

Can you identify a merger between the government's maternal health care policy and the doctrine of your church, or cultural beliefs?

What are the cultural and religious practices around pregnancy and childbirth?

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