Social Sciences
2022; 11(4): 194-200
http://www.sciencepublishinggroup.com/j/ss
doi: 10.11648/j.ss.20221104.11
ISSN: 2326-9863 (Print); ISSN: 2326-988X (Online)

Structural Violence and Maternal Health Care in sub-Saharan Africa: A Theoretical Perspective

Simona Simona

Department of Social Work and Sociology, School of Humanities and Social Sciences, University of Zambia, Lusaka, Zambia

Email address:
simona.simona@unza.zm

To cite this article:
Simona Simona. Structural Violence and Maternal Health Care in sub-Saharan Africa: A Theoretical Perspective. *Social Sciences*. Vol. 11, No. 4, 2022, pp. 194-200. doi: 10.11648/j.ss.20221104.11

Received: May 30, 2022; **Accepted**: June 20, 2022; **Published**: July 5, 2022

Abstract: This paper is intended to contribute to the debate about the influence of the social structure on maternal healthcare in sub-Saharan Africa in view of the increased interest to consider broader social determinants of health in social, medical, and public health research. The concept of structural violence was deployed as an overarching framework that conceptualize aspects of the social structure which may prevent individual women from realizing their maternal health needs in terms of utilization of maternal healthcare services. The paper argues that gender norms, human rights violations and globalization may be regarded as such, and collectively, they may bolster in-adequate maternal healthcare utilization. The gender division of labor in most sub-Saharan African societies is such that women are assigned maternal and childbirth roles often without adequate accompanying resources to fulfil those roles. This phenomenon, coupled with pervasive violations of both civil and socio-economic rights as well as a stratified global economic and social system may be detrimental to maternal healthcare. It is critical though, that further research uses a holistic approach that does not only focus on the influence of structural violence on individual outcomes but also how individual capabilities can be harnessed to circumvent the influence of structural violence.

Keywords: Structural Violence, Maternal Health Care, sub-Saharan Africa, Gender Norms, Globalization, Human Rights

1. Introduction

The paradigm shift of research into the determinants of health and healthcare has gained ground from depicting a simplistic story that disease and illness are predominantly the consequences of bio-medical, behavioral and lifestyle mechanisms to a broader outlook which considers structural conditions as the major determinants of health [1, 2]. Several disciplines including public health, social epidemiology, medical sociology, population health and many others have contributed to this body of knowledge. However, it is perhaps the concept of structural violence which has better encapsulated the way broader structural mechanisms impacts on health and healthcare outcomes. With origins in sociology and peace and conflict studies, the theory of structural violence builds on many decades of debates on the role of structure and agency in individual decision-making processes. Structural violence represents an aspect of the social structure which has negative connotations and is detrimental to individual well-being.

This paper shows how the theory of structural violence is useful in analysing the sub-optimal utilization of maternal health care services in sub-Saharan Africa. It argues that structural violence can impact negatively on individual women's choices, making it difficult for them to utilize maternal healthcare services despite the willingness to do so. The paper also presents potential social mechanisms that. The paper develops the idea of structural violence from a sociological perspective grounding it in the long-standing theoretical frameworks developed over time. But before that, the paper presents the context of sub-Saharan Africa relative to inadequate progress in maternal healthcare and the macro-level processes that has contributed to it over time.

2. sub-Saharan Africa and Maternal Healthcare in Context

Access and utilization of healthcare in low and middle-income countries (LMICs) is a constant concern for state governments and global health actors alike. The 1978 Declaration of Alma-Ata was intended to ensure universal

access to primary healthcare worldwide. For sub-Saharan Africa, this was implemented via the Bamako Initiative of 1987 (principle of community involvement) which ensured partial exemption or targeted free health care provision for the poorest population [3]. This policy has resulted into significant improvements but still fell short of the Millennium Development Goals, especially in relation to maternal health [4]. The fact that universal health coverage is among the 2030 Sustainable Development Goals indicates the sub-optimal progress in the total free care provision and user fee exemption policies (UFEPs), which are frequently cited as options to improve healthcare access and utilisation in sub-Saharan Africa [5, 6].

Several factors are responsible for inadequate maternal healthcare progress in sub-Saharan Africa. The sub-continent's high poverty levels cannot be left out in any discussion about poor health and healthcare outcomes. Despite remarkable progress in the reduction of extreme poverty amounting to about 36% from 1990 to 2015, sub-Saharan Africa is the only continent which saw an increase in people living in poverty from 278 million in 1990 to 413 million in 2015 [7]. The failure to reduce poverty in sub-Saharan Africa has often been due to several inter-related factors. Support from the International Monetary Fund (IMF) and World Bank for countries with crippling debt doesn't seem to have helped matters as it has been contingent on governments adopting painful structural adjustment programmes (SAPs). The SAPs had a negative influence on the health sector of most countries. It is evident that these programmes could have widened health inequalities in the region as they led to a reduction in public health expenditure and the introduction of out-of-pocket fees in public hospitals [8].

The other factor may be due to the institutions of governance are often too weak to provide checks and balances on the ruling governments. This has opened corruption and weakened channels of accountability to citizens and thus, fuelling unequal distribution of resources which may not prioritise healthcare. Conflict and civil wars have not been helpful either. They have affected several sub-Saharan African countries with devastating consequences for health and healthcare [8].

The social and cultural fabric of sub-Saharan Africa which is mainly patriarchal in nature, with rigid cultural and social norms has often an obstacle for women to seek, access and use maternal healthcare services [9–11]. The decision-making process to seek maternal healthcare may seem personal but it is embedded in several social mechanisms larger the concerned individual actors including such things as masculinity ideologies or cultural beliefs [12].

3. Structural Violence

The discussion above implies that the decision-making process of a single woman in sub-Saharan Africa to attend antenatal care or deliver in a health facility is impacted by several combinations of factors most of which lie outside her own sphere of influence. Poor health systems, lack of poor governance, corruption and lack of accountability, economic stagnation, war and conflict, and rigidity in cultural and social norms are all macro-level factors that can negatively affect health and healthcare at the individual level. The concept of structural violence integrates all these factors and provides a better framework to understand how macro structures contribute to inadequate access and utilisation of maternal healthcare.

The concept of structural violence was first introduced to the social sciences by Norwegian sociologist Johan Galtung in his *Violence, peace, and peace research* article in the Journal of Peace Research in 1969. Considering a working definition of structural violence, Galtung argued that "violence is present when human beings are being influenced so that their actual somatic and mental realisations are below their potential realizations" [13]. Potential realizations in this case can be adequate utilization of maternal healthcare and reduced maternal mortality. The actual realization is inadequate use of maternal healthcare and higher maternal mortality, which is often the case in sub-Saharan Africa. The concept of 'avoidability' was very important to Gultung's structural violence. He maintains that when the 'potential realisations' are hampered by factors that are *avoidable,* then violence is present. He illustrates this by giving an example of a person who dies from tuberculosis today versus the eighteenth century. He posits that this may not be conceived as 'violence' then since it might have been unavoidable but dying from it today when we have all the medical resources and technology in the world then violence would be present.

Structural violence is distinguished from the more orthodox forms of violence called personal or direct. According to Galtung, the difference is that structural violence is not necessitated by an aggressive actor nor is it necessarily intentional, but it has similar or worse consequences on recipients. For instance, people's lives can be terminated by an active shooter or by the social and political environment that inhibits access to health care. In both cases the outcome is the same but the circumstances that have brought the outcome are different. It is personal or direct violence when an active shooter is involved, and it is structural violence when death is caused by the social and political structure. The *structural* part comes from the fact that it is embedded in large-scale historical processes of social and economic inequalities that shape individual choices and actions [14, 15]. *Violence* because of the harm that is associated with it whereby it hampers complete realisation of somatic and mental potential [13].

In medical and public health issues, the concept has been applied and popularised by physician and medical anthropologist Paul Farmer in his numerous studies on the spread of health, human rights, and poverty in developing countries. Farmer defines the term as "suffering, structured by historically given (and often economically driven) processes and forces that conspire – whether through routine, ritual or as is more commonly the case, the hard surfaces of life – to constrain human agency" [14]. Farmer's conceptualisation of

structural violence places power in the social structure which uses it to impose limitations upon groups of people and constrain them from achieving the quality of life that would have otherwise been possible. These limitations are broad, but they are historical, social, political, economic, legal, religious, and cultural in nature [13].

Farmer argues that although the definition of structural violence does not implicate any direct perpetrator of the *violence* as is the case with direct violence, its distribution is often patterned in a systematic and logical manner. What this entails is that structural violence is not an accident, but it is clearly orchestrated by human agency, directly or otherwise.

For maternal healthcare utilisation in sub-Saharan Africa, structural violence offers a unique perspective. Since structural violence is a product of human decisions and not a naturally occurring phenomenon, it is avoidable. Indeed, several statistics that show a disproportionately higher maternal mortality in sub-Saharan Africa are indicative of this fact [16]. The structural violence question therefore is not why women die from maternal health complications but rather why is maternal mortality more prevalent in sub-Saharan Africa and among certain categories of women? Also, why is it much harder for these women to utilise maternal healthcare services? This essay argues that there is no one person that directly prevents women from accessing and utilising maternal healthcare, rather the problem is combination of structural conditions including institutionalised gender norms that lowers the status of women and unequal distribution of resources at both the national and global level. The harm which is caused by structural violence is the failure by women to use maternal healthcare. In this essay, I will focus on how gender norms, human rights violation, and globalisation are conceptualised as structural violence on one hand and how they contribute to inadequate utilisation of maternal healthcare on the other.

4. Structural Violence, Gender Norms and Maternal Healthcare

Gender norms could be categorised as part of what Galtung called cultural violence which he defined it as "any part of culture can be used to legitimise violence in its direct or structural form" [17]. Gender norms that help to buttress gender inequalities that disadvantage women can be categorised as *violence* in Galtung's typology. In sub-Saharan Africa, where the gender division of labour assigns women with pregnancy and childbirth responsibilities, the burden becomes unbearable, with limited access to resources. Cultural expectations could be helping to perpetuate women's vulnerability. Gender identities are part of social norms and rules governing social behaviour and they are internalised through the process of socialisation. Gender performances are acts of conformity to biological givens but doing so especially in patriarchal societies is often an affirmation of inequalities in access to social and material resources [18].

Gender norms are generally unchallenged in most societies in sub-Saharan Africa because they are legitimised by social institutions and deviance is usually met by direct or indirect sanctions such that people are compelled to oblige and sustain them even at their own expense [19]. Women who have been raised in such environments may look up to men to make decisions about antenatal care visits, hospital delivery and postnatal care [20]. However, this may be counterproductive because the man also may be adhering to his own cultural expectations to leave pregnancy and childbirth issues up to women. This phenomenon may result into inadequate utilisation of maternal healthcare, which would in turn compromise the health of the mother and unborn child.

Culture is a factor that explains how individual agency is constrained by shared values and norms [21]. In sub-Saharan Africa, community solidarity is usually considered to be more important than individual choices in the spirit of *ubuntu* [22]. This means cultural norms that disadvantage women may be upheld as a matter of sustaining community integrity at the expense of individual freedom. Cultural discourses around the world may help to exacerbate the problem that is imposed by culture on disadvantaged members of society. For example, cultural differences could diminish even the idea of women's rights violations. Abuses against women in certain cultures are protected by arguments which frame any attempt aimed at fighting problematic gender norms as cultural ethnocentrism– which is the view that discourages judging a culture based on the values of one's culture. This view is against the universalism of human rights and that rights are culture-specific and culturally determined.

Most women in sub-Saharan African have less access to resources and this makes them dependent on men. Because the cultural system which is universally considered supreme in the community buttresses their subordination, they may use maternal healthcare only with the permission of their partners. Lack of resources worsens the situation because it mostly requires money to visit health facilities especially in rural areas where there can be long distances to health facilities.

5. Structural Violence, Human Rights Violations, and Maternal Healthcare

Human rights violations can also be considered as structural violence hindering adequate utilisation of maternal healthcare in sub-Saharan Africa. The question that needs to be addressed here is how structural violence becomes a violation of human rights and how these violations affect utilisation of maternal healthcare. It is common knowledge that the rights-based approach has gotten much traction in global maternal healthcare discourse [4, 23]. Human rights are universal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity [24]. They are international norms that are binding in all countries that have accepted them and they

provide ethical and legal frameworks for individuals, communities, and governments. Human rights are broadly categorised as civil and political on one hand and economic, social, and cultural rights on the other. Civil and political rights include but are not limited to the right to life, freedom of movement, right to liberty and security, freedom of opinion, freedom of assembly, freedom from slavery and forced labour and freedom of thought among others. Economic, social, and cultural rights may include right to work, right to social security, right to adequate standard of life, right to health and the right to education [25].

From the definition of structural violence above, we have seen that the discrepancy between the potential and actual somatic and mental realisations is crucial to the presence of violence. Upholding human rights is the ideal or potential situation and societies where human rights violations exists meet the first criterion of structural violence. However, as it has already been stated, those violations would not be 'violent' if they were unavoidable. Human rights violations are avoidable because they are all ratified by nation states who have pledged to uphold them. States may not be motivated to commit to something they know is unattainable in their territory. Additionally, human rights violations just like structural violence, also stem from unequal distribution of power whereby those who wield it tend to distribute societal resources in a manner that benefits the agency of some at the expense of and inhibiting the agency of others. For example, state governments have the power to render civil and political freedoms to their supporters and denying them to opposition groups. When lack of human rights violations constrain agency to the extent that fundamental human needs cannot be attained, structural violence becomes a violation of human rights [26]. Economic, social, and cultural rights such as the right to education, the right to health, the right to employment and better standard of life could demonstrate the existence of violence by equally asserting how avoidable power inequalities produce violent results. These rights are usually referred to as "second generation" and they are often rendered invisible by institutionalised social and economic inequalities [27]. But they are of great importance to the realisation of human dignity and better standard of living. If they are not met, humans may face severe threats to health and life that would compromise realisations of their mental and somatic potential [28]. Deprivation of these rights impacts negatively on development in society because the affected population may not participate effectively in the political, economic, and social life. In this regard, poverty is a function of deprivation of socio-economic rights.

Poverty is not an isolated concept. It is created in the interaction process between people and between societies. The economic exchange and transformation of the world tends to benefit some while impoverishing others and the disparity between the two groups is increasing [29]. Although there has been a significant reduction in extreme poverty from 36% in 1990 to about 10% in 2015, in the world, evidence still show staggering disparities across the regions of the world. For example, poverty levels have increased to up to 41% in sub-Saharan Africa during the same period. Many scholars have emphasised the role played by structural violence in this inequality by linking global institutions and macroeconomic policies to poverty disparities between countries [30, 31].

In *Development as Freedom*, Sen sees poverty as the failure of basic capabilities to reach certain minimally acceptable levels, where basic capabilities are understood as basic freedoms, such as the freedom to avoid hunger, disease, illiteracy and so on [32]. For Sen, the full realisation of agency which is the possession of basic capabilities, is the opposite of poverty and this is possible in the presence of economic and social inequalities which constrain it. Therefore, in Gultang's definition of structural violence, the discrepancy between the potential realisation of basic needs and the actual realisation is comparable to the gap between prevailing rights and potential rights. In this sense, structural violence is directly applicable to the human rights discourse.

Maternal health just like health in general is driven by cultural and social contexts in which it exists, which could range from the most intimate to the macroeconomic policies of international institutions. Much more so in a globalised world where people are connected. It motivates the need to drive an understanding about what human well-being really is and how to arrive at it. Human rights are relevant to maternal healthcare because they provide women with the opportunity for full realisation of agency. Socioeconomic rights for example, provide capabilities for women to use maternal healthcare throughout the maternal health continuum from pregnancy to postnatal care. Capabilities may entail adequate education, employment security and a steady income. Furthermore, the political and social environment in which they live should provide civil and political liberty and ensure rights such as freedom of movement, freedom of expression and freedom to participate in the electoral process. In this regard, the human rights perspective may be used in terms of empowerment and agency for better use of maternal healthcare [24] accountability for those with the responsibility to guarantee rights [4, 23] and litigation when the human rights have been abrogated [33].

6. Structural Violence, Globalisation, and Maternal Healthcare

Although the common narrative of globalisation may be in terms of increased interdependencies and the diffusion of post-industrial technologies across the world, its ideological and socio-political dimensions may present a different picture. Ideologically globalisation is seen as a creation of the global monoculture that reshapes diverse cultures to resemble western industrialised capitalist societies [34]. The concept of "development" is the centrepiece of this narrative whereby non-western societies are encouraged to aspire to the 'western' way of life which promises a better standard of life,

education, women's rights, freedom, technology, and democracy among other things [35]. This framing of non-western societies as places which require "development" feeds into international economic integration story which can be regarded as the method used by global financial institutions to liberate diverse cultures and 'rescuing' them from economic stagnation and poverty. This is the socio-political dimension of globalisation, which I would argue is also an exemplification of the concept of structural violence.

This dimension of globalisation is considered by some scholars to have been appropriated by the powerful to bolster global economic hegemony by international institutions like the World Trade Organisation (WTO), the IMF, and the World Bank that impose a development model designed to benefit transnational corporations over workers; foreign investors over local businesses; and wealthy countries over developing nations [33]. The hegemonic paradigm could be further highlighted by the proliferation of foreign direct investments, trade liberalism and foreign debt. These seemingly well-conceived packages to help poor countries have often resulted into worsened situations and the opposite intended consequences. [36] gives detailed treatment of this discussion. Unfair agreements are often the case because third world countries which are the major recipients of these financial regimes are often disproportionately underrepresented in the executive boards of international organisations responsible for the distribution of financial resources. Sachs for example, observes the G7 despite representing only 14% of global population, have 56% votes on the IMF Executive Boards [34]. In Paul Farmer's definition, structural violence is evident here as these global institutions could be conceptualised as historically given and economically driven forces conspiring to constrain human agency.

The world systems theory contributes to a better understanding of the structural violence of globalisation. It posits that the capitalist world economy developed first in Europe and other developed regions and was accompanied by full development and dominance in the global market trade, creating global economic stratification which disadvantages the majority of nations [37]. That global capitalist world system perpetuates a global division of labour whereby countries are divided in three successive zones each performing a specialised function in a complex hierarchical system. The core countries (First World) monopolise high-tech, high-profit enterprises, the semi-periphery nations (Second World) perform inter-mediate functions of transport, local capital mobilization, and less complex, less profitable forms of manufacturing and lastly, the periphery (Third World) which specializes in primary production of agricultural commodities and raw materials [38].

Proponents of the world systems theory argue that the unequal trade relationship resulting from division of labour distorts the domestic economy of many third world countries in many ways including reducing economic growth and increasing income inequality which in turn impacts on the well-being for a large portion of the population [39]. The relationship also creates a dependency syndrome among developing nations for finished goods which they are not able to produce and according to [31], this dependency has always been characterised by a continued lowering of prices for the periphery's primary goods relative to processed goods. As a result, the state's ability to raise revenues is weakened and the resulting lack of revenues affects the funding of health and other basic social service programs [40].

The effects of globalisation on health and healthcare are pivoted on transnational business organisations and macroeconomic policies propagated by the IMF and World Bank [39]. FDI in the third world countries was ordinarily supposed to contribute to development by facilitating the creation of jobs, expanding local production and improvement of technology. However, it is suggested by some scholars that FDI exacerbates the underdevelopment of third world countries through erosion of tax avenues as multinational cooperation in third world countries are usually offered tax holidays and other economic incentives such as cheap labour for attraction purposes [39]. The result is the failure of third world countries to adequately support health sector including better maternal healthcare services.

Macroeconomic policies affect healthcare in third world countries in terms of the international debt crisis that most of them have been grappling with since the 1970s. Foreign debt expansion and austerity measures dictated by lending institutions offer challenges to already constrained economies of third world countries. This makes it particularly difficult for most countries to prioritise service delivery to address maternal healthcare challenges. Some studies have confirmed the hypothesis that debt dependency has a positive relationship with poor health outcomes [41]. Also, globalization often comes with structural adjustment programs (SAPs) that impose conditions for getting loans from international organizations. SAPs have had negative effects on health because they usually demand privatisation of public services to for-profit organisations, a reduction in the labour force and reductions in public spending for health and education [42]. All these are factors that can be said to constrain the use of maternal healthcare services in sub-Saharan Africa.

Structural violence is a product of the social structure, which also often renders it invisible [26]. The location of individuals on the social hierarchy is critical in determining the extent to which agency would be constrained and subsequently how much they are negatively impacted by structural violence. We know that women in sub-Saharan Africa occupy lower socioeconomic status and therefore are likely to be mostly affected by the inequalities in the global financial policies because they are already disadvantaged by sociocultural factors within communities which gives them a subordinate status. Gender inequalities, human rights violations and globalisation are different manifestations of structural violence resulting from gender norms and global stratification.

7. Conclusion

The concept of structural violence encapsulates the

negative influence of macro-level structures on individual decision-making processes. But structural violence does not impact all members of society uniformly. The location of individuals on the social hierarchy is critical in determining the extent to which agency would be constrained and subsequently how much they are negatively impacted by structural violence. Since women in sub-Saharan Africa occupy lower socioeconomic status, they are likely to be mostly affected by inequalities in the global financial system and human rights violations because they may already be disadvantaged by sociocultural factors within communities which gives them a subordinate status. Therefore, individual capabilities such as higher educational attainment, higher economic status, and women empowerment as well as social and cultural capital should bolster disadvantaged women's capacity to circumvent the influence of structural violence at the individual level and access important health services. It is also crucial that research and social analyses which deal with the influence of macro structures on individual-level outcomes also focus on how individual capabilities can help cushion or resist negative influences. Amartya Sen's capability framework and Pierre Bourdieu's capital theory are a good starting point in doing this. Consequently, it is recommended that multilevel modelling techniques be used in future empirical research in this area so that the influence of structural violence and individual capabilities is simultaneously modelled to delineate the relative effect of each level on health and health care outcomes.

Conflict of Interest

The author reports no conflict of interest.

References

[1] Bloom S William (2002) The Word as Scalpel: A History of Medical Sociology. Oxford University Press, Oxford.

[2] Labonté R, Schrecker T (2007) Globalization and social determinants of health: Introduction and methodological background (part 1 of 3). Globalization and Health 3: 1–10.

[3] Audibert M, Mathonnat J (2013) Facilitating access to healthcare in low-income countries: a contribution to the debate. Field Actions Science Reports. The journal of field actions, (Special Issue, 8).

[4] Das S (2018) Maternal health, human rights, and the politics of state accountability: Lessons from the Millennium Development Goals and implications for the Sustainable Development Goals. Journal of Human Rights 17: 550–567.

[5] Robert E, Samb OM, Marchal B, Ridde V (2017) Building a middle-range theory of free public healthcare seeking in sub-Saharan Africa: a realist review. Health policy and planning 32: 1002–1014.

[6] Robert E, Ridde V, Marchal B, Fournier P (2012) Protocol: a realist review of user fee exemption policies for health services in Africa. BMJ Open 2: e000706.

[7] Bank W (2018) Poverty and shared prosperity 2018: Piecing together the poverty puzzle. The World Bank.

[8] Sanders DM, Todd C, Chopra M (2005) Confronting Africa's health crisis: more of the same will not be enough. BMJ 331: 755–758.

[9] Simona S, Muchindu M, Ntalasha H (2018) Intimate Partner Violence (IPV) in Zambia: Socio-demographic Determinants and Association with Use of Maternal Health Care. Int'l J Soc Sci Stud 6: 42.

[10] Adjiwanou V, LeGrand T (2014) Gender inequality and the use of maternal healthcare services in rural sub-Saharan Africa. Health & place 29: 67–78.

[11] Simona SJ (2020) Structural violence and maternal healthcare Utilisation in sub-Saharan Africa: A Bayesian multilevel analysis. University of Glasgow.

[12] Say L, Raine R (2007) A systematic review of inequalities in the use of maternal health care in developing countries: examining the scale of the problem and the importance of context. Bulletin of the World Health Organization 85: 812–819.

[13] Galtung J (1969) Violence, peace, and peace research. Journal of peace research 6: 167–191.

[14] Farmer P (1999) Pathologies of power: rethinking health and human rights. American journal of public health 89: 1486–1496.

[15] Farmer P (2004) Pathologies of power. University of California Press.

[16] Alkema L, Chou D, Hogan D, Zhang S, Moller A-B, Gemmill A, Fat DM, Boerma T, Temmerman M, Mathers C (2016) Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. The lancet 387: 462–474.

[17] Galtung J (1990) Cultural violence. Journal of peace research 27: 291–305.

[18] Calasanti T (2010) Gender relations and applied research on aging. The Gerontologist 50: 720–734.

[19] West C, Fenstermaker S (1995) Doing difference. Gender & society 9: 8–37.

[20] Simona S, Lumamba C, Moyo F, Ng'andu E, Phiri M (2022) The Influence of Contextual Factors on Maternal Healthcare Utilization in sub-Saharan Africa: A Scoping Review of Multilevel Models. medRxiv Preprint. DOI: https://doi.org/10.1101/2022.03.15.22272437

[21] Eckersley R (2015) Beyond inequality: Acknowledging the complexity of social determinants of health. Social science & medicine 147: 121–125.

[22] Mawere M, Mubaya TR (2016) African philosophy and thought systems: A search for a culture and philosophy of belonging. Langaa Research and Publishing CIG.

[23] Simona S, Likando N, Banda A, Phiri M (2022) Integrating the Rights-based and Capability Approaches in the Analysis of Maternal Healthcare Utilization in sub-Saharan Africa: A Multilevel Modelling Study. Research Square Preprint: DOI: https://doi.org/10.21203/rs.3.rs-1627881/v1

[24] Ratsma YE, Malongo J (2009) Maternal health and human rights. Malawi Medical Journal 21: 2.

[25] Assembly UG (1948) Universal declaration of human rights. UN General Assembly 302: 14–25.

[26] Ho K (2007) Structural violence as a human rights violation. University of Essex, Essex.

[27] Evans M (2016) Structural violence, socioeconomic rights, and transformative justice. Journal of Human Rights 15: 1–20.

[28] Liebenberg S (2005) The value of human dignity in interpreting socio-economic rights. South African Journal on human rights 21: 1–31.

[29] Pogge T (2005) World poverty and human rights. Ethics & international affairs 19: 1–7.

[30] Pogge T (2001) Priorities of global justice. Metaphilosophy 32: 6–24.

[31] Frank AG (1967) Capitalism and underdevelopment in Latin America. NYU Press.

[32] Sen AK (1999) Development as Freedom Oxford University Press Shaw TM & Heard. 1979) The Politics of Africa: Dependence and Development London: Longman

[33] Dunn JT, Lesyna K, Zaret A (2017) The role of human rights litigation in improving access to reproductive health care and achieving reductions in maternal mortality. BMC pregnancy and childbirth 17: 1–13.

[34] Srikantia J (2016) The structural violence of globalization. Critical perspectives on international business.

[35] Sachs W (1997) Development dictionary, The: A guide to knowledge as power. Orient Blackswan.

[36] Moyo D (2009) Dead aid: Why aid is not working and how there is a better way for Africa. Macmillan.

[37] Wallerstein I (1974) The modern world-system: Capitalist agriculture and the origins of the European world-economy in the sixteenth century. JSTOR.

[38] McCormick TJ (1990) World systems. The Journal of American History 77: 125–132.

[39] Gereffi G (1989) Rethinking development theory: insights from East Asia and Latin America. In: Sociological Forum. Springer, pp 505–533.

[40] Shandra JM, Nobles JE, London B, Williamson JB (2005) Multinational corporations, democracy and child mortality: a quantitative, cross-national analysis of developing countries. Social Indicators Research 73: 267–293.

[41] Frey RS, Field C (2000) The determinants of infant mortality in the less developed countries: a cross-national test of five theories. Social Indicators Research 52: 215–234.

[42] Schoepf BG, Schoepf C, Millen JV (2000) Theoretical therapies, remote remedies: SAPs and the political ecology of poverty and health in Africa. Dying for growth: Global inequality and the health of the poor 91–126.