ISSN No:-2456-2165

From the Promotion and Protection of the Right to Access Health Care for a Newborn, Child and Pregnant Woman under Congolese Law: A Decentralized and Structured Violence Health Equity in the North Kivu Division' Health System, DRC

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Abstract:-

- ***Background:***

In many legislative document of DR Congo, many laws have violate the rights and women health equity. That is why this study has purpose to advocate pregnant women's access to maternity healthcare starting at community level. For legal evidence, in DR Congo, according to the legislation, article N^0 87 clause 010 of the 1st August 1987 on Family code, polygamy or polyandrous marriage is not recognised. But a number of health related to pregnant women problems occurred in most of single motherhoods. The below analysis starts on nuptiality and pregnancy complication risks, and show equity in interventions in the North Kivu Hospitals. For each woman who succumbs to maternal death, many more will suffer injuries, infections, and disabilities brought about by pregnancy or childbirth complications, such as obstetric fistula. In North health division, about 104 children and 68 women died from a direct complication related to pregnancy out of 100000Live Births, 15 women have a disability due to childbirth out of 100000 Live Births during that particular time of the survey. This is a burden, an obligation of the state to provide the population with a minimum standard of living acceptable. Another thing that weakens international agreements on health is that they are not binding: Making international agreements and resolutions binding on states could contribute to their implementation.

- ***Objectives:***

To advocate to an easy access opportunity to maternity healthcare services at the right time and promote awareness of gendered health equity through some strategies implementation, policies, regulations and establishing clinical legal laws that gathering both maternal and child health and equity promotion.

- ***Design:***

This is a clinical and community-based description cross-sectional study on data analysis review (DHS2014) on access to maternal health service by mothers and children at the time needed in the Health division system of North Kivu Province, DR Congo. Statically systematic analysis of RDC-DHS 2014 data on maternal and child health promotion in North Kivu Health Division System, DR Congo are tracked and compared with the synthesis statement and the profiles and level of interventions that have been made to prevent maternal-child death and equity promotion in communities and health facilities.

- ***Results***

The results show proportions that nurse (76.6%) provided maternity care at pre-pregnancy stage followed by birth attendants (11%), only biomedical or physician (9.8%) provided assistance to a pregnant woman during prenatal period and women who did not received assistance (2.2%) at prenatal stage. During delivery, biomedical or physician (14%), followed by the assistance of nurse (55.2%), and birth attendants (22.4%), only community experienced woman (6.6%) provided care during delivery. At postnatal stage, biomedical or physician assistance (49%), nurse assistance were (9.1%), women who were not assisted (41.3%). Infant mortality could be avoided by improving the quality of children's health care, by taking preventive measures and treatment. Educational measures to encourage parents, for example, to massively vaccinate their children. This would be one of the strategies. In the context of the study, the challenge is that vaccine is it enough for all the children, and are all vaccines available at the right time for immunasation children period? Household living conditions strongly influence the risk of dying. In North Kivu health Division, DRC, about one of ten children dies before reaching the age of five. The risk of dying before the age of five shows significant differences depending on the urban and rural area of residence and the access to the health facility. In general, infant mortality is much lower in urban areas (59%) than in rural areas (68%). Improved health, environmental, socio-economic and cultural conditions would also contribute to children's access to primary health care. This is a burden, an obligation of the state to provide the population with a minimum standard of living acceptable. And implement decentralised community-based strategies, interventions and programme.

ISSN No:-2456-2165

➢ ***Conclusion:***

As promotion and protection of the right to access health care for a newborn, child and pregnant woman under Congolese law: A decentralized and structured violence health equity. It has been shown that there is women' violence in all aspects (38%) and that some legal text have limited the achievement to promote equity in health and the right to access healthcare for newborn, child and pregnant women. Therefore there is a pressing need to undertake more study that will establish monitored indicators on promoting and protecting the right to access healthcare for newborns, child and pregnant women in the North Kivu Division' health system, DRC.

Keywords:- *DR Congo, Congolese Law, Clinic Community-Based Description, Protection, Health Equity, Right To Health, Access To Primary Health Care, Structured Violence, Vertical Equity, Horizontal Equity, Health Prevention Strategies.*

I. INTRODUCTION

➢ *Context*

Stene and others have enumerate some evidence that since 2008 and 2009,a number of NGOs with government ministries and WHO commissions worked in Low Income Developing Countries to readjust their changes of official Maternal and child health prevention strategies and programme through a specific evaluative study [1][2][3][4]. The study outlined that a number of considerable elements were left away such as family planning insufficient budget, lack of infrastructures, lack of human labour, absence of strategic plan, and limitation in monitoring and needs assessment [5][6][7][8][9]. Freedman added that mother and infant health prevention strategies have been the most important innovation and change of the national maternal and infant health prevention programme for many of Low Income Developing Countries [10][11][12][13] [14][15][16][17].But the community member that can benefit within these programme need to be contacted before an important prevention in maternal and infant deaths can realistically be achieved [18][19][20][21][22][23]. From our perceptive view Stene wanted to emphasise that a number of countries throughout yet to provide global coverage of sexual and reproductive health care before 25 years passed they have tried to value some important actions and many are not on track to reach the Sustainable Development Goals related to maternal and newborn from 2015 to 2030 [1] [2]". this explanation meant and tried to show that: the strength to low down maternal and infant deaths are reducing results in an increasing number of nations, but as many as 42% of countries with high maternal death ratios, mainly in Sub-Saharan Africa, thus a multitude of vulnerabilities such as lack of national commitment; a very low level of national budgeting for health and health services; unreasonable coordination between key stakeholders and entrepreneurs; poorly functioning health systems with weak referral mechanisms including for obstetric and neonatal emergencies[24][25][26][27][28]; poor logistics for supply; distribution and management of essential medicines, family planning commodities, and equipment [29][30][31][32][33][25]; shortage of skilled health professionals and weak education and training in specific programmes for health professionals; persistent institution, community and regional conflicts that is expressed by nepotism, discrimination of race[2][14][2], origin, and level of health education; regular migration of skilled health personnel across borders from poorer to better-off countries both within and outside Africa[34][4][35], and also from the public to the private health sector[36][37][38][39][40], weakening public health sectors further; unclear and poorly implemented policies and guidelines on recommended practice and poor regulation; quasi inexistence of strategic plans and no hope of monitoring and evaluation; conceptualisation of oriented goal for individual profit making especially for humanitarian health actors [41][42][43][44][45][46][47]. The main challenge to be addressed by these countries including DR Congo in particular remains on how to ensure the scaling-up of effective interventions to avoid preventable deaths in health facilities and households settings and how to structure and assign work to both clinicians and community members in a respectful and transparent ways. This matter motivated us to analyse the findings of the DRC-HDS 2014 basic on North Kivu information[48][49][50][51]. The aim is to identify and analyse progress and gaps of the provincial maternal and newborn health schedule and it utility of process variables and results to measure services efficiency, especially in how they linked to family planning, skilled attendance at birth, and emergency obstetric and neonatal care, including prevention and management of unsafe delivery[14][15][16][17]. Second objective was to describe the impact of the equity in health maternity care promotion for the newborn, child and pregnant woman based on available secondary data of North Kivu in the DRC-DHS 2014[52][53][4][54]. To illustrate a decentralized and structured violence health equity in the North Kivu Division' health system, DRC we developed two approaches mainly Galtung and Abigael approaches.

➢ *Structural Violence Theory*

Introduced from 1975 and 1969 by Jahan Galtung started explain the theory that Social exclusion is the relegation or social marginalization of individuals, corresponding more or not the dominant business model, including older people, people with disabilities (physical or mental), or other minorities. It is usually really deliberate or socially accepted, but constitutes a more or less brutal process sometimes progressive failure of social links. This term has begun to find a social common use in the early 1980s in post-industrial societies. While the phenomenon of putting away is found in so many societies and dates back to ancient times, the current phenomenon of social exclusion does not necessarily, or exactly, poverty. One of the dominant expressions of Western societies is the active participation in the labour market. Number of unemployed feel excluded socially. Social exclusion, by depriving an individual or a group of recognition, denies his identity. And when the individual passes the State of fact to the status, then, is a process of stigma. It may involve different

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fields or values such as family, marriage, housing, culture, or education. When this exclusion concerns very vulnerable groups (economically), it maintains their stigma(Farmer, 2014)[55][37][21][56][16][57].

From the perspective point of view in terms of globalization and world order, our current study is explained as a holistic research on maternal health violence rights. He added that Abuse is unfair consideration (casual, sustainable or repeated) inflicted on a person (or a group) are treated with violence, contempt, or indignity. Abuse implies a relationship of power or domination between the author and the victim, who is so often dependent and helpless. Related to the abuse of power, abuse frequently has consequences lasting health not only physiological but also psychic victims, due to the moral trauma. In addition, forms of abuse during childhood are of assault and violence, excision, or rapes, have often such major consequences on the development of children and adolescents that studied by Daniel Schechter and Erica Willheim1,. which translates to adulthood in uneven propensities to happiness or suffering, or even in the reproduction of violent behaviour, on others, or oneself (Johan Galtung, 1975) (Joshua S. Goldstein, 2002) (Maar, 2011) (Honorld., 2007)[58][59][60][61][62].

- *Assessment of the Severity of the Abuse as Inequality Factor*

To measure the severity of the abuse, it is important to analyse what elements which can be consequences. Firstly at the level of the social or family group in which they take place, abuse can play a disruptive role. One of the members of the group to mistreat another with the tacit complicity or the passivity of other members is always heavy and ambivalent feelings. Guilt interfere with the resentment of the aggressor as the victim who we can blame not resist or even have a special relationship with his torturer. Then, at the level of individuals, these consequences can be of two types: on the one hand, injuries and physical damage and, on the other hand, the reactions at the level of the psyche. For example, often observed in victims feelings of powerlessness and humiliation without any relation to the importance of the injury. But in other cases, these reactions are ambivalent and mixed both pleasure and pain. The complexity of the modes of internalization of situations of dependence explains the wide variety of the consequences of abuse (Larchanche, 2011). According to Galtung, 'when the potential is higher than the current [it] is by definition *avoidable* and when it is avoidable, then violence is present (Catharine MacKinnon, 20013). Galtung offers an example,if a pregnant woman died from eclampsia in the eighteenth century it would be hard to conceive of this as violence since it might have been quite unavoidable, but if she dies from it today, despite all the medical resources in the world then violence is present according to our Galtung definition this case is taken as human health violence[63][64][28][65][66][67][64][66]. From this illustration , the potential and actual levels match in the case of the tuberculosis patient in the eighteenth century; whereas the potential afforded by medical resources in the present day is higher than the actual (Janet Page-Reeves, 2012; Niforatos, 2012)[68][10][69][70]. Galtung's conceptualization: violence is about preventing human beings from achieving their physical and mental potential. Three types of violence (even though the discourse has privileged agent driven, direct forms of violence). Direct or personal violence, structural violence, and cultural violence. These violences are both visible and invisible in social life and institutions[71][72][73][74][75][27].

According to the illustration Fig1. below on a Gender Perspective on Conflict Resolution by Taillon, 1992 in Grant-Aided or Taken for Granted? A Study of Women's Voluntary Organisations in Northern Ireland. Studies on people using the services of free care show, for example, the links between abuse, health and social inequities related to human violence and especially gender based during childhood, propensity to find themselves in situations precarious and more high frequency of risk-taking health. the work of Serge Paugam (2005) regarding other trajectories out go in the same direction, particularly the study of the so-called cohort in Gender Perspective on Conflict Resolution which is based on a survey conducted in island-of-France in five areas with the support of the national Observatory of poverty and social exclusion, Ined and Inserm.

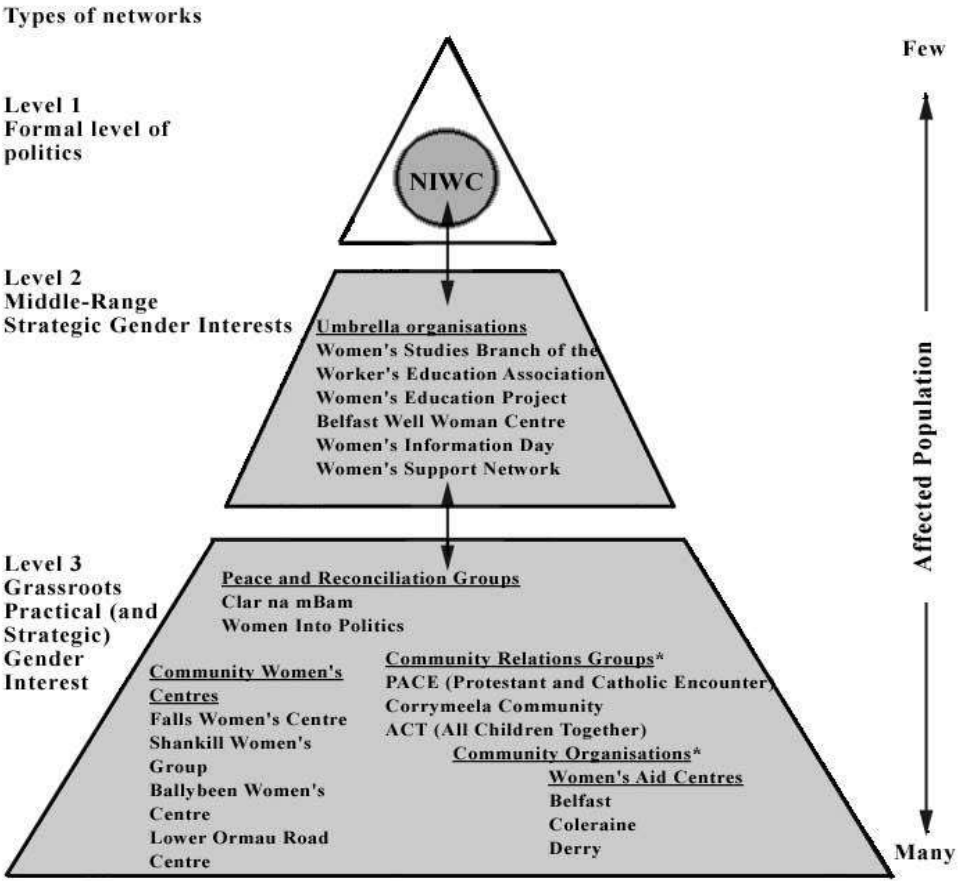

Fig 1:- Gender Perspective on Conflict Resolution by Taillon, 1992.

- Physical violence (shots or even injuries carried out with guns) can put the victims in situations of complete prostration, but they can also give no further action if the people are involved in a project where they are intended to be exceed ;
- Situations of deprivation (of food, of care, of affection or attention) can lead to despair and the refusal to live but, in other cases, they do not lead to consequences if an authority has managed to give them a sense; deprivation of material resources and money for example may be felt as bans to enjoy the existence or, instead, can be understood as the opportunity to prove to the world its spiritual elevation ;
- Psychological violence will have completely different implications depending on the grip of the individual abuser on the victim: insults of a superior or parent will be able to be printed sustainably in the consciousness of the person who will have undergone such disparaging words, while bashing and denial of tenderness of a spouse or parent may be considered in another context such as games or the paradoxical ways to testify its interest ;
- Sexual violence (rape, assault and sexual interference, incest), finally, are less ambivalent and often lead to feelings of humiliation, powerlessness and negation of itself as depression and suicide; Yet, in some cases, women have faced such experiences of abuse and have transformed them considering them at the broader level of the situation of the female gender (see King Kong theory of Virginie Despentes, for example, or the book) of Anne Delabre on Clémentine Autain).

➢ *Consequences of Mistreatment (Observations of a Cohorte)*

According to Georges Menahem (1992, 1994)[76][60][77][78][79] has work from large surveys of population studies, abuse known in childhood result in larger frequencies both risk-taking and health in adulthood. The separation of the parents has far fewer negative consequences in adulthood that the extension of the situations of disagreement or conflict of parents would have had to bear the child during conception, gestation and birth (67% more statements diseases in the case of parental conflict without separation in cases of separation without conflict, for a list of 28 chronic diseases and for comparable proportions for age and sex)[80][81][82][83]. Serious emotional lack or absence of parents more than one year are associated with more frequent risk-taking and most likely damage to health (respectively 49% and 36% more chronic disease than the population mean). The illness or disability of the father or of the mother that the child would have to endure during his youth also corresponds with notable aggravations of risk of accidents and illness (respectively 26% and 23% more chronic illnesses than average). Similarly, surveys on victims of serious accidents motorcycle or auto showed that they had been the object of brutality and abuse during their childhood[84][85][86][87][88][89]. Other examples include vulnerability to situations of social exclusion, topic on

ISSN No:-2456-2165

which many surveys have been conducted in France, the United States and the United Kingdom. The work of Jean-Marie Firdion and Maryse Marpsat (2000) clearly show that the risk of engaging in a trajectory of SDF grown strongly by the fact of having experienced severe family problems (misunderstanding or violence of parents) during his youth. These results are confirmed by investigations of Maryse IPU-Hedibel (1997) for routes of youth engaging in strips to violent behaviour[90][91][92][93]. Another approach is to legally define what is an act of inequality and abuse within the meaning of Act No. 2002-2 of 2 January 2002 renewing social and medico-social action. In this proposed approach by the lawyer and researcher Olivier Poinsot, be distinguished from situations that give rise to a duty to report within the meaning of article 434-3 of the penal Code (reached at the physical or moral integrity of the person) of those in which the breach of a human right is characterized without however justify the realisation of a report, or situations of non-quality hospitality or assistance that are independent of any infringement of a right. According to the psychologist and psychoanalyst Gerard Mendel, having internalized during his youth in patterns of violent behaviour encourages to consider as normal such brutal attitudes to age an adult Alice Miller, researcher on childhood, suggests that the violence in our society, including crime, are due to the abuse and other abuse suffered in childhood, however the individual victim can get by using a helpful witness. Humiliation, blows, slaps, deception, sexual exploitation, mockery, negligence etc are forms of abuse because they injure the integrity and dignity of the child, even if the effects are not visible on[94][95][96][97][98][99][100].

First of all, these inequalities also translate inequality before the risk of die.6, which exists for all causes of deces7. The gates of lectures8 and synthetic indicators more specific are therefore sought or used to measure the degree of social inequality in health for a community, a country where everyone, or the way to go in terms of reduction of inequalities; These indicators can be: Variables individual, ad hoc indicators of deprivation, elements of administrative databases (which must then manage data of health in accordance with the regulations in force, in particular concerning anonymization).

For example a thesis used two tax databases (survey heritage to death in 1988 and survey on income tax of households in the year 1990)[101][102][103][104][105] to assess to what extent certain determinants (level of wealth, for example) could be a predictor of the risk of dying young more or less. Ways to fight against inequalities according to Dourgnon et al., (2001)[106][107][26][108][109] health insurance is one of the ways to limit the excess mortality of the poorest, but in France, for example, the eraser of not all the effects of social inequalities and health

The KVG article 64A review makes it impossible for those affected to get certain medical services, including the delivery of medication in pharmacies. Between the months of May and August 2006, 84 people have consulted at the Polyclinic of the HUG medicine to get drugs. These people generally have chronic diseases (88%) with a high prevalence of psychiatric abuses (59%) and low socio-economic level. This revision makes random access to the care of the weak and opens a gap in the universal nature of health insurance. Since the first of January 2006, section 64 of the Act on health insurance (KVG) allows insurers to suspend the refund of benefits in the event of incomplete payment of the co-payments or insurance premiums[110][36][111][112][113].

Last April, the Geneva State Council mandates the Polyclinic of medicine and Consultation of infectious diseases of the University Hospital of Geneva (UHG) to ensure continuity of care for people affected by these measures. Here, we deliver a first assessment of the introduction of this article and a description of the population concerned. We are also trying to situate this problem in the more global, social inequalities in health[114][115][116][39][1][3].

A direct correlation between social status, morbidity and mortality has been reported in most Western countries. In recent decades, this phenomenon has even increased in some countries such as England or the Etats-Unis.2, 3, between 1930 and 1990, the difference in mortality between skilled professionals and unskilled in England has more than doubled to a life expectancy of ten years4 difference if this trend seems to be inflected in 1990, the difference in terms of healthy life years continued to increase (66.2 vs 49.4 years)[3][14][117].

The prognostic influence of socioeconomic status also could be demonstrated for different pathologies such as cancers or heart attack. A correlation with biological markers such as Creactive protein, HDL-cholesterol and Fibrinogen was also observed.

Nevertheless, differences in access to specialized care are found even in countries with universal insurance coverage. A linear relationship between income and access to an angiogram and an inverse relationship with the waiting time could be observed in a Canadian study of more than 50,000 patients admitted for a heart attack of the myocarde.12 moreover each difference of annual salary of $ 10,000 was correlated with a 10% decrease in mortality to one year[118][5][119]. These results have been achieved after correction for age, sex, the severity of the illness, the specialty of the physician and hospital characteristics.

We can also wonder about the interest for the community to continue to pay large sums for insurance premiums, while the benefits are suspended and that the community will eventually provide itself care which part don't will probably never be refunded.

Pending a decision of the political power to solve the difficulties brought about by the entry into force of article 64A satisfactorily, it is important for any player in the health care system, and in particular for the primary care physician, to know this problem and to inform the patients concerned to the procedure in force in their canton[49][7].

ISSN No:-2456-2165

More generally, knowledge of the socio-economic situation of the patient should be identified systematically; Firstly, because it represents, like the traditional risk factors, a predictor of morbidity and mortality, and on the other hand in order to ensure the possibility for the patient to get the treatment or medication prescribed. It may indeed be more problematic for a significant part of the population, especially for people with low income and high deductibles.

Finally, it is important to try to identify behavioral, material, environmental, psychosocial or related to the healthcare system factors explaining social inequalities in health and to implement, to the extent possible, possible strategies to address them [3]. Hatcher illustrated the safe and sound model in South Africa based on the below:

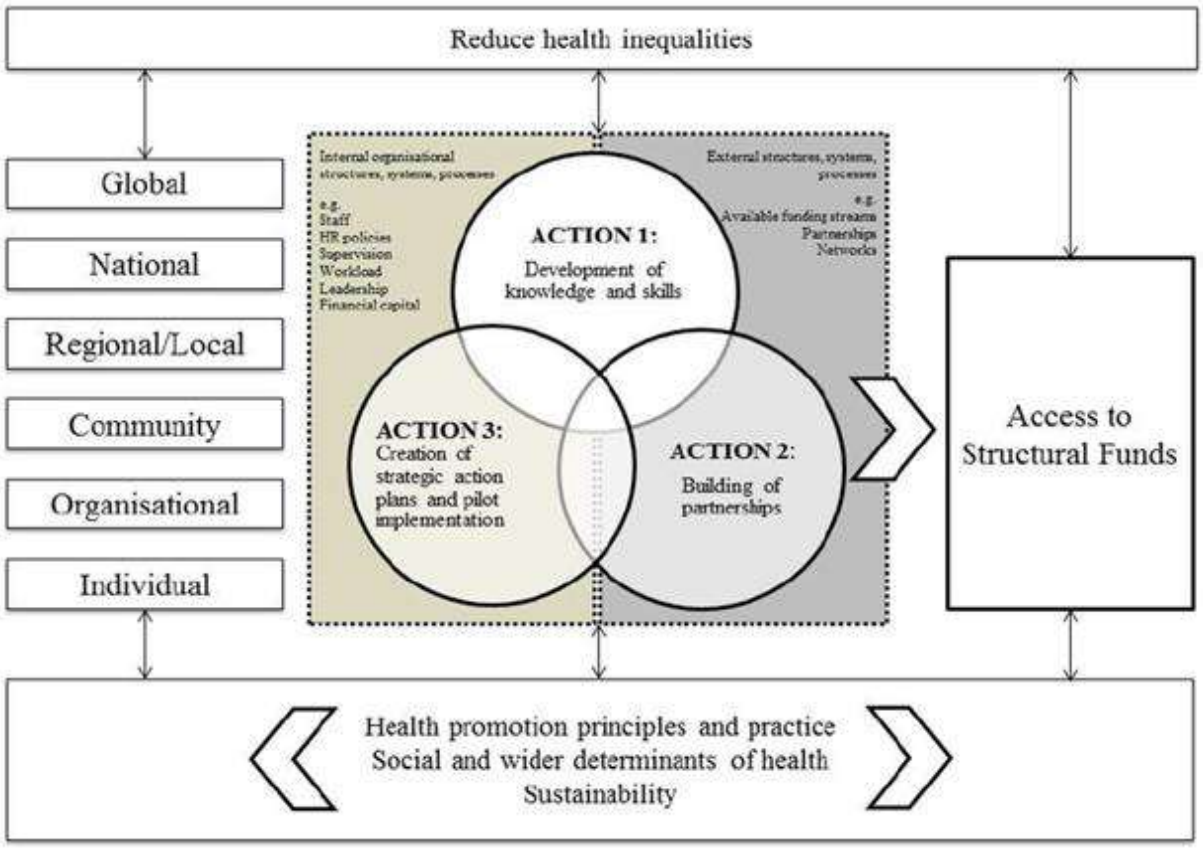

Fig 2:- Illustration Reduce Health Inequalities Conceptual Framework by Abigael M. Hatcher in 2017.

Hatcher wanted to explain the fact that: “violence in terms of its avoidability criteria and the idea of a gap between what is possible and what is actually attained presents a myriad of contestable issues. How does one define what is possible or potential? How does one decide or even ascertain when something is avoidable or not? These inequalities are powered by a variable degree of access to environmental resources, wealth, education and health (they are therefore part of spatial segregation). In the cities and territories the ISS translates into territorial inequalities of health sometimes very marked. The prison populations, migrant, displaced populations in war, civil war or living in slums are special cases [120][121][18][19][38][82][102][122][123][124].These inequalities and the number of people being most vulnerable could increase in the context of the double crisis of climate and biodiversity. Social and health inequalities (ISS) are (more or less depending on the countries and eras) cross-sectoral policies on health, environmental health and the fight against social inequalities in health. To produce these policies, it must first understand these inequalities, and then be able to assess trends. These policies are more and more in the policies of sustainable development of the territories, which sometimes give more space to the "participation of people in decisions affecting their health. the lack of access to a healthy and safe environment, the lack of access to good nutrition, the access to work, lack of access to care and prevention. Ooften further aggravated by a delayed care use (the doctor is seen too late). Iincreased exposure to drugs (including alcohol and tobacco), often due to unfavorable economic constraints, but also in the case of environment degraded (social environment, legacy of war, consequences of pollution and living environment and ecological gradients, which explain differences) regional mortality of several points, the ecological inequalities are so often involved[125][126][127][128][129][130]. Abuse can have devastating long-term health consequences, including physical injuries and mental health problems such as depression and anxiety disorders. Despite these challenges, basic on low income countries have shown that black women actively seek out support from multiple formal

institutions to keep themselves and their families safe. Yet Black women face structural barriers when they seek assistance. Using a Black feminist perspective, this study describes strategies that can be employed to improve institutional responses to Black women survivors and concludes with suggestions for future practice.

II. CONCEPTUAL FRAMEWORK OF SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUALITIES

The gross inequalities in health that we see within and between countries present a challenge to the world. That there should be a spread of life expectancy of 48 years among countries and 20 years or more within countries is not inevitable[131][132][133][134][135]. A burgeoning volume of research identifies social factors at the root of much of these inequalities in health. Social determinants are relevant to communicable and non-communicable disease alike[136][137][138][139][140] . Health status, therefore, should be of concern to policy makers in every sector, not solely those involved in health policy. As a response to this global challenge, since 2005 WHO launched a Commission on Social Determinants of Health, which would review the evidence, and now is raising societal debate, and recommend policies with the goal of improving health of the world's most vulnerable people[141][142][143][128][129][127]. A major thrust of the Commission is turning public-health knowledge into political action. A range of factors contribute to health Inequalities: Socio-economic or material factors such as government social spending and the distribution of income and other resources in society which influence the social and built environment[144][26][145][146].

➢ *Disparities*

In the context of human being like Congolese, Kenyan, Ugandan people. Woman with maternal illnesses seem to be poverty associated environmental complex determinant[76][26][32][104][147]. In all low income countries the determinants look alike. We agree that social determinants of health are the conditions in which people are born, grow, live, work and age with. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. Social inequalities in environment and health are related to e.g. income, employment, education, as well as demographic differences, such as age or gender that are associated with unequal exposure to environmental risk factors[148][112][149][150]. We can thus define on one hand that effects and causes of these determinants are known as social inequality. In most community, social inequality is the existence of unequal opportunities and rewards for different social positions or statuses within a group of communities. Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair. In our context there is inequity in health services in DR Congo health system that refers to unfair, avoidable differences arising from poor governance, corruption or cultural exclusion this system management behaviour has decentralized inequality in health planning where uneven distribution of health or health resources have influence maternal health epidemics as a result of genetic. Poor governance determine negative performance of health system. Health system that is influenced by social determinants such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying as contributing factors of health inequities. The Centers for Disease Control and Prevention (CDC) is committed to achieving improvements in people's lives by reducing health inequities (DCD.Mar 21, 2014). In most Low income countries, there are health disparities and these are same among services which refer to differences in the health status of different groups of people. Some groups of people have higher rates of certain diseases, and more deaths and suffering from them, compared to others. These groups may be based on race, ethnicity, age group individuals, origin, and religion. The social determinants of health in poverty describe the factors that affect impoverished populations' health and health inequality. Daily living conditions work together with these structural drivers to result in the social determinants of health. Poverty and poor health are inseparably linked to the range of behavioural, biological, socio-economic and environmental factors that influence the health status of individuals or populations. Adapted from the World Health Organization 1998. Health promotion glossary. Geneva: WHO, p. 6[151] [4]. Whittemore and Knafl's (2005) (Whittemore & Knafl, 2005)[152]. The WHO SDH conceptual framework was also applied so that current knowledge was not only summarized but also critically advanced (Solar & Irwin, 2010; Whittemore & Knafl, 2005). The SDH framework was used to define the variables of interest (social determinants of health) to extract the relevant data from the articles included in the review (Whittemore & Knafl, 2005) [153][154]"..

III. METHODOLOGY

➢ *Design*

This is a clinical and community-based description cross-sectional study on data analysis review (DHS2014) [5] on access to maternal health service by mothers and children at the time needed in the Health division system of North Kivu Province, DR Congo. Statically systematic analysis of RDC-DHS 2014 data on maternal and child health promotion in North Kivu Health Division System, DR Congo are tracked and compared with the synthesis statement and the profiles and level of interventions that have been made to prevent maternal-child death and equity promotion in communities and health facilities. Data of the Demographic and Health Survey conducted by the DR Congo Ministry of Planning, the Ministry of Public Health, ICF international in collaboration with UNICEF and other international donors in 2014. The objective of the DHS is to produce representative results at the national and provincial as well as urban and rural levels. The use of these two-stage for selection probabilistic sample technic is to select clusters that is community settings and health facility settings (DRC-Ministère du Plan et al, 2014).

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➢ *Population and Sample Size*

Since protection of maternal and child rights to access to healthcare services in North Kivu Province was the only main outcome measure with hard data available in the DHS 2014, the sample size was powered in general statistical calculation and test on the variables associated with access to health services. Most the recent prevalence estimated in North Kivu pregnant population which are reported 35% with physical, social, and sexual partner/armed person violence in year before, during, and after pregnancy termination and that without any access to healthcare assistances.

➢ *Data Analysis*

Results as been obtained statistically from the DHS 2014 quantitative data were first recorded on paper in a structured form by the researcher and then reinterred into an SPSS (Statistical Package of social Sciences) database. Quality control and data cleaning was processed from row to rows, and Colum to columns to verify omitted and misspelled figures and variables. Descriptive analysis was performed for both study arms socio-demographic and psychosocial health outcomes, health gendered based services and equity promotion, formal and informal health right help-seeking behaviour, reediness to change, violent and safety behaviour at the health facilities, silencing in perceived helpfulness of any intervention. Arguments on survey socio-demographic, health services promotion, access to health services and psychosocial aspects with gendered healthcare needs were compared between both the DHS conclusions and study synthesis reviews on right towards access to maternal, newborn, and child healthcare services in North Kivu Health Division, DR Congo health system.

➢ *Data Interpretation Approaches*

The study synthesis, states that in medicine principles are still exercised in way that disease requiring special knowledge and special expertise for management, and adherence to each disease guideline adding linearly to the quality of care provided. In this perspective, there is no opportunity for recognising that diseases are not distinct biological entities that exist alone and apart from the person. In last years, according to literatures reviews, clinicians recognised that it is more important to know what sort of disease a patient has. The only change that might be made to this dictum a century later is to substitute diseases risk factors, and adverse effects for diseases. It is assumed that a whole-patient oriented view of disease is more accurate than a disease oriented view (strarfield B,2015). It was shown that: “diseases are more likely to occur and to be more serious in socially disadvantaged people. This greater likelihood of occurrence, severity, and adverse effects is compounded even further by multiple illnesses, multiple serious illnesses, and greater likelihood of adverse events from incompatible interventions. Only a person-focused rather than a disease-focused view of morbidity, in which multiple illnesses interact in myriad ways, can accurately depict the much greater impact of illness among socially disadvantaged people and the nature of the interventions that are required to adequately manage the increased vulnerability to and interactions among diseases”.

IV. RESULTS

➢ *The Promotion and Protection of the Right to Access Health Care for a Pregnant Woman*

In many legislative document of DR Congo, many laws have violate the rights and women health equity. That is why this study has purpose to advocate pregnant women’s access to maternity healthcare starting at community level[1]. For legal evidence, in DR Congo, according to the legislation, article N^0 87 clause 010 of the 1st August 1987 on Family code, polygamy or polyandrous marriage is not recognised. But a number of health related to pregnant women problems occurred in most of single motherhoods. The below analysis starts on nuptiality and pregnancy complication risks, and show equity in interventions in the North Kivu Hospitals. From our analysis point of view, the protection of the right to access health care is limited due commitment of being a union with man as husband. This is big challenge for decision-makers in terms of regulations and laws reviews.

[1] Loi n°09 /001 du 10 janvier 2009 portant protection de l’enfant article 2, Al.1.

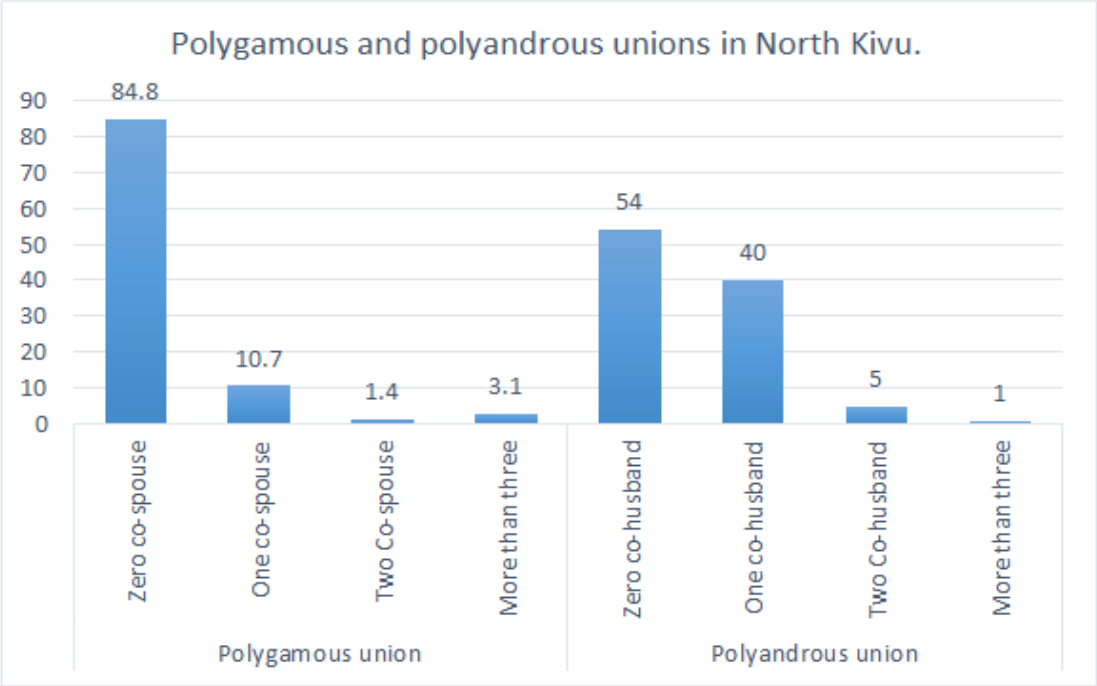

Chart 1:- Polygamous Union: Number of Co-Spouses per Man.

Men who has zero co-spouse (84.8%), one co-spouse (10.7%), more than three spouse (3.1%) comparing women who has co-husband (54%) with zero, one co-husband (40%), and only women who have more than three (1%). This shows that polyandrous union is high in North Kivu where the proportion women (46%) at least has one co-husband.

- *Reproductive Needs during Adolescent Fecondability (15-19years) and Family Planning*

In most Low Income Developing Countries (LIDC), reproductive needs are illimited due socio-economic factors and cultural values while reproductive strategies are limited in most of LIDC. There is need of a large number of resources in terms of formal and informal education, integration of changeable influences of rigid behaviours. These factors because of not being addressed earlier pregnancies are rampant. Adolescent lack access to basic reproductive education at community level. This matter has hindered the family planning effectiveness in many countries.

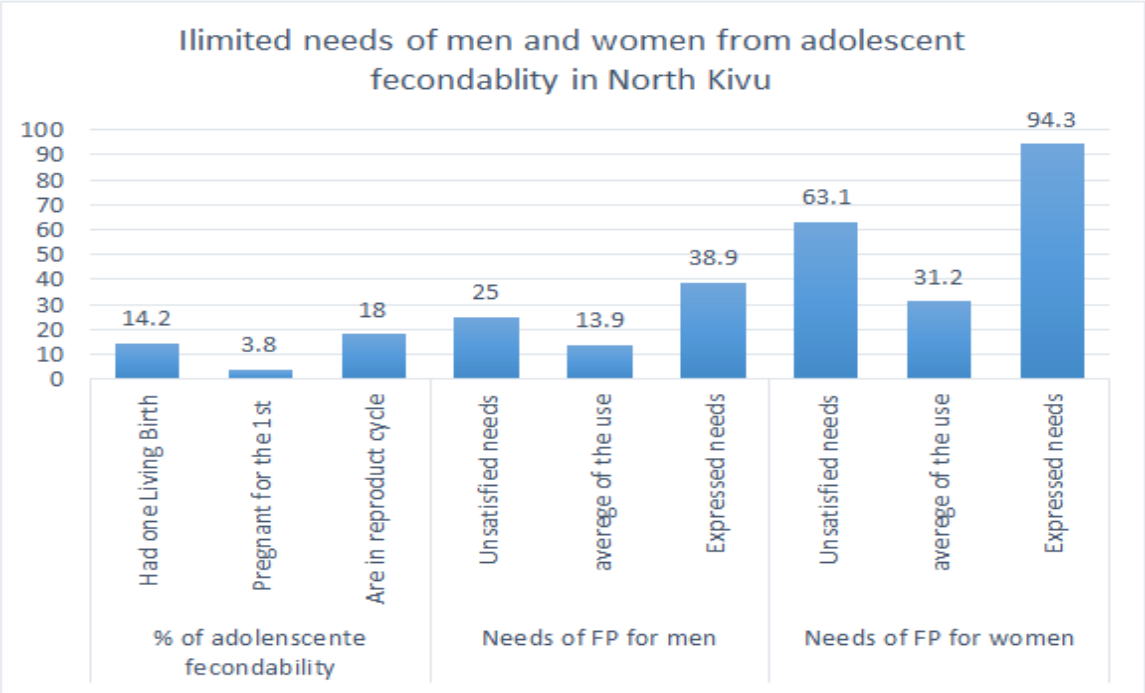

Chart 2:- Ilimited Needs during Adolescent Fecondability (15-19years) and Family Planning

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The proportion of adolescent fecondability (18%), needs of Family Planning for men (38.9%), and needs of Family Planning for women (94.3%). This shows that the more the population entre in reproductive cycle, the higher is the need of family planning services for both men and women.

- *Provision of Parental Care Services*

This service is improving in most of health facilities where pregnant women are motivated for the first pregnancy. But for multipara women such those with more seven births parental care services utilisation rate is low.

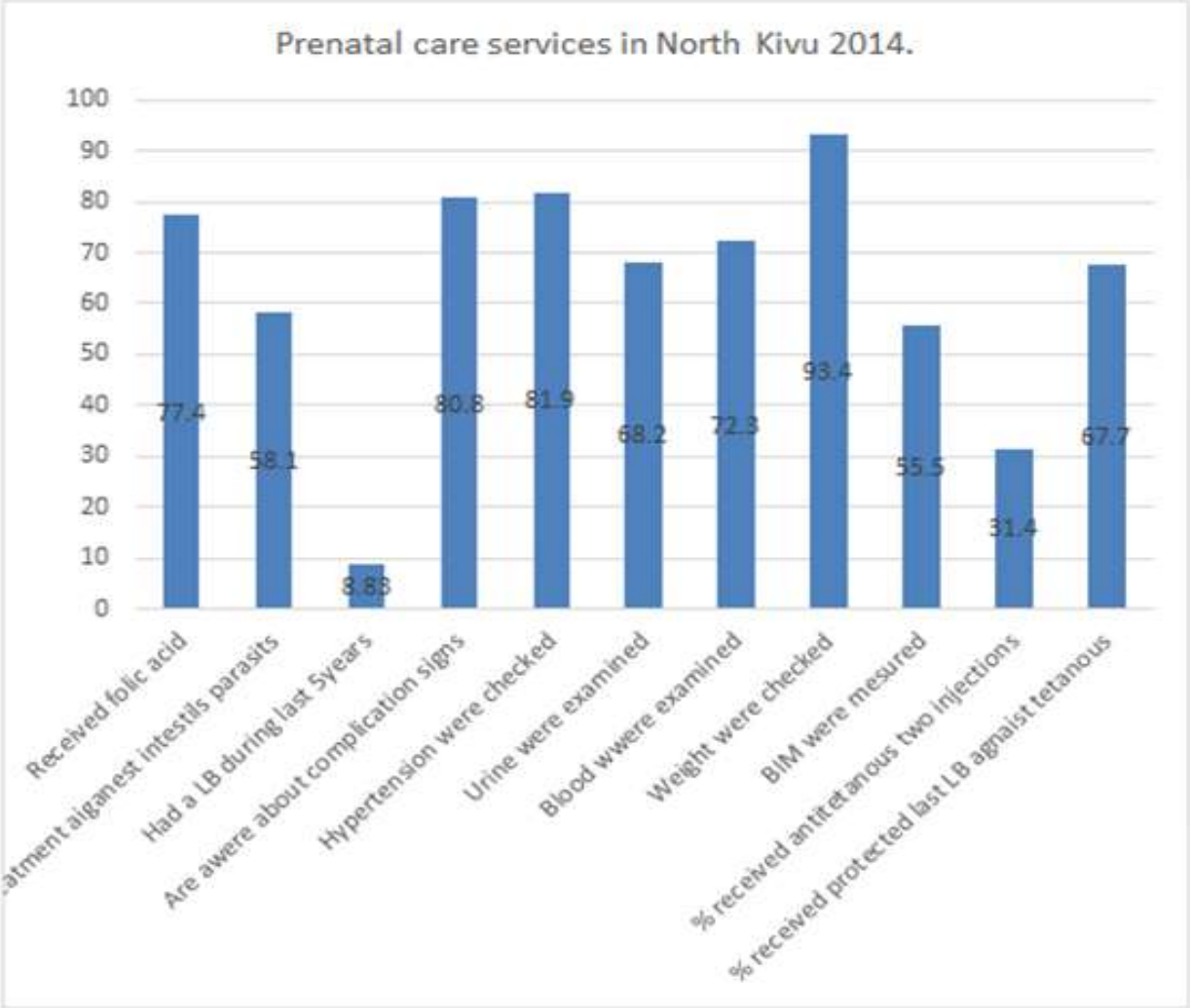

Chart 3:- Women who Received Prenatal Care Services for their Recent Pregnancy

The above chart shows that among prenatal services, the proportion that is high (93.4%) of pregnant women were checked weight, hypertension were checked (81.9%), they know about complication of pregnancy sign risks (80.0%), and women who had a live birth during last five years only (8.83%). The results show that the irregularities in the above services have impacted newborns' lives. The proportion of women who received antitetanous only two injections (31.4%).

- *Place of Birth and Duration of Maternity and Neonatal Care*

This information is about the types of place where the pregnant women was taken in critical labour situation may be because of limited means to access the right health facility with appropriate maternity healthcare services. It is also about the last treatment during gestation period and labour time but to the child, the care given from gestation, birth, and neonatal period.

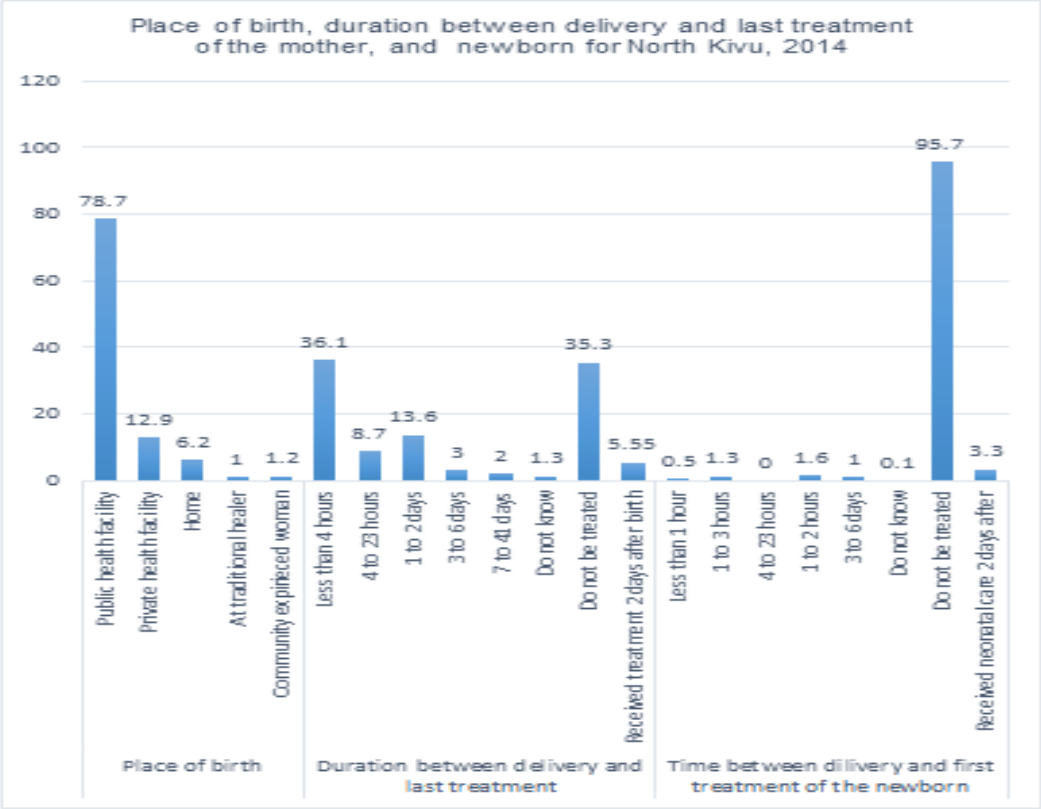

Chart 4:- Place of Birth, Duration Maternity and Neonatal Care

Place of birth in public health facility (78.7%) and at traditional healer (1%). For the duration between delivery and last treatment of the mother less than four hours (36.1%), followed by those ones who were not treated (35.3%), compared with women who did not know if were treated (1.3%). The newborns who were treated less than 1 hour after being born (0.5%), those whom their recognised they did not receive any treatment (95.7%) but they were given medical prescription to go to the pharmacy.

➢ *Access to Assistance of Qualified Health Personnel*

Maternal healthcare and neonatal need specific attention in order to minimise the rate of maternal and neonatal deaths. This implies that access to quality care services with qualified health personnel is right to both mother and child in this particular time during pregnancy management time period.

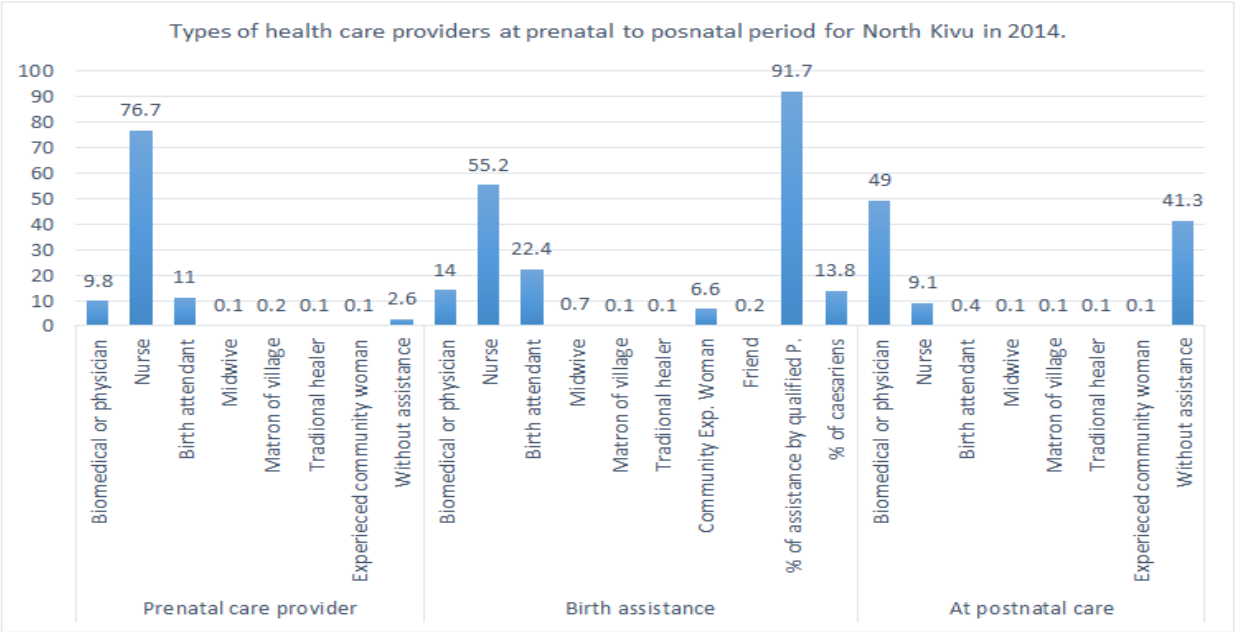

Chart 5:- Types of Health Personnel who Provided Prenatal Up to Postnatal Care to the Mother

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Types of health personnel who provided prenatal up to postnatal care to the mother. The results show proportions that nurse (76.6%) provided maternity care at pre-pregnancy stage followed by birth attendants (11%), only biomedical or physician (9.8%) provided assistance to a pregnant woman during prenatal period and women who did not received assistance (2.2%) at prenatal stage. During delivery, biomedical or physician (14%), followed by the assistance of nurse (55.2%), and birth attendants (22.4%), only community experienced woman (6.6%) provided care during delivery. At postnatal stage, biomedical or physician assistance (49%), nurse assistance were (9.1%), women who did not assistance (41.3%).

- *Socio-Economic Reasons to Accessibility to Health Care by Pregnant Woman*

General reasons seem originated from the responsible' will to provide their experts for assisting the pregnant woman. Social influence in seeking permission to access maternity services from community members, health professionals and actors, and health and community authorities. The mentioned factors were analysed in terms of money kind cash.

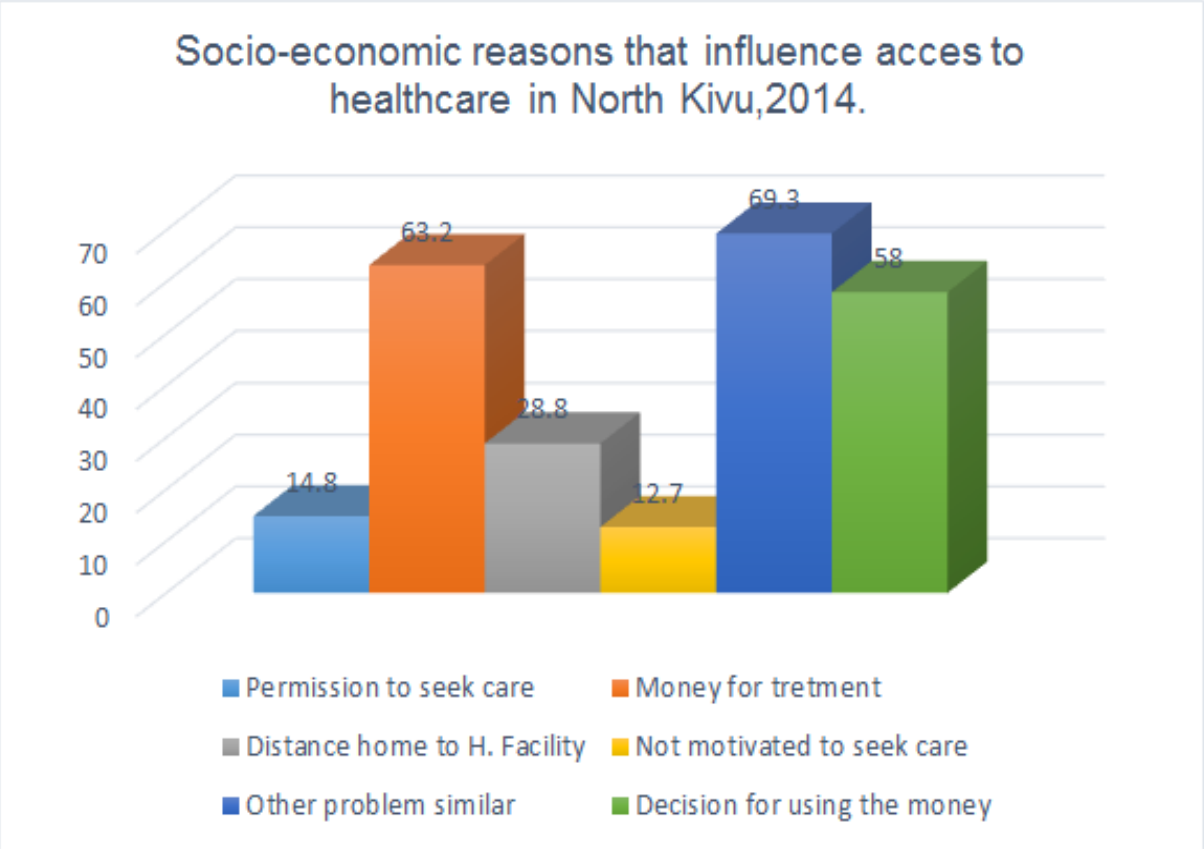

Chart 6:- Socio-Economic Reasons that Influence Pregnant, Newborn, and Child to Access or Not Access to Healthcare at the Needed Right Time

The socio-economic is the major reason to influence pregnant women. This means the shortage of money to seek health services were a big challenge to responsible in taking decision on the behalf of the parturient. Permission to seek care (63.2%), followed by the decision for using the money to the priorities (58%), but also similar reasons of other problem that need money to be solved (69.3%). This implies that the possession of money by responsible of the pregnant women influence a lot on the decision to seek healthcare on time, at the right place and the right health personnel.

ISSN No:-2456-2165

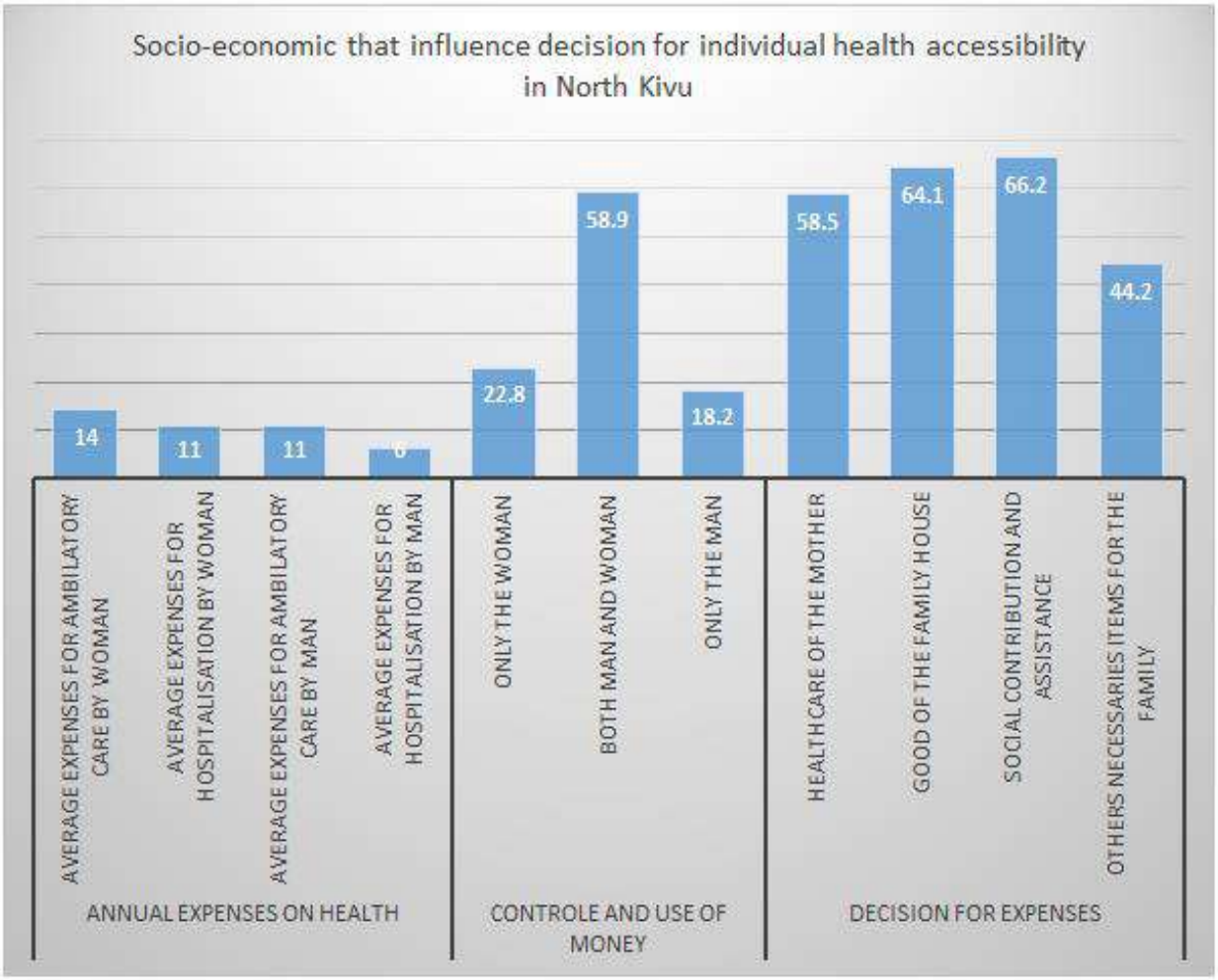

Chart 7:- Specific Reasons Related Individual Economic or Family State and Responsibilities of Family Expenses.

Annual expenses on health (42%), which is influenced by control and use of money of both man and woman (58.9%). Regarding decision for expenses, social contribution and assistance (66.2%) has impacted on health responsibilities, only the average expenses for hospitalisation of woman (11%) a year. This shows that the woman's health is sacrificed on the behalf of social expenses whereas the increase in family health security influence the increase of family income.

V. DISCUSSION

- *What is Protection of the Right to Access Health Care for a Newborn, Child.*

The word child comes etymologically from the Latin "INFANS" which means the one who does not speak, who cannot give his opinion, and who depends only on the choice and decisions of adults.[2] "Without weight and without rights", the child was considered in many societies as an exclusive property of his parents. [3]Roman law, like the old French law, bears witness to this conception of the child which was conceived as the object of paternal power and could not thus be considered as the holder of rights.[4] This conception will gradually evolve through circumstances whose competition will ultimately lead to actions in favor of the child and its protection. It is in this sense that; at the national level, a specific law Law No. 09/001 of 10 January 2009 on the protection of the child was adopted [6]8. The protection of the child arises even in the penal code and in the law on the sexual violence. Similarly on the international and regional African level, several treaties and agreements have been ratified by the states including the DRC, among which we can cite: The Pact on the Rights of the Child and the Convention on the Rights of the Child CRC 1990; African Charter on the Rights and Welfare of the Child (1990/1999); The African Charter on Human and Peoples' Rights adopted at the Eighteenth Conference of Heads of State and Government in June 1981 in Nairobi etc ... all these texts recognize the right of the child to health and well-being. These beautiful texts suffer from a great problem that of the implementation

[2] F.Dekeuwer Defossez, « Les droits de l'enfant », *Coll. Que sais-je?*, PUF, 1ère éd., Paris, 1991, p.3.

[3] G. Chancoco, La problématique de l'effectivité du droit de l'enfant à la santé et à l'éducation dans les situations de conflit armé interne en Afrique : Réflexions à la lumière de la crise en Côte d'Ivoire, Thèse en droit, Août, 2014, p.66. (Inédit).

[4] *Ibidem.*

ISSN No:-2456-2165

on the pan practice in the country. It can be seen that not all children in the DRC have easy access to primary health care and the country is among those in which the infant mortality rate persists.

Despite these incredible advances, more than 6 million children still die before their fifth birthday each year. Hundreds of women die every day during pregnancy or childbirth-related complications, and in developing regions, only 56LoL deliveries in rural areas are attended by a competent professional. As result, the present study is geared towards identifying obstacles to the implementation of national and international child health resolutions and programs, and the search for some strategies that can contribute to the search of some strategies that can contribute to the implementation of these programs.

A prospective cohort study done in Lubumbashi on comparing women who did or did no, low, moderate, or high numbers of antenatal care visits; three different levels of delivery care; and who did or did not attend postnatal care. Concluded that perinatal mortality, maternal health services, perinatal care, postnatal care, emergency obstetric and neonatal care was high among the infants of women during postpartum period. The problematic is to find the strategy for implementing declarations and resolutions on the child's right to health. The questions.

- *What Causes the Failure of Children' Right to Access to Primary Health Care in North Kivu Health Division, DRC?.*

Through this study, interest is to contribute to ideas that can make primary maternity healthcare accessible to the mother and children. Driven by the concern for the protection of the rights of the child, the study proposed ways of claiming and defending the child's right to health. In fact, it is an absolute necessity for every human being to receive appropriate health care in her/his context in order to be able to use his / her competences, because all we can do is depending on the quality of our health and what we have been when we were children. A healthy child can develop his personality through physical and intellectual abilities. Indeed, the development of our country does not depend solely on its geological potential; but also the quality and accessibility of its young population to health and education**.**

- *Study Significant Conceptualisation*

Fig 3:- Promotion Health System Model, WHO, 2007.

For the health facilities, this model is stipulated that health provision and access should be beyond treated sickness. This means that for the social wellbeing of the mother, newborn, child needs, all needful services should be available at any time. Beyond the individual efforts, all agents of health are call to promoting health and wellbeing all at domestic, national however international factors may impacting on health and health system agents. System refers to any collection of related parts that interact in an organized way for a purpose**.** To better progress we want to define the concepts that constitute the core of this paper and this for a good understanding of the rest of this paper on health equity. Children[5], the Child Protection Act No. 09/001 of 10 January 2009 defines the child as any person,

[5]*The child is the boy or the girl who has not reached adolescence (Dictionnaire Petit Larousse illustré 2013). . They also define the scope of international standards vis-à-vis domestic law and how to integrate them into the hierarchy. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, not only in the absence of disease or infirmity.*

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girl or boy, under the age of eighteen[6]. It is also the minor. Right, all the laws and provisions regulating relations between the members of a society. It is also the science whose object is the study of the laws and rules of society. By the sources of public international law we find treaties and international agreements. These are rules of law negotiated by several states for the purpose of committing themselves to each other in the field they define, for example, health and commerce. It is up to the constitutions of the countries concerned to define which authorities are competent to conduct negotiations and to ratify the treaties[7]. Health, it is the state of someone whose body functions normally, the health status of a community[8] [9] [10]. Health system, an ordered set of principles forming a body of doctrine. It is still the whole of the methods of the processes intended to assure a function, to produce a result.

The field of health is a very important area and a major concern for the policies of States and international organizations. Indeed, all the themes that are currently being developed to reduce global warming, the conservation of nature and a healthy environment have a very strong impact on the health of living beings and humans in particular. Thus in the concern to preserve a good health of the population the states meet and take different agreements and resolution favorable to the improvement of the sanitary conditions of the options and their access to primary health care. Among the layers that make up the population there is a nursery layer that are children. Child protection laws recognize the child's right to health. Primary health care, are clues that reflect: (i) reflect the economic conditions and the socio-cultural and political characteristics of the country and the communities from which they emanate and are based on the application of the relevant results of social and biomedical research and health services research, as well as public health experience; (ii) aim to solve the main health problems of the community by providing the necessary promotion, prevention, care and rehabilitation services for this purpose; (iii) include at a minimum: education about health problems as well as the prevention and control methods applicable to them, promotion of good food and nutrition conditions, adequate supply of safe water and sanitation measures maternal and child health care including family planning, vaccination against major infectious diseases, prevention and control of local endemics, treatment of common diseases and injuries, and provision of essential drugs. Article 21 every child has the right to the enjoyment of the highest attainable standard of health. This right includes health care, breastfeeding and a healthy, sufficient, balanced and varied diet. The state develops and implements effective strategies to reduce child morbidity and mortality[11], and especially children, which they can only fulfill by providing adequate health and social services. One of the major social goals of governments, international organizations and the entire international community over the next few decades is to provide all peoples of the world with a level of health that enables them to lead socially and economically productive lives. And ensure normal growth for children by eradicating all epidemics to which children are exposed, such as the cholera epidemic that has sprung up in some areas. The main problems faced by children in the Democratic Republic of Congo: The infant mortality rate in the DRC is 199 ‰ which is extremely high. Access to care and especially vaccinations remains problematic given the limited resources granted to hospitals and hospitals. The lack of information of the population. In order to ensure children's quality of health the DRC, to adhere to resolutions among which Alma ATA statement on primary health care. A country that wants to be developed must reach for the well-being of its population. It is an ideal that is not yet achieved in the DRC. Primary health care is essential health care based on methods and technics that are practical, scientifically sound and socially acceptable, made universally accessible to all individuals and families in the community with full participation and at a cost that the community and the country can assume at all stages of their development in a spirit of self-responsibility and self-determination. They are an integral part of the national health system, of which they are the linchpin and the main focus, as well as the overall economic and social development of the community. The universal declaration of Alma Ata was made by the states including the Congo. According to this declaration primary health care should be accessible to all by the year 2000, this ideal had not been achieved and it was a failure on the part of the States. Other objectives have been taken, these are the objectives of sustainable development, among these objectives the third is aimed at good health and well-being. It mainly concerns mothers and children, the fight against epidemics, road safety and access to healthcare. All states are in the race to reach them as far as possible.

- *What are the Limits of Mother' Right to Access to Maternal Health Care in North Kivu Health Division, DRC?*

Chart 1. Shows that men who has zero co-spouse (84.8%), one co-spouse (10.7%), more than three spouse (3.1%) comparing women who has co-husband (54%) with zero, one co-husband (40%), and only women who have more than three co-husband (1%). This shows that polyandrous union is high in North Kivu where the proportion rate of monogamous women (46%) is less than the half. This implies that the responsibility of women's health by couple is assumed to 46% if each is responsible of his wife's reproductive life span in terms of support. The opposite is that women 'are responsible of their own health

[6] *Loi n°09 /001 du 10 janvier 2009 portant protection de l'enfant article 2, Al.1.*
[7] *Loi n°09 /001 du 10 janvier 2009 portant protection de l'enfant article 2, Al.1.*
[8] *www.cours- de-droit.net »droit international. Droit de l'enfant.*
[9] *Conférence d'Alma Ata ; 12 septembre 1978 : Déclaration d'Alma-Ata sur les soins de santé primaires.*
[10] *Conférence d'Alma Ata ; 12 septembre 1978 : Déclaration d'Alma-Ata sur les soins de santé primaires.*
[11] *Governments have a responsibility for the health of populations (LOI N° 09/001 PORTANT PROTECTION DE L'ENFANT).*

ISSN No:-2456-2165

54%. This is a contributor factor on violation of mother' right to access health care. Because they satisfy other Ilimited needs then reproductive health needs. In Chart 2. The proportion of adolescent fecondability (18%), needs of Family Planning for men (38.9%), and needs of Family Planning for women (94.3%). This shows that the more the population entre in reproductive cycle, the higher is the need of family planning services for both men and women. But limits are that health system actors do not plan for new needs. Studies and evaluations on FP has shown that planning for the entire population are done on estimations without any baseline study that direct health planning. **Chart 3.** shows that among prenatal services, the proportion that is high (93.4%) of pregnant women were checked weight, hypertension were checked (81.9%), they know about complication of pregnancy sign risks (80.0%), and women who had a live birth during last five years only (8.83%). The results show that the irregularities in the above services have impacted newborns' lives. The proportion of women who received antitetanous only two injections (31.4%). Chart 4. On the Place of birth, duration maternity and neonatal care, place of birth in public health facility (78.7%) and at traditional healer (1%). For the duration between delivery and last treatment of the mother less than four hours (36.1%), followed by those ones who were not treated (35.3%), compared with women who did not know if were treated (1.3%). The newborns who were treated less than 1 hour after being born (0.5%), those whom their recognised they did not receive any treatment (95.7%) but they were given medical prescription to go to the pharmacy. Chart 5. Types of health personnel who provided prenatal up to postnatal care to the mother, types of health personnel who provided prenatal up to postnatal care to the mother. The results show proportions that nurse (76.6%) provided maternity care at pre-pregnancy stage followed by birth attendants (11%), only biomedical or physician (9.8%) provided assistance to a pregnant woman during prenatal period and women who did not received assistance (2.2%) at prenatal stage. During delivery, biomedical or physician (14%), followed by the assistance of nurse (55.2%), and birth attendants (22.4%), only community experienced woman (6.6%) provided care during delivery. At postnatal stage, biomedical or physician assistance (49%), nurse assistance were (9.1%), women who were not assisted (41.3%).

The socio-economic is the major reason to influence pregnant women. This means the shortage of money to seek health services were a big challenge to responsible in taking decision on the behalf of the parturient. Permission to seek care (63.2%), followed by the decision for using the money to the priorities (58%), but also similar reasons of other problem that need money to be solved (69.3%). This implies that the possession of money by responsible of the pregnant women influence a lot on the decision to seek healthcare on time, at the right place and the right health personnel.

Infant mortality could be avoided by improving the quality of children's health care, by taking preventive measures and treatment. Educational measures to encourage parents, for example, to massively vaccinate their children. This would be one of the strategies. The challenge is that vaccine is it enough for all the children, and are all vaccines available at the right time for immunasation children period? Household living conditions strongly influence the risk of dying. DRC, about one of ten children dies before reaching the age of five. The risk of dying before the age of five shows significant differences depending on the urban and rural area of residence. In general, infant mortality is much lower in urban areas (59%) than in rural areas (68%). Improved health, environmental, socio-economic and cultural conditions would also contribute to children's access to primary health care. This is a burden, an obligation of the state to provide the population with a minimum standard of living acceptable. Another thing that weakens international agreements on health is that they are not binding: Making international agreements and resolutions binding on states could contribute to their implementation.

He also points out that; mortality levels drop sharply with the increase in the mother's education level, regardless of the mortality indicator considered. Thus, a child whose mother has no education is at risk of dying before the first birthday, 1.2 times higher than that of a child whose mother has a secondary education (72 ‰ versus 58 ‰).

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VI. INNOVATION OF THE STUDY

In most industrialized countries have achieved both horizontal and vertical equity in the use of primary care services, meaning that people with greater health needs receive more primary care services. Although some countries have achieved horizontal equity in use of specialist services, very few have achieved vertical equity because socially-deprived populations have less access to specialist services than their needs require. Inequity in healthcare services is the process of systematic and potentially remediable differences among population groups defined socially, economically, or geographically. It is not the same as inequality, which is a much broader term, generally used in the human rights field to describe differences among individuals, some of which are not remediable. In some literature, "unfairness" is termed to say inequity, but unfairness is not measurable and therefore not a useful term for policy evaluation. Inequity can be horizontal or vertical in provision and access to health it has a large meaning[155][5][156]. Horizontal inequity

indicates that people with the same needs do not have access to the same resources to respond on at the right time. Vertical inequity exists when people with greater needs are not provided with greater resources to respond on at the right time[6][1][2][3][4]. However resources do exist in their community but under a non-available sources of resources provision. This is the violence of right to access of services. In population surveys, similar use of services across population groups signifies inequity, because different population subgroups have different needs, some more than others. Equity is considered as an equal *proportional use* across population *subgroups* to their minor and major needs at the right time, if not then in fact is inequity, thus violence of right to access to that particular service at the needed time[53][157][158].

According to Barker who said that: " the impact of gender power for physical and mental health of girls, women and transgender/intersex people, and also of boys and men can be profound. It affects health norms and practices, exposures and vulnerabilities to health problems and the ways in which health systems and research respond. While gender systems tend to change slowly, they can sometimes be altered by sudden sharp bursts of social upheaval. The social upheavals set off by the civil rights and women's movements of the 1960s and the intensified focus on a broad human rights agenda at the United Nations conferences of the 1990s have challenged the narrower understanding of human rights that had prevailed until then (Laurie & Petchesky, 2008)[5][6][7][8][9].The intermediary factors are broadly four-fold: (i) discriminatory values, norms, practices and behaviours in relation to health within households and communities; (ii) differential exposures and vulnerabilities to disease, disability and injuries; (iii) biases in health systems; and (iv) biased health research. These intermediary factors result in biased and inequitable health outcomes, which in turn can have serious economic and social consequences for girls and boys, women and men, for their families and communities, and for their countries. These social norms create the conditions in which some young and adult men (in the family or outside of it) sexually abuse girls or use physical violence against them, the preference by some adult men for younger female sexual partners, and the practice of sexual coercion by too many men and boys against girls (Barker, 2006)".

VII. CONCLUSION

The right of the child to health is a right whose implementation is still utopian in the Congo, because primary health care is not accessible to all. The Alma-Ata Declaration of 1978 was revolutionary in that it linked the rights-based approach to health as a viable strategy for achieving it. The statement from the work of the International Conference on Primary Health Care identified primary health care as an ambitious goal but not yet achieved "Health for All" by the year 2000.Taht is a big step for the countries, but requires that other factors intervene to contribute to its realization, for example, that the population must have the financial means to obtain care and that there is a qualified staff, a healthy environment such as the obstacles that hindered the achievement of this goal.

On the other hand, the declaration was non-binding. From the start, there were conceptual disagreements about how to define fundamental terms such as "universal access", which persist today. And many other international resolutions on health suffer from non-fulfillment because non-binding sanctions or no responsibility is exercised against states that do not implement them. It will be difficult to focus attention on the implementation of primary health care for children when even in adults this is not real. Thus, in order to claim the rights of children, effective education of the population and health structures on the issue of the specific requirements of children's health is required, inviting parents to take responsibility for their own care and the relevant political and administrative authorities. To make a commitment, in all respects, to respect the rights of the child. Concrete actions are needed to claim the right of children to health. Finally, as a reminder, the fundamental rights of the child are those of education, life, health care and protection, in order to promote its full development.

RECOMMENDATIONS

It should be known that proposed strategies for the implementation of the laws on the health of the children; and their easy access to primary health care become a priority for the decision makers and that: "

Economic policy should aim to generate livelihoods for all people, providing stable incomes at a level necessary for their physical, mental and social well-being; complementary social policies should ensure social protection for those unable to attain or sustain such a livelihood. This will mean, inter alia, bringing employment and employment conditions back in as a central concern of economic and development policy, in contrast to their recent invisibility (see e.g. Chen et al., 2005; Chen, Vanek and Heintz, 2006)".

Adoption and effective implementation of the four core labour standards (which address free association, collective bargaining, elimination of economic discrimination by gender, and the elimination of forced labour) should be a priority of all national governments and multilateral institutions, while ensuring that the process does not unintentionally cut off income streams that are vital to the survival of the most vulnerable households within a society.

Ensuring that labour standards exist in practice as well as in law, priority should be given to providing all women with access to child care, free of charge or at minimal cost, through direct public expenditure by national governments and development assistance providers.

Governments should ensure that national health priorities are not negatively affected by trade policy decisions. This requires building up their capacity for analyzing potential trade policy impacts and ensuring that health ministries are better able to articulate the evidence during trade negotiations.

WHO through the health division, health facilities, health personnel and other health providers should ensure that they have enough and sufficient capacity and expertise, including legal expertise, to provide Member States with technical guidance and support in availing healthcare services to mothers, newborns, and children at the needed time. And also promote easy access to services providers (resources) by mobile service provision, lowing the service bill, or exonerated the service for the mother and children.

Health Division should actively participate in the Intergovernmental Working Group on Intellectual Property Rights established by the World Health Assembly; ensure that their provincial and national legislation allows full use of the flexibilities. A pressing need in short term and urgent should pay attention to the North Kivu Health Division in particular and DR Congo health system in general to encouraging research in communities and health facilities on maternal health epidemiology influences that the data will help to create progress indicators on gendered health equity promotion.

REFERENCES

[1]. A.-S. Van Parys, E. Deschepper, K. Roelens, M. Temmerman, and H. Verstraelen, "The impact of a referral card-based intervention on intimate partner violence, psychosocial health, help-seeking and safety behaviour during pregnancy and postpartum: a randomized controlled trial."

[2]. D. Barthel *et al.*, "Trajectories of maternal ante- and postpartum depressive symptoms and their association with child- and mother-related characteristics in a West African birth cohort study," 2017.

[3]. K. Finlayson and S. Downe, "Why Do Women Not Use Antenatal Services in Low-and Middle-Income Countries? A Meta-Synthesis of Qualitative Studies."

[4]. S. S. Gopalan, S. Mohanty, and A. Das, "Assessing community health workers ' performance motivation : a mixed-methods approach on India ' s Accredited Social Health Activists (ASHA) programme," pp. 1–11, 2012.

[5]. L. Eilin Stene, G. Dyb, A. Tverdal, G. Wenberg Jacobsen, and B. Schei, "Intimate partner violence and prescription of potentially addictive drugs: prospective cohort study of women in the Oslo Health Study," *BMJ Open*, vol. 2, p. 614, 2012.

[6]. A. C. Tsai, M. Tomlinson, W. S. Comulada, and M. J. Rotheram-Borus, "Intimate Partner Violence and Depression Symptom Severity among South African Women during Pregnancy and Postpartum: Population-Based Prospective Cohort Study," *PLOS Med.*, vol. 13, no. 1, p. e1001943, 2016.

[7]. N. J. Christofides *et al.*, "A cluster randomised controlled trial to determine the effect of community mobilisation and advocacy on men's use of violence in periurban South Africa: study protocol.," *BMJ Open*, vol. 8, no. 3, p. e017579, Mar. 2018.

[8]. Ministry of Health, "Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda," 2007.

[9]. *Sauver les mères et les enfants en situations de crise humanitaire Table des matières*. 2014.

[10]. "_2015_-_Nichole_Young_Lin_-_Healthcareprovidersperspectivesonthesocialreintegr[retrieved_2018-07-04] (1).pdf." .

[11]. "_2016_-_Marjorie_Koblinsky_-_Qualitymaternitycareforeverywomaneverywhereacallto[retrieved_2018-07-04].pdf." .

[12]. "_2017_-_Karen_D_Cowgill_-_Postpartumdetentionofinsolventwomenandtheirnewborn[retrieved_2018-07-04].pdf." .

[13]. J. H. Lee and R. Sadana, "Improving Equity in Health by Addressing Social Determinants."

[14]. E. M. Mafuta *et al.*, "Social accountability for maternal health services in Muanda and Bolenge Health Zones , Democratic Republic of Congo : a situation analysis," *BMC Health Serv. Res.*, pp. 1–18, 2015.

[15]. E. E. Lindskog, "The effect of war on infant mortality in the Democratic Republic of Congo," *BMC Public Health*, pp. 1–10, 2016.

[16]. T. Barnay, "Thomas Barnay (2004), « La santé comme facteur d'équité dans la cessation d'activité »," pp. 1–7, 2004.

[17]. M. Hynes *et al.*, "Using a quality improvement approach to improve maternal and neonatal care in North Kivu , Democratic Republic of Congo Using a quality improvement approach to improve maternal and neonatal care in North Kivu , Democratic Republic of Congo," vol. 8080, 2017.

[18]. J. M. Bland and D. G. Altman, "STATISTICAL METHODS FOR ASSESSING AGREEMENT BETWEEN TWO METHODS OF CLINICAL MEASUREMENT," no. fig 1, pp. 1–9.

[19]. S. Questions, "Measures of Morbidity and Mortality Used in Epidemiology," pp. 7–14, 2014.

[20]. C. Olsen, "Measures in Epidemiology."

[21]. "Developing a Protocol for Observational Comparative Effectiveness Research A User ' s Guide."

[22]. L. K. Alexander, B. Lopes, K. Ricchetti-masterson, and K. B. Yeatts, "Common Measures and Statistics in Epidemiological Literature Second Edition Authors : PA G E 2 ERIC at the UNC CH Department of Epidemiology Medical Center."

[23]. K. Aberer and L. De, "Chapter 4 – Data Mining A Short Introduction Today ' s Question," pp. 1–27, 2007.

[24]. T. Mukaba, A. Binanga, S. Fohl, and T. Bertrand, "Family Planning Policy Environment in the Democratic Republic of the Congo : Levers of

Positive Change and Prospects for Sustainability," vol. 3, no. 2, pp. 163–173, 2015.
[25]. A. M. Ntambue, F. K. Malonga, M. Dramaix-wilmet, R. N. Ngatu, and P. Donnen, "Better than nothing ? maternal , newborn , and child health services and perinatal mortality , Lubumbashi , democratic republic of the Congo : a cohort study," *BMC Pregnancy Childbirth*, pp. 1–12, 2016.
[26]. B. Congo, D. Sanon, T. Millogo, and C. M. Ouedraogo, "Inadequate programming , insufficient communication and non-compliance with the basic principles of maternal death audits in health districts in Burkina Faso : a qualitative study," pp. 1–11, 2017.
[27]. L. Feinstein *et al.*, "Antenatal and delivery services in Kinshasa , Democratic Republic of Congo : care-seeking and experiences reported by women in a household-based survey," vol. 18, no. 10, pp. 1211–1221, 2013.
[28]. "_1987_-_SharonM_White_-_EMERGENCYOBSTETRICSURGERYPERFORMEDBYNURSESINZAIRE[retrieved_2018-07-04].pdf." .
[29]. "_Goldenberg_et_al-2017-International_Journal_of_Gynecology_%26amp%3B_Obstetrics.pdf." .
[30]. D. Deboutte, T. O. Dempsey, B. Faragher, and A. Baba, "Women ' s Health and Wellness Socioeconomic Consequences of Maternal Death : A Qualitative Study in Bunia , Democratic Republic of the Congo ClinMed," vol. 2, no. 3, 2016.
[31]. D. Master, M. Human, R. Centre, and H. Rights, "HIGH MATERNAL MORTALITY RATES IN SUB-SAHARAN AFRICA AS A HUMAN RIGHTS VIOLATION : THE CASE OF THE DEMOCRATIC REPUBLIC OF CONGO Mini-dissertation submitted in partial fulfilment of the requirements for the Degree Master of Laws (LLM) in Multidisciplinary," no. October, 2013.
[32]. S. Le Coeur, G. Pictet, and P. M. Pelé, "Catalytic converters and prevention of suicides Direct estimation of maternal mortality in Africa Evaluation of cyberdocs," vol. 352, pp. 1525–1526, 1998.
[33]. O. Access, "Avoiding maternal-child death in DR Congo through infection control," vol. 5, no. Suppl 6, 2011.
[34]. J. W. Mcarthur, K. Rasmussen, and G. Yamey, "How many lives are at stake ? Assessing 2030 sustainable development goal trajectories for maternal and child health," vol. 373, no. February, pp. 1–9, 2018.
[35]. K. D. Cowgill and A. Ntambue, "Post-partum detention of insolvent women and their newborns in Lubumbashi , Democratic Republic of the Congo : a cross-sectional survey," *Lancet Glob. Heal.*, vol. 5, p. S4.
[36]. D. A. Freedman, "Ecological Inference and the Ecological Fallacy," pp. 1–7, 1999.
[37]. B. J. D. E. Bruijn, "Models , Concepts AND DEVELOPMENT OF," pp. 549–569, 2006.
[38]. C. Jackson, "Ecological inference with R : the ecoreg package," 2006.
[39]. P. A. Jargowsky, "The Encyclopedia of Social Measurement," 2002.
[40]. P. J. Donaldson, "Population and Health : An Introduction to," vol. 54, no. 4, 1999.
[41]. M. Bauserman *et al.*, "Risk factors for maternal death and trends in maternal mortality in low- and middle-income countries: A prospective longitudinal cohort analysis," *Reproductive Health*, vol. 12, no. 2. 2015.
[42]. "La violence sexuelle."
[43]. M. S. Schimmel *et al.*, "The effects of maternal age and parity on maternal and neonatal outcome," *Arch. Gynecol. Obstet.*, vol. 291, no. 4, 2015.
[44]. P. Recto and J. D. Champion, "Assessment of Mental Health Literacy among Perinatal Hispanic Adolescents," *Issues Ment. Health Nurs.*, vol. 38, no. 12, 2017.
[45]. M. S. and A. D., "Adolescent Health Determinants for Pregnancy and Child Health Outcomes among the Urban Poor," *Indian Pediatr.*, vol. 41, no. 2, 2004.
[46]. J. O. Swanson *et al.*, "Web-Based Quality Assurance Process Drives Improvements in Obstetric Ultrasound in 5 Low- and Middle-Income Countries," *Glob. Heal. Sci. Pract.*, vol. 4, no. 4, 2016.
[47]. J. Kahindo and A. Wodon, "Stratégie de Renforcement du Système de Santé en RD Congo," 2011.
[48]. M. Care and T. Assistance, "Integrating Primary Care and Behavioral Health Services : A Compass and A Horizon," no. 509.
[49]. R. Labonté and T. Schrecker, "Introduction Globalization ' s Challenges to People ' s Health," pp. 1–33, 2005.
[50]. L. K. Viici-iaelsen, "Leader Orientation , Leader Behavior , Group Effectiveness and Situational Favorability : An Empirical Extension of the Contingency Model 1," vol. 245, 1973.
[51]. V. Simpson, "Models and Theories to Support Health Behavior Intervention and Program Planning," 2002.
[52]. L. S. Ashford, D. R. Gwatkin, and A. S. Yazbeck, "to Reach the Poor Health Programs."
[53]. "A Guide to Health Promotion through Social Marketing A Guide to Health Promotion through Social Marketing."
[54]. T. Interplay *et al.*, *Copyright © National Academy of Sciences. All rights reserved. Unless otherwise indicated, all materials in this PDF File are copyrighted by the National Academy of Sciences. Distribution, posting, or copying is strictly prohibited without written permiss*. 2001.
[55]. C. Adolph, "Report on the 2004 Washington Gubernatorial Election," pp. 1–28, 2005.
[56]. A. U. Québec, E. N. Relation, A. L. Incidence, and E. T. La, "Les variations géographiques de la mortalité par cancer au Québec en relation avec l ' incidence et la létalité , 2000-2004," pp. 2000–2004,

2010.
[57]. S. Appliqu, "LA GESTION DES DECHETS SOLIDES MENAGERS A NIAMEY AU NIGER : ESSAI POUR UNE STRATEGIE DE DOMESTIC SOLID WASTE MANAGEMENT IN NIAMEY – NIGER :," 2003.
[58]. L. Rochaix and M. Khlat, "Revenu et Mortalité : Analyse Economique des Inégalités Sociales de Santé en France Florence Jusot Revenu et Mortalité : Analyse Economique des Inégalités Sociales de Santé en France," pp. 1–9, 2003.
[59]. G. Br, "É pid é miologie des priorit é s de sant é dans les pays pauvres Malgr é des progr è s mesurables durant ces vingt derni è res ann é es , la situation," pp. 20–23, 2000.
[60]. L. A. Situation, D. E. S. Enfants, and D. Le, *LA SITUATION DES ENFANTS DANS LE MONDE 2009 La santé maternelle et néonatale*. 2009.
[61]. D. M. Philibert, "Épidémiologie de la mortalité maternelle en France , fréquence et caractéristiques Maternal mortality in France : epidemiological study , prevalence and characteristics," vol. 16, pp. 358–365, 2007.
[62]. "_2008_-_STUART_RENNIE_-_ETHICSOFMANDATORYPREMARITALHIVTESTINGINAFRICATHECA[retrieved_2018-07-04].pdf." .
[63]. "_2009_-_Archana_Shah_-_CesareandeliveryoutcomesfromtheWHOglobalsurveyonma[retrieved_2018-07-04].pdf." .
[64]. "_1992_-__-_Maternalmortalitycommunitybasedinterventions[retrieved_2018-07-04].pdf." .
[65]. "_2012_-_Christine_Ekechi_-_MaternalNewbornHealthRoadMapsareviewofprogressin33[retrieved_2018-07-04].pdf." .
[66]. "_2010_-_Margaret_C_Hogan_-_Maternalmortalityfor181countries19802008asystemati[retrieved_2018-07-04].pdf." .
[67]. "_2009_-_C_Engmann_-_Usingverbalautopsytoascertainperinatalcauseofdeath[retrieved_2018-07-04].pdf." .
[68]. "_2014_-_Nicole_C_Rodney_-_Abioculturalstudyoftheeffectsofmaternalstressonmot[retrieved_2018-07-04].pdf." .
[69]. "_2014_-_Wim_Van_Lerberghe_-_Countryexperiencewithstrengtheningofhealthsystemsa[retrieved_2018-07-04].pdf." .
[70]. "_2014_-_Andrea_Nove_-_Maternalmortalityinadolescentscomparedwithwomenofo[retrieved_2018-07-04].pdf." .
[71]. "_Democratic Republic of the Congo Maternal mortality ratio, 1960-2017 - knoema.com.pdf." .
[72]. "_Deboutte_et_al-2015-The_International_Journal_of_Health_Planning_and_Management.pdf." .
[73]. "_Cannula-Assisted--Transabdominal-Ultrasound-Guided-In_2017_Current-Problems-.pdf." .
[74]. "_Can-a-developed-country-s-maternal-mortalit_2002_European-Journal-of-Obstetr.pdf." .
[75]. "_Coeur_et_al-2006-Tropical_Medicine_%26_International_Health.pdf." .
[76]. E. M. Mafuta *et al.*, "Factors influencing the capacity of women to voice their concerns about maternal health services in the Muanda and Bolenge Health Zones , Democratic Republic of the Congo : a multi-method study," pp. 1–14, 2018.
[77]. H. Finnbogadóttir, A. K. Dykes, and C. Wann-Hansson, "Prevalence and incidence of domestic violence during pregnancy and associated risk factors: A longitudinal cohort study in the south of Sweden," *BMC Pregnancy Childbirth*, 2016.
[78]. W. Bank, P. Dates, T. M. Funding, C. T. Leader, and P. Taylor, "MCHIP Country Brief : Democratic Republic of Congo."
[79]. W. Africa and M. States, "Ebola virus disease (EVD), implications of introduction in the Americas," *OMS PAHO*, vol. 9, no. August, pp. 1–14, 2014.
[80]. M. G. Foundation, "Articles Effect of early tranexamic acid administration on mortality , hysterectomy , and other morbidities in women with post-partum haemorrhage (WOMAN): an international ," pp. 2105–2116, 2017.
[81]. C. Shen and J. B. Williamson, "Maternal mortality , women ' s status , and economic dependency in less developed countries : a cross-national analysis," vol. 49, 1999.
[82]. I. Prevention and D. Mini-course, "Epidemiology and Surveillance," 2013.
[83]. J. P. Vogel *et al.*, "Role of faith-based and nongovernment organizations in the provision of obstetric services in 3 African countries," *YMOB*, vol. 207, no. 6, pp. 495.e1-495.e7, 2012.
[84]. E. M. McClure *et al.*, "Global Network for Women's and Children's Health Research: probable causes of stillbirth in low- and middle-income countries using a prospectively defined classification system," *BJOG An Int. J. Obstet. Gynaecol.*, vol. 125, no. 2, 2018.
[85]. E. Ozmete, "Conceptual Analysis of Behavioral Theories / Models : Application to Financial Behavior," vol. 18, no. 3, 2011.
[86]. N. Diamond-Smith, M. Sudhinaraset, J. Melo, and N. Murthy, "The relationship between women's experiences of mistreatment at facilities during childbirth, types of support received and person providing the support in Lucknow, India," *Midwifery*, 2016.
[87]. K. M. Devries *et al.*, "Witnessing intimate partner violence and child maltreatment in Ugandan children: A cross-sectional survey," *BMJ Open*. 2017.
[88]. "ANALYSE DE LA SITUATION DES ENFANTS ET DES FEMMES DU NIGER SELON UNE APPROCHE BASEE SUR L ' EQUITE ET LES DROITS HUMAINS Table des Matières."
[89]. A. R. Bado and A. S. Susuman, "Women ' s Education and Health Inequalities in Under-Five Mortality in Selected Sub- Saharan African Countries , 1990 – 2015," pp. 1–18, 2016.

[90]. "_Bedside-ultrasound-training-at-Muhimbili-National-Hospi_2016_African-Journal.pdf." .
[91]. "_Accelerating-the-global-response-to-reduce-maternal-mortality_2012_The-Lance.pdf." .
[92]. M. Yotebieng *et al.*, "Ten Steps to Successful Breastfeeding programme to promote early initiation and exclusive breastfeeding in DR Congo : a cluster-randomised controlled trial," *Lancet Glob. Heal.*, vol. 3, no. 9, pp. e546–e555, 2015.
[93]. N. D. E. La *et al.*, "VOLUME 8 INTERVENTIONS A BASE DU NOUVEAU- NE ET DE L ' ENFANT," vol. 8, 2012.
[94]. G. Perspectives, I. Disaster, R. Reduction, and C. C. Adaptation, "Gender sensitive tools for climate change adaptation and disaster risk reduction," pp. 55–76.
[95]. M. Declaration, "Maternal Survival 1 Maternal mortality : who , when , where , and why," pp. 1189–1200, 2015.
[96]. (M J Knol *et al.*, "Temporal associations between national outbreaks of meningococcal serogroup W and C disease in the Netherlands and England: an observational cohort study," *Artic. Lancet Public Heal.*, vol. 2, pp. 473–82, 2017.
[97]. W. Graham *et al.*, "Maternal Health 1 Diversity and divergence : the dynamic burden of poor," *Lancet*, vol. 388, no. 10056, pp. 2164–2175, 2016.
[98]. M. H. Homes, "The Collaborative Care Model : An Approach for Integrating Physical and Mental Health Care in," no. May, 2013.
[99]. R. Maroc, "Guide sur la participation communautaire en santé," 2013.
[100]. B. O. Olusanya and O. A. Solanke, "Perinatal correlates of delayed childbearing in a developing country," *Arch. Gynecol. Obstet.*, vol. 285, no. 4, 2012.
[101]. E. M. McClure *et al.*, "Stillbirth rates in low-middle income countries 2010 - 2013: A population-based, multi-country study from the Global Network," *Reproductive Health*, vol. 12, no. 2. 2015.
[102]. R. Kidman, T. Palermo, and J. Bertrand, "Intimate partner violence, modern contraceptive use and conflict in the Democratic Republic of the Congo," *Soc. Sci. Med.*, vol. 133, 2015.
[103]. A. N. Ml, F. M. K, M. Dramaix-wilmet, and P. Donnen, "Determinants of maternal health services utilization in urban settings of the Democratic Republic of Congo – A Case study of Lubumbashi City," pp. 1–13, 2012.
[104]. N. Unies, N. York, and S. D. G. A. Campaign, "Objectifs de développement durable (ODD) Sélection de ressources en ligne," vol. 2030, pp. 1–5, 2015.
[105]. G. C. Patton *et al.*, "Global patterns of mortality in young people : a systematic analysis of population health data," pp. 881–892.
[106]. "AGENDA 2030," vol. 2030, no. page 2, pp. 1–7, 2015.
[107]. C. C. Adaptation, "Gender Perspectives : Integrating Disaster Risk Reduction into Climate Change Adaptation," 2008.
[108]. C. D. Acosta *et al.*, "Evidence-based dialogue with communities for district health systems ' performance improvement," *Reprod. Health*, vol. 12, no. 6, pp. 595–610, 2015.
[109]. A. C. Tsai, M. Tomlinson, W. S. Comulada, and M. J. Rotheram-Borus, "Intimate Partner Violence and Depression Symptom Severity among South African Women during Pregnancy and Postpartum: Population-Based Prospective Cohort Study," *PLOS Med.*, vol. 13, no. 1, p. e1001943, Jan. 2016.
[110]. J. J. Rogathi *et al.*, "Postpartum depression among women who have experienced intimate partner violence: A prospective cohort study at Moshi, Tanzania," *J. Affect. Disord.*, vol. 218, pp. 238–245, Aug. 2017.
[111]. S. Edition and A. Epidemiology, "PRINCIPLES OF INFECTIOUS DISEASE EPIDEMIOLOGY MODULE IV – STATISTICAL MEASURES II . HOW DO WE USE STATISTICAL MEASURES IN EPIDEMIOLOGY ? III . FREQUENCY DISTRIBUTIONS," no. Cdc, pp. 1–17.
[112]. S. Richardson, L. Leblond, I. Jaussent, and P. J. Green, "Mixture models in measurement error problems , with reference to epidemiological studies," pp. 549–566, 2002.
[113]. N. D. E. La, Z. D. E. Sante, R. Aux, I. Integrees, D. E. S. D. E. La, and D. D. U. Congo, "Volume 5 interventions de sante adaptees aux adolescents et jeunes," vol. 5, 2012.
[114]. N. D. E. La *et al.*, "Volume 6 les interventions de planification familiale," vol. 6, 2012.
[115]. R. Democratique *et al.*, "VOLUME 3 SOINS ESSENTIELS ET D ' URGENCE AU NOUVEAU-NE," vol. 3, 2012.
[116]. L. E. S. Avis and C. Basset, "La protection maternelle et infantile," 2014.
[117]. J. Lef, "Epid ´ emiologie de la mortalit ´ e maternelle hospitali ` Etude observationnelle r ´ ealis ´ ee ` a la R ´ eunion To cite this version : Discipline : MÉDECINE GÉNÉRALE Mr le Professeur Malik BOUKERROU ..... Président du jury," 2014.
[118]. S. E. Casey and M. Tshipamba, "Contraceptive availability leads to increase in use in conflict-affected Democratic Republic of the Congo : evidence from cross-sectional cluster surveys , facility assessments and service statistics," pp. 1–10, 2017.
[119]. S. Dhakal, J. S. Song, D. E. Shin, T. H. Lee, A. Y. So, and E. W. Nam, "Unintended pregnancy and its correlates among currently pregnant women in the Kwango District , Democratic Republic of the Congo," *Reprod. Health*, pp. 1–7, 2016.
[120]. J. Kambale, "Obstetric Hysterectomy in Rural Democratic Republic of the Congo : An Analysis of 40 Cases at Katwa Hospital," 2018.
[121]. P. Maternal, M. In, T. H. E. Organizational, M. Of, and H. Care, "DEMOCRATIC REPUBLIC OF THE CONGO : EFFECT OF," 2015.
[122]. N. Morisaki *et al.*, "Risk factors for spontaneous and provider-initiated preterm delivery in high and low

Human Development Index countries : a secondary analysis of the World Health Organization Multicountry Survey on Maternal and Newborn Health," vol. 121, pp. 101–109, 2014.
[123]. L. Cabero-roura and H. Rushwan, "International Journal of Gynecology and Obstetrics An update on maternal mortality in low-resource countries," *Int. J. Gynecol. Obstet.*, vol. 125, no. 2, pp. 175–180, 2015.
[124]. W. Van Lerberghe *et al.*, "Midwifery 3 Country experience with strengthening of health systems and deployment of midwives in countries with high," *Lancet*, vol. 384, no. 9949, pp. 1215–1225, 2014.
[125]. N. C. Rodney and C. J. Mulligan, "A Biocultural Study of the Effects of Maternal Stress on Mother and Newborn Health in the Democratic Republic of Congo," vol. 209, no. July, pp. 200–209, 2014.
[126]. M. Dumbaugh *et al.*, "Evaluating the comparative effectiveness of different demand side interventions to increase maternal health service utilization and practice of birth spacing in South Kivu , Democratic Republic of Congo : an innovative , mixed methods approach," pp. 1–9, 2017.
[127]. L. Keyser, J. Mckinney, C. Salmon, C. Furaha, R. Kinsindja, and N. Ben, "International Journal of Gynecology and Obstetrics Analysis of a pilot program to implement physical therapy for women with gynecologic fi stula in the Democratic Republic of Congo," vol. 127, pp. 127–131, 2014.
[128]. C. Ekechi, Y. Wolman, and D. Bernis, "Maternal & Newborn Health Road Maps : a review of progress in," *RHM*, vol. 20, no. 39, pp. 164–168, 2009.
[129]. F. Bill and M. G. Foundation, "Global , regional , and national levels of maternal mortality , 1990 – 2015 : a systematic analysis for the Global Burden of Disease Study 2015," pp. 1990–2015, 2016.
[130]. N. Young-lin, E. N. Namugunga, J. P. Lussy, and N. Ben, "International Journal of Gynecology and Obstetrics Healthcare providers ' perspectives on the social reintegration of patients after surgical fi stula repair in the eastern Democratic Republic of Congo ☆," vol. 130, pp. 161–164, 2015.
[131]. L. Alkema *et al.*, "Global , regional , and national levels and trends in maternal mortality between 1990 and 2015 , with scenario-based projections to 2030 : a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group," *Lancet*, vol. 387, no. 10017, pp. 462–474, 2016.
[132]. Y. Sano, R. Antabe, K. N. Atuoye, J. A. Braimah, S. Z. Galaa, and I. Luginaah, "Married women ' s autonomy and post- delivery modern contraceptive use in the Democratic Republic of Congo," pp. 4–10, 2018.
[133]. P. E. Bailey *et al.*, "Institutional maternal and perinatal deaths : a review of 40 low and middle income countries," pp. 1–14, 2017.
[134]. T. Godal and L. Quam, "Accelerating the global response to reduce maternal mortality," *Lancet*, vol. 379, no. 9831, pp. 2025–2026, 2012.
[135]. D. B. L, "An alternative strategy to reduce maternal mortality The printed journal includes an image merely for illustration," vol. 6736, no. 06, pp. 1477–1479, 2006.
[136]. "_Training-Midwives-to-Perform-Basic-Obstetric-Point-of-Care-_2017_Ultrasound-.pdf." .
[137]. "_Trends-in-maternal-mortality-in-the-United-State_2016_Reproductive-Toxicolog.pdf." .
[138]. J. A. N. V. A. N. D. E. N. Broeck, R. Eeckels, and G. U. Y. Massa, "Maternal Determinants of Child Survival in a Rural African Community," vol. 25, no. 5, pp. 998–1004, 2018.
[139]. "_WHO Report Maternal Mortality in DRC.pdf." .
[140]. A. Pettifor *et al.*, "Bed net ownership , use and perceptions among women seeking antenatal care in Kinshasa , Democratic Republic of the Congo (DRC): Opportunities for improved maternal and child health," vol. 10, pp. 1–10, 2008.
[141]. J. M. Kirigia, G. M. Mwabu, J. N. Orem, R. Deborah, and K. Muthuri, "Indirect cost of maternal deaths in the WHO African Region in 2010," pp. 1–11, 2015.
[142]. K. G. Merrill, L. Knight, J. R. Glynn, E. Allen, D. Naker, and K. M. Devries, "School staff perpetration of physical violence against students in Uganda: a multilevel analysis of risk factors.," *BMJ Open*, vol. 7, no. 8, p. e015567, Aug. 2017.
[143]. L. Underwood *et al.*, "Paternal Depression Symptoms During Pregnancy and After Childbirth Among Participants in the Growing Up in New Zealand Study," *JAMA Psychiatry*, vol. 74, no. 4, p. 360, Apr. 2017.
[144]. S. U. V Inayak, J. O. S. Ande, H. A. N. Isenbaum, and C. P. Hristian, "Original Contribution TRAINING MIDWIVES TO PERFORM BASIC OBSTETRIC POINT-OF-CARE ULTRASOUND IN RURAL AREAS USING A TABLET PLATFORM AND MOBILE," vol. 43, no. 10, pp. 2125–2132, 2017.
[145]. S. General, "Pcima .,16+6 $95,/," vol. 6, 1875.
[146]. U. D'ottawa, "Information guide on sexual violence," 2015.
[147]. J. Simmons, B. Wijma, and K. Swahnberg, "Lifetime co-occurrence of violence victimisation and symptoms of psychological ill health: a cross-sectional study of Swedish male and female clinical and population samples," *BMC Public Health*, 2015.
[148]. R. Maini *et al.*, "Picking up the bill - improving health-care utilisation in the Democratic Republic of Congo through user fee subsidisation : a before and after study," 2014.
[149]. J. P. Souza *et al.*, "Moving beyond essential interventions for reduction of maternal mortality (the WHO Multicountry Survey on Maternal and Newborn Health): a cross-sectional study," pp. 1747–1755, 2013.