

# Respectful Maternity Care and Social Accountability



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*This brief is intended for the Respectful Maternity Care (RMC) and the social accountability practitioner and research communities. Though these two fields are natural allies, there are few formal efforts to integrate the two program areas. The brief provides background on each field and suggests how these two communities can work together to advance social accountability for respectful maternity care. We suggest ways that RMC practitioners could integrate lessons learned from social accountability into existing programs and vice versa.*

## Respectful maternity care

A growing body of evidence reveals that women worldwide are subjected to disrespectful and abusive treatment at the hands of maternity care providers. In addition to causing psychological distress, this treatment can discourage women from accessing facilities for maternity care, and may ultimately result in avoidable death and disability (Ogangah et al., 2007; Bowser & Hill, 2010; Freedman & Kruk, 2014; Abuya et al., 2015; Bohren et al., 2015). **Disrespect and abuse (D&A)**—also referred to as mistreatment, obstetric violence, and dehumanized care—can manifest in many forms, including physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care (i.e. lack of informed consent and confidentiality, painful examinations and procedures or failure to provide pain relief, and neglect and abandonment); poor rapport between women and providers; and health systems constraints. Health system constraints

include lack of resources, such as infrastructure to ensure privacy, supplies to ensure standards of care are met, and personnel to ensure that providers are not overly stressed and can effectively attend to the needs of each woman and baby. They also include lack of policies sanctioning inappropriate behavior, and facility cultures that promote bribery and extortion; have unclear fee structures; or make unreasonable requests of women by health workers (Bohren et al., 2015).

In light of this evidence, health and human rights organizations have deemed D&A during maternity care a violation of women's human rights. When defining D&A, it is important to note that the absence of D&A does not equal respect; respectful, quality, woman-centered care requires conscious effort and should be prioritized by both care providers and health systems (Freedman & Kruk, 2014). Thus, campaigners have called for respectful care and protection of all childbearing women, especially the marginalized and vulnerable, such as adolescents, minorities, and women with disabilities (Amnesty International, 2010; White Ribbon Alliance, 2011; World Health Organization, 2015). Although there is no consensus on what constitutes respectful care, the emerging **respectful maternity care (RMC)** movement generally advocates for a patient-centered care approach based on respect for women's basic human rights and clinical evidence. The RMC Charter, a normative document that was developed collaboratively by researchers, clinicians, program implementers, and advocates, outlines a rights-based approach to many aspects of care. The Charter is based on universally recognized international instruments to which many countries are signatories, such as the International Covenant on Civil and Political Rights; International Covenant on Economic, Social, and Cultural Rights; and the Convention on the Elimination of all Forms of Discrimination against Women.

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The seven rights of childbearing women it describes are the rights to:

- freedom from harm and ill treatment;
- information, informed consent, and refusal, and respect for choices and preferences, including the right to a companion of choice wherever possible;
- confidentiality and privacy;
- dignity and respect;
- equality, freedom from discrimination, and equitable care;
- timely healthcare and the highest attainable level of health;
- and liberty, autonomy, self-determination, and freedom from coercion (White Ribbon Alliance, 2011).

Efforts to flesh out the content of these rights have identified the importance of services such as continuous care during labor and birth; freedom of movement during labor; freedom to eat and drink during labor; and non-separation of mother and newborn (USAID MCHIP, n.d.; Positive Birth Movement, n.d.). Respectful maternity care will vary in different contexts, and more research is needed to define and promote effective RMC behaviors.

Research has shown that the issue of D&A in facilities is complex, occurring at various levels of the health care system and caused by a multiplicity of drivers (Bowser & Hill, 2010; Freedman & Kruk, 2014; Bohren et al., 2015). Thus, D&A can best be reduced through multi-pronged and targeted approaches that work at different levels of the health system and engage allies from the government in order to address the larger health system factors that contribute to D&A, including lack of accountability (Abuya et al., 2015; Bohren et al., 2017).

## Social accountability

**Social accountability** is an area of growing research and programmatic interest in the broader accountability field; it consists of “ongoing and collective effort[s] to hold public officials to account for the provision of public goods which are existing state obligations” (Houtzager & Joshi, 2008), or that are consistent with “socially accepted standards and norms,” such as polite treatment (Feruglio, 2017). Operationally, these efforts generally include “(a) an agreed set of standards against which conduct is assessed, (b) information about the public actions undertaken, and (c) justification for those” (Joshi & Houtzager, 2012, p. 151). Examples of social accountability measures include social audits, community monitoring, and community report cards. These efforts are typically undertaken by non-governmental organizations and citizen coalitions, sometimes in collaboration with the government.

Through social accountability mechanisms, service users’ voices are heard (White Ribbon Alliance, 2015); in the context of maternal health, this ‘meaningful participation’ can ensure that women get what they want and need during pregnancy and childbirth (Freedman & Kruk, 2014; World Health Organization, n.d.). The somewhat limited research available on social accountability and health shows that social accountability can lead to improvements in health care at the local level, including in respectful care. Several studies and reviews have found that social accountability efforts can enhance knowledge and empowerment among community members, increase the quality of health service delivery, enhance trust between communities and the health system, enhance the functioning of government-supported institutions, increase health service utilization, and improve health outcomes (Wild & Harris, 2011; Papp et al., 2013; Mafuta et al., 2015; Ho et al., 2015; Lodenstein et al., 2016; Schaaf et al., 2017; Gullo et al., 2016; Gullo et al., 2017; Bjorkman & Svensson, 2009).



In the domain of respectful maternity care specifically, studies have found that social accountability can contribute to reduced demands for informal payments, more polite treatment, shorter wait times, better availability of drugs, and reduced absenteeism among providers (Maru, 2010; Ho et al., 2015; Schaaf et al., 2017; Gullo et al., 2016). These changes allow for better clinical care and more respectful interpersonal care, both of which are vital elements of respectful maternity care.

Here, we discuss a few examples of citizen monitoring of quality of care, a common approach to social accountability. Citizens are unable to assess some elements of clinical quality, but they can assess factors such as whether the required number of maternity beds is present, whether they are treated politely and in a timely manner, and whether they were physically or verbally abused. Though there may be under-reporting because disrespect and abuse is normalized, there are many examples of projects to enable citizen reporting of disrespect and abuse. One approach, for instance, is training a select group of community members as monitors to assess staff availability, wait times, users' experiences with providers, quality of the information provided by providers, and availability of drugs. In Peru, this citizen monitoring approach led to improvements in quality of treatment and organization of services (Frisancho & Vasquez, 2008). Increasingly, mobile phones and other information and communication technology (ICT) have allowed members of a community to engage in real time monitoring and reporting to improve transparency and accountability. Through programs like UNICEF's mTrac and U-report, citizens can report problems such as drug stock outs and requests that they make informal payments to receive health care (Asiimwe et al., 2013; Chai & Cummins, 2014; Cummins & Huddleston, 2013). Nazdeek, a legal empowerment organization in India, empowers women volunteers to report health

care violations by SMS, then compiles the data and makes it publically available; their End Maternal Mortality Now campaign in the tea gardens of Assam has captured about 70 examples of violations, including undue payment, provider absenteeism, ambulance and blood unavailability, inappropriate patient referral, and poor conditions (Nazdeek, 2015). Also in India, SAHAYOG's Mera Swasthya, Meri Aawaz (My Health, My Voice) project receives reports via a free telephone hotline, providing a way for even illiterate women to contribute to the monitoring of demands for informal payments and denial of care during pregnancy and maternity care (Dasgupta et al., 2015).

For social accountability efforts to be effective, implementers must build trust in the target communities and overcome entrenched norms that prevent marginalized people from claiming their rights. Implementers also have a responsibility to protect community members who are engaged in accountability efforts from state reprisal (Dasgupta, 2011; Dasgupta et al., 2015; Fox, 2015). Another important consideration is that "vertically integrated" efforts, meaning those occurring at multiple levels of the government and involving multiple actors, tend to be the most effective (Fox, 2015). Implementers warn against tool-based approaches; successful efforts are those that adapt and respond to emerging challenges and priorities, and that are informed by a nuanced understanding of the social and political context (Fox, 2015; Joshi & Houtzager, 2012; Grandvoinnet et al., 2015). This resonates with the RMC literature, which also finds that multi-level, multi-pronged, and contextually driven engagement is more successful (Koblinsky et al., 2016). In the end, however, social accountability is a mechanism for pressuring decision makers and health providers to make changes or uphold their promises; it is critical that government officials and providers have both the capacity and the willingness to review and act on the findings (Banerjee & Duflo, 2006; Schatz, 2013;



Dasgupta et al., 2015). Thus, in the context of RMC, social accountability efforts might be combined with quality improvement or other strategies to improve governmental capacity to provide quality maternity care.

## To Learn More

This factsheet offers a brief overview of the role of social accountability in promoting respectful maternity care. For more information on respectful maternity care, please refer to the following resources:

- Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Coneglian, F.S., Diniz, A.L.A., Tuncalp, O., Javadi, D., Oladapo, O.T., Khosla, R., Hindin, M.J., & Gulmezoglu, A.M. (2015). The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Medicine*, 12(6), e1001847.
- Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility-based childbirth. Boston: USAID-TRAction Project, Harvard School of Public Health.
- Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., Kujawski, S., Moyo, W., Kruk, M.E., & Mbaruku, G. (2014). Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. *Bulletin of the World Health Organization*, 92(12), 915-917.
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For more on social accountability, the following resources are available:

- Das, A., and Dasgupta, J. (2013). Claiming entitlements: The story of women leaders' struggle for the right to health in Uttar Pradesh, India. New Delhi: Centre for Health and Social Justice and COPASAH.
- Dasgupta, J., Sandhya, Y. K., Lobis, S., Verma, P., & Schaaf, M. (2015). Using Technology to Claim Rights to Free Maternal Health Care: Lessons about Impact from the My Health, My Voice Pilot Project in India. *Health & Human Rights: An International Journal*, 17(2).
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- Chai, J., & Cummins, M. (2014). *From 'What Happened?' to 'What's Happening?' Equity in Action Through Real Time Monitoring*. New York: UNICEF.
- Cummins, M., & Huddlestone, B. (2013). Real time monitoring for the most vulnerable: UNICEF's experience in Uganda. *IDS Bulletin*, 44(2), 57-68.
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