**Office of the High Commissioner for Human Rights**

**Submission from the Respectful Maternity Care Global Council**

*On the Implementation of the Technical Guidance on the Application of a Human Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality, (A/HRC/21/22)*

**Questions from OHCHR**

1.        What steps has your Government or organization taken to implement the recommendations in the report of the High Commissioner concerning the application of the technical guidance on a human rights based approach to preventable maternal mortality and morbidity?   
  
2.        Has the technical guidance assisted your Government or organization in building enhanced understanding of the requirements of a human rights-based approach? If so, please expand upon the impact that such enhanced understanding has for the design and implementation of policies and programmes in this area.   
  
3.        In implementing the 2030 Agenda for Sustainable Development and the Global Strategy for Women’s, Children’s and Adolescent’s Health, both of which are grounded in international human rights obligations, how can the technical guidance aid your Government or organization to design policies and programmes to prevent maternal mortality and morbidity? Please specify any plans in place to utilize the technical guidance in this manner.   
  
4.        What challenges does your Government or organization face in implementing the technical guidance? Please elaborate on the nature of these challenges and steps taken to address them.

**Respectful Maternity Care**

Respectful maternity care (RMC) is a universal human right that is due to every childbearing woman in every health system around the world. It expands the notion of safe motherhood beyond the prevention of morbidity or mortality to encompass respect for women’s basic human rights, including respect for women’s autonomy, dignity, feelings, choices, and preferences, including choice of companionship wherever possible. In 2011, the White Ribbon Alliance convened a global and multisectoral Community of Concern to launch a global campaign that would promote a clear standard for RMC rooted in international human rights. The RMC Community of Concern produced a groundbreaking consensus document, the *Respectful Maternity Care Charter: the Universal Rights of Childbearing Women[[1]](#footnote-1)* (RMC Charter), which demonstrates how fundamental human rights apply in the context of maternal health.

The Global Respectful Maternity Care Council (GRMCC) is a multisectoral group of 22 organizations, representing over 200 members from around the world including researchers, clinicians, advocates, professional associations, UN agencies and donors dedicated to identifying, implementing and advocating for strategies to promote respectful maternity care and tackle the problem of disrespect and abuse during childbirth in order to improve the quality of reproductive, maternal, and newborn health.

The OHCHR Technical Guidance, A/HRC/21/22, states that “a human rights-based approach identifies rights-holdersand their entitlements and corresponding duty-bearersand their obligations, and promotes strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations.”[[2]](#footnote-2) It further recognizes that it is important to empower women to claim their rights and not merely avoid maternal death or morbidity. Mortality and morbidity are seen by the technical guidance as a “product of discrimination against women, and denial of their human rights, including sexual and reproductive health rights.”[[3]](#footnote-3)

The aim of this report is to highlight program possibilities and challenges RMC council member organizations and other peer organizations encounter in operationalizing certain aspects of A/HRC/21/22. By contributing to the evidence base on the impact of social accountability mechanisms, we hope this report will drive increased application of these methods in maternal health initiatives to ensure that women receive the respectful care they deserve.

**The Challenge**

Women’s experiences with maternity providers can empower and comfort them, or inflict lasting damage and emotional trauma. Disrespect and abuse of women in maternal healthcare is a prevalent and serious issue in many countries. Physical abuse, lack of informed consent, lack of confidential and dignified care, discrimination, abandonment during care, and detention in facilities are some examples of the disrespect and abuse that women are experiencing.[[4]](#footnote-4)[[5]](#footnote-5)[[6]](#footnote-6)[[7]](#footnote-7)[[8]](#footnote-8)

While many interventions aim to improve access to skilled birth care, the quality of relationships with caregivers has received less attention. Fear of disrespect and abuse that women often encounter in facility-based maternity care is a powerful deterrent to the use of skilled care.[[9]](#footnote-9)

**The Solution**

Disrespect and abuse of women in maternal healthcare continues to occur in part because governments have not committed to nor invested in participatory accountability mechanisms that ensure that women’s rights to respectful maternity care are upheld. To ensure that governments follow through with their commitments to make pregnancy and childbirth safe for all women and provide an environment that supports service providers to deliver high-quality care, it is essential that effective accountability mechanisms informed by women and their experiences are established and implemented.

In the context of respectful maternity care, accountability mechanisms include methods of tracking funds allocated to maternal health services, overseeing implementation of these services, setting and enforcing standards of care, and monitoring quality of care. Through social accountability mechanisms, citizens and civil society hold decision makers accountable and contribute to improvement by monitoring the quality of services and participating in facilitated user-provider discussions where their voices and experiences of care can be heard.[[10]](#footnote-10)

**Social Accountability**

All states have obligations to their citizens, and citizens in turn have a right to demand accountability from the state. Social accountability is the constructive engagement between citizens and government in monitoring the government’s use of public resources to improve service delivery, protect rights, and promote community welfare. Social accountability initiatives empower citizens—including those most marginalized by society—to monitor how governments allocate resources and deliver services, to demand that their needs are taken into account, and to mobilize for change.[[11]](#footnote-11)

According to the Technical Guidance (A/HRC/21/22), “in a human rights framework, women are active agents who are entitled to participate in decisions that affect their sexual and reproductive health.”[[12]](#footnote-12) “Accountability is not an afterthought in a rights-based approach, but fundamental to each stage of the process – from identifying accountability gaps in a situational analysis to ensuring appropriate monitoring mechanisms and remedies in a national plan, to allocating resources for these mechanisms and remedies, to ensuring feedback from the ground through to implementation in practice.”[[13]](#footnote-13)

Several social accountability tools have been successfully used – often together - in ensuring the participation of women in demanding accountability for maternal health:

*Community monitoring:* Community monitoring is a form of public oversight to increase the accountability and quality of social services. In Peru’s Puno Region, indigenous Quechua and Aymara female community leaders engaged with ForoSalud, CARE Peru and the regional office of the Human Rights Ombudsman to monitor women’s health rights, particularly the right to high quality, culturally appropriate and respectful maternal health services. There were five key components: capacity building specific to the initiative; direct citizen monitoring of health facilities, documentation and production of reports on the monitors’ findings, the monthly analysis of these findings with the regional Ombudsman’s office, CARE Peru, the Departmental Officer for Integral Health Insurance (ODESIS) and ForoSalud members, and the creation of “dialogue spaces” with health authorities and health providers.[[14]](#footnote-14) This project led to improved service quality and policy changes. WRA Uganda has organized Community Based Monitoring Action Teams in Kabale, Lira and Mityana to maintain momentum in improvements to EmONC services as a result of their advocacy.[[15]](#footnote-15)

Another organization, SAHAYOG, developed a program in India that allows women to anonymously report informal fees levied on them, through the use of interactive voice response and mobile phones. The monitoring empowered women and made them hopeful they could end the harassment for payments. The program had direct effects in emergency cases, where women called because they were refused services or were asked for additional payment. In those cases, the hotline representative immediately contacted a senior health official in the district, who intervened to ensure that the emergency was addressed.[[16]](#footnote-16) Utilizing mobile technology provided anonymity to women, which made it more feasible for them to report an informal payment. It also provided aggregate data on facilities where informal payments were requested, thus pointing to deficiencies in the system and placing accountability with the people in charge of the facility and those higher up in the health system.[[17]](#footnote-17) Documenting demands in real time and aggregating the data online also increased officials’ willingness to attend to rights claims.[[18]](#footnote-18)

*Social Audits:* Social audits consist of government and civil society working together to analyze implementation, quality, and beneficiaries’ experiences and satisfaction with existing health services.[[19]](#footnote-19) For example, youth in Panama have been trained as social auditors to assess the youth friendly services of clinics in four districts in their country. The collated results and recommendations passed on to decision makers have resulted in agreements and guidelines to make sexual and reproductive health services more accessible for youth. WRA Pakistan published the first ever survey of women’s experiences of disrespect and abuse in three provinces of Pakistan. The very detailed report, with policy recommendations, was shared with policy makers and practitioners at a national consultation meeting.[[20]](#footnote-20)

*Public Hearings and Community Meetings:* Public hearings and community meetings provide a platform for government officials, stakeholders, and community members to gather together and discuss concerns regarding health services and, together, develop solutions and plans for action. They serve a double purpose of empowering citizens to know their rights and to hold their leaders to account on commitments made to end the preventable deaths of women and newborns.[[21]](#footnote-21) Both BRAC (formerly Bangladesh Rural Advancement Committee), and WRA India have created forums and reported high levels of participation. BRAC’s Maternal and Neonatal and Child Health committee and WRA’s public hearings both include the involvement of elected leaders, health workers, health providers, and women in the community.WRA Nigeria organized “Family Health Days” in Kwara State to allow families and health workers to come together to discuss quality of care and for community members to learn about their rights to services at the health facilities, the chain of command and how they could lodge complaints with the leadership of the health facility whenever they felt they had experienced disrespect or abuse.

*Citizen Report Cards and Community Scorecards:* Citizen Report Cards (CRCs) are participatory surveys providing feedback on quality and efficiency of public services. The Community Score Card brings health providers, community members and government officials together to jointly identify and overcome barriers to service access, utilization and quality provision.[[22]](#footnote-22) CRCs used by WRA India have led to actions to improve health facilities, including budgetary allocations to create new labor rooms. The use of Community Scorecards by CARE Ethiopia, Rwanda, Malawi, and Tanzania has led to greater trust and mutual respect between users and providers, as well as improved performance by providers.[[23]](#footnote-23)

*Verbal and Social Autopsies:* A verbal autopsy is performed by interviewing health providers and family members of those recently deceased about symptoms that occurred prior to death, while social autopsies involve interviewing these individuals to investigate social, behavioral, and health system determinants of maternal deaths.[[24]](#footnote-24) Both are categorized as community-based maternal death reviews and serve as nonjudgmental means of gathering information about causal factors for maternal death that are analyzed by the health system so that it can organize an improved response to similar challenges and avoid such deaths in the future.[[25]](#footnote-25) Verbal and social autopsies have been successfully implemented by various organizations focused on maternal health. For example, BRAC’s MANOSHI program discovered two leading causes of maternal death through social autopsies and then developed a two-pronged approach to reduce deaths resulting from these complications. *[[26]](#footnote-26)*

*Partnership Defined Quality (PDQ):* PDQ is a method used to improve quality and accessibility of services by including community members in the defining, implementing, and monitoring process through such tools as supervisory checklists, mapping tools, and exit interviews.[[27]](#footnote-27) Positive results from PDQ have been seen in various countries, including Afghanistan, Pakistan, Peru, and Uganda. For instance, when implemented by IntraHealth International and Save the Children in Rwanda, PDQ led to better communication between elected officials and health workers, improvements in health service quality, and higher rates of health service utilization.[[28]](#footnote-28)

*Other client feedback mechanisms:* Ensuring that opportunities exist for community members to voice their concerns and provide feedback about the health programs designed to serve them creates the basis for identifying and addressing key issues and developing action plans. For example, Jhpiego’s “satisfactometer” constantly monitors patient satisfaction with quality of care through surveys and ballot boxes, and responses are posted for all to see. WRA India’s Citizens’ Voice Reporter provides a platform for citizens to hold leaders, politicians and governments accountable for their commitments to women and children by conducting and publishing interviews that document government follow-through on obligations regarding safe pregnancy and childbirth.

*Citizen-led budget advocacy:* Budget advocacy is a strategic approach to influence how money is allocated and spent on maternal health. In the Rukwa region of Tanzania citizen monitoring and budget advocacy succeeded in ensuring that at least 50% of health centers provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) in a region where emergency obstetric and newborn care was almost nonexistent.[[29]](#footnote-29) The results and influence of WRA Tanzania’s campaign reached beyond the borders of Rukwa. All 169 districts of Tanzania now include a specific budget for CEmONC in their 2015 Comprehensive Council Health Plans.

**Integration of Social Accountability and Legal Empowerment**

Social accountability (SA) and legal empowerment (LE) entail parallel activities, and groups are starting to organically incorporate elements from both.[[30]](#footnote-30) For example, Nazdeek, a legal capacity building organization based in India, added community monitoring (an SA tool) to an existing paralegal program addressing maternal and newborn health. The program, led by Nazdeek among tea garden workers in Assam, India, fuses legal empowerment, community monitoring and technology to encourage women to report maternal and infant health violations. End MM Now maps and visualizes ground-level data, which is verified and made available to the public and the government. This way, the platform bridges an existing information gap and increases transparency in the delivery of health services.[[31]](#footnote-31) The monitoring data shows the incidence of maternal and newborn health rights violations, buttressing Nazdeek’s LE work. They are able to go to court with this data as part of their evidence. This strengthens Nazdeek’s case and provides helpful information that they can use to ask for a targeted remedy.[[32]](#footnote-32)

HERA, a sexual and reproductive health and rights organization based in Macedonia, was applying the two approaches (SA and LE) separately while working on advancing the reproductive health and rights of Roma women. Within the scope of their SA work, HERA monitors the delivery of gynecological services to women, using citizen score cards. Through a LE project, they also provide legal services to Roma women in the communities where SA is undertaken. Over time, it became clear that the SA and LE projects had substantial overlap in the methods they were using to approach, educate, and mobilize the community. When using both approaches, they are effectively bombarding the institutions with different tools, creating multiple accountability pressures.[[33]](#footnote-33)

In Kenya RMC toolkit alternative dispute resolution built upon FIDAs work at community level based on other legal matters such as land and wife inheritance. CHWS were trained to inform women and communities on human rights and rights to quality health care.[[34]](#footnote-34) [[35]](#footnote-35)

**Lessons Learned**

Several factors appear to influence the degree to which social accountability initiatives achieve success. Rather than simply transferring strategies from one location to the next, organizations should carefully consider these contextual factors. First, if social accountability (SA) activities increase access to information, this information must be interpreted as useful and actionable by citizens. There should be a clear progression from access to information to action. Simply distributing large amounts of data to citizens will likely not bring about change.[[36]](#footnote-36) Similarly, SA initiatives should take seriously citizens’ fear of reprisals as a result of participation and take measures to address these well-founded fears. In some activities, like SAHAYOG referenced above, anonymous participation reduces fears of reprisal.[[37]](#footnote-37) In addition to threats of violence and retribution, SA activities may be more successful if they consciously address norms and biases that restrict participation based upon gender, class, or ethnicity.[[38]](#footnote-38) Social accountability programs that targeted underlying factors include the CARE community scorecard, which challenged the ‘culture of silence’ around gender-based violence, and public hearings in India, which allowed female participants to challenge patriarchal norms around women’s decision-making.[[39]](#footnote-39)

Further recommendations for social accountability initiatives focus on programs’ relationships to systemic factors. First, initiatives should have a wide scope, focusing on local, regional, and national governance. Likewise, civil society should endeavor to collaborate across these three levels. In a review of social accountability mechanisms, Fox states that a system-wide focus will avoid the “squeezing the balloon” problem, whereby attention in one area will cause problematic activities to transfer to other areas of the government. Within SA initiatives, having large alliances of local and international actors has been highlighted as a strength.[[40]](#footnote-40) Fox’s recommendation to focus on underlying root causes corresponds to a wide focus. Concentrating on factors at the local level may only address consequences of more fundamental issues.[[41]](#footnote-41) Finally, evidence from previous programs suggests that externally-driven initiatives are less successful than local programs; external programs generally “do not examine a longer trajectory of citizen-state relationships or civil society networks that underpin the outcomes in specific social accountability initiatives, neither do they examine the influence of citizen-led activities outside the narrow scope of the initiative.”[[42]](#footnote-42)

**Role of Government**

Despite the emphasis upon civil society organizations in social accountability initiatives, there is an essential role for local, regional, and national governments to play. In previous initiatives, civil society actors have partnered with allies in the government who are “both willing and able to get involved.”[[43]](#footnote-43) This partnership, described as the “sandwich strategy,” allows government and civil society actors to collaborate towards their shared goals. Furthermore, governments may advance systemic reforms that create a more enabling environment; this could include “bolstering the autonomy and capacity of oversight agencies, as well as access to the rule of law more generally.”[[44]](#footnote-44) Contrary to SA models that place all responsibility with civil society, governments have been important collaborators and mediators of these processes. Government responsiveness is a crucial element of social accountability.

**Signed:**

**White Ribbon Alliance**

**IntraHealth International**

**Human Rights in Childbirth**

**International MotherBaby Childbirth Organization (IMBCO)**

**Regroupement Naissance-Renaissance, Province of Québec, Canada**

**Averting Maternal Death and Disability, Columbia University Mailman School of Public Health**

**CARE**

**Center for Health and Gender Equity (CHANGE)**

**Medical Women's International Association**

**Management Sciences for Health**

**Pathfinder International**

**Women’s Circles, Slovakia**

**Population Council**

**American College of Nurse-Midwives**

**Save the Children US**

**Childbirth Survival International**

**American Refugee Committee**

**Birthrights**

**HealthRight International**

**Maternal Health Taskforce**

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