



THE ROLE OF SOCIAL ACCOUNTABILITY IN IMPROVING RESPECTFUL CARE

Technical Report

MOMENTUM KNOWLEDGE ACCELERATOR



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ABBREVIATIONS

AMDD	Averting Maternal Death and Disability Program at Columbia University
CEGSS	Center for the Study of Equity and Governance in Health Systems
CHW	Community Health Worker
CSC	Community Score Card
FP2030	Family Planning 2030
HCW	Health Care Worker
HEARD	Health Evaluation and Applied Research Development
JSI	John Snow Research and Training Institute, Inc.
NGOs	Nongovernmental Organizations
PMNCH	Partnership for Maternal, Newborn, and Child Health
PMTCT	Prevention of Mother-To-Child Transmission
PRB	Population Research Bureau
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
UCSF	University of California, San Francisco
UNFPA	United Nations Population Fund
URC	University Research Co.
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	White Ribbon Alliance

EXECUTIVE SUMMARY

Respectful care is of increasing interest within reproductive, maternal, newborn, child, and adolescent health (RMNCAH). Concurrently, there has been an increased call for health systems to be accountable to the populations they serve for delivering quality care through social accountability approaches. This technical report aims to help elucidate the completed and ongoing work around social accountability approaches to transform health systems, with a focus on their use in improving respectful care in RMNCAH services. We conducted a rapid literature review and implemented key informant interviews and focus group discussions to examine the empirical evidence and theoretical basis of social accountability interventions' influence on respectful care across the RMNCAH continuum. Key informant interviews and focus group discussions also permitted us to map the work underway or being planned in this space.

The findings from the rapid literature review, key informant interviews, and stakeholder focus group discussions informed a background paper that served as the fulcrum for discussions in a convening of USAID and key external stakeholders held on July 13-14, 2022, and a third session for USAID stakeholders on July 19, 2022. The inputs solicited, points discussed, recommendations, and conclusions were incorporated into the background paper to develop this technical report.

To guide this work, we developed and vetted with USAID the following definition for respectful care: "Care is respectful if it maintains all individuals' dignity, privacy, and confidentiality; ensures that interactions with individuals or carers enhance informed decision-making, without inducement or coercion; promotes continuous support (as appropriate); is compassionate and responsive to their preferences, needs, and values; and is free from stigma, discrimination, mistreatment, and harm."

Existing research and programs related to respectful care mainly focus on respectful maternity care, with less exploration of family planning, reproductive health, and adolescent health, and very little formal study of newborn and child health. Factors that shape whether care is respectful or not include the extent to which the health care system and facilities are more broadly oriented to patient care, the level of engagement and feedback from patients and communities, provider knowledge and expertise, the health policy and legal context, and the prevalence of providers' prejudicial and discriminatory beliefs. These factors are influenced by training, incentives, and leadership, among other factors. The existing research assessing ways to promote respectful care is somewhat limited, generally focusing on efforts at the facility level, as opposed to addressing social norms and other structural factors, such as stigma or national-level policy.

Social accountability consists of "citizen-led, collective processes for holding duty-bearers (including politicians, government officials, and/or service providers) to account for their actions" (Squires et al., 2020).¹ There are many different types of social accountability efforts that seek to improve health care access and quality. The majority of programs implemented to address health include social accountability as a process of providing information to communities about their rights and entitlements, community and health provider assessments of current service provision against these rights and entitlements, and an "interface" meeting or dialogue, wherein community members and health providers identify priorities and create an action plan.

The link between social accountability mechanisms and respectful care appears intuitive. However, respectful care is not typically identified as a distinct outcome in social accountability efforts, though some studies and programs address respectful care or collect related data. The extant evidence demonstrates that social accountability interventions have influenced outcomes related to respectful care, including increased: patient

satisfaction, the (observed) provision of respectful maternity care, information provision during a clinical/counseling encounter, attention to privacy and confidentiality, polite treatment, perceived quality of care, patient willingness to seek care, a perceived commitment of service providers, trust in service providers, and mutual interest between clients and providers.

Social accountability may be a promising strategy for improving respectful RMNCAH care. Social accountability programs typically entail members of the community assessing health system performance, and respectful care can and should be monitored—at least in part—by communities themselves. Among the elements of quality of care, respectful care might be the most amenable to community monitoring. Health care providers know that patients with knowledge about respectful care may be assessing care as it is delivered, and that lack of respectful care may be brought up as part of social accountability activities, such as community dialogues. Further, many elements of respectful care are within the control of local health providers, such as polite treatment, respect for privacy, the provision of information, and compliance with consent processes. Thus, local-level social accountability efforts could engender improvements in respectful care.

Synthesizing and building on existing empirical evidence and theory in social accountability, health, RMNCAH, and respectful care, we propose a possible theoretical pathway from social accountability to respectful care in RMNCAH. We also identify several challenges and gaps related to social accountability and respectful care in RMNCAH, including limited evidence for social accountability as a strategy to promote respectful RMNCAH care; variation in the ways social accountability and respectful care are operationalized and measured; short implementation periods and a lack of flexibility in the way projects are structured; and challenges related to the scalability and sustainability of interventions. While there is work underway and planned to generate more evidence, gaps remain. We conclude with a series of recommendations for refining the conceptualization of respectful RMNCAH care, building a stronger evidence base, developing consolidated tools and guidance, improving measurement, and strengthening implementation.

INTRODUCTION

OVERVIEW

While significant progress has been achieved in reproductive, maternal, newborn, child, and adolescent health (RMNCAH), there is still room for improvement. Enhancing the quality of RMNCAH services has the potential to improve the experience of care and subsequent care-seeking, as well as health outcomes (Kruk et al., 2017; Akachi & Kruk, 2017).

The World Health Organization (WHO) has defined quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes” (World Health Organization, 2006). There is an overall consensus that quality care must be safe, effective, and people-centered. Several terms are used to capture the dimensions of quality of care that center around its recipients, including but not limited to “respectful care,” “experience of care,” “service experience,” “patient-centered care,” “person-centered care,” and “client-centered care.” Quality of care is a focus in RMNCAH (National Academies of Sciences, Engineering, and Medicine, 2015) and respectful care is of increasing interest within many of these health areas. However, these health areas have not focused equally on respectful care. In addition, there is limited work to date looking across these health areas to identify areas of commonality and areas of divergence in the conceptualization of respectful care in health care delivery.

Simultaneously, there has been an increased call for health systems to be accountable for delivering quality care to the populations they serve. Social accountability is a set of community-led approaches used to increase the answerability of health systems to the populations they serve.

The link between social accountability mechanisms and respectful care appears intuitive; however, the existing theoretical foundation and empirical evidence supporting this link have not been fully explored.

OBJECTIVES

The purpose of this technical report is to help elucidate the completed and ongoing work around social accountability approaches to transform health systems, with a focus on improving respectful care in RMNCAH services.

This technical report has several objectives:

- Present definitions and common elements of respectful care across subfields within RMNCAH
- Present definitions of social accountability
- Identify contributions of social accountability to achieving more respectful care across the RMNCAH continuum
- Propose a theoretical pathway from social accountability to respectful care
- Make recommendations to strengthen social accountability approaches that improve respectful care in RMNCAH

METHODOLOGY

We conducted a rapid literature review and implemented key informant interviews and focus group discussions to examine the empirical evidence and theoretical basis of social accountability interventions’

influence on respectful care across the RMNCAH continuum. The literature review was carried out primarily by one author (Marta Schaaf), while the key informant interviews and focus group discussions were carried out by the others (Megan Ivankovich, Mahua Mandal, Cathryn Streifel, and Lara Vaz).

The rapid literature review included peer-reviewed and gray literature from searches on Google Scholar and PubMed, and the authors' expertise with social accountability. Given that the review needed to be rapid, the key focus was to identify and synthesize germane literature in the social accountability and respectful care fields, rather than to exhaustively catalogue all related research in allied fields. The literature focused on low- and middle-income countries. For the [Framing and Current Evidence: Respectful Care](#) section, keywords searched included *respectful care* and each of the following terms, separately: *reproductive, maternal, newborn, child, adolescent*. Additional keywords included: *disrespect and abuse, experience of care, patient-centered care, patient-defined quality, interpersonal quality of care, adolescent-friendly services, adolescent-friendly care, and culturally competent care*. These search terms were chosen because of their evident connection to our research objectives. Limitations include the fact that we may have missed relevant research that was framed as primary health care, as opposed to the discrete areas of RMNCAH. Additionally, relevant literature on efforts in other health areas, such as HIV/AIDS, was not included. In addition, it is possible that there is other relevant research on programs that were seeking to improve quality of care more broadly, as opposed to respectful care as such.

For the [Framing and Current Evidence: Social Accountability](#) section, keywords used were *social accountability* and *community scorecards*. The search term *community engagement* was not used, as community engagement activities are much broader than social accountability. However, it is possible that there are programs that meet our definition of social accountability that are described as community engagement. To inform the [Can social accountability improve respectful care?](#) section, we used the search terms *social accountability* and *health*; search terms specific to RMNCAH produced too few results. Key gray literature referenced in peer-reviewed articles identified in the search—namely, papers that described in detail and/or evaluated social accountability programs in health—were also included. Additional peer-reviewed and gray literature recommended by colleagues and experts in the field during key informant interviews and focus group discussions were included for review. The authors used an extraction tool to record information about each article, with particular attention to respectful RMNCAH outcomes, mechanisms of change, and enablers and challenges of change.

We conducted key informant interviews and focus group discussions with 34 individuals working at the intersection of social accountability and respectful care in RMNCAH. The qualitative explorations served to collect information on current and planned work related to social accountability and respectful care in RMNCAH, including who are the key stakeholders involved, and to identify gaps in work. Several participants were identified via snowball sampling. Together, stakeholders represented all RMNCAH technical areas and all main global geographic regions. Interviews and focus group discussions were conducted between March 21, 2022, and April 15, 2022, using a semi-structured interview guide. The authors used thematic analysis to identify the themes that emerged during the interviews and focus group discussions and categorize each informant's responses by theme. The results of the analysis are summarized in [Mapping the stakeholders at the intersection of social accountability and respectful care](#).

MKA presented the findings from the literature review and stakeholder mapping and preliminary recommendations during a three-part convening that combined presentations with interactive small group working sessions. Participants included USAID officials based at headquarters and in select Missions, external stakeholders working at the intersection of social accountability and respectful care, and representatives from MOMENTUM projects. The third session, which included only USAID participants, focused on developing a plan of action around the recommendations emerging from the first two days of the convening.

and prioritized by USAID. Resources, key takeaways, and updated recommendations from the convening series have been incorporated into the technical report. See Appendix D for a summary of the convening series.

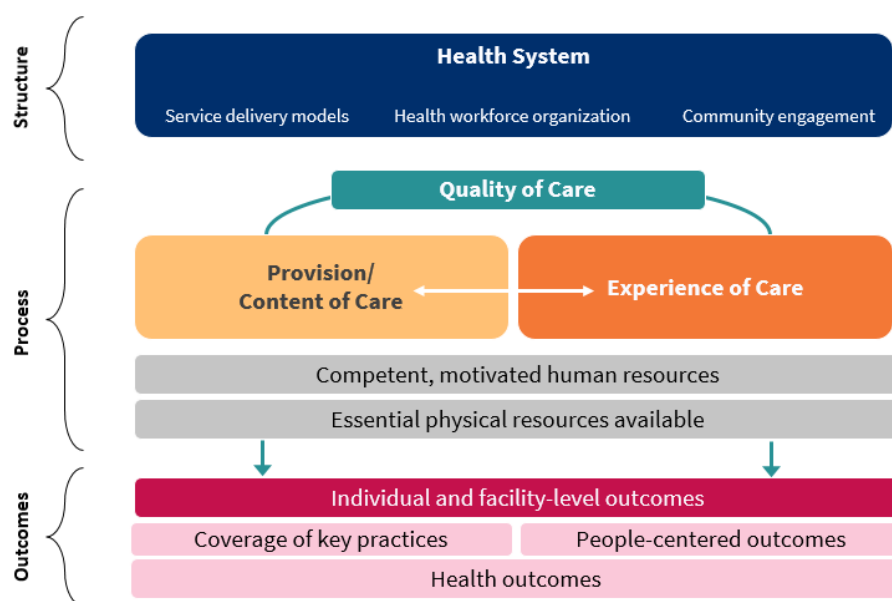
FRAMING AND CURRENT EVIDENCE

RESPECTFUL CARE

CONCEPTUALIZATION

In RMNCAH, respectful care is often conceptualized as part of quality of care. The World Health Organization (WHO)'s Quality of Care framework initially developed for maternal and newborn health (World Health Organization [WHO], 2016) and later adapted for child health (WHO, 2018). further informs the conceptualization of respectful care. Figure 1 captures the common elements of the various WHO Quality of Care Frameworks. The framework separates quality of care into the areas of *Provision/Content of Care* and *Experience of Care*. Several quality of care domains within each of these areas, along with human and physical resources, lead to the **coverage of key practices**, which is particularly informed by the *Provision/Content of Care*; and to **people-centered outcomes**, informed especially by the *Experience of Care*.

FIGURE 1. GENERIC WHO FRAMEWORK FOR QUALITY OF CARE



Experience of care has been defined as the “sum of all interactions, shaped by an organization’s culture, that influence patient perceptions, across the continuum of care” (Oben, 2020). WHO defines people-centered care as “an approach to care that consciously adopts the perspectives of individuals, carers, families, and communities as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centered care also requires that people have the education and support they need to make decisions and participate in their own care” (WHO, 2006). Examination of frameworks and definitions used by WHO and in other literature reveal that the manner in which *experience of care*, *people-centered care*, and *respectful care* are conceptualized and defined vary across the sub-fields within public health. In an attempt to synthesize and present a uniform and coherent conceptualization of these terms across the RMNCAH continuum, we present one conceptualization in Figure 2A: quality of care

incorporates a person's experience of care, which may be positive or negative, person-centered or not. Respectful care can be conceptualized as one component of person-centered care. The USAID-funded MOMENTUM Country and Global Leadership project has posited another conceptualization of the relationship between several terms, presented as Figure 2B (MOMENTUM Country and Global Leadership, 2022).

FIGURE 2A. OVERLAPPING DOMAINS UNDER QUALITY OF CARE

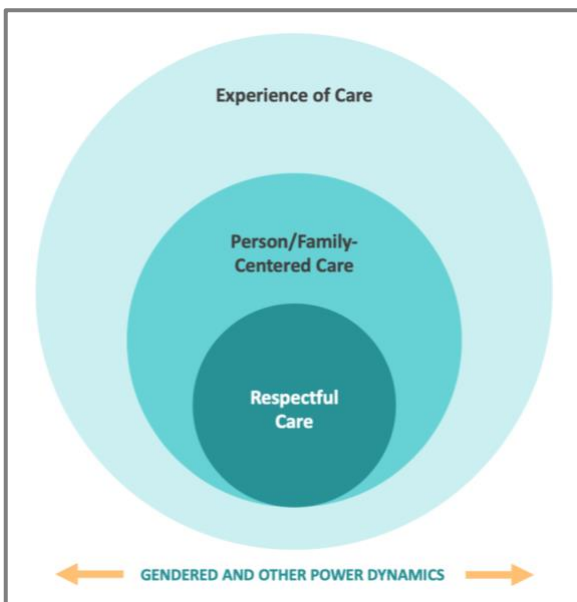


FIGURE 2B. RELATIONSHIP BETWEEN ELEMENTS IN QUALITY OF CARE



Respectful care is intrinsically important insofar as all individuals should be treated with dignity by the health care system. It is also important for health outcomes (Laterra et al., 2020; Samuel & Frisancho, 2015; Karim et al., 2016; Creanga et al., 2017) and intended or actual health behaviors (Larson, et al., 2015; Larson, et al., 2017; Dehlendorf et al., 2016; Pedro et al., 2013; Hoopes et al., 2016). Respectful care may be a key component in these relationships.

A working definition of respectful care across the RMNCAH continuum was developed by a MOMENTUM Knowledge Accelerator team working to help frame this technical report. This working definition (Box 1) was drafted after an initial review of definitions and conceptualizations of respectful care and related terms within each sub-field and finalized in collaboration with USAID stakeholders. Additional information about

the definition and the process to develop the definition is presented in [Appendix A](#). Box 2 lists out key elements of the definition.

The construct of respectful RMNCAH care is complex for several reasons. First, there is no global consensus regarding either inputs required for, nor outputs and outcomes resulting from, respectful RMNCAH care. Existing research and programs largely focus on respectful maternity care,² with less exploration of respectful care in adolescent health and in family planning and reproductive health (though other terminology, with overlapping concepts, such as person-centered care, has been explored), and exceedingly little exploration in newborn and child health. Additionally, the operationalization of respectful care is also nascent. Even in maternity care, where the concept of respectful care is relatively well-established, there is no consensus regarding evidence-based standards for the provision of respectful care (Jolivet et al., 2021). At present, few national-level research, monitoring, and feedback mechanisms include respectful care in their assessment of quality of care (Bohren et al., 2020).

As mentioned above, the term “respectful care” overlaps with other existing constructs whose definitions and measures vary significantly across contexts. For example, as illustrated in Figure 2B, MOMENTUM Country and Global Leadership offers one conceptualization of how the broad framework for people-centered care aligns with related terminology used across different health areas. Using a life-course approach, they illustrate how respectful maternity care is applicable from pregnancy and childbirth through post-natal and newborn care and infant care, and how nurturing care is applicable from pregnancy and childbirth through young childhood (3 years of age). Right-based care and people-centered care are applicable through the life course. As another example, the adolescent health sub-field often uses the term “adolescent-friendly.” In some contexts, such as in Malaysia, adolescent-friendly is gauged by adolescent clients’ comfort and willingness to share information with the provider (Awang et al., 2020), which is likely influenced by respectful care; in other contexts, such as in Mongolia, the term is defined more broadly and includes an adequate facility physical environment (Sovd et

BOX 1. DEFINITION OF RESPECTFUL RMNCAH CARE

Care is respectful if it maintains all individuals' dignity, privacy, and confidentiality; ensures that interactions with individuals or carers enhance informed decision-making, without inducement or coercion; promotes continuous support (as appropriate); is compassionate and responsive to their preferences, needs, and values; and is free from stigma, discrimination, mistreatment, and harm.

BOX 2. KEY ELEMENTS OF RESPECTFUL RMNCAH CARE

- Dignity
- Privacy and confidentiality
- Enables informed decision-making
 - Provision of information
 - Opportunity to ask questions
 - Ability to make decisions
- Free of inducement or coercion
 - Free of bias in provision of information and services
- Promotes continuous support
 - Care is coordinated
 - Patient is satisfied and willing to return
- Compassionate
- Responsive to preferences, needs, and values
 - Culturally competent
 - Appropriate to life stage and socio-economic position
- Free from stigma, discrimination, mistreatment, and harm

² The definition of respectful maternity care is evolving from a focus only on the birthing mother to a broader focus inclusive of the newborn.

al., 2006). Thus, the overlap of definitions, measurements, and operationalizations of related constructs are important to assess in relation to respectful care.

Finally, respectful care is often understood to be an intermediate outcome between program activities and objectives related to health care coverage, utilization, or health outcomes. This has implications for the evidence base, insofar as the causal pathway between policies and programs and respectful care is under-theorized and under-measured.

FACTORS THAT INFLUENCE RESPECTFUL CARE

Unsurprisingly, the breadth and depth of evidence on factors that influence respectful care parallels the variability in how well the construct is conceptualized across the sub-fields within RMNCAH. Notably, the extant literature describing factors that promote respectful care is largely intervention- and evaluation-focused, with little primary research examining the associations between respectful care and broad health strategies, health facility characteristics, or patient/provider attributes.

Table 1 summarizes the types and breadth of literature around respectful care within each sub-field. Respectful care has been most thoroughly researched within maternal health, where the term originated, with robust literature describing the drivers of mistreatment (i.e., absence of respectful care) of women in maternity care. Relevant research in family planning and reproductive health focuses on patient-centered care, experience of care, and adolescent-friendly services. Some of the lessons from respectful maternal health apply to adolescents, as there is evidence that they experience mistreatment and abuse in maternity care. Research around respectful newborn care is emerging and is tied to that of respectful maternal care. There is very limited literature on respectful child health care.

TABLE 1. OVERVIEW OF LITERATURE FOUND RELEVANT TO RESPECTFUL RMNCAH CARE

Health overall	<ul style="list-style-type: none"> • Patient-centered care. • Quality of care (especially patient-defined quality).
Family planning & Reproductive health	<ul style="list-style-type: none"> • Patient-centered reproductive health care, with limited evidence on programs. • Quality reproductive health care, with limited evidence on programs.
Maternal health	<ul style="list-style-type: none"> • Mistreatment of women in maternity care. • Respectful maternity care, including literature on birth companions. • Limited literature on culturally competent care, mostly in high income countries.
Newborn health	<ul style="list-style-type: none"> • Limited exploration of mistreatment of newborns. • Some respectful maternity care work includes newborn care.
Child health	<ul style="list-style-type: none"> • Service experience (especially related to immunizations).
Adolescent health	<ul style="list-style-type: none"> • Often included as a subpopulation in literature on mistreatment of women and respectful maternity care. • Adolescent-friendly services in context of reproductive health care and sexually transmitted infection prevention and treatment.

The drivers of disrespectful maternity care described in the literature fall under two broad categories: (1) attributes of the health care setting, and (2) attributes of the patient as perceived by the health care provider. Attributes of the health system and health care setting described include: prioritization of health facility and health care worker (HCW) needs over patient needs; lack of adequate infrastructure and inputs; high work burden and insufficient human resources; prejudicial social norms regarding who is fit for sexual activity and/or motherhood based on age, ethnicity, parity, education, and other factors; discrimination; and normalization of mistreatment (Aguilar et al., 2013; Akasreku et al., 2018; Amroussia et al., 2017; Ansari et al., 2015; Bradley et al., 2016; Boydell et al., 2020). Some research looks at broader health system factors and upstream drivers, such as HCW training curricula that focus on biomedical elements without due attention to patient concerns and rights; health care system or political goals related to programmatic outputs and goals, rather than quality of care; and financial resource scarcity (De Man et al., 2016).

The most widely described patient attributes associated with experiencing mistreatment are the patient belonging to a stigmatized group, such as pregnant adolescents or members of a lower caste (Baranowska et al., 2019; Bohren et al., 2019; Morgan et al., 2017) and, in the case of newborns, low birth weight or being born in a particular facility (Sacks et al., 2017). It should be noted that the driver of disrespect in these contexts is stigma and discrimination relative to the patient's identity—not the patient's identity itself. Some findings are echoed in the literature describing poor implementation of adolescent-friendly service standards, which describes challenges, including lack of training for providers, adolescent perceptions of poor privacy and confidentiality in facilities, conflict between adolescent patients and clinical staff, and moralizing staff attitudes towards the sexual health needs of adolescents (Chandra-Mouli et al., 2013; Pandey et al., 2019; Zanoni et al., 2019).

Several elements of respectful care, such as informed decision-making, continuous support, and respect of dignity, require resources and provider know-how and extend beyond the mere absence of mistreatment and abuse. Research relevant to factors that promote respectful care include discrete choice experiments and other studies aiming to identify what matters to patients (a component of respectful care), and then suggesting how health systems can meet these expectations. For example, a discrete choice experiment regarding preferences for delivery care among Tanzanian women found that the variable with the greatest magnitude of association with health care facility preference was being treated kindly by the doctor (Larson et al., 2015). These findings were consistent with similar studies on maternal health care elsewhere in sub-Saharan Africa, adolescent-friendly care in Malaysia, and culturally competent care in Ethiopia, with the authors concluding that training and supporting HCWs to provide respectful or culturally competent care was a crucial step to increasing facility delivery (Larson et al., 2015; Awang et al., 2020; Aragaw et al., 2015). Similarly, the very limited literature on respectful child health care identifies provider training as essential to the provision of some elements of respectful care. A cross-sectional analysis found that provider pre-service education and training in integrated management of childhood illness were associated with better communication (another component of respectful care) with caregivers of sick children in low- and middle-income countries (Larson et al., 2017).

An evidence base is emerging around the benefits of birth companionship in relation to respectful maternity care. In a Cochrane Review, a systematic review of health care and health policy research that is published in the Cochrane Database of Systematic Reviews, birth companionship improves labor-related outcomes (Hodnett et al., 2013); however, there are many barriers to implementation identified in a 2017 systematic review (Kabakian-Khasholian & Portela, 2017). At the facility level, birth companionship has been associated with reductions in disrespect and abuse from women's perspective (Singh et al., 2021; Ortiz Contreras et al., 2021; Mengistu et al., 2021) and provider perspective (Adu-Bonsaffoh et al., 2022). Further, person-centered maternity care scores were higher in women who had a birth companion (Rishard et al., 2021). A WHO

evidence-to-policy brief on birth companionship notes that enabling policies; training; raising awareness among women and health providers; and improvements in infrastructure, particularly as related to privacy, are key to supporting implementation of birth companionship (WHO, 2020). Law and policy are particularly important, as companionship is prohibited or simply ignored in some settings (WHO, 2020). In sum, though the relevant literature is sprawling and spans several discrete areas (e.g., disrespect and abuse in maternity care and patient-centered contraceptive care) several themes emerge. The extent to which a facility and the system more broadly are oriented to patient care, engagement and feedback from patients and communities, provider knowledge and expertise, and the presence of discriminatory beliefs among providers all shape whether care is respectful or not. These factors are influenced by training, incentives, and leadership, among other factors. We briefly explore how these factors can be influenced in the next section.

EVIDENCE OF EFFECTIVE APPROACHES AND GAPS AROUND IMPROVING RESPECTFUL CARE

Policies and programs to promote respectful care use a wide variety of approaches. The existing research assessing ways to promote respectful care is somewhat limited and generally focuses on efforts at the facility level as opposed to addressing social norms and other structural factors, such as stigma or national-level policy. Here we summarize the limited and amorphous evidence base on efforts to influence social norms and national policy to improve respectful care. Research specifically on accountability efforts to improve respectful care, including social accountability, will be described in the next section, [*Can Social Accountability Improve Respectful Care in RMNCAH?*](#)

Systems- and structural-level approaches

Some national or system-wide quality improvement efforts include respectful care or an overlapping construct as an intermediate or final outcome. For example, the monitoring and evaluation of a national primary quality of care improvement program in India entails regular patient satisfaction surveys (Thapa et al., 2019); some countries participating in a five-country effort to improve maternal and child health quality of

BOX 3. KEY GLOBAL LEVEL GUIDANCE DOCUMENTS REGARDING RESPECTFUL RMNCAH CARE

The [UN Office of the High Commissioner for Human Rights Technical guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality](#) and other international guidance documents and recommendations regarding the quality of care describe possible policies to promote respectful care. These include the [WHO Recommendation on Respectful Maternity Care](#), the [WHO Guidance on ensuring human rights in the provision of contraceptive information and services](#), the [WHO Standards for improving the quality of care for children and young adolescents in health facilities](#), the [Respectful Maternity Care Charter](#), the [Lancet Midwifery Series Framework for Quality Maternal and Newborn Care](#), and the [Interagency Working Group on Reproductive Health in Crises report on Approaching Implementation of Respectful Maternity Care in Humanitarian Settings](#). Strategies identified by these guidance documents and recommendations include training for health providers, ranging from pre-service training to values clarification exercises; facility-level mechanisms for remedy and redress, such as patient complaint processes; as well as enabling policies, such as a policy allowing laboring women to bring in a birth companion of their choice.

care in sub-Saharan Africa measured community satisfaction as a part of their theory of change (Hirschhorn et al., 2013). The evidence base is insufficient to state whether and in what circumstances such efforts influence respectful care.

A recent mapping review found that few studies directly link efforts to transform structural drivers, such as pervasive discrimination and gender inequity, to more respectful maternity care (Betron et al., 2018). The interventions in Kenya's Heshima Project included: advocating for respectful maternity care in the maternal health bill; supporting alternative dispute resolutions between communities and facilities; general awareness-raising on respectful maternity care as a rights-based approach for all; the development and enforcement of a local client charter; an anonymous client complaint mechanism; and anonymous client feedback surveys (Abuya et al., 2015). The project's evaluation found it contributed to a decrease in the prevalence of disrespect and abuse in maternity care from 20 percent to 13 percent, and the likelihood of patients experiencing some types of mistreatment and abuse were cut in half. Patient and infant detainment until medical bills were paid also declined, though there may have been additional policy explanations, such as free maternal health services in public health facilities being guaranteed as a constitutional right (Abuya et al., 2015). Since the project had multiple interventions, it is hard to determine the contributions of each intervention to the outcomes observed.

Grassroots-led efforts that are part of broader social movements—but less likely to be documented in peer-reviewed or gray literature—may tackle structural drivers of respectful care at multiple levels. For example, civil society members of the International Initiative on Maternal Mortality and Human Rights lead human rights-based approaches to addressing maternal mortality, including budget monitoring with a focus on funding rights-based care, and developing and tracking community-specific indicators for dignity (Jolivet et al., 2015).

Facility- and provider-level approaches

Specific reviews and studies at the facility level on constructs overlapping with respectful care, such as person-centered care and adolescent-friendly services, provide further insight into interventions used to increase respectful care. A 2018 review assessed 24 programs to improve person-centered care in reproductive health services, defining person-centered care as “dignity (i.e., receive care in respectful and caring setting), autonomy (i.e., involving women in decision-making), privacy/confidentiality, communication with providers/patients, social support in the facility, including family members, supportive care (i.e., timely, compassionate and caring manner of care), trust in providers, and health facility environment” (Diamond-Smith et al., 2018, p. 2). The study found that just under half of the programs reviewed aimed to increase the quantity and quality of the information provided to patients; other programs sought to enhance provider capacity to provide supportive care, promote dignity, provide social support, or enhance trust. Of the 11 studies that examined person-centered care as an outcome, nine found that the intervention had a positive impact (Diamond-Smith et al., 2018).

An evidence review regarding respectful maternity care was undertaken in order to inform the WHO Recommendation on Respectful Maternity Care (Bohren et al., 2020). This review identified five controlled experiments, finding that programs to promote respectful maternity care—such as training health care providers in values and attitudes transformation, disrespect and abuse monitoring, staff mentorship, improving privacy in wards, improving staff conditions, and educating women on their rights—appeared to reduce women's experiences of disrespect and abuse (Downe et al., 2018).

A review of 18 programs to improve health worker performance in delivering adolescent-friendly services found “no discernable patterns” in terms of the type of intervention and their relationship to various

dimensions of adolescent friendliness, defined as services that are accessible, acceptable, equitable, appropriate, and effective for adolescents (Denno et al., 2021). Overall, the authors concluded that while most programs employed staff training as a key strategy, few described participatory or interactive training methodologies, both of which have a strong evidence base. Moreover, the majority of the adolescent-focused studies used two or fewer health worker performance interventions beyond training, despite the widespread finding in global health programs that training alone is insufficient (Denno et al., 2021). A realist evaluation assessing the implementation of adolescent-friendly services in Ecuador outlined a more participatory and comprehensive program, concluding that training and ongoing activities to promote “personal change” in the knowledge, values, and beliefs of health providers was key to achieving truly adolescent friendly services (Goicolea et al., 2012). It should be noted that a review regarding ways to promote respectful maternity care for adolescent mothers is ongoing (Habib et al., 2021).

Community- and patient-level approaches

Some papers note that patients and communities can be engaged in designing tools and programs to promote patient-centered care, including respectful care (Brault et al., 2021). Human-centered design takes participation a step further by involving stakeholders in identifying and describing the problem, designing and prototyping a solution, and putting the chosen solution into practice; this approach is increasingly used in global health efforts (Vohra et al., 2019; November 29, 2021).

Evidence gaps

There are substantial gaps in the evidence around effective approaches that influence respectful care, both in terms of health sub-fields (i.e., newborn, child, and adolescent health), and in terms of respectful care as an outcome. However, as evidenced by the reviews on person-centered care and adolescent-friendly services described above, there is other literature that can be reviewed to shed light on how respectful care can be improved. Moreover, possible intervention strategies, such as health worker training, have been subject to extensive research and evaluation across the RMNCAH continuum (Joynt, 2011; Rowe et al., 2019; Dieleman et al., 2009).

Existing evidence is related primarily to interventions and their evaluations, rather than to examination of national-level strategies or policies. The intervention-based literature has mostly focused on reducing disrespect and abuse in maternity care and/or improved communication between patient and provider. The elements of respectful care that are less commonly of focus in current intervention research include: having a companion of one’s choice, particularly outside of maternity care; ensuring that interactions with individuals or carers enhance informed decision-making beyond the provision of information from provider to patient/carer; the promotion of continuous support; and ensuring care is responsive to patient preferences, needs, and values, particularly outside of maternity care and outside the framework of culturally competent care.

SOCIAL ACCOUNTABILITY

CONCEPTUALIZATION

An overarching definition of accountability is “A condition in which individuals who exercise power are constrained by external means and by internal norms” (Chandler, 1988). *Social* accountability consists of “citizen-led, collective processes for holding duty-bearers (including politicians, government officials, and/or service providers) to account for their actions” (Squires et al., 2020). A recent literature synthesis explains that social accountability efforts can be undertaken at the national and sub-national levels and at the

“frontlines” of the system (Paina et al., 2019). This technical report focuses on frontline and sub-national social accountability programs, as these are often funded by development partners and thus of immediate interest to its readers. However, many of the frontline accountability practitioners cooperate with efforts at the sub-national *and* national levels, or they aggregate data from many communities to advocate for change at either the sub-national or national level. In addition to programs described as social accountability programs, those described as community engagement/participation and advocacy often employ social accountability strategies (Robinson & Adams, 2022).

The field of social accountability grew in part out of the recognition that state-centered accountability mechanisms were weak, including inadequate systems for legal remedy and redress, weak service delivery supervisory structures, and poor state regulation (Brinkerhoff & Wetterberg, 2016). New public management, decentralization, and other reforms had largely not resulted in the improved governance and service delivery at the frontlines that government planners desired. In its influential 2004 World Development Report, “The Voices of the Poor,” the World Bank described citizen engagement at the frontlines of service delivery as the “short route” to accountability; in contrast, voting (the long route), direct citizen engagement, or social accountability, would bring the priorities and collective power of service users to service providers (World Bank, 2003).

While a significant portion of the existing literature is not linked to an explicit theory of change (Marston et al., 2020), much of it explores the mechanisms of change associated with social accountability efforts. Analyses find that social accountability efforts create new processes for state-society interaction, such as community/health facility interface meetings, or democratize existing processes, such as Village Health Committee meetings (Samuel & Frisancho, 2015; Schaaf et al., 2017; Wild et al., 2015). In some contexts, existing structures that straddle the state-society divide, such as village health committees, are strengthened by social accountability efforts so that they function as key mechanisms³ through which collective goals are articulated and accomplished (Wild et al., 2015; Schaaf et al., 2020). These new and improved processes may become the “new normal,” such that communities and health providers and decision-makers enact more democratic means of engaging on issues beyond what a given social accountability program is intended to address (Schaaf et al., 2017). Many papers explain that these spaces provide an opportunity for health providers to learn about community priorities and concerns, as well as for communities to hear about health provider limitations and decision-space, giving them more realistic expectations (Gullo et al., 2016; Ball & Westhorp, 2018). This mutual trust-building is not necessarily confined to relationships between communities and health sector actors; many programs successfully engage political and community leaders who provide additional oversight to health sector response, as well as, potentially, knowledge and material resources that could facilitate health system responsiveness (Ball & Westhorp, 2018; Schaaf et al., 2017).

Theorists generally specify three ways that social accountability programs affect desired outcomes; they may: (1) increase the effectiveness of service delivery, (2) improve the quality of governance and democracy, or (3) empower individuals and communities (Brinkerhoff & Wetterberg, 2016; Joshi, 2014). Social accountability programs are premised on the assumption that information on rights, entitlements, and service quality among service users will lead them to make collective demands for improvement. In tandem, they assume that information on community priorities and health sector performance will spur action and responsiveness among service providers and policymakers. Common theories of change suggest that service providers respond for one or more of the following reasons: a) they have information that they were previously lacking

³ Here, we use the term “mechanism” to mean the underlying processes that operate in particular contexts to generate outcomes. This helps us to open the “black box” of change to understand how and to what extent various links in the conceptual framework are activated, and why (or why not).

and have pro-social motivations to improve; b) they gain greater empathy for community members; c) they feel shame for poor performance; d) they fear formal or informal sanctions from their supervisors/the health system hierarchy; and e) they feel indirect political pressure. Typical social accountability programs provide scaffolding for these changes by (1) sharing information with individuals and communities or supporting them to gather their own information, (2) boosting individual and collective capacity to make claims, and (3) facilitating an interface between communities and service providers (Boydell et al., 2014).

There are many different types of social accountability efforts seeking to improve health care access and quality. They range from program models developed by international nongovernmental organizations (NGOs) implemented in many different countries to distinct approaches developed and iterated in a particular context, such as among Indigenous communities in Guatemala (Gullo et al., 2016; Samuel et al., 2020). The majority of programs implemented to address health include a process of providing information to communities about their rights and entitlements, community and health provider assessments of current service provision against these rights and entitlements, and an “interface” meeting or dialogue, wherein community members and health providers identify priorities and create an action plan. There is great variation in the way these activities are completed, however. For example, there is a continuum of approaches to include marginalized groups in social accountability processes. Some implementers create standalone community meetings for such groups, e.g., youth-only community meetings. Others reach out to representatives of such groups and ask them to attend general community meetings. Still others make community meetings open to all (Gullo et al., 2016; Van Belle et al., 2018; Squires et al., 2020). Some social accountability programs use current health policy standards and data (e.g., local health facility data, such as the number of antenatal visits per pregnant woman or the number of vaccination days per year) as a yardstick for assessing service quality, while others include indicators reported by the community (e.g., reception at the local health facility at last visit). Many programs interact extensively with existing structures intended to increase community engagement or oversight, such as village health committees or Safe Motherhood Action groups, often “activating” these groups and/or building their capacity to fulfill their mandate (Marston et al., 2020; Robinson & Adams, 2022; Schaaf et al., 2017).

ENABLERS OF AND BARRIERS TO SOCIAL ACCOUNTABILITY

Many researchers and practitioners insist on the importance of political economy analysis⁴ and problem-driven approaches⁵ that focus on the contextual conditions in which these theories of change can be realized. A comprehensive World Bank review identified three key contextual factors, including the strength of civil society, the nature of state-society relations, and intra-society relations (e.g., social cohesion) that influence whether or not—and how—social accountability efforts are effective (O’Meally, 2013). Similar factors are described in other analyses of social accountability programs (Blake et al., 2016; Nove et al., 2019; (Lodenstein et al., 2017; Sebert et al., 2017). The role of contextual factors may be distinct for particular reproductive and maternal health concerns and especially among adolescents (Boydell et al., 2019). For example, even in settings where unmarried individuals have a legal right to access contraception, access may be a socially contentious issue, complicating social accountability efforts to promote respectful contraceptive care for unmarried individuals (Schaaf et al., 2022). To ensure that social accountability programs respond to these contextual factors, researchers and program planners increasingly integrate processes for co-design

⁴ A political economy analysis is a structured approach to examining power dynamics and economic and social forces that influence development (Center of Excellence on Democracy, Human Rights, and Governance, April 2018).

⁵ “Problem-driven approaches” is a method used within political economy analysis that identifies a specific development challenge, analyzes the political economy drivers (particularly structural factors) of the challenge, and identifies ways forward (The World Bank, 2014).

and iterative adaption of existing approaches (McMullen et al., 2021; Arkedis et al., 2021). Yet, while the importance of context is widely recognized, recent reviews note that many research studies do not engage deeply with political, historical, and geographical context, making it difficult to draw lessons about effective strategies to accommodate or influence contextual factors in social accountability efforts (Marston et al., 2020; Van Belle et al., 2018).

EVIDENCE OF EFFECTIVE SOCIAL ACCOUNTABILITY APPROACHES FOR HEALTH

Given the documented literature and acknowledging the variety of social accountability approaches and research, we first present evidence regarding the influence of social accountability approaches for health in general, and then present evidence for social accountability approaches for RMNCAH specifically. The strength of the evidence of effect is variable across health and also across RMNCAH.

Evidence regarding social accountability and health

One randomized control trial to evaluate the impact of social accountability on health comes from Uganda. As part of a seminal 2004 “Power to the People” study in Uganda, participating community-based organizations set up community meetings, health facility staff meetings, and health facility staff/community interface meetings and aimed to strengthen local capacities to hold local health facilities accountable for improved health services. Along with the general public, individuals from marginalized groups (e.g., youth, older people, people with disabilities, women) were invited to the community and interface meetings. Health sector performance data discussed at these meetings were drawn from a household survey and from a health facility assessment, including how the local facility performed according to the regional averages (Björkman & Svensson, 2007). Action plans were developed at the community, health facility staff, and interface meetings with specified roles and a timeline for task completion for each. Implementation was monitored through follow-up meetings (Björkman & Svensson, 2007). The study found statistically and programmatically significant differences between the treatment and control villages in post-intervention measures of infant weight, under-5 mortality (a 33 percent reduction in child deaths), place of delivery (i.e., at home or at the health facility), and the use of antenatal care and family planning. The researchers also found improvements in immunization rates, waiting time, quality of examinations, and absenteeism, and hypothesized that these changes drove the improvements in health outcomes (Björkman & Svensson, 2007). The study, however, did not note whether any of the improvements seen were related to the definition of respectful care used in this review.

Subsequent quasi-experimental studies have found mixed results for the key morbidity and mortality outcomes measured. These studies have tested varying types of information provision and facilitation (such as interface meetings). Theories of change have typically included social accountability-related constructs, such as the development of mutual trust, as well as classic health behavior models, working from the assumption that the provision of information on health care issues and entitlements will impel community members to seek health care. One study attempted to replicate the Uganda study, resulting in statistically significant—but programmatically not very significant—impacts on treatment quality and patient satisfaction. However, there was no evidence that treatment quality was affected by citizen monitoring, and the intervention had no effect on utilization rates or on child mortality at both eight and 20 months after the intervention (Raffler et al., 2019). Several possible reasons for these disparate findings have been raised, including that significant improvements were possible in the context of Uganda’s very high child mortality rate at the time of the original Power to the People study, while there was much less “low hanging fruit” at the time the second study was conducted 10 years later (Raffler et al., 2019; Christensen et al., 2021). Like the original study, the outcomes of interest in this study, while including treatment quality and patient satisfaction, did not look specifically at respectful care but more broadly at experience of care.

Subsequent studies in high mortality settings have found more robust impacts on both intermediate and outcome indicators, lending some credence to the baseline mortality thesis (Raffler et al., 2019). For example, Mohanan et al. (2021) found that information plus facilitation had a statistically and programmatically significant impact on health care utilization and maternal and child health outcomes, including institutional delivery, stunting and underweight, and immunization rates. “Lighter touch” versions of Power to the People, however, failed, with a randomized control trial in Indonesia and Tanzania finding no effect on any of the constructs in their causal pathway, including civic participation, maternal and newborn health quality of care (as reported by women in the community), and health outcomes (Arkedis et al., 2021). In-depth qualitative work shed light on these null effects, raising questions about dose and sustainability, as 18 months after the end of the project, only 35 percent of participants could remember one tangible improvement resulting from the project (Arkedis et al., 2021).

While experimental studies are important to the evidence base and donor priorities, some social accountability experts point out that the dictates of experimental study design limit the types of social accountability efforts that can be studied using these methods. Most programs assessed through experimental methods are designed *a priori* and cannot be adapted, and they are assessed in isolation from other efforts and campaigns. However, there is widespread agreement in the field of social accountability that multi-pronged and multi-level efforts are more likely to bear fruit (Fox, 2019; Bailey & Mujune, 2021). Moreover, experimental and quasi-experimental analysts may draw erroneous conclusions (e.g., “bottom-up approaches do not work”) based on limitations related to intervention dose (duration and scope), and measures lacking construct validity because they fail to capture the nature of key processes, such as participation, monitoring, and sanctions (Fox, 2019).

While the number of experimental studies is relatively small, there is a large body of qualitative research exploring the effect of social accountability on RMNCAH. Many of these studies described complex programs that have adapted over time, some of which might be part of a larger civil society strategy to effect change in health care quality. As such, they offer significant insight into strategies, processes of change, and the relationship between programs and context. These studies generally assess small-scale programs, limited to just a few health facilities or districts; as they are largely cross-sectional in design, they are vulnerable to biases related to recall and other factors. For example, programs that use community scorecards (CSCs) often use changes (or lack thereof) in scorecard scores themselves as an evaluative tool (Laterra et al., 2020; Ball & Westhorp, 2018; Bailey & Mujune, 2021). Where CSCs are used at multiple time points, they can be a useful tool to show the rate of change, though perceptions-based scorecards are vulnerable to bias. For example, in their study of a CSC program addressing child health, Ball and Westhorp (2018) identified leveling off of effect in the program’s second year, with some indicator values remaining the same and a few dropping below the high they had reached after one year of program implementation.

The findings from qualitative studies often show that HCWs and health decision-makers become more effective, accountable, and responsive following a social accountability intervention. There is widespread agreement in the literature that program participants gain valuable knowledge about their rights and entitlements and report feeling more confident and capable in interacting with health providers and other individuals with power (Gullo et al., 2016; Samuel & Frisancho, 2015; Ball & Westhorp, 2018; Boydell et al., 2018; Schaaf et al., 2017; Lodenstein et al., 2017; Papp et al., 2013). Program participants and researchers also note improvements affecting their overall experience of care, such as: HCWs’ compliance with official working hours (Gullo et al., 2016) and/or more convenient opening hours (Edward et al., 2020); increased availability of supplies and equipment and improvements in health facility infrastructure and hygiene (Boydell et al., 2018; Gullo et al., 2016; Robinson & Adams, 2022; Blake et al., 2016; Edward et al., 2020; Ho et al., 2015; Schaaf et al., 2017); and increased numbers of qualified health providers at the facility (Gullo et al.,

2016; Laterra et al., 2020; Samuel & Frisancho, 2015; Ball & Westthorp, 2018; Boydell et al., 2020; Robinson et al., 2019).

Evidence regarding social accountability and RMNCAH

As noted above, many social accountability and health programs focus on primary health care. The social accountability programs addressing RMNCAH typically focus on maternal and child health or reproductive health. There is little specific to newborns, although postnatal care is sometimes included in maternal health programs. While the literature on disrespect and abuse in maternity care and quality of family planning care identifies adolescents and younger mothers as being more likely to experience disrespect and poor-quality care (Bohren et al., 2019; Chandra-Mouli et al., 2014), there is little evidence about adolescents in the context of social accountability. There is increasing investment in youth-led social accountability, however, so evidence production is possible (UNFPA and Restless Development).

This review attempted to summarize the empirical evidence on the links between social accountability and respectful care across the RMNCAH continuum. However, no study or evaluation of social accountability approaches identified reported isolating and examining respectful care, or related concepts such as person-centered care, as an outcome. A few studies explored the relationship of social accountability interventions to the broader construct of quality of care, and the related measure of patient satisfaction, as outcome.

BOX 4. SOCIAL ACCOUNTABILITY APPROACHES USED IN HEALTH AND DEVELOPMENT

The **Community Score Card (CSC)** methodology was pioneered in 2002 by CARE Malawi. It involves bringing together community members, health providers, and government officials to jointly identify issues women face when accessing health services and develop solutions for overcoming these quality and equity obstacles. By employing a collaborative approach, the CSC builds relationships and a mutual accountability process.

The **Partnership Defined Quality** methodology was developed in 2003 by Save the Children to improve the quality and accessibility of health services. It links quality assessment and improvement with community mobilization by involving health providers and the community in defining, implementing, and monitoring the quality improvement process. The Partnership Defined Quality process is often paired with other community interventions and relies on existing platforms, such as facility community committees, to engage facility staff and community members.

The **Citizen Voice and Action** approach was developed by World Vision to facilitate the transformation of the relationships between citizens, government, and service providers. Citizen Voice and Action begins with civic education on people's rights, entitlements, and responsibilities, followed by a social audit that allows the community to assess whether government services meet the existing standards as set by government. In a separate set of activities, communities use a scorecard to rank their satisfaction with those services. At a town hall meeting, they discuss their findings and recommendations with government representatives. Together, community members and government representatives agree upon an action plan to improve services. Communities then continue to work with government and other local partners to ensure that agreed commitments are met.

Site Walk-Throughs were developed by EngenderHealth to strengthen community-facility linkages. A Site Walk-Through is a guided tour of a health facility that provides an opportunity for community representatives to learn about the services that are available and the health problems in the community that the staff are trying to address. Site Walk-Throughs lead to increased awareness among community representatives about health services, the identification of priority problems and barriers to use of services, and the development of an action plan.

The descriptions of these approaches were developed based on information and literature shared by key informants during the stakeholder mapping. They include descriptions of community engagement strategies that may be broader than how some experts conceptualize and define social accountability.

CAN SOCIAL ACCOUNTABILITY IMPROVE RESPECTFUL CARE IN RMNCAH?

While social accountability strategies have been used to improve health, and RMNCAH care specifically, the idea of using social accountability to improve *respectful* RMNCAH care is new. However, given what we know about how social accountability works and the barriers and facilitators to respectful RMNCAH care, there are reasons to believe that social accountability is a promising strategy to improve respectful RMNCAH care. In this section we outline potential mechanisms for this relationship by first describing the evidence and evidence gaps around the influence of social accountability on respectful care, including within RMNCAH. We then describe key themes related to the intersection of social accountability and respectful care that emerged from our key informant interviews and focus group discussions with experts in the field. Finally, we

outline a theoretical framework and a proposed conceptual framework describing how social accountability approaches may lead to respectful care in RMNCAH.

EVIDENCE AND GAPS IN EVIDENCE TO DATE

EVIDENCE REGARDING SOCIAL ACCOUNTABILITY AND RESPECTFUL CARE

While some literature exists relevant to social accountability and its impact on **respectful care**, social accountability and respectful care is not a specific field of study. That is, respectful care is not typically identified as a distinct outcome in social accountability efforts, though some studies and programs address respectful care or collect related data. Some of these studies include measures related to respectful care, such as “improved information transparency” or “improved attitude, efforts, or trust of provider”, as part of their theory of change (Arkedis et al., 2021), but do not measure and/or present these in published analyses, focusing instead on health outcomes. Others include respectful care measures to assess comparability between treatment and control populations, but do not include these measures in their outcomes (Björkman & Svensson, 2007).

EVIDENCE REGARDING SOCIAL ACCOUNTABILITY AND ITS IMPACT ON RESPECTFUL CARE IN RMNCAH

There is almost no evidence base specific to social accountability processes of change regarding respectful care in RMNCAH. Nonetheless, we are able to look at literature on social accountability for health and pull out the measures that either fit within our working definition of respectful care (e.g., polite treatment) or overlap with our definition (e.g., patient satisfaction). The measures used or outcomes specified in the existing studies do not capture the full, multi-dimensional construct of respectful care. Our conclusions are therefore limited by the literature available.

Table 2 presents relevant quantitative studies, including a brief description of the intervention/program implemented, the measures of respectful care (or that are “respectful care adjacent”) they used, study outcomes, and the domain of RMNCAH health the program sought to address. We complement this table with a narrative summary of the non-experimental (quantitative pre- and post-test, qualitative, etc.) research on respectful care-related outcomes of social accountability. We then discuss what the literature as a whole reveals about the mechanisms of change. We explore how these mechanisms might play out in respectful care in RMNCAH.

TABLE 2. SUMMARY OF STUDIES ASSESSING SOCIAL ACCOUNTABILITY AND RESPECTFUL CARE-RELATED OUTCOMES IN RMNCAH

Citation	Social accountability program/intervention	Measure/scale/index	Outcome	RMNCAH Domain
Steyn et al., 2020 Community and Provider Driver Social Accountability	Introduction of social accountability to community participants and providers, followed by health, rights, and civic education with community participants.	General feelings about the reproductive health provider they saw Questions about whether the patient was	N/A Study not yet completed	Family planning

Citation	Social accountability program/intervention	Measure/scale/index	Outcome	RMNCAH Domain
Intervention (CaPSAI study)	The group rates existing services against rights-based standards and identifies local priorities, then bring these priorities to a larger community group, which collectively scores the issues and indicators and sets priority areas for action. Service providers have a similar process among themselves. There is a meeting between community and providers with joint action planning, with follow-up meetings at 3 and 6 months.	provided with information re: method Questions about privacy and confidentiality Wait time Awareness of social accountability activities		
Boydell et al., 2020 (CaPSAI study)		Mistreatment by HCWs Perception of quality		
Gullo et al., 2017 (CARE CSC)	Following a planning phase, during which facilitators are identified and local leaders and other stakeholders are sensitized to the program objectives, a CSC is completed through focus group discussions with community members (separated into groups such as men, women, youth, and others, depending on the card's sectoral scope) to identify and prioritize issues (e.g., service access, utilization, quality provision). The service providers go through the same process as the community. As	Overall service satisfaction (other outcomes assessed qualitatively)	Difference in difference analysis showed statistically and programmatically significant increase	Reproductive health (defined as antenatal care, prevention of mother-to-child transmission (PMTCT), maternity services, post-partum services, family planning)
Gullo et al., 2018 (CARE CSC)		Trust in HCWs (includes, among other factors, that the belief that the HCW is looking out of the patient's best interest and will maintain confidentiality) Mutual responsibility (includes assessment of one's ability to impact whether or not women are treated with respect by HCWs, and one's	Trust in HCWs negatively associated with participation in the CSC program. Subpopulation analyses for those who participated in a meeting were not programmatically significant; those receiving a home visit from a HCW were more likely to	

Citation	Social accountability program/intervention	Measure/scale/index	Outcome	RMNCAH Domain
	with the community discussions, similar types of providers were grouped together so that those at different levels in the health system feel more comfortable speaking candidly about the issues and barriers they face. This was followed by meetings between providers and communities and action planning, with follow-ups every 6 months.	<p>impact on making sure the poorest & most vulnerable women & children in the community receive care)</p> <p>Power-sharing (includes the belief that the community can influence health care service delivery)</p> <p>Service satisfaction</p>	<p>have increased trust scores</p> <p>Mutual responsibility negatively associated with participation in the CSC program. Subpopulation analyses for those who participated in a meeting were not programmatically significant; those receiving a home visit from a HCW were more likely to have increased mutual responsibility scores</p> <p>Power-sharing estimates were not significant in any analysis</p> <p>Women who indicated that CSC interface meetings had occurred in their community were less likely to be satisfied with health services than their counterparts.</p>	
Laterra et al., 2020		Providers' stigma and discriminatory behaviors	Reduction in prevalence of stigma and discriminatory behaviors	Maternal and child health (PMTCT)

Citation	Social accountability program/intervention	Measure/scale/index	Outcome	RMNCAH Domain
		<p>Providers' positive attitude and commitment</p> <p>Providers' support for HIV disclosure support</p> <p>Providers' respect for confidentiality</p>	<p>Improvements in positive attitude and commitment</p> <p>Improvements in support for HIV disclosure support</p> <p>Improvements in respect for confidentiality</p>	
Mohanan et al., 2018	<p>Intervention Arm 1: Information only included information provision on village-level health indicators for children under 5 relative to the district average, and on roles and responsibilities of a local health committee Village Health Sanitation and Nutrition Committee (VHSNC).</p> <p>Intervention Arm 2: Information plus facilitation. The villages in this arm received all information interventions as well as government-appointed facilitators to help activate and facilitate monthly VHSNC meetings. Village members were encouraged to attend the meetings and discuss issues in the village related to health, sanitation, and nutrition.</p>	Satisfaction with three different cadres of maternal and child health community health workers	Both arms of the study (provision of information only; information plus facilitated interface) had a statistically and programmatically significant impact on satisfaction with one cadre of community health worker (CHW), the CHW addressing maternal health care. The increase was larger in the information plus facilitation arm	Maternal and child health, with particular focus on nutrition
Raffler et al., 2019 (ACT Health)	"intervention delivered information about patient rights and responsibilities,	Patient satisfaction (includes perceived quality, polite	Small, but statistically significant increase	Primary healthcare

Citation	Social accountability program/intervention	Measure/scale/index	Outcome	RMNCAH Domain
	utilization patterns, and health outcomes at the local health center, worked with health center staff and community members to develop action plans in light of that information, and organized meetings between members of the community and health center staff to generate a joint social contract to guide both actors' future behavior and interactions"	treatment, whether patient felt free to express his/herself and listened to)	in patient satisfaction	
Christensen et al., 2021	"created scorecards ranking local health services; convenes interface meetings between community members and clinic staff to discuss these ratings and to develop joint action plans to improve service delivery; and follows up with meetings to monitor progress after one, three, and nine months"	Satisfaction with health workers	Satisfaction increased by 0.1 standard deviations among those living in treatment areas	Primary healthcare

These studies reveal a generally—though not entirely—positive picture of social accountability efforts leading to improvements in respectful care. For example, a large-scale study assessing change over time in the CARE CSC indicators as part of a program focused on the PMTCT of HIV in Malawi showed statistically and programmatically significant reductions in prevalence of stigma and discriminatory behaviors and improvements in positive attitude and commitment of service providers, HIV disclosure support, and respect for confidentiality (Lattera et al., 2020). However, there were negative associations between participation in the CARE CSC efforts and trust in health workers and mutual responsibility (Gullo et al., 2018). It is important to note that because these programs did not focus on respectful care as such, it can be somewhat misleading to look at these outcomes in isolation, as some of the respectful care indicators were used as part of a broader construct, such as mutual trust. Moreover, the respectful care outcomes may be related to other outcomes through feedback loops, or they may be one of several outcomes associated with a mechanism of

change, such as fear of sanction from one's supervisor. However, we present them in isolation here to illustrate the extent to which respectful care is addressed and measured in the existing experimental evidence base. Most of the studies below are quasi-experimental in design.

Qualitative research studies on various types of social accountability programs report improvements in reproductive, maternal, and primary health care service delivery, including respectful care, where relevant. However, the outcomes relevant to respectful care are often described in general terms. Several studies report that social accountability efforts have led to more patient-centered, respectful, culturally competent care, including the provision of more information to patients and culturally responsive birthing practices (Edward et al., 2020; Ho et al., 2015; Samuel & Frisancho, 2015; Schaaf et al., 2017). When asked about changes stemming from social accountability programs, some community members explained that health providers had become more polite (Wild et al., 2015; Schaaf et al., 2017), received patients better at the health facility (Gullo et al., 2017), or demonstrated greater care for the health of their patients (Hamal et al., 2018; Gullo et al., 2017). Of the programs that addressed HCW demands that patients make informal payments, many reported some reduction in this practice, though institutionalized barriers remained (Samuel & Frisancho, 2015; Boydell et al., 2018; Edward et al., 2020; Ho et al., 2015; Schaaf & Dasgupta, 2019).

While not necessarily the respectful care elements of interest to this paper, many studies report that the social accountability program resulted in improved client satisfaction and trust in health services, and in many cases increased utilization (Gullo et al., 2016; Laterra et al., 2020; Samuel, 2016; Samuel & Frisancho, 2015; Ball & Westthorp, 2018; Blake et al., 2016; Schaaf et al., 2017; Boydell et al., 2020). Trust emerged as a key mechanism and outcome, though the evidence regarding its link to the social accountability activities is muddy. As indicated in Table 3, Gullo et al. (2018) found that participation in the CSC program was **negatively** associated with trust in health workers in Malawi. This result raises the possibility that improved awareness of entitlements or service quality meeting with governmental failure to follow through on action plan commitments can undermine community trust (Gullo et al., 2018). However, this finding is surprising in light of the fact that, as part of the same study in Malawi, comparison of the scorecards themselves revealed improvements in the reported relationship between health workers and communities (Gullo et al., 2018). In contrast, a program in Sierra Leone found marked and sustained improvements in community trust in the health system. The West African Ebola epidemic allowed researchers to assess the medium-term impact of a community-based monitoring program on trust in the health system (Christensen et al., 2021). They compared Ebola case reporting rates in intervention and control communities after the program had finished, finding that villages exposed to the community monitoring program had case reporting more than 60 percent higher than control communities. The findings suggest a sustainable improvement in trust in the health system (Christensen et al., 2021). Similarly, a post-hoc study of the impact of a CSC program (addressing public services overall) in Ethiopia, Malawi, and Rwanda found improvements in mutual trust—that is, among community members, service providers, and local politicians—that had persisted several years after the end of the project (Wild et al., 2015).

Practitioners and researchers explain that the improvements in trust stem in part from the relationships and dialogue that occur in the social accountability program interface events (Hamal et al., 2018; Schaaf et al., 2017; Boydell et al., 2020). These spaces generally require careful preparation and facilitation, suggesting that “light touch” efforts may be less likely to be effective, as suggested by Arkedis (et al., 2021) and colleagues. These spaces are a component of program activities and may become a vehicle for improvements in the quality of governance and democracy, at least in the context of health service governance at the local level (Gullo et al., 2016; Samuel & Frisancho, 2015; Boydell et al., 2018; Ball & Westthorp, 2018); Schaaf et al., 2017) and transparency in health facility operations and decision-making (Ho et al., 2015; Boydell et al., 2020).

Community ability to influence health provider and decision-maker behavior can be framed as a shift in power relations; however, few studies explored power dynamics within RMNCAH. The broader literature on social accountability and health suggests that shifts in power relations are possible in part because community members feel more empowered as a result of learning about their rights and entitlements and having the opportunity and legitimacy to address representatives of the state—HCWs and decision-makers—with their feedback (Ball & Westthorp, 2018; Schaaf et al., 2017; Papp et al., 2013). Moreover, in contrast to many efforts to gather patient feedback, such as patient suggestion boxes, social accountability entails collective action. Feedback from a group—especially if that feedback is gathered through a transparent process—is harder to dismiss than feedback from a single individual (Ball & Westthorp, 2018). Indeed, the perceived legitimacy of rights claimants is key. The creation of new mechanisms for soliciting community input and facilitating interactions with duty bearers may enhance legitimacy and create space for “micro-transgressions” of existing power dynamics (Lodenstein et al., 2017; Scott et al., 2017, p. 9). These micro-transgressions may engender a situation in which reproductive health issues that were heretofore taboo, such as family planning, can become an issue of legitimate public dialogue (Boydell et al., 2020).

Health care actor perceptions of community legitimacy shape the health system responsiveness to social accountability programs; this raises questions about equity and agenda-setting. For example, one paper documented findings from an analysis examining 10 years of an NGO’s social accountability work with Dalit and Muslim women in India (Dasgupta, 2011). The analysis uncovered numerous challenges in applying rights-based frameworks in contexts where marginalized communities lack the confidence and resources to make claims against the state. An individual’s lack of confidence and internalized stigma can also impede the development of a sense of shared injustice and solidarity that enable collective action (Boydell et al., 2019). These factors may be especially relevant in the domains of RMNCAH where stigma and norms regarding sexuality—namely, reproductive, maternal, and adolescent health—are important.

In some contexts, individuals who point out disrespectful care or who ask for better quality face a real risk of retaliation, such as being denied care for themselves or their children at their local health facility (Bailey & Mujune, 2021; Schaaf & Dasgupta, 2019; Nove et al., 2019). Moreover, in the context of hierarchy within the health system coupled with social hierarchies related to gender, ethnic group, caste, religion, and other factors, health providers and decision-makers may not perceive themselves as accountable to marginalized groups (Dasgupta, 2011). Indigenous citizen monitors in Peru report that many of the “everyday injustices” they had been able to decrease return to practice when they are not present in the health facility, suggesting an inadequate level of commitment to change among health providers (Samuel, 2016). Some programs try to forge and strengthen community relationships with NGOs, other community groups, and leaders in order to legitimize community demands, but there is a risk that these relationships are managed by the more elite members of the community acting as gatekeepers (Boydell et al., 2020). In other words, the community members who functionally represent community demands may be those who already had the most power. This has implications for the kinds of issues that can be raised through social accountability efforts, as well as the extent to which intra-community power dynamics change. Some of the larger quantitative studies have identified inequities in the distribution of positive impacts resulting from a social accountability program (Edward et al., 2020). Few studies explicitly explore how social accountability program influence equity, though many programs aim to empower marginalized groups (Squires et al., 2020).

BARRIERS TO IMPACT OF SOCIAL ACCOUNTABILITY ON RESPECTFUL CARE IN RMNCAH

The studies reviewed described barriers to change. Here, we summarize key barriers and explore how they might relate to respectful care in RMNCAH.

Many studies report that social accountability programs are more successful at effecting change that can be made solely at the local level, as opposed to changes that required input or decisions from higher levels of the health system and government (Gullo et al., 2017; Samuel & Frisancho, 2015; Blake et al., 2016; Laterra et al., 2020; Wild et al., 2015). Some of these “more easily solvable” frontline issues are key to respectful care, such as patient reception, but some system-wide problems are also key to dignified care, such as availability of human resources and equipment (Samuel & Frisancho, 2015). Many social accountability efforts also assume that communities are able to access or produce accurate data on performance, including regarding potentially sensitive issues, such as discrimination or corruption (Joshi, 2014).

Lack of responsiveness can undermine trust and investment in a social accountability program, as participants see that their engagement did not result in the improvements desired (Gullo et al., 2016). Some program implementers try to enhance government responsiveness by aggregating local-level challenges from multiple sites and sharing these with higher-level authorities (Schaaf & Dasgupta, 2019; Samuel & Frisancho, 2015). Government-run community participation programs offer some lessons in terms of “vertical integration,” that is, addressing accountability failures at multiple levels of the government at the same time (Fox, 2015). For example, the Mama Ye program in Nigeria entailed the creation of maternal, newborn, and child health state-led accountability mechanisms, co-chaired by civil society and government representatives. These mechanisms created scorecards for facility performance, illustrating gaps at the local level, as well as state- and national-level patterns, resulting in budgetary increases, state-level directives, and other system-level changes (MamaYe and Options, 2019).

In Table 3 below, we present the factors identified relating to the context, mechanisms, and outcomes for social accountability and respectful care in the literature. This table is meant to spur thinking about program considerations; it can serve as a nascent theoretical synthesis of empirical findings. It is important to note that the literature is heterogenous and research does not address respectful care *per se*. The relevance of particular factors depends very much on context. The factors listed are not all comparable within the same category; for example, some mechanisms are at higher levels of abstraction than others. Moreover, the table does not incorporate key elements of a theory of change, such as changes over time and feedback loops. As noted, positive results from social accountability programs can deepen trust, spurring a virtuous loop of further responsiveness. The opposite is also true; early success followed by a lack of responsiveness can instigate a downward spiral of trust.

TABLE 3. FACTORS RELATED TO CONTEXT, MECHANISMS, AND OUTCOMES FOR SOCIAL ACCOUNTABILITY FOR HEALTH, WITH A FOCUS ON RESPECTFUL CARE

Program Micro-Context		Mechanisms		Outcomes
How health care providers and decision-makers perceive the legitimacy of the community making claims and of claims made		Change of provider/decision-maker behavior due to professional, pro-social motivation		Patient satisfaction
Extent to which marginalized groups engaged in social accountability effort		Change in provider/decision-maker behavior due to fear of sanction from ministry of health hierarchy or political structure		Respectful maternity care (observed)
				Information provision during a clinical/counseling encounter
				Privacy confidentiality

Program Micro-Context		Mechanisms		Outcomes
<p>Extent of knowledge regarding rights, entitlements, and state processes among patients/community</p> <p>Extent of knowledge regarding health provider limitations among patients/community</p> <p>Extent of knowledge among providers and decision-makers of patient/community priorities</p> <p>Extent of knowledge about RMNCAH rights and entitlements among local political leaders</p> <p>Extent of trust between community and health providers/decision-makers</p> <p>Extent to which structures that straddle the state/society divide, such as village health committees, solicit and represent community priorities</p> <p>Transparency, inclusion, and participation in social accountability interface processes</p> <p>Provider decision-space at the facility level</p>		<p>Change in provider/decision-maker behavior due to shame</p> <p>Financial resources allocated by political/bureaucratic leadership due to collective pressure</p> <p>Greater alignment among local political, civil society, and bureaucratic (administrative) leaders</p> <p>Greater willingness to discuss heretofore taboo RMNCAH issues within the community</p> <p>Greater willingness to discuss heretofore taboo reproductive, maternal, and adolescent health issues within the health system</p> <p>Health system accountability/quality assurance mechanism triggered at subnational/national level due to political pressure</p> <p>Citizen/community confidence and ability to navigate interface opportunities, administrative structures, and/or processes for remedy and redress</p>		<p>Polite treatment</p> <p>Perceived quality of care</p> <p>Willingness to seek care</p> <p>Perceived commitment of service providers</p> <p>Trust in service providers</p> <p>Mutual trust</p>
Macro-context: Social hierarchies (e.g., based on gender, religion, ethnicity, age), funding for the health sector, health system characteristics				

MAPPING THE STAKEHOLDERS AT THE INTERSECTION OF SOCIAL ACCOUNTABILITY AND RESPECTFUL CARE

Below, we summarize information gathered from key informant interviews and focus group discussions with key individuals and groups engaged in research and/or implementation at the intersection of social accountability and respectful care for RMNCAH. In addition to their time and knowledge of work occurring or planned in this field, participants also shared additional resources for inclusion in this review. See Appendix B for a list of key informants and a mapping of social accountability activities by organization, approach,

geography, and technical area. This section provides an overview of key themes and findings from the stakeholder mapping.

Stakeholders. Interview and focus group participants were asked to list the organizations they considered to be the leading funders, researchers, and implementers of work at the intersection of social accountability and respectful care for RMNCAH. Several stakeholders felt unable to name specific organizations due to their niche focus or lack of familiarity with global efforts on the topic.

TABLE 4. MAIN FUNDERS, RESEARCHERS, AND IMPLEMENTERS OF WORK AT THE INTERSECTION OF SOCIAL ACCOUNTABILITY AND RESPECTFUL CARE

Funders	Researchers	Implementers
<ul style="list-style-type: none"> • USAID • Bill & Melinda Gates Foundation • Foreign Commonwealth and Development Office • William and Flora Hewlett Foundation • Open Society Foundation • European Union • Merck for Mothers 	<ul style="list-style-type: none"> • WHO • Averting Maternal Death and Disability at Columbia University (AMDD) • Population Council • University Research Co. (URC) 	<ul style="list-style-type: none"> • CARE • Save the Children • World Vision • White Ribbon Alliance (WRA) • Jhpiego

Evidence generation. Several organizations have conducted research to strengthen and synthesize the evidence base related to social accountability. WHO conducted a systematic review to measure the effects of social accountability interventions in RMNCAH, as well as a “review of reviews” that summarizes the current evidence on social accountability for RMNCAH. Under the Health Evaluation and Applied Research Development (HEARD) project, URC developed a tool to assess the success of social accountability mechanisms that have been institutionalized in Rwanda and Malawi.

In terms of research related to respectful care in RMNCAH, WHO conducted measurement reviews of experience of care and respectful maternal and newborn care. WHO is also conducting a review of five different aspects of respectful care—stigma and discrimination, physical and verbal abuse, communication, health systems and health workforce, and power—to identify the strategies and pathways to improve respectful maternity care. In collaboration with UNFPA, WHO, and UNICEF, and with engagement of a broad base of stakeholders, the Averting Maternal Death and Disability project (AMDD) is re-envisioning the emergency obstetric and newborn care global framework developed in the 1990s; changes include the potential addition of an experience of care indicator.

Few organizations are conducting research focused on the intersection of social accountability and respectful care due in part to the lack of a standard measurement for respectful care. Research to improve metrics around experience of care, including respectful care, is being conducted by Patience Afulani (et al., 2019) and colleagues. Rima Jolivet (et al., 2021), Katherine Semrau, and colleagues, while not working directly in the intersection of social accountability with respectful care, are reviewing pre-service training for evidence of elements of respectful care as per their recent review, which would influence what aspects of services could be better held accountable by communities through social mechanisms.

Social accountability interventions used to improve respectful care. CSC, Partnership Defined Quality, and Citizen Voice and Action were the main social accountability approaches used by stakeholders to enhance respectful care in RMNCAH services. These participatory approaches aim to build trust and a mutual accountability process by bringing health providers and community members together for dialogue about quality health services. Social accountability approaches are adapted based on context-specific factors, including the openness of the civil society space and the history and experience of both rights holders and duty bearers in a specific context. CSC, Partnership Defined Quality, and Citizen Voice and Action have each been applied and adapted for particular contexts by a variety of organizations across a range of sectors—health, water, sanitation—and countries. See Box 4 for a description of these approaches. Other social accountability approaches include facility walk-throughs and media engagement.

To organize collective opinion and make it harder for the issues faced by communities to be disregarded by decision-makers, several organizations, including the White Ribbon Alliance (WRA) and the Africa Health Budget Network, engage journalists to amplify messages. For example, WRA trained midwives in Malawi to be citizen journalists who could report on the conditions in health facilities.

Several organizations go beyond traditional social accountability approaches and include a redress and/or legal empowerment component. WRA and the Africa Health Budget Network work with regulatory agencies to ensure that those responsible for providing oversight of health providers receive complaints directly from patients and that patients can report negligence/malpractice and seek redress. The Center for the Study of Equity and Governance in Health Systems (CEGSS), which works with Indigenous communities in Guatemala, has documented cases of discrimination and human rights violations by providers. CEGSS combines social accountability interventions with legal empowerment in its interventions.

Relevant communities of practice. The Committee of Practitioners in Accountability and Social Action in Health is a bottom-up learning global network of community practitioners primarily from the global south, working to strengthen the linkages between communities and health systems to provide quality and accountable health care. It is composed of several hundred individuals/organizations from Africa, Asia, and Latin America and is currently hosted by the Africa Health Budget Network. WHO hosts a community of practice on measuring social accountability in RMNCH, as well as the Partnership for Maternal, Newborn, and Child Health (PMNCH). PMNCH is developing a digital compendium of social accountability tools for adolescents' and women's health. Through the Global Partnership for Social Accountability, the World Bank provides grants to civil society organizations to develop social accountability interventions related to health, education, water, social inclusion, climate change, and resilience; several of the health-related grants have included a component related to improving the experience of care, which includes components of respectful care.

Potential pathways of change from social accountability to respectful care. Interview and focus group participants shared several pathways observed through their work by which social accountability interventions can enhance respectful care in RMNCAH. Social accountability activities can be a powerful conscientization process for both health providers and clients. Social accountability interventions allow community members to understand themselves to be rights-holders and become empowered to claim their entitlement to health and quality health care services at the individual and community level. Similarly, health providers can be empowered by the process to claim what they need to provide quality services and not just be held responsible. Social accountability interventions can also improve the relationships between health providers and clients and allow each party to gain an understanding of the constrained environment the other party is operating in. When communities have a better understanding of the structural difficulties on the provider side, they have a better understanding of the barriers to respectful care, which leads to improved problem-solving. Social accountability interventions can have a ripple effect: Once a community is

conscious of their right to respectful care and receives respectful care in one area, they will want it every time they access health services. Following social accountability interventions, clients report feeling heard and more satisfied with the care they receive.

Challenges and Gaps. Key informants identified several challenges and gaps related to social accountability and respectful care in RMNCAH. Social accountability and respectful care are defined differently by different stakeholders. For example, while many definitions of social accountability include holding duty bearers accountable, the definition used by the WHO focuses on community participation. Concerning respectful care, organizations use different terminology to refer to similar concepts. For example, some stakeholders use respectful care while others prefer using patient-centered care as they consider it to be more aligned with the broader global health community. WRA considers that respectful care is something that only the person receiving services can determine and prefers to not define this term. Lastly, some stakeholders felt that not all components of the respectful care definition as it is defined for the purposes of this activity are well-suited for child health and immunizations.

In part due to the lack of standard definitions, there is a lack of uniformity in measurements related to social accountability and respectful care, which impacts comparability. Because there is a variety of social accountability approaches, there are no standard indicators for social accountability. Moreover, current social accountability indicators measure process (e.g., has an action plan been developed?) rather than the effects within the health facility. Respectful care indicators are not institutionalized in monitoring and evaluation frameworks, nor are they necessarily suitable for routine capture through existing systems. Some stakeholders highlighted that it can be challenging to measure respectful care using quantitative measures given that the construct is ultimately experiential.

There are several research gaps related to social accountability and respectful care. There is a lack of research assessing whether social accountability is an effective method for addressing respectful care, which types/characteristics of social accountability interventions are most commonly effective, and under which context and conditions it is so. This is in part because social accountability is a broad, complex, multi-stepped, and sometimes lengthy process. Additionally, given that social accountability (both the process and desired outcomes) is context-specific, it is not possible to examine the level of relative effectiveness of interventions by comparing different types of social accountability across different contexts. The specificity of the local context can also make it difficult for projects to achieve the same results in different contexts due in part to the lack of research on which contextual factors are most amenable to different types of social accountability approaches. Furthermore, the ways in which social accountability interacts with other interventions to affect the experience and provision of respectful care are also unknown.

There is also a lack of research related to the effectiveness of social accountability and respectful care in fragile and humanitarian settings, as opposed to development contexts. Some stakeholders feel that there are challenges intrinsic to fragile and humanitarian settings for social accountability, including lack of time for consultation in sudden onset disasters, poor understanding of power dynamics within affected populations, and lack of relevant skills among humanitarian providers. Considerations and adaptations made in fragile and humanitarian contexts should be documented. In terms of respectful care, one key informant noted that respectful care is the first thing to go during periods of crisis and pointed to birth companions not being allowed during deliveries in high-income countries during the initial phase of the COVID-19 pandemic as an example.

There is also a lack of research on the role that working conditions for health facility providers and community health workers plays on their ability to provide respectful care. Addressing the working conditions and needs of providers was identified as a gap in addressing the provision of respectful care.

Health providers work in constrained environments and can themselves be subject to mistreatment and abuse by their employers and managers, which impacts their ability to provide high-quality services and hold the health system accountable.

Lastly, there is a lack of research on what is required for social accountability efforts to be sustainable at multiple levels of the system and what measures are needed to prevent fallback once gains are achieved. For example, while interactions between community members, health providers, and policymakers are considered to be a required ingredient for sustainable social accountability efforts, there is a lack of research on which elements of those interactions are particularly important for sustainability.

There are several challenges identified related to the funding environment. Most social accountability projects are externally funded, which has implications for sustainability and scale-up. Short implementation periods can lead to activities that are not the most effective being implemented (e.g., curtains for privacy) and to interruptions and/or cessation of activities based on project cycles. Moreover, projects can be structured in a way that does not allow for the flexibility and iteration needed for social accountability activities to be successful. Additionally, it can be difficult to see the impact of social accountability interventions in short implementation periods. Lastly, the amount of donor resources and attention dedicated to social accountability is inadequate, with social accountability tending to be an aspect of broader projects rather than the primary focus.

There are several programmatic challenges related to navigating the power differentials, underlying social hierarchies, and inequities. While respectful care is intuitively understood by public health practitioners and researchers, it is perceived to be challenging for patients to separate respectful care from the overall experience of care. Some stakeholders purported that the quality of some elements of care, such as adequate physical infrastructure, could be indirectly construed as a manifestation of respect.

Social accountability efforts more broadly focus on the overall experience of care and not only respectful care. In settings where disrespectful care is normalized, concerns around respectful care may not come up first in community processes. Further, respectful care may not emerge as a priority if individuals accessing health services have low expectations of care or perceptions of low self-worth.

Skilled facilitation involves giving people the space to talk through problems honestly while ending with a discussion about solutions. However, finding skilled facilitators from within the community who can guide community members and health providers through a defined process of dialogue can be challenging. If social accountability work is not well-facilitated, it can lead to more tension and conflict between groups than solutions.

Securing buy-in from health providers to participate in social accountability processes can be challenging given that claims of lack of respectful care can threaten their livelihoods. Additionally, health providers may lack the training to receive community feedback without resistance and there may not be a system in place for health service managers and providers to process and follow up on the feedback received.

Authentic, equitable participation of civil society at all levels can be challenging to achieve and at scale, given that social accountability efforts are implemented at the level of the lowest structure. In certain countries, the local political and cultural setting and norms may not provide a safe space for community participation to influence social accountability and civil society organizations may be operating in a more and more constricted environment. Even in contexts where there is an open space for civil society, the most marginalized groups and voices are not always included within those groups.

Some stakeholders consider that there is an inherent tension between the need for collaboration between community members and health providers and the need to report claims of abuse. As a result, they consider traditional social accountability interventions to be too narrow as they do not include a redress mechanism or legal empowerment.

Opportunities. Despite many challenges, stakeholders also observed key opportunities to advance work in this space. Social accountability and respectful care are two areas that are increasingly receiving interest. The COVID-19 pandemic drew attention to the need to improve the quality of health services. Increased attention to diversity, equity, inclusion, and gender transformative programming can be leveraged to support addressing the social-cultural context for health care provision. Further, digital health and social media offer an opportunity to better collect and understand public opinion. This interest represents an opportunity to learn about approaches that work in a systematic way.

The Bill & Melinda Gates Foundation is planning to support the development and implementation of a research and learning agenda, in partnership with the International Development Research Centre, in four to six countries to assess how social accountability interventions that enhance respectful care in RMNCAH can be scaled without losing the voices of women. USAID is planning a multi-country learning opportunity focused on social accountability, health workforce strengthening, and measurement. Family Planning 2030 (FP2030) conducted a mapping of existing accountability mechanisms that could be leveraged for family planning across the RMNCAH spectrum; based on this mapping, they are also developing a guidance and accountability framework with guidance for countries making commitments to a new FP2030 framework. USAID and the WHO are in discussions related to routinizing measurement of experience of care for MNH.

CONCEPTUAL FRAMEWORK

Based on current evidence around social accountability and its mechanisms, as well as the drivers and other considerations for respectful RMNCAH care, we outline ways in which respectful care in RMNCAH may be particularly well-suited as a specific outcome of interest to address in social accountability approaches. Table 5 maps attributes of social accountability and respectful RMNCAH care against key constructs in a social accountability conceptual framework, suggesting potential synergies and pitfalls.

First, social accountability programs typically entail members of the community assessing health system performance. Respectful care can and should be monitored—at least in part—by communities themselves.

Among the elements of quality of care, respectful care might be the most amenable to community monitoring. Community members can more easily assess factors such as dignity, confidentiality, and the provision of information than they are able to assess, for example, whether or not a health provider prescribed the correct medicine. Hence, health providers would know that patients with knowledge about respectful care may be assessing care as it is delivered, and that lack of respectful care may be brought up as part of social accountability activities, such as community dialogues. As a result, the external pressures brought by social accountability for respectful care may be greater than for attributes of health care that are harder for patients to assess. In addition, community monitoring might be the best way to assess certain attributes of respectful care, as some attributes cannot easily be tracked using routine health system monitoring. In contrast to top-down, state-run, accountability or quality assurance structures, local efforts, such as health facility monitors or community groups, are well-suited to document the “everyday injustices” that some marginalized groups experience, such as disrespect or coercive demands for informal payments (Samuel & Frisncho, 2015). Patient perceptions are critical for respectful care. Patients and communities may have their own priorities around receiving respectful care; social accountability mechanisms could be one way to gather and to share their priorities (Hoffman, 2014). Social accountability programs can collect

and collate qualitative feedback and transform this feedback into collective demands, allowing for context-specific formulations of concepts such as dignity, including pinpointing context-specific impediments to respectful care.

Second, many elements of respectful care are within the control of local health providers, such as polite treatment, respect for privacy, the provision of information, and compliance with consent processes (Laterra et al., 2020). Thus, local-level efforts could realistically engender improvements in respectful care, resulting in short-term improvements and building engagement among participants who see that the process bears fruit.

Third, social accountability efforts aim to change the power dynamics between health systems and patients and their families; such power dynamics are especially pertinent to RMNCAH. Power asymmetries are a characteristic of most health care interactions, where patients lack the information and expertise to judge clinical quality (Bloom et al., 2008; Tucker & Adams, 2001); social hierarchies also influence resource allocation and the way particular patients are treated. However, norms regarding gender and sexuality in particular pervade RMNCAH care, as the research on the drivers of mistreatment of women in maternity care elucidates. Beliefs about appropriate sexuality and motherhood underlie HCW behavior, including discrimination, respect for informed consent procedures, and the provision of information and dignified care (Squires et al., 2020; Schaaf et al., 2021; Boydell et al., 2019; Sen et al., 2020; Schaaf et al., 2021; Sadler et al., 2016). Employing varying strategies of cooperation and confrontation, many social accountability programs aim to change power dynamics at multiple levels of the health system. Indeed, changes in power dynamics are implicit in most social accountability theories of change, as communities are expected to become “empowered” and collectively muster the countervailing power required to change the behavior of providers and decision-makers (Boydell et al., 2014; Fox, 2015).

TABLE 5. MAPPING ATTRIBUTES OF SOCIAL ACCOUNTABILITY AND RESPECTFUL RMNCAH CARE AGAINST KEY CONSTRUCTS IN A SOCIAL ACCOUNTABILITY CONCEPTUAL FRAMEWORK

Formulation of collective demands	Health sector responsiveness	Empowerment	Factors that may stymie success
Respectful care is relatively easy to assess as compared to other attributes of quality	Many elements of respectful care are within the decision-space of frontline providers and health facility managers	Lack of respectful care is driven in part by stigma and social hierarchies; social accountability is designed to erode such hierarchies	Health system resourcing and management are very important to the delivery of respectful care; these factors are hard to address at the local level

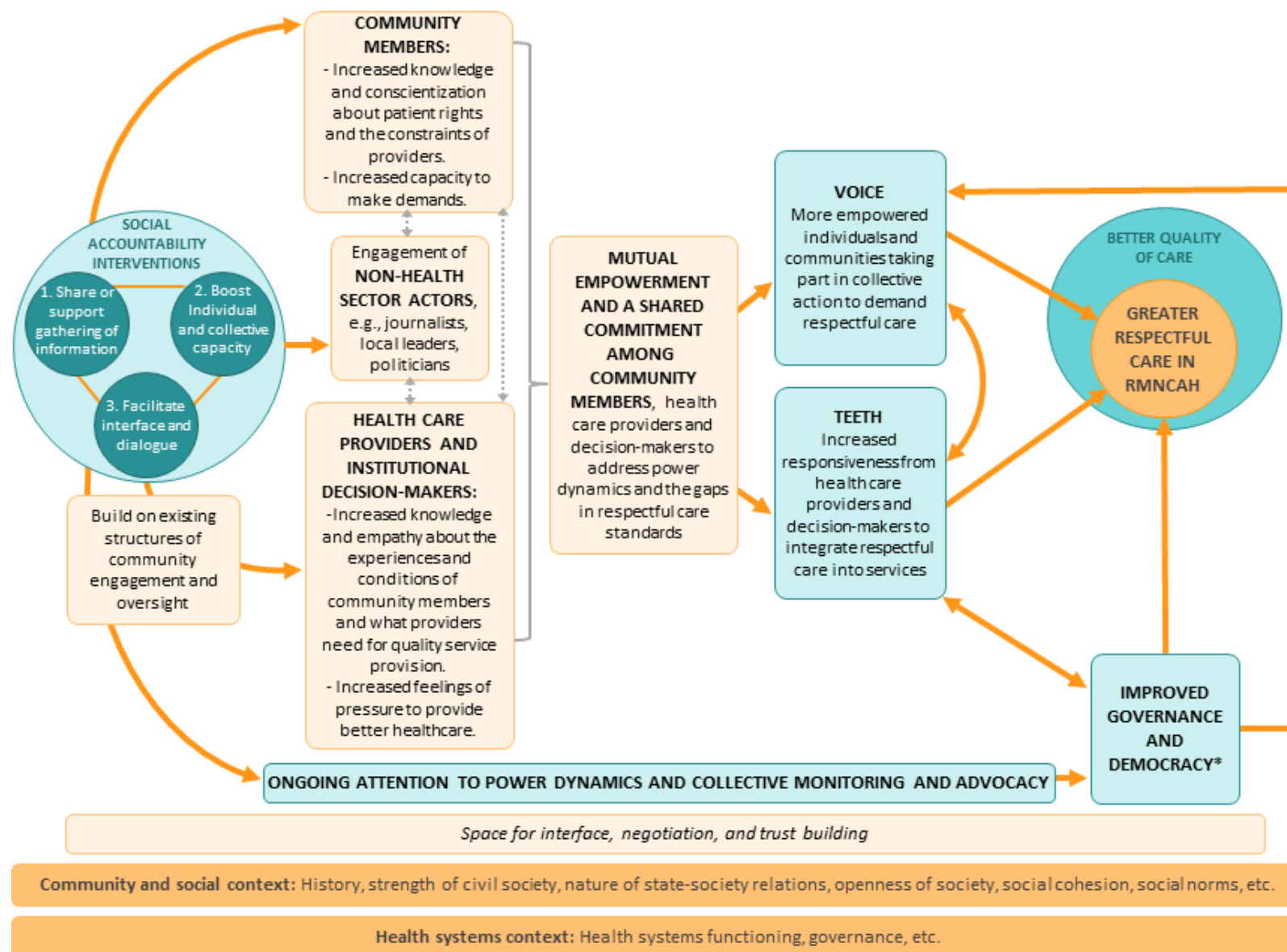
While social accountability could address respectful care for the reasons stated above, respectful care can also be a challenge to address through these mechanisms. First, because the assessment of some elements of respectful care, such as polite treatment, is considered to be “subjective” by providers or decision-makers, it can be harder for communities and organizations to make demands for respectful care than for more quantifiable elements of care, such as the number of maternity beds in a ward (Lodenstein et al., 2019). Second, power dynamics are not easily changed in a project timeframe, particularly when the relevant dynamics are embedded social norms and informal norms about “how works get done” in a given health system, and/or when the people asking for change are historically marginalized groups (Boydell et al., 2019; Behague et al., 2008). For their part, the people asked to respond to social accountability efforts—HCWs and

decision-makers—may react to claims made regarding RMNCAH differently than to claims in other areas. For example, providers may object to providing certain services (e.g., contraception) based on personal bias or incorrect information regarding national guidelines (Boydell et al., 2019).

Potential Pathways from Social Accountability to Respectful Care in RMNCAH

Based on the literature review and stakeholder mapping, this paper proposes a generic pathway from which social accountability may lead to respectful care in RMNCAH. The proposed conceptual framework is presented in Figure 3. It was developed by the authors based on 1) empirical evidence of social accountability interventions for health, and on 2) theories, including assumptions about causal links, described in the literature. Insights provided by key informants during interviews and focus group discussions augmented the information from the literature and were incorporated into the framework. Given that this is a higher order conceptual framework reflecting a generic social accountability approach within an unspecified context, each of the proposed pathways are informed by both the empirical evidence and by theory.

FIGURE 4. POSSIBLE CONCEPTUAL FRAMEWORK FOR THE INFLUENCE OF SOCIAL ACCOUNTABILITY ON RESPECTFUL RMNCAH CARE



*Potential of spillover to social accountability in other areas

In this conceptual framework, social accountability is a process by which, first, information on rights and entitlements is either shared with community members or community members are supported in gathering this information themselves. Then, the intervention strengthens individuals' and community collective capacity to make claims based on the information shared or gathered. Finally, the process facilitates interface and dialogue between community members and health providers and institutional decision-makers about the community's desired changes in quality of health care received, including respectful care.

This multifaceted and iterative process often builds on existing community engagement platforms and leads to an increase in knowledge and conscientization by community members about their rights and entitlement, state processes, and the constraints of providers. Community members also learn about local health service utilization patterns and health outcomes in their community. Furthermore, they feel increased confidence and capability in interacting with health care providers and other individuals with power, thus increasing their capacity to make demands.

Concurrently, health care providers learn about and empathize with the experiences of community members when seeking health services. Health care providers also learn what skills, tools, and support they require to provide quality health services, including respectful care and they feel internal and external pressure to provide higher quality health care to community members. These pressures may include feelings of shame for poor performance, fear of formal or information sanctions from their supervisors or the health system hierarchy, and indirect political pressure. Simultaneously, social accountability interventions often engage with non-health sector actors, such as traditional leaders, politicians, and journalists, who interface with both community members and health care providers. These non-health sector actors may facilitate negotiation between community members and health-care providers and decision-makers through amplifying the messages of community members; acting as interlocutors between parties; and identifying actional pathways through which community collective action can leverage responses from health care providers and decision-makers.

The increases in knowledge, conscientization, capacity, empathy, and feelings of pressure, along with the interaction of community members and health care providers and decision-makers with non-health sector actors, lead to mutual empowerment and a shared commitment among all parties to address power dynamics and the gaps in respectful care standards. Community members are then motivated from having participated in this process and the initial success, and they strengthen and harmonize their VOICE to continue to take part in collective action to demand respectful care. These demands may include participating in the budgeting of sub-national and health facility resource allocation; community monitoring of health care provider behaviors related to respectful care; negotiation with health care providers of expected respectful care actions; and social audits of sub-national and health facility policies and processes that influence or are related to respectful care. Concurrently, the empowerment and commitment experienced by health care providers and decision-makers lead them to be more responsive to community members' requests and demands, and to provide TEETH to integrating respectful care into services. They may do this through allocating larger portions of sub-national resources to RMNCAH services; instituting social rewards and sanctions for health care providers, based on their behaviors related to respectful care; and negotiating with communities or interlocutors about respectful care actions of health care providers and sub-national and health facility policies and processes that influence or are related to respectful care.

Over time, this leads to the provision of greater respectful care in RMNCAH. Given the iterative nature of social accountability, the community remains attentive to the power dynamics between communities and health care providers/decision-makers and engaged in monitoring and advocacy activities throughout the entire process, leading to improved governance and democracy. Improvements in governance and democracy may, in turn, lead to greater responsiveness from health care providers and decision-makers to

integrate respectful care into services, resulting in a feedback loop between TEETH and governance and democracy. Moreover, the space for interface, negotiation, and trust-building between communities, health care providers/decision-makers, and non-health sector actors is created (or enhanced) and nurtured and underpins the entire process. Individuals who have experienced respectful care when accessing RMNCAH services may expect to experience it in other areas and may undertake other social accountability interventions focused on other areas.

Context underlies every aspect of this conceptual framework and directly and indirectly shapes the processes and outcomes. The community and social context, including the strength of civil society, nature of state-society relations, openness of society, social cohesion, and social norms, as well as the health systems context, including the health systems functioning and governance can enhance or entirely stymie social accountability.

While not represented in Figure 3, numerous moderators influence the relationships depicted in the conceptual framework; and specifically, the extent to which gains in knowledge and capacity among community members, and increases in knowledge, empathy, and feelings of pressure among health care providers and decision-makers, would lead to mutual empowerment and a shared commitment to address power dynamics and the gaps in respectful care standards. Within the sphere of the community, this includes the extent to which marginalized groups are engaged in efforts, and their level of inclusion and participation. At the state level, these include how health care providers and decision-makers perceive the legitimacy of the community making claims and of the claims made and, relatedly, the extent of knowledge about RMNCAH rights and entitlements among local political leaders. At the interface of these spheres, moderators include the extent of trust between the community and health care providers/decision-makers; and the extent to which the structures that are part of the social accountability approaches and that straddle the state/society divide solicit and represent community priorities.

Furthermore, while this conceptual framework does not use a socio-ecological framework to separate the different levels where social accountability interventions may occur (individual, relationship, community, societal), it explicitly names the types of individuals involved in social accountability approaches and their relationships—that is, community members, health care providers, decision-makers, and their relationships with one another. The conceptual framework also explicitly names the community as a whole. Additionally, societal-level components (civil society, social cohesion, health systems) are included in the conceptual framework as part of the context of social accountability approaches. This proposed conceptual framework has several limitations. First, social accountability approaches are, in essence, local political processes that unfold based, in part, on the desires and demands of the community, the level of responsiveness of the state, and the parties' interactions and negotiations with each other. Ideally, the community and health care providers and decision-makers would identify their desired outcomes towards the beginning of the process (while keeping in mind that, given their organic and iterative nature, the desired outcomes may shift). Outlining a conceptual framework that pre-determines a specific desired outcome risks social accountability interventions becoming development “widget” instead of true organic, local processes.

Relatedly, most social accountability programs are designed to address broader issues in health care and quality of care rather than focusing solely on respectful care. Empirical data linking social accountability and respectful care in RMNCAH are very limited. The effect of social accountability on other components of quality of care may improve respectful care, or there may be feedback loops between these other components and respectful care that are not represented in this conceptual framework.

Third, many social accountability efforts assume that communities can access or produce accurate data, including health care provider and health systems performance data regarding potentially sensitive issues

such as discrimination or corruption (Joshi, 2014). Accurate data may not exist, or government actors may try to stymie community efforts to gather such data.

Importantly, the assumed causal chain between information, collective action, and health care system response can be obstructed by several factors, including lack of trust among communities that their actions will result in change and the risk to marginalized community members posed by making demands on local service providers. Moreover, service providers' lack of material resources, decision-space, or shame for poor performance can undercut responsiveness (Fox, 2007; Lodenstein et al., 2017). There is also considerable debate on how the outcomes are interrelated; for example, it is not known whether improved governance enables community empowerment, or whether empowerment must come first, as governmental power rarely concedes willingly (Brinkerhoff et al., 2016).

Finally, while the conceptual framework acknowledges the importance of the local context, including factors related to the community and social context and the health systems context, it does not explain all possible systematic or structural factors that may lead (or inhibit) health care providers and decision-makers to be responsive to the demands of community members.

THE ROAD AHEAD

EMERGING RECOMMENDATIONS

Despite serious challenges and gaps, social accountability may be an important strategy for enhancing respectful care in RMNCAH. To strengthen the pathway from social accountability to respectful care in RMNCAH, we present key recommendations that emerged from our review of the evidence, stakeholder mapping, and the convening series for consideration by the donor community and program implementers. Recommendations identified as high priority for USAID during the convening series are bolded.

Refine conceptualization

- An umbrella definition of respectful care across RMNCAH is needed to better capture and measure evidence of its effects. The definition of respectful care developed for this activity (see Box 1 on page 8) can serve as a useful starting point for developing an umbrella definition. Once consensus is achieved around an umbrella definition for respectful RMNCAH care, each technical area can then develop health area-specific definitions and (sentinel) indicators. The breadth, intensity, and types of social accountability approaches vary widely across geographies and institutions, and terminologies to describe these are at times inconsistent. Some practitioners may categorize traditional community engagement programs that do not additionally include the element of working with the state as social accountability interventions, while other practitioners may refer to the multi-component, iterative, and complex processes described in this paper solely as community engagement. Future work in RMNCAH and respectful care must ensure that there is a common understanding across all involved with design, implementation, and evaluation of the key characteristics of social accountability approaches.

Improve measurement

- **Research and documentation on social accountability, respectful care, and RMNCAH should pay attention to how each of these constructs and areas are operationalized and measured. Given the amount of variation in terminology, definitions, operationalizations, and measurements, it is vital to accurately capture and document each of these concepts and constructs, irrespective of the**

labels used to describe activities and outcomes. In addition, new indicators along the pathway from social accountability to respectful care should be developed.

Build stronger evidence

- The evidence base for social accountability as a strategy to promote respectful RMNCAH care is limited. New research and research methodologies are needed to explore the effectiveness of social accountability programs to address key barriers to respectful care, such as the prioritization of health facility and provider needs over patient needs and insufficient human resources. Further, additional research is needed to determine the most commonly effective components of social accountability.
- The field of social accountability lacks research and evaluations focused on the sustainability of interventions at multiple levels of the system, including maintaining activities over the long term and sustaining progress after a program has ended. Research is needed on sustainability, including what measures prevent fallback once gains are achieved. For example, research on the ways in which the interactions between policymakers, community members, and providers influence the uptake, effectiveness, and sustainability of social accountability efforts is needed.
- **Much of the social accountability theorizing has been led by political scientists, with less representation from health systems specialists, somewhat limiting the ability to draw conclusions about social accountability for respectful care in RMNCAH. Greater engagement of health systems specialists to test and elucidate the pathways for health system responsiveness, a key challenge in any social accountability effort, is needed.**
- The evidence base on the effectiveness of social accountability approaches in a wide range of contexts, including fragile settings, is limited. Considerations and adaptations made for fragile settings should be documented. Moreover, additional research on the effectiveness of specific social accountability approaches on respectful RMNCAH care in these settings is needed, particularly given the increase in shocks and stressors experienced by many geographic areas of the globe.
- Given the importance of contextual and systemic factors in shaping the outcomes of social accountability interventions, additional research to determine what contextual factors are most amenable to social accountability intervention and how social accountability can influence the context is needed. Additionally, integrating analytic tools from the field of political science, such as political economy analyses, including problem-driven approaches, should be used to examine how structural factors can facilitate or hinder the ability of social accountability approaches to enhance respectful care. This type of approach would require close collaboration between experts across a variety of disciplines, including (but not limited to) political science, democracy and governance, and public health.
- Additional research is needed on how other interventions, such as social behavior change programs, results-based financing, and other policy interventions interact with social accountability efforts to affect the provision and experience of care.
- Additional research is needed to assess whether social accountability interventions should be paired with efforts to engage the regulatory agencies that provide oversight for health providers to effectively address power differentials between health providers and patients.
- Although some of the most impressive impacts of social accountability on health have been in the sphere of child health, the evidence base regarding its impacts specifically on respectful care is

extremely limited. Donors and researchers should engage current players in the social accountability and child health space, such as UNICEF and World Vision International, to further explore these pathways.

- Adolescents are frequently marginalized because of their age and stigmatized when seeking health services. Donor and researcher investment in program pilots and research that specifically incorporate youth voices to promote social accountability and youth responsive systems may be especially fruitful. Research on respectful care should include a qualitative component given that respectful care is experiential.
- Research on the role the working conditions of health facility providers and community health workers plays on their ability to provide respectful care is needed.

Develop consolidated tools and guidance

- **There are many program guidance documents (e.g., “how to”) for social accountability, including those created by international NGOs working in this area. Such tools often include assessments specific to issues that have been identified as important in our review, including political, economic, and contextual analyses; community readiness; and mitigating risk for those engaged in the program. Several program guidance documents for respectful care and RMNCAH are under development. Mapping existing social accountability tools specific to respectful care and RMNCAH as well as funding and developing additional ones could help to lay the groundwork for a more consolidated evidence base.**

Strengthen implementation

- The donor community should elevate attention and resources to social accountability and respectful care. Donors should provide grants aligned with country policies related to social accountability and respectful care that have greater flexibility and longer time horizons. Greater flexibility will allow implementers to iterate based on the local context. Establishing new social norms takes time; longer time horizons will allow projects to deepen the results they are able to achieve. Donors should also avoid supporting pilot projects that cannot be scaled.
- Strategies for community engagement within social accountability approaches should reflect community priorities; these may include factors outside of respectful care but related to the experience of care, such as the availability of essential medicines. Donors and implementers should facilitate equitable community engagement—including marginalized groups—early in the process, such that program focus reflects community priorities.
- Social accountability interventions should rely on existing platforms and accountability, such as community and facility health committees. This will strengthen existing systems and avoid developing parallel structures.
- Community members should be enabled, supported, and empowered to become facilitators who can create a safe space for dialogue between community members in different positions and health providers. Further, a defined facilitation process and an effective system to process and act on community feedback should be established.
- Respectful care activities should include a focus on health providers, while avoiding blaming and shaming them. Special attention should be paid to securing provider buy-in early in the social accountability process. Health providers should also receive training and/or refresher training on the provision of respectful care in RMNCAH, how to positively manage stress during difficult situations,

how to receive, process, and act on community feedback without defensiveness, and on unconscious bias. In addition to enhancing the quality of care, these trainings can foster effective leadership. Activities should also aim to improve the working conditions of health providers.

- Respectful care activities should include rights literacy and values clarification activities to address patients' low expectations of care and perceptions of low self-worth and enhance their prioritization of respectful care.
- Respectful care activities should be incorporated into quality improvement processes rather than addressed as a standalone activity. This can reduce defensive responses and reactions from providers.
- The donor community should support policy and advocacy activities to support the inclusion of social accountability approaches in national norms and guidance.
- Implementation guidance is needed on how to support development, implementation, monitoring, and adaptation of social accountability programs designed to address respectful care.

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APPENDIX A – RESPECTFUL CARE DEFINITION

PREFACE

This appendix expands upon the definition of respectful care developed by MOMENTUM Knowledge Accelerator in consultation with USAID stakeholders and informed by a review of existing definitions. The purpose of this appendix is to provide more details regarding the operationalization of concepts and constructs referred to in the definition.

THE NEED FOR A DEFINITION OF RESPECTFUL CARE

Respectful care is an area of research and programming that has grown along with the “quality revolution” in healthcare (Kruk et al., 2016). Respectful care emerged in mainstream global health discussions with the publication of studies revealing widespread mistreatment of women in maternity care, though the humanization of childbirth had long been a feminist priority in Latin America (Grilo Diniz et al., 2018; Laako, 2017). In 2007, the Kenyan Federation of Women Lawyers and the Center for Reproductive Rights published a report documenting serious human rights violations in maternity wards in Kenya (Center for Reproductive Rights and Federation of Women Lawyers - Kenya, 2007; Laako, 2017). In 2010, USAID funded a landscape review on disrespect and abuse in maternity care (Bowser & Hill, 2014).

While disrespect and abuse have been well-defined and studied, experts note that respectful care is not merely the absence of mistreatment: it is a multi-dimensional construct that implies multiple affirmative rights (Shakibazadeh et al., 2018). We are using the term “respectful care” over negative terms such as “disrespect and abuse,” “mistreatment” or “harm and abuse” in order to focus on the positive aspects of care and caring, as a broader concept that encompasses all of what people and their families deserve during their interaction with the health system. Since the groundbreaking work on mistreatment of women in maternity care in 2010, research and policy efforts to define and promote respectful maternity care have blossomed (Bohren et al., 2020), yet the “positive dimension” of respectful maternity care has not been as well conceptualized, defined, described, or measured to date.

The UN Secretary General’s Global Strategy for Women’s, Children’s, and Adolescents’ Health identifies respectful care as part of health providers’ and broader health systems’ obligations to advance the Sustainable Development Goals related to maternal and child health (Kuravilla et al., 2016). In alignment with the Global Strategy, in 2016, WHO issued standards for improving quality of maternal and newborn care in health facilities (WHO, 2016), and in 2017, WHO, UNICEF, and UNFPA supported the launch of a nine-country Quality, Equity, and Dignity network to serve as a learning platform for the implementation of the standards (WHO, 2016). The WHO standards for improving quality of maternal and newborn care in health facilities describe many components of respectful maternal and newborn care, such as an overall respectful environment, confidentiality, freedom from mistreatment, support to make informed choices, care that respects dignity, and laboring women’s right to have a birth companion of their choice (WHO, 2016).

The literature on patient-defined quality explores what matters to patients and communities, helping us to understand key elements of what is considered to be dignified and responsive care. When asked directly about quality, patients have said that they care about factors such as responsiveness, assurance, communication, getting better, waiting time, politeness, drug availability, perceived technical competence of provider, and health providers’ service orientation (Andaleeb, 2001; Atkinson & Haran, 2005; Bassett et al., 1997; Nabbuye-Sekandi et al., 2011; Aldana, 2001). These factors can be made more specific for various health domains. For example, in the context of family planning, good quality communication might include

adequate time for the consultation; the provision of information about side effects of various contraceptive choices; opportunities for the client to ask questions; respect for privacy and confidentiality; absence of coercion or subtle pressure regarding method choice; absence of stigma or discrimination related to the client's age, ethnicity, or other attributes; and friendly demeanor by the health provider/counselor (Tessema et al., 2016; Dey et al., 2021; Dehingia et al., 2019). The “What Women Want” Campaign asked 1.2 million women across 114 countries what they cared about in reproductive health care; these responses or similar efforts can be used to further flesh out what patients and carers define as compassionate, dignified, and responsive to their preferences, needs, and values.

In summary, there are multiple definitions available on respectful care with no established consensus across health areas on a single definition—or on what respectful care looks like operationally (i.e., specific behaviors, practices, or standards). Most of the definitions are associated with respectful maternity care, with less work to date on its application to newborn, child, and adolescent health, and reproductive health/family planning. The different terms used often share the same basic principles. However, differing terminology can be a barrier to finding common approaches, building the evidence base, and definitively asserting how different constructs are related. A definition of respectful care across the RMNCAH spectrum is needed that will enable USAID and its stakeholders to have a common language when advancing work on respectful care across these topics.

METHODOLOGY

To develop a working definition, we first conducted a rapid scoping review of relevant definitions from published and gray literature to identify specific definitions and components of respectful care and related frameworks. We also obtained relevant definitions from USAID and MOMENTUM stakeholders that they used in their work. Using these inputs, we developed a draft definition based on the inputs from the literature and outreach.

We validated and adapted the definition with members of the USAID Respectful Care and Social Accountability Extended Steering Committee at a three-hour convening held on February 2, 2022. Our convening aimed to adopt a working definition of respectful care relevant across the RMNCAH spectrum that was “good enough” to guide efforts to explore the relationship between social accountability and respectful care. There were 17 USAID staff members at the convening, along with three MOMENTUM Knowledge Accelerator facilitators and two additional participants from MOMENTUM Knowledge Accelerator with extensive experience on the topic in key technical areas. The format of the convening was a mixture of traditional presentations, large group discussions, and small and large group working sessions.

SCOPE OF WORKING DEFINITION

We sought to adopt a definition that could be operationalized to help study, design, implement, and assess respectful care. For the purposes of this working definition, we intended that the definition:

- Represent the perspective of the individual seeking care or the carers of the client, such as in the case of newborn or child health. While this experience is informed by interactions with the provider, our definition is not intended to represent the perspective of the provider.
- Does not capture the entirety of the experience of care, although the definition aims to capture aspects of the person's experience of care. For example, an individual could receive respectful care but not be a part of a health system that regularly allows for efficient and effective care.

- Focus on the conceptualization of respectful care only. While we hope the definition takes steps towards allowing for measurement by offering concrete domains of respectful care, measurement of our definition is outside the scope of this activity.
- Address specific needs for individuals and their carers across the life course.
- Be relevant across different sociocultural and political contexts.

We envision the users of the definition to be USAID staff and implementing partners working across the RMNCAH spectrum. While we hope the definition is relevant to other actors working on respectful RMNCAH care, we acknowledge that they were not present at our convening to contribute to the discussions in crafting and adopting our working definition. It is important to note that the definition of respectful care may vary by individual client or their carer(s) as well as vary from place to place (e.g., geographic location, rural/urban, point of service delivery), making it critically important to solicit a wide variety of inputs and perspectives on any definition of respectful care before using more widely.

WORKING DEFINITION OF RESPECTFUL RMNCAH CARE

“Care is respectful if it maintains all individuals' dignity, privacy, and confidentiality; ensures that interactions with individuals or carers enhance informed decision-making, without inducement or coercion; promotes continuous support (as appropriate); is compassionate and responsive to their preferences, needs, and values; and is free from stigma, discrimination, mistreatment, and harm.”

Some components of the definition merit additional explanation.

- Participants of the February 2022 meeting wanted to go beyond care that “enables” components of respectful care to instead more strongly call on care that “ensures” and “promotes” those key characteristics. They felt that “enabling” thus moved respectful care from a stance of judging to one of characterizing the care provided—or to reflect the health system’s responsibility for care provision more strongly.
- There was some debate about whether or not to incorporate more rights-based language. While specific mention of “rights” was seen to make the definition complicated, relevant concepts were referred to in various components of the definition. For example, convening participants wanted the definition to go beyond the concept of “informed choice” to be more intentional in stating that the provision of information and counseling is indispensable in respectful care and that **how** the information and counseling are provided is extremely important in ensuring respect and the preservation of dignity. They also wanted to reinforce language around concepts of care being “voluntary” and the concept of “agency,” as represented in “without inducements and coercion,” so this language was included in the definition.

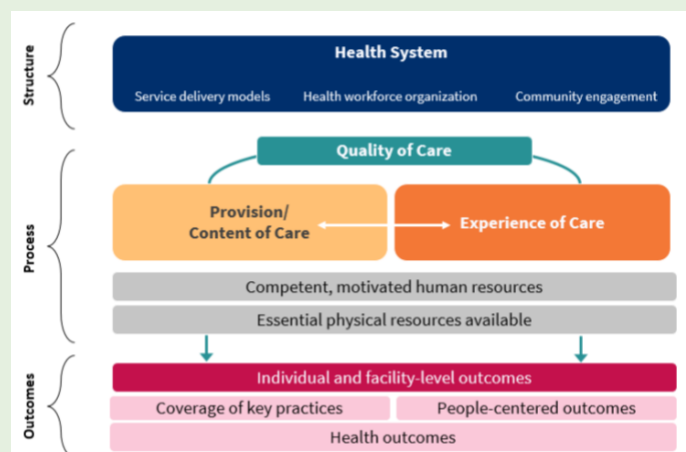
- While “continuous support” was added to the definition due to its implications on respectful care, convening participants thought it important to clarify that it may not be relevant across all services that are shorter in duration or frequency, such as immunization.

There were a couple of elements were not included in the final definition.

- While there was a call to include recognition and respect of the needs and values of the community, there was concern that they potentially contradict those of the individual.
- Adding “nurturing” (a form of supportive care) was suggested, but there was concern it does not cut across content areas or all population groups and could run contrary to autonomy and agency.
- Incorporating language around equity was discussed but seen as a longer-term outcome. After some debate, convening participants decided that respectful care is an input into the delivery of equitable care and quality of care; an equitable process increases the likelihood of achieving equal health outcomes. In other words, the group considered respectful care to be an intermediate outcome towards the achievement of equitable care. Other intermediate outcomes contributing to equitable care might be increased trust in the health care system, increased resources at the health facility level, and improved clinical capacity among providers, among others.
- As a result of respectful care being considered an intermediate outcome, the mechanisms between program activities and more respectful care and the assessment of respectful care itself might be limited, complicating our efforts to understand and document how respectful care is measured and to develop an evidence base regarding respectful care. Participants agreed that there should be a defined process on how respectful care is achieved, which goes beyond the scope of this activity.

We propose that respectful care is a facet of a person-centered outcome, and that it captures the processes required to be in place for respectful care to exist. In the Figure below, we map the different components of the definition against elements of a generic WHO quality of care framework, further described on page 6 (WHO, 2016; WHO, 2018). The mapping highlights that the elements of the proposed definition maps mostly across the elements related to process, rather than structure or outcomes.

BOX 1: Generic WHO Quality of Care Framework



Care is respectful if it...					
	maintains all individuals' dignity, privacy, and confidentiality	ensures that interactions with individuals or carers enhance informed decision-making, without inducement or coercion	promotes continuous support (as appropriate);	is compassionate and responsive to their preferences, needs, and values; and	is free from stigma, discrimination, mistreatment, and harm.
Structure	• Service delivery model				
	• Health workforce organization				
	• Community engagement				
Processes	• Provision/ content of care	•	•	•	
	• Experience of care	•	•	•	•
	• Competent, motivated human resources	•	•	•	•
	• Essential physical resources available				

APPENDIX B – STAKEHOLDER MAPPING

Table B1 lists individuals that participated in key informant interviews, focus group discussions, or who submitted written responses to questions. Participants were selected from a list of 80 stakeholders using the following inclusion criteria: individuals working at the intersection of social accountability and respectful care, individuals who can jointly represent all RMNCAH technical areas and all main global geographic regions, and individuals conducting research and/or implementing activities related to social accountability and respectful care. Several participants were identified via snowball sampling.

TABLE B1. LIST OF PARTICIPANTS IN INTERVIEWS AND FOCUS GROUP DISCUSSIONS

Name	Project/Organization
Patience Afulani	University of California, San Francisco (UCSF)
Elizabeth Allen	GOAL Uganda
Elena Ateva	White Ribbon Alliance
Antje Becker-Benton	Breakthrough Action/Save the Children
Vicky Boydell	Independent Consultant
Sanni Bundgaard	International Rescue Committee
Iyeme Efem	MOMENTUM Safe Surgery in Family Planning and Obstetrics /EngenderHealth
Rebecca Fields	MOMENTUM Routine Immunization Transformation and Equity/JSI, Inc
Saad Filali Meknassi	World Bank
Walter Flores	Center for the Study of Equity in Governance in Health Systems (CEGGS)/Accountability Research Center
Lynn Freedman	Averting Maternal Death and Disability/Columbia University
Christine Galavotti	Bill & Melinda Gates Foundation
Aminu Garba	African Health Budget Network
Adriane Hilber	Health Evaluation and Applied Research Development (HEARD)/Swiss Tropical and Public Health Institute
Kathleen Hill	MOMENTUM Country and Global Leadership/Jhpiego
Susannah Hurd	Global Health Visions
Edgar Kitembo	World Vision
Eva Lathrop	MOMENTUM Private Healthcare Delivery/Population Services International
Elsbet Lodenstein	Royal Tropical Institute (Amsterdam)

Moise Muzigaba	World Health Organization
Sarah Onduko	World Vision
Anayda Portela	World Health Organization
Ana Lorena Ruano	CEGGS/Accountability Research Center
Emma Sacks	Independent consultant
Gaurav Sharma	MOMENTUM Private Healthcare Delivery/Jhpiego
Callie Simon	MOMENTUM Country and Global Leadership/Save the Children
Pooja Sripad	Population Council
Suzanne Stalls	MOMENTUM Country and Global Leadership/Jhpiego
Petrus Steyn	World Health Organization
Vandana Tripathi	MOMENTUM Safe Surgery in Family Planning and Obstetrics /EngenderHealth
Özge Tuncalp	World Health Organization
Sara Van Belle	Institute of Tropical Medicine (Antwerp)
Chandra-Mouli Venkatraman	World Health Organization
Charlotte Warren	Population Council

Table B2 maps the focus of each key informant’s social accountability/respectful care activities by approach, geography, and technical area. This is a visual representation of the work highlighted during key informant interviews and focus group discussions and not a comprehensive representation of any organization’s activities. Organizations that are not working at the intersection of social accountability and respectful care in RMNCAH were not included in this table. For MOMENTUM projects, the mapping captured the work completed under the MOMENTUM project and not of the organization.

TABLE B2. SUMMARY OF STAKEHOLDERS' SOCIAL ACCOUNTABILITY/RESPECTFUL CARE WORK

Organization/Project	Social Accountability Intervention/Area of Work							Geographic Area				Technical Area				
	Research	Community Score Card	Partnership Defined Quality	Citizen Voice and Action	Media Engagement	Facility Walk-Throughs	Legal Redress	Africa	Asia	Latin America and the Caribbean	Eastern Europe	Family Planning/ Reproductive Health	Maternal Health	Newborn Health	Child Health	Adolescent Health
Africa Health Budget Network		X			X		X	X	X	X	X	X	X	X	X	X
AMDD	X							X	X	X	X		X	X		
CARE		X						X				X	X		X	
CEGSS	X						X			X			X			
MOMENTUM Country and Global Leadership		X						X				X	X			X
MOMENTUM Routine Immunization Transformation and Equity		X						X							X	
MOMENTUM Safe Surgery in Family Planning and Obstetrics						X						X				
Population Council		X				X		X				X	X	X		
UCSF								X								
HEARD/ Swiss Tropical and Public Health Institute	X							X								
Save the Children		X	X					X	X				X	X		
WRA					X		X	X	X	X		X	X	X	X	X
World Bank		X						X	X	X	X					
WHO	X							X	X	X	X	X	X	X	X	X
World Vision				X				X	X				X		X	

APPENDIX C – RESPECTFUL CARE MEASURES

Table C1 includes a list of measures of respectful care and other constructs related to respectful care, such as person-centered care and client-reported quality of care, that emerged during the rapid review undertaken during this study, and that the authors were familiar with from prior work. It should be noted that this is not an exhaustive list of such measures.

TABLE C1. COMPENDIUM OF RESPECTFUL CARE SCALES, INDEXES AND TOOLS

Name of measure/scale	Domains/Sub-scales	Reference	Country/Countries of Validation
<i>Maternal OR Maternal and Newborn</i>			
Person-Centered Maternity Care Scale	<ol style="list-style-type: none"> 1. Dignity/Respect 2. Privacy/Confidentiality 3. Autonomy 	<p>Afulani, P., Diamond-Smith, N., Golub, G., Sudhinaraset, M. (2017). Development of a tool to measure person-centered maternity care in developing settings: validation in a rural and urban Kenyan population</p> <p>Afulani, P., Diamond-Smith, N., Phillips, B., Singhal, S., Sudhinaraset, M. (2018). Validation of the person-centered maternity care scale in India</p>	Kenya India
Women's Perception of Respectful Maternity Care (WP-RMC)	<ol style="list-style-type: none"> 1. Providing comfort 2. Participatory care 3. Mistreatment 	Ayoubi, S., Pazandeh, F., Simbar, M., Moridi, M., Zare, E., & Potrata, B. (2020). A questionnaire to assess women's perception of respectful maternity care (WP-RMC): Development and psychometric properties	Iran (Tehran)
Respectful maternal care measurement tool Respectful newborn care measurement tool	<p>The overall scale and its sub-scales are measured separately for respectful maternal care and respectful newborn care:</p> <ol style="list-style-type: none"> 1. Physical abuse (M + N) 2. Sexual abuse (M + N) 3. Verbal abuse (M + N) 4. Stigma and discrimination (M) 5. Failure to meet professional standards of newborn care (N) 	Gurung, R., Ruysen, H., Sunny, A. K., Day, L. T., Penn-Kekana, L., Målqvist, M., ... & Ashish, K. C. (2021). Respectful maternal and newborn care: measurement in one EN-BIRTH study hospital in Nepal.	Nepal (Pokhara)

Name of measure/scale	Domains/Sub-scales	Reference	Country/Countries of Validation
	6. Poor rapport between woman and provider (M + N) 7. Health system constraints (M)		
<i>Family Planning</i>			
Person-Centered Family Planning Scale	1. Dignity/Respect 2. Privacy/Confidentiality 3. Autonomy 4. Communication 5. Supportive care 6. Social support 7. Trust 8. Health facility environment	Sudhinaraset, M., Afulani, P., Diamond-Smith, N., Golub, G., Srivastava, A. (2018). Development of a Person-Centered Family Planning Scale in India and Kenya	Kenya India
Client-Reported Quality of Contraceptive Counseling Scale	1. Information exchange 2. Interpersonal relationship 3. Disrespect and abuse	Holt, K., Zavala, I., Quintero, X., Hessler, D., Langer, A. (2019). Development and validation of the client-reported quality of contraceptive counseling scale to measure quality and fulfillment of rights in family planning programs	Mexico (Mexico City and San Luis Potosí)
Jain Quality of Care Scale	1. Effective use of method selected and continuity of contraceptive use and care 2. Method selection 3. Respectful care	Jain, A., Aruldas, K., Mozumdar, A., Tobey, E. Acharya, R. (2019). Validation of Two Quality of Care Measures: Results from a Longitudinal Study of Reversible Contraceptive Users in India	India

APPENDIX D – JULY 2022 CONVENING PARTICIPANTS

	Day 1 – July 13, 2022	Day 2 – July 14, 2022	Day 3 – July 19, 2022
USAID	Neal Brandes, Salamatu Futa, Kristina Granger, Sachin Gupta, Whitney Hudlund, Bev Johnston, Lily Kak, Zewditu Kebede, Joan Kraft, Shawn Malarcher, Hector Menendez, Katie Meyer, Barbara Rawlins, Sarah Safi, Raz Stevenson, Linda Sussman	Deb Armbruster, Neal Brandes, Diana Frymus, Salamatu Futa, Christine Galavotti, Kristina Granger, Sachin Gupta, Whitney Hudlund, Bev Johnston, Patty Jodrey, Lily Kak, Zewditu Kebede, Joan Kraft, Shawn Malarcher, Hector Menendez, Katie Meyer, Barbara Rawlins, Sarah Safi, Raz Stevenson, Linda Sussman	Deb Armbruster, Neal Brandes, Robyn Churchill, Diana Frymus, Salamatu Futa, Kristina Granger, Sachin Gupta, Bev Johnston, Patty Jodrey, Lily Kak, Zewditu Kebede, Joan Kraft, Shawn Malarcher, Hector Menendez, Erin Mielke, Barbara Rawlins, Sarah Safi, Raz Stevenson, Linda Sussman
MOMENTUM	Rebecca Fields, Kamden Hoffman, Eva Lathrop, Hailemariam Segni, Mallika Singhai, Suzanne Stalls, Vandana Tripathi	Rebecca Fields, Kamden Hoffman, Eva Lathrop, Tina Liang, Hailemariam Segni, Mallika Singhai, Suzanne Stalls, Vandana Tripathi, Jessica Vandermark	
External partners	Christine Galavotti (Gates Foundation), Emma Sacks (JHSPH), Petrus Steyn (WHO)	Vicky Boydell (Global Health Centre), Angela Nguku (White Ribbon Alliance), Emma Sacks (JHSPH), Petrus Steyn (WHO), Ozge Tuncalp (WHO)	
MOMENTUM Knowledge Accelerator	Participants: Kate Gilroy Facilitators/Organizers: Mahua Mandal, Marta Schaaf, Cathryn Streifel, Lara Vaz, Rachel Yavinsky	Participants: Kate Gilroy, Kate Sheahan Facilitators/Organizers: Megan Ivankovich, Mahua Mandal, Marta Schaaf, Cathryn Streifel, Lara Vaz, Rachel Yavinsky	Participants: Kate Gilroy, Kate Sheahan, Katherine Semrau Facilitators/Organizers: Cathryn Streifel, Lara Vaz, Rachel Yavinsky



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