

Formative Research Report:
**Respectful Maternity
Care in India**

December 2024



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Agency for All Project

Center on Gender Equity and Health | UC San Diego School of Medicine
9500 Gilman Drive, Mail Code 0507 La Jolla, CA 92093
info@agency4all.org
www.agency4all.org
X: @Agency4All

Roadmap

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Agency of Women

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Study **Introduction**

RETURN
TO ROADMAP



Overview

1. Overview of formative research
2. Discussion on findings from the facilities
3. Discussion on findings from the communities
4. Implications for intervention approaches



Research on Respectful Maternity Care

Respectful Maternity Care (RMC) in India

Standard protocols, practices, and guidelines are focused on service delivery standards.

Government initiatives like Surakshit Matritva Aashwasan (SUMAN) and LaQshya focus on quality of care with a specific emphasis on RMC.

Gaps in our understanding of RMC

1. Whether and how the practice standards translate into action within the facilities
2. Existing institutional, provider, and community norms and practices that contribute to women's experience of care at health facilities
3. Intersections of institutional and community norms for providing and seeking RMC
4. Lack of targeted RMC interventions taking into account perspectives and agency of women and communities.

Study Objectives

The primary research objective is to inform the development of an intervention to support RMC at the community and facility levels.

Specific Objectives

1. Assess and understand **institutional norms**, including provider attitudes, networks, and practices around RMC at health facilities.
2. Explore and understand **community norms** around RMC at health facilities.
3. Understand the **meaning of women's agency in the context of RMC** from the provider, community, and women's perspectives.
4. Use the findings to **support the development and delivery of programmatic interventions** to improve provision of RMC at the facility level and demand for RMC at the community level in health facilities in India.

Methodology



Design

Exploratory multiple case-study design using a qualitative approach across four secondary and tertiary care public and private health facilities in states of Maharashtra, Telangana, and Jharkhand with mix of rural and urban catchment areas as communities



Methods



Health Facilities



Community



Observation of client-provider interactions



RMC Focused Facility Readiness Tool



IDIs (+ Network Mapping) w RMNCH Service Providers
KIIs with facility administrators



IDIs interviews with postpartum women



FGDs with women, and men, and birth companions



KIIs with FLWs and local self-governance officials

Overview of Methods Health Facility



Research Question(s)	Method(s)	Study Population(s)
RQ1: How do institutional norms contribute to women’s experience of care during childbirth at health facilities?	<i>IDIs + Institutional Network Mapping using qualitative social network analysis</i>	<ul style="list-style-type: none"> • Doctor • Staff Nurse • Support Staff
RQ3: How do health facility actors (service providers and managers) and community members perceive women’s agency and rights within the context of respectful maternity care?	<i>Key Informant Interviews</i>	<i>Facility leaders/Facility Administrators</i>
	<i>In-Depth Interviews</i>	<i>Additional Facility influencers identified from social network analysis</i>
RQ1: How do institutional norms contribute to women’s experience of care during childbirth at health facilities?	<i>Observations of client-provider interactions</i>	<i>ANC outpatient departments, ANC, PNC and Labor wards</i>
	<i>RMC Focused Structured facility readiness tool</i>	<i>Sampled facilities</i>

Overview of Methods Community

Research Question(s)	Method(s)	Study Population(s)
<p>RQ2: How do community norms impact the way that individuals (community members including PRI and FLWs) perceive and respond to disrespect and abuse during maternal care at health facilities?</p> <p>RQ3: How do health facility actors (service providers and managers) and community members perceive women’s agency and rights within the context of respectful maternity care?</p> <p>RQ4: What SBC approaches can be used to promote RMC across communities and health facilities?</p>	<p><i>Key Informant Interviews</i></p>	<ul style="list-style-type: none"> • <i>Auxiliary Nurse Midwife (ANM)</i> • <i>ASHA</i> • <i>Panchayati Raj Institution (PRI) Member</i>
	<p><i>In-Depth Interviews</i></p>	<p><i>Women who delivered in the sampled health facility</i></p>
	<p><i>Focus Group Discussions</i></p>	<p><i>Women who delivered in health facility in last six months</i></p>
	<p><i>Focus Group Discussions</i></p>	<p><i>Birth companions for women who delivered at any health facility in last six months</i></p>
	<p><i>Focus Group Discussions/Interviews</i></p>	<p><i>Men from households where women delivered in any health facility in last six months</i></p>

Project Geographies and Facilities

Maharashtra

-  Government Medical College & Hospital
Aurangabad (Tertiary care – urban facility)
 -  Women's Maternity Hospital, Jalna
(Secondary care – peri-urban facility)
-

Telangana

-  Modern Government Maternity Hospital,
Hyderabad (Tertiary care – urban facility)
-

Jharkhand

-  Constant Lievens Hospital & Research
Center, Ranchi (Private care – rural facility)



Summary of Primary Data Collection

Category of participants	Study Sites				
	Telangana	Aurangabad	Jalna	Ranchi	Total
Facility					
Client-provider interaction observations	12	11	10	6	39
RMC focused facility readiness	1	1	1	1	4
IDIs: maternity care service providers (with network mapping)	8 (6)	6 (5)	5(2)	7(3)	26 (16)
IDIs: Identified facility member	2	2	2	2	8
KII: facility administrator/leaders	1	1	1	1	4
Community					
Tracer IDIs: women	10	12	6	6	34
FGDs: women	2	2	1	1	6
FGDs: men	1	2	1	1	5
FGDs: birth companions	1	1	1	1	4
KIIs: ASHA & ANM	2+2	2+2	1+2	1+2	14
KIIs: PRI member		1	1	1	3

Summary of Primary Data Collection — Facility

Category	Total number
Client-provider interaction observations	27
RMC focused facility readiness	4
IDIs w maternity care service providers (With Network Mapping)	26 (16)
IDIs w identified facility member	8
KII w facility administrator/leaders	4



Summary of Primary Data Collection - Community

Category	Total number
Tracer IDIs w women	34
FGDs w women	6
FGDs w men (& interviews)	5
FGDs w birth companions	4
KIIs w ASHA & ANM	14
KIIs w PRI member	3



Framework for Qualitative Analysis

Community context and norms

- Norms on seeking RMC
- Norms on decision making around pregnancy and childbirth
- Norms around acceptance of disrespectful and abusive care
- Norms around birth companions (choice of birth companions)
- Knowledge and awareness of RMC rights
- Community influencers — awareness of RMC, attitudes toward RMC
- Grievance redressal mechanisms — awareness, accessibility, perceptions

Provider and institutional norms

- Current RMC related descriptive norms:
 - Current practices related to RMC
 - Conditions of abuse and its justification
 - Any repercussions
- Current understanding and knowledge around RMC — rights, skills
- Norms between providers
 - Abuse behaviors, disrespect
 - Environmental stress that may influence behavior
 - Deflection of responsibility
- Relationship between providers, decision making, support, etc.

Workplace environment/institutional conditions

- Resources
- Policy — enforcement
- Time



Facility Level **Findings**

RETURN
TO ROADMAP

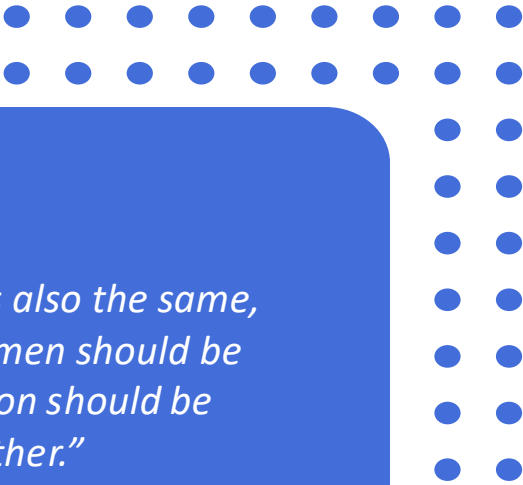
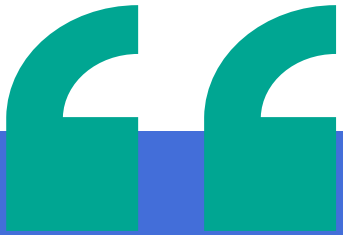


Analytical Framework

15

Provider/facility norms

- **Knowledge of RMC and disrespect and abuse**
 - patient rights
 - what constitutes abuse
- **RMC descriptive norms**
 - RMC practices
 - abusive behaviors
- **Justifications for abuse**
- **Inter-provider dynamics**
 - hierarchy
 - empathy
 - deflection of responsibility
- **Institutional drivers**



“What I have read about RMC in my PG is also the same, which is specific to the labor room. ... Women should be covered with the curtains...birth companion should be allowed...informing everything to the mother.”

— Senior resident, case facility 1

“In the labor ward it would be birth companions and positions, and then during her delivery it would be birth positions.” — Junior resident, case facility 2

‘Yes, I know a bit about that [RMC]. Those are the set of guidelines which needs to be followed to provide respectful delivery care. And although they are important, they don’t take priority in delivering a baby and maternal care.’

— Junior resident, case facility 4



Provider Awareness of RMC Domains

- **Awareness of RMC largely around domains of**
 - Consent
 - Privacy
 - Providing information
 - Allowing only birth companions to attend births: described as a step of clinical scope of practice
- Awareness of allowing different birthing positions, noted at only one of the case facilities

What is Missing When Providers Discuss RMC?

- **Awareness of RMC in context of rights of women and newborns**
- **Rights language (corresponding to the RMC charter):**
 - Right to raising grievances
 - Dignity
 - Refusing demand for bribes
 - Ensuring equal, equitable, discrimination-free care
 - Freedom from arbitrary detention
- **Focus on newborn respectful care (except the PNC ward providers)**

“If we look at the RMC ... it has various components but the components which we are practicing over here is birth companion and doula and birthing positions.”
— *Junior resident, case facility 2*

Provider Understanding of RMC

- **Understanding of RMC is limited to clinical scope of practice** — mainly around issues of consent, privacy, and provision of birth companions (highlighted in more than one of the facilities)
- Limited understanding of rights of women and newborns as a foundational aspect of RMC

What Providers Understand by Disrespect and Abuse

“

- Understanding of disrespect and abuse limited to:**
- Verbal abuse: e.g., shouting and insulting
 - Physical abuse: e.g., hitting and pinching

“Verbal and physical abuse (is disrespectful). Usually, physical abuse is when the mother is not cooperative during labor. They try to close the thighs, so hitting on the thighs happens.”

— Senior resident,
case facility 1

“If you are talking back rudely or saying something inappropriate, I think that's what harsh behavior is.”

— Junior doctor,
case facility 3

“Harsh treatment means even if the patient does not like it, we force them to do it. We say, push fast like that.”

— Staff nurse
case facility 1



”

Variation in Understanding Across Types of Providers

- **All providers** stressed the importance of positive interactions with the mother: speaking softly and kindly.
- **Senior doctors** (also junior doctors in private facilities) note that maternity care should encompass RMC for mothers, with a focus on **dignity and compassion**.
- **Nurses and midwives** emphasize that RMC should encompass the **psychological well-being** of women.
- **Support staff** define it in context of **their role** (cleaning, shifting women to wards).

“RMC, as I understand it, means that if we follow all the components or ideology of RMC when the mother is facing the intra-partum or immediate pre-period, her maternity experience will become delightful and pleasant.”

— Senior leadership, case facility 2

“During delivery, mothers have anxiety and need psychological support, so supporting them and explain the condition to the birth companion. Informing the mother before the procedure.”

—Staff nurse, case facility 2

“If the women vomit or any body fluids come out, we clean that. We also look after the women and help in providing them comfort. I also talk to the relatives and tell them to look after their respective patients.”

— Support staff, case facility 4

Provider Behaviors Based on Direct Observations



Provider Behaviors: RMC is Not Practiced Consistently

We observed a “Know-Do” gap, as providers do not practice even the behaviors that were identified by them as respectful care. In our observations these behaviors were consistently neglected in facilities.

- Providing privacy during ANC, active labor, and PNC
- Informed consent before every procedure
- Allowing birth companions in labor room
 - Contextual differences in allowing birth companions across case facilities
- Providing information regarding pregnancy, childbirth and neonatal care

Provider Behaviors: Disrespect and Abuse are Common

Providers frequently engaged in disrespectful and abusive behaviors:

- Verbal abuse by providers:
 - **Shouting** when asked questions or when women call out in pain
 - **Threatening with dire consequences** for mother and child for not understanding or following instructions
- **Ignoring requests** for care during labor pains
- **Disregarding privacy** of women

- **Less common disrespectful behaviors observed included physical abuse such as hitting thighs or pinching during labor or during pelvic exams**

Provider Behaviors: Support Staff Contribute to Difficult Conditions

Observations around behaviors of support staff:

- **Unhygienic environment in public facilities** : unclean washrooms and labor areas; sometimes women or birth companions were asked to clean up after childbirth
- **Demands for informal payments seen across facilities at different points**
 - Abandonment of care if demands were not met
 - Detainment if demands were not met

Facility Readiness for RMC



RMC Specific Facility Readiness

- **Privacy curtains available** in the labor ward at case facilities: 1, 2, & 4
- **Infection prevention and control resources in place** at case facilities 1, 2, & 3
- **Information, education, and communication (IEC)** materials regarding RMC rights available at case facilities 1 & 2



Facility Images

Case facility 1



RMC posters near prenatal care out-patient department



Prenatal care out-patient department

Facility Images

Case facility 2



Prenatal care out-patient department



RMC posters at prenatal care out-patient department

Facility Images

Case facility 3



Entrance to maternity ward



Labor room

Facility Images

Case facility 4



Poster on birth companion at the entrance of the facility



Postpartum care ward

Provider and Institutional Norms



Provider Norms and Attitudes on Disrespect and Abuse

- **Norm: providers engage in disrespectful behaviors under certain circumstances**
- **Disrespect and abuse is acceptable:**
 - In emergencies and during complications
 - When there are limited resources in health systems
 - When providers are overburdened
 - To control uncooperative women
 - Among women in certain socio-demographic categories: those who are uneducated, have language barriers, are primigravida
 - Because patients have unreasonable expectations around the type of care to be administered

Provider Norms and Attitude on Disrespect and Abuse

“

“If the child doesn’t come out early in the last stage, then there are high chances that there is a tear. For such reasons we need to scold.”

— Staff nurse,
case facility 4

“If mothers come from Rajasthan, Orissa those mothers, staff do verbal abuse.”

— Midwife,
case facility 1

“Just to control the mind of the women during the labor, usually the staff raises their voice.”

— Senior resident,
case facility 2



”

Provider Justification of Disrespect and Abuse

“As you can see, the women listen to us only if we speak a bit roughly. I don’t think they take it as disrespect or anything. They know that whatever we’ll do would be for their health benefit.”

— MOIC, case facility 4

“With such restricted facilities, the doctors sometimes have to be harsh to get good patient outcomes.”

— Junior resident, case facility 4

“Primi mothers, they usually do not bear down. When they are on full dilatation and get bradycardia, the situation gets complicated, and the staff get frustrated and raise their voice to instruct the women. Then they will listen to us.”

— Senior resident, case facility 1

Disrespect and abuse is justified to support the clinical well-being of women and newborns.

Provider Care Provision Norms

“I have seen this [shouting] kind of behavior in class 4 employees. Not doctors.”

— *Midwife, case facility 1*

“If there is an unexpected complication, the PG student might think everyone will question them about how the complication occurred, the senior doctors might also feel responsible if the delivery doesn’t go well.”

— *Junior resident, case facility 2*

“Due to high BP...she does not stay in bed. So, we tie her legs and to avoid tongue biting and falling from the bed...we give aggressive treatment to control her. Without her consent, we do all.”

— *Staff nurse, case facility 1*

- **Senior staff deflect** blame for engaging in disrespectful behavior to junior providers
- **Fear of sanctions** around **negative clinical outcomes**
 - From senior providers
 - From community
- **Lack of empathy** toward women and their conditions

Provider Descriptive Norm

“I think everyone is on the same page because our ultimate motive is to work for the patient.”

— Junior resident, case facility 2

“I feel like everyone has similar thoughts about the care and the way you should behave with the patients or the way they should be, whatever doubts they have, the way they should be answered.”

— Junior doctor, case facility 3

“Even senior sisters say to junior staff...we also treat patients. So, all sisters follow the same procedure.”

— Staff nurse, case facility 1

- **Providers perceive that their peers** provide respectful care from their understanding of RMC
 - Possible social desirability

Facility Norms: Higher Level Cultural Models and Meta-Norms

“I think their focus will be on the procedure. I think they will raise their voice sometimes. ... They say, ‘We can explain this later to her, now it is not necessary.’ We have to focus on the safety of the baby.”

— *Senior resident, case facility 1*

“You have to take that standard/decision. You are not the doctor there; I am the doctor. ... If you want the mother and the baby healthy, then follow what I am saying because you know, we have studied for that.”

— *Junior doctor, case facility 3*

“The doctor asks us to hold her legs, so we do it. Even we are uncomfortable doing it, but we feel bad when a baby dies in the womb after completing nine months.”

— *Support staff, case facility 2*

- **Rigid hierarchies restrict agency**
 - inter-provider: e.g., support staff engage in harsh behaviors following doctors’ instructions
 - mothers revere doctors so they don’t challenge them
- **Accountability** is primarily focused on **clinical outcomes of childbirth over other aspects of care, including RMC**
- **Lack of awareness around psycho-social** support for providers

Facility Factors

- **Defunct grievance reporting** system for women
- **No recognition or reward system** for respectful care
- **Overburdened providers and** workplace stress
- **Lack of infrastructure** and resources for provision of proper care
- **Lack of infrastructure and awareness for psycho-social support** for providers

“Some women will complain to the head nurse or the doctor in charge. But all of this will be manageable. The doctors and nurses will warn the support staff at that moment but it continues.”

— Ward boy, case facility 1

“Sometimes we accommodate floor deliveries also. In those situations there are less helping hands and more women. Then the doctors and staff get overloaded and frustrated and may react in this manner.”

— Staff nurse, case facility 1

“We have our seniors; we talk to them. They support us in situations if we are right. ... They also don't have time...they are also doctors only.”

— Junior resident, case facility 4

“I think a common barrier is that RMC should be included in the curriculum for residents.”

— Assistant professor, Case facility 2

“I think that every two months we could have a drill, you know like reinforcing everything. ... So, how it works is every day you practice RMC but don't know the exact guidelines.”

— Junior resident, case facility 1

“Sometimes there are 10 women at a time in the delivery room. How can they handle? There are only two to three staff in morning. ... It becomes very difficult for the staff to handle all the things. So, more people should be hired.”

— ANM, case facility 4

Suggestions from Providers to Promote RMC

- Inclusion of **RMC as a subject** in the curriculum for medical residents
- Regular **refresher training** on RMC for all providers
- **Infrastructural improvements** such as equipment, beds, more staff, CCTV cameras for security, TVs for dissemination of information

Suggestions from Providers to Promote RMC at the Patient Level

“The thing is work with the very primary level is very important because when patient comes to us lot of time all the things are missed like basic things should never be missed because that forms a basic ground for the treatment of the patient. ... It is important to propagate RMC.” — Junior resident, case facility 2

“ASHA workers could give better education on ground level to the pregnant women and their relatives. If the women are counseled and mentally prepared beforehand, it would help during delivery.” — Junior resident, case facility 4

- Patients to maintain **ANC medical records** and bring to facility during birth
- **Counselling for mothers and birth companions** on family planning, nutrition, and childcare, such as breastfeeding and immunization **during ANC and predelivery period**

Social Network Analysis



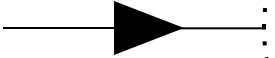
Social Network Analysis

- ✓ Identifying key network actors or people in the network of providers
- ✓ Flow of communication – how people communicate with each other
- ✓ Interpersonal relationships – how people connect with each other
- ✓ Importance of how understanding social network could contribute/influence norms around RMC

Locating Social Network Analysis



Qualitative social network analysis



Methods

In-depth interviews and network mapping, including name generator questions



- Total 16 health care providers
 - 8 doctors
 - 8 staff nurses

Sample



Focus of SNA

- Identify key people in network
- How people communicate and connect with each other
- Facility structures and mechanisms influencing networks, RMC practices and norms

Name Generator Questions **to identify and map key network members**

45

1

Who in the facility supervises the work that you do? To whom are you directly accountable?

2

Whom in the facility do you supervise? Who is directly accountable to you?

3

Within the facility, whom do you turn to for help in case of problems in your work?

4

Within the facility, who turns to you for help in case of problems in their work?

5

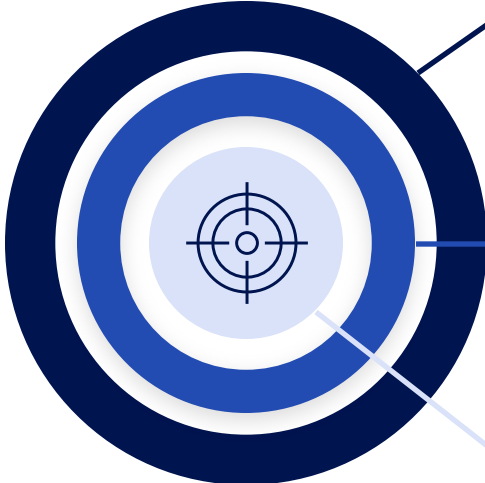
Within the facility, whom do you turn to to raise any concerns/grievances you may have?

6

Whom in the facility would you prefer not to talk to/seek advice from concerning issues that you have at your job?

Measures of SNA

In-depth interviews with
maternity care service
providers



01

Name generator
questions – 6



02

Identifying decision
makers (DM)
identifying influencers (I)




03


Information about who
has been nominated
(alters)



Identify the care provision
network members for
providers



Understand the networks

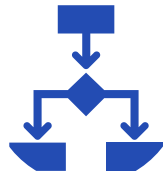


Explore the role, interactions
(nature and frequency) with
alters

Analytical Strategy for SNA



Identifying key network actors – who can influence and help promote RMC practices



Flow of communication and interpersonal relationships – understanding how people communicate and connect



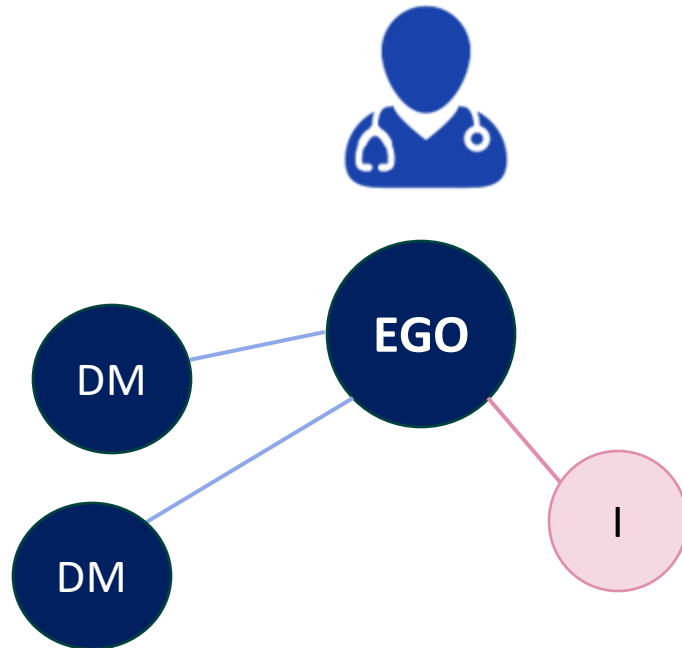
Decision-making and problem-solving – leverage points for fostering RMC culture



Aspects and structures contributing to/influencing norms around RMC

- **Leadership – as change agents**
- **Work environment and motivation to promote RMC practices**

What the Network Looks Like

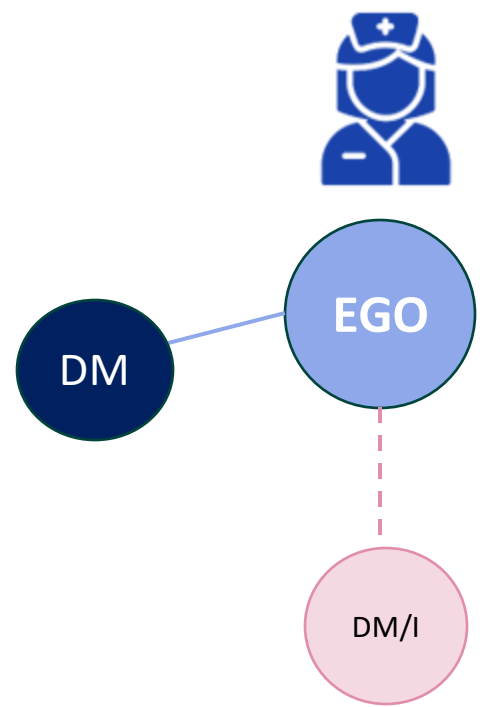


For doctors

Network Members	Decision Makers	Influencers
26	17	9

On average, doctors identified three categories of network members: senior doctors, administrative heads, and professors.

What the Network Looks Like

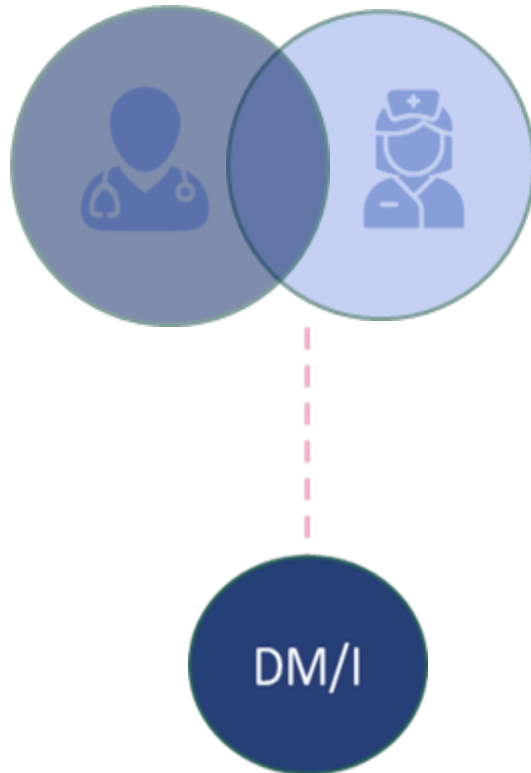


For staff nurses

Network Members	Decision Makers	Influencers
21	14	07

On average, nurses identified three categories of network members: senior nurse, nurse in-charge and head of department.

What the Network Looks Like



Doctors have a wider network than nurses for professional and emotional support.

Nurses named doctors (residents) in their networks; however, doctors did not name nurses as key actors in their network

Flow of Communication

Description of how formal communication happens within networks of participants (doctors and nurses)

- 1. Regular interaction with peers and immediate work supervisors; primarily focusing on clinical decision making and work**
- 2. Guided by defined reporting pathway and hierarchy — the regularity of interaction decreases with those higher up**
- 3. Almost all providers (doctors and nurses) expressed the ability to put forth their opinions on clinical decisions**
- 4. Understanding these communication dynamics can help foster respectful care practices and their integration**

Interpersonal Relationships

- **Work relationships are strong with peers, especially among doctors as compared to nurses**
- **Respectful interactions with supervisors – no public reprimands**
- **Work takes precedence over personal differences**

“Yes, she [nurse in charge] scolds. If you do a mistake, then she does scold...She is superior so she should scold a little. She never scolds in front of everyone. When we are alone, she says- that this was wrong do it like this.”

Staff nurse, case facility 2

“



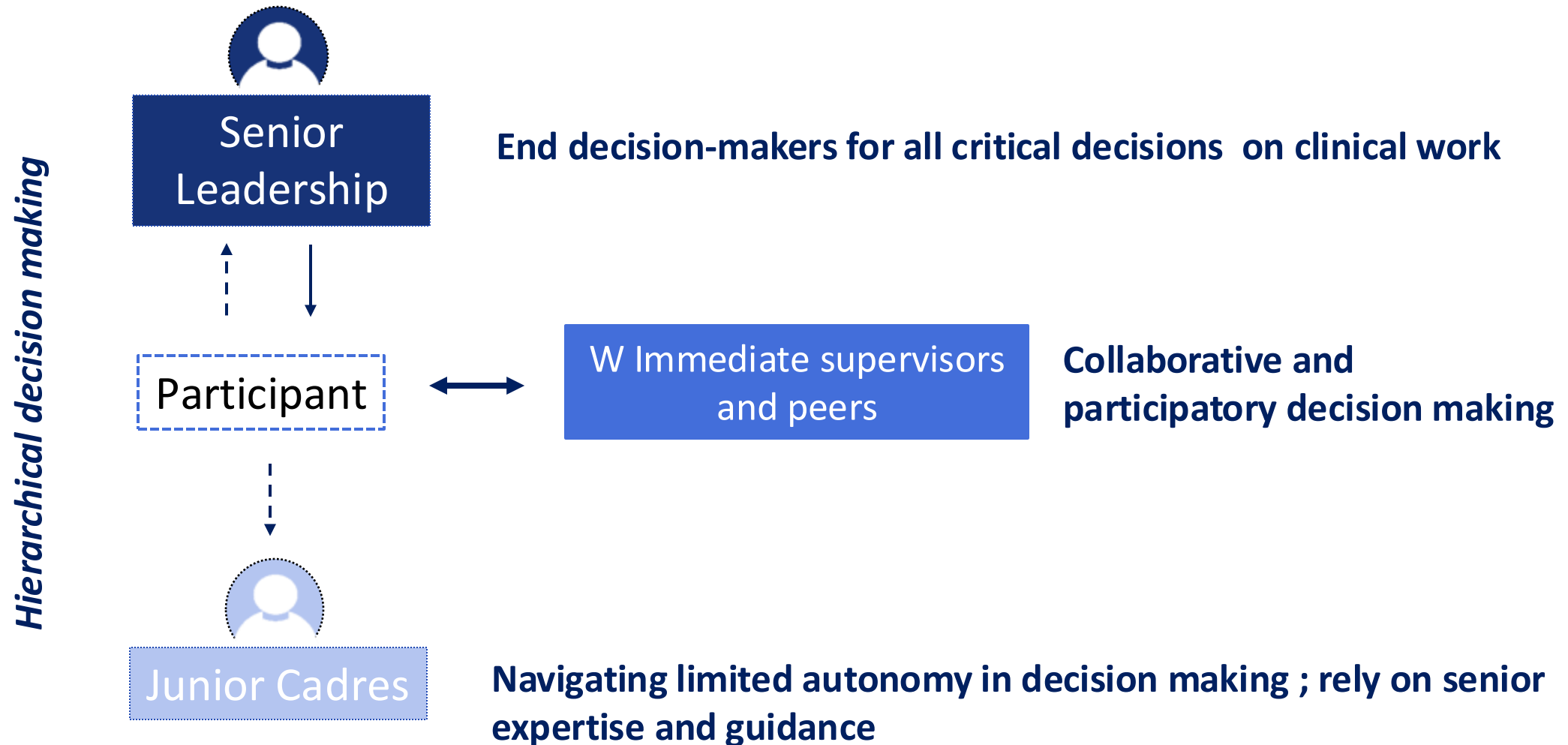
“Well, there are a few individuals I might not get along with, but that's natural. It doesn't mean I won't approach them if necessary for work.”

Gynecologist, case facility 3

“



Decision Making among providers 52



Decision Making

Healthcare Providers

"It depends on the level of the decision. If it's about a critical patient, I'll follow the senior's decision. However, if it's about minor decisions, I might express my opinion but ultimately respect their experience."

— Junior resident,
case facility 2



"Eventually, if some critical decision has to be made, we will contact nursing superintendent. She is the decision maker."

— Nurse,
case facility 4



"I do (advocate my ideas during decision making). We explain what the condition is and what we can do. And importantly mostly you will not have any disagreements with the superiors."

— Senior resident,
case facility 1



Leadership

“RMC starts at every level. Right from entry to exit. How she is received (at the hospital), taken care of, her privacy, her confidentiality...whether she is aware of what procedure is going on...her baby's condition. And it is catered by everyone working in this facility.”

***Medical superintendent,
case facility 1***

Final decision makers



Strong advocates of RMC



Key influencers for facility norms



Perceptions of Leadership

1. **Role models for providers, including doctors and nurses**
2. **Open to feedback from juniors**
3. **Problem solvers for major or critical problems in facilities**

“

“I have only worked with that senior doctor here; she is really good with this patient interaction thing. I've actually observed the way she talks and I'm learning from her. So, the patients get really comfortable with her, they don't even just share the health aspect but doubts that may sound very insignificant, but they do ask her.”

— Junior resident, case facility 3



”

Work Environment



“Personal problems we will keep to ourselves, why will we go to the sister (nurse superintendent).”

INTERVIEWER: “When you are experiencing mental stress due to work or some personal problems, who do you talk to in the hospital? Are you able to share with anyone?”

INTERVIEWEE: “No, I keep it to myself, I don’t share with anyone.”

Staff nurse, case facility 3

Stressful working conditions with high workloads



Task-oriented environment with limited social interaction



Lack of psychosocial support



Work Motivation

1. Job satisfaction and pride in profession
2. Lack of rewards and recognition within facilities and systems
3. Strong hierarchy with focus on clinical outcomes



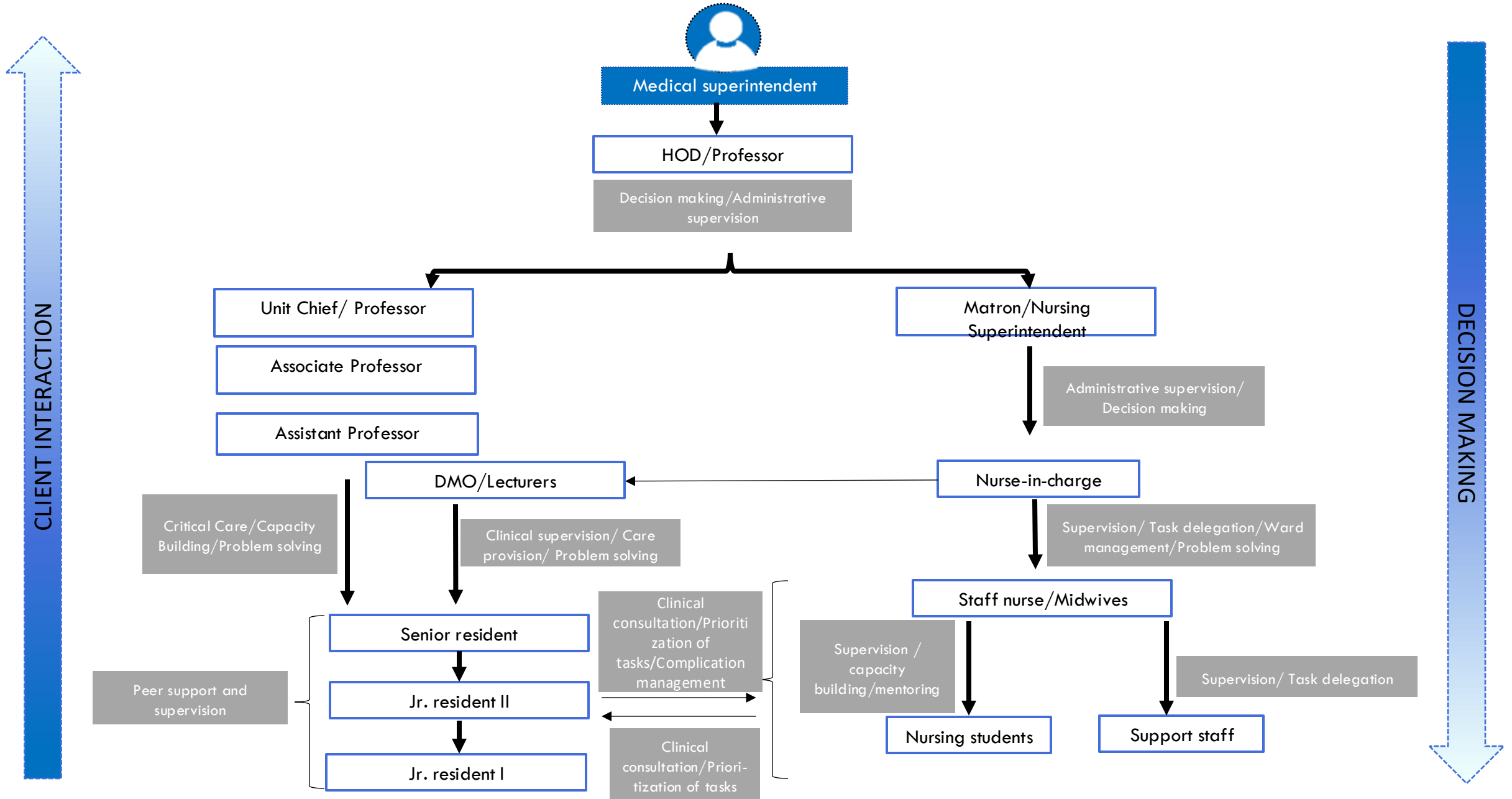
“If there is an unexpected complication, the PG student might think everyone will question them about how the complication occurred; the senior doctors might also feel responsible if the delivery doesn't go well.”

— Junior resident, case facility 2

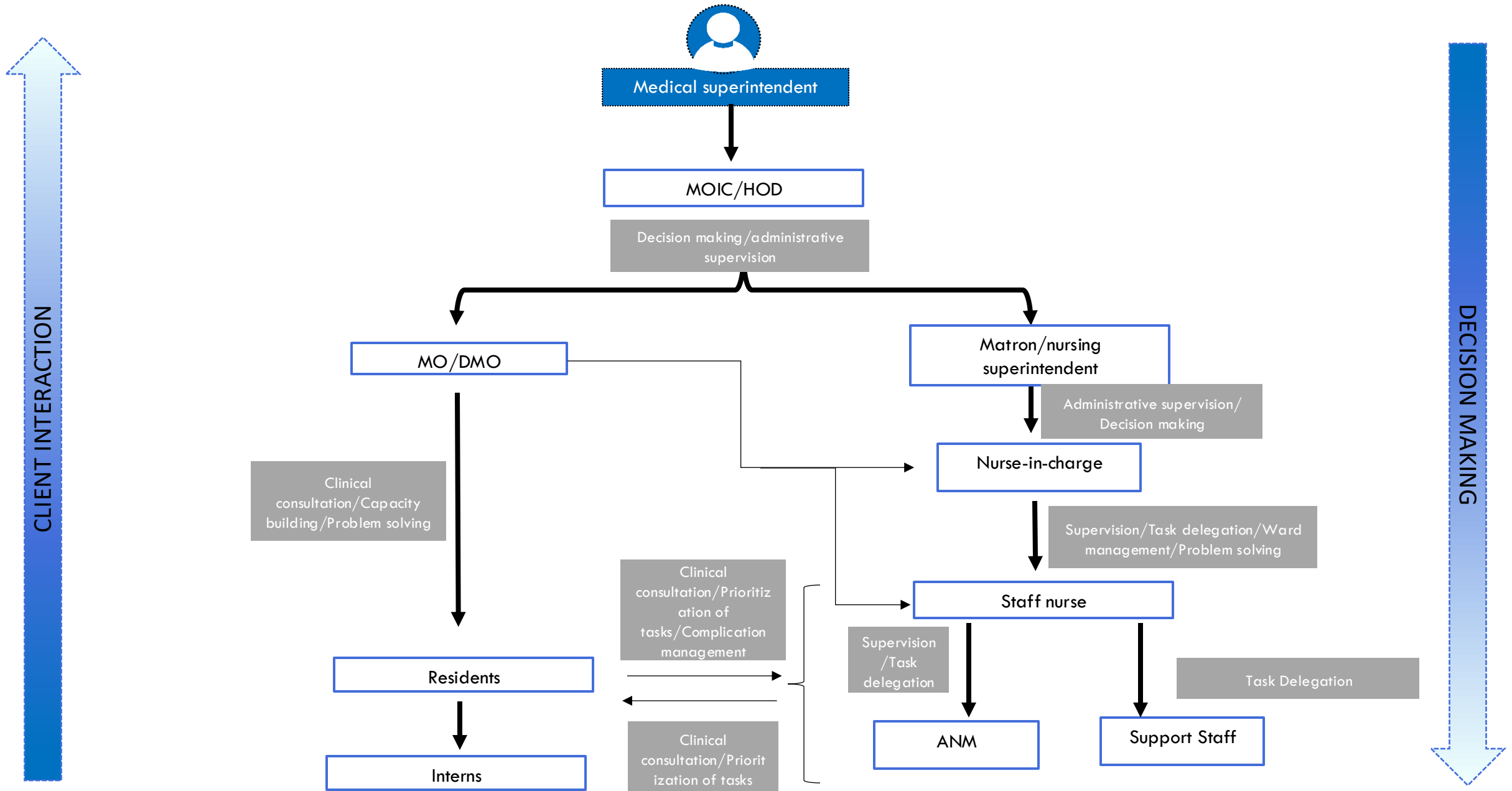
Representation of Facility Hierarchy



Representation of tertiary care facility hierarchy



Representation of secondary care facility hierarchy



Providers' Agency



Dimensions of Provider's Agency

"We tell her/him [HOD] and s/he listens to us about it. S/he sorts out our problems."

– Nurse, case facility 2

"Yes, it is bedside teaching for us. They told us to take consent from the women and cover all the sides while doing checkups." — Senior resident, case facility 1

"As soon as you become more senior you start to develop more patience, because you are dealing only with high risks finally; like our senior residents never really scold patients at all, because they come and only visit the high risks, so they're really not that overburdened."

— Junior resident, case facility 2



Critical Consciousness

- Varied ability to articulate RMC across cadres
- Lack of recognition of need for psycho-social support



Can/Self-efficacy

- Limited ability to question decisions by senior providers
- Seeks support from fellow/senior providers

Dimensions of Provider's Agency



Act

- Work environment and conditions influence provider behaviors
- Facility and provider norms



Resist

- Prioritizing clinical outcomes over RMC - fear of negative sanctions if clinical outcomes aren't good
- Hierarchy and power dynamics

“You are far more sleepless when you are first year junior resident, you hardly ever sleep so you are bound to be on the more frustrated side, and you're like always working.”
— **Junior resident, case facility 1**

“So, if it's a minor concern, senior residents can handle it themselves. But if you think that it requires attention from a senior authority to help you out, they might not have that much power. You can directly message, call, or contact anyone; everyone is reachable over the phone. It's not a restricted process where you have to first inform your immediate senior, and then it goes higher. ...There is a formal mechanism, but most problems need to be solved on the spot, which is why you often go through the informal route.” — **Senior resident, case facility 2**

Implications of SNA Findings for Intervention

“I have only worked with this senior doctor here and is good with this patient interaction thing. I've observed the way she talks and I'm learning from her. The patients get comfortable with her, and don't just share health aspects like the disease/problems they have but doubts, which sounds very insignificant, but they do ask her.”

— Senior resident, case facility 3

“While we have the liberty to make decisions, they are supervised by our seniors. If they agree with our decisions, that's great. If they feel more needs to be done or changes are required, we follow their decisions. ... Decision making is a unit teamwork effort. All decisions are finalized collectively by everyone in our unit.”

— Junior resident, case facility 2

- **Identifying RMC role models from senior leadership**
 - Senior leaders are critical decision makers
 - Most providers express a desire to emulate senior leadership in their articulation and advocacy of RMC
- **Recognizing RMC champions**
 - Rewarding and celebrating peers since most providers have regular interactions; collaborative decision making for everyday roles

Implications of Findings for Intervention

“RMC needs to be sensitized and there should be a curriculum in post graduation. Once In a fortnight or in a month we should train doctors, nurses, and all other health care providers. Someone should own up and do all this. First comes awareness, training, and mentorship. It’s a continuous process. And with collaboration we can improve things.” — Senior leadership, case facility 1

“Now it is what it is. We can’t do much...we are so overburdened and there are so many patients. What could be done...If providers themselves are stressed, agitated, angry from their personal issues, it gets taken out on patients. The treatment of women depends on mental state of providers.” — Staff nurse, case facility 4

- **Continuous and collaborative training and mentoring on RMC**
 - Regular capacity bridging on RMC
 - Including RMC in curriculum
 - Introducing refresher drills and training for residents and doctors
- **Caring for caregivers:** supporting the existing psychosocial support mechanisms and improving awareness on need and utilization of psychosocial support among providers



Findings from the Community

RETURN
TO ROADMAP



Analytical Framework

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Community context and norms

- **Norms**
 - Demanding RMC
 - Decision making around pregnancy and childbirth
 - Acceptance of disrespectful and abusive care
- **Birth companions**
- **Knowledge and awareness of RMC rights**
 - Grievance redressal
 - Rights
- **Community influencers**
 - Awareness of and attitudes toward RMC

Reported Experience of Care


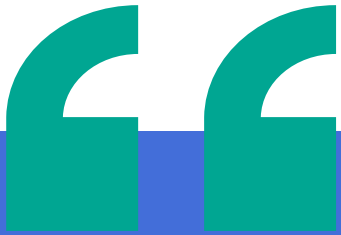


Women's Experience of Respectful Care

“The staff mostly is nice as they try to do normal delivery, and they all talked to me nicely and told about newborn care. The nurse was helpful and even came to check on me at my house later.” — Woman, community 3

“There were to to three doctors; they were all calling me ‘choti choti’ (a nickname). They were asking where choti was and they were looking for me. They were paying a lot of attention to me. They looked for me if they could not see me at my bed—‘Where did choti go?’—as my bed was the corner one. I liked that they were calling me choti. And when I was delivering, they were telling me that I was doing good.” — Younger woman, community 2

- **Written consent** is taken as a formality at the onset of care, but not during the course of care as procedures are administered
- **Some of the positive experiences of women included:**
 - Receiving information and education
 - Being spoken to kindly
 - Being allowed to have birth companions present
 - Being allowed to try for normal delivery
 - Help with pain management



“When I was screaming in pain, doctor and nurses weren’t listening to me.”

— **Woman, community 3**

“Nurses used to raise their voice to instruct. When I went for a checkup during my 7th month of pregnancy, in the OPD the doctors was shouting at many mothers.”

— **Woman, community 1**

“For the newborns, they have to take special care. Though it had NICU, the doctors are not available. If you need a consultation with a pediatrician, you have to wait from 10 a.m. to 5 p.m. During the wait time, who will be responsible if something happens to the newborn?”

— **Woman, community 2**



Women’s Experience of Disrespect and Abuse

- Women reported adjusting their own behavior to avoid the following types of disrespect and abuse:
- Verbal mistreatment
- Lack of empathy
- Lack of privacy and confidentiality
- Lack of information
- Bribes
- Expecting women to provide their own care
- Physical mistreatment
- Unhygienic environment
- Lack of action against grievances raised

Birth Companions Reports of Respectful Care

*“Now, what about like or dislike, she goes there to get treated, so she has to bear the pain and discomfort till her delivery. ...The providers are just doing their job by doing the delivery. So, if our work gets done fairly well, then its okay. Let them ask us to get out, they’re doing it for the patient’s welfare, so its okay; we can tolerate that for a while.” — **Birth companion, community 2***

*“From what I have seen, we are treated very nicely; now we are treated nicely. They behave nicely with us. ... Nurses frequently ask, ‘How are you feeling?’ to the patient. And if we ask for anything, they help us. So we felt good only.” — **Birth companion, community 3***

- Reports of respectful care include:
 - Providers trying for vaginal childbirth
 - Providing emotional support to the patient
 - Respectful communication with birth companions as well as the patient

Birth Companions Reports of Disrespect and Abuse

“We go with the woman inside the ward, but they don’t even let us in. They push us out. We go in to give our patient some water or tea, but the nurses inside are like, ‘Your patient’s time hasn’t come yet,’ so you leave, and won’t let us be there all the times.”

— **Birth companion, community 4**

“Some patients don’t know how to go about labor contractions (lack of experience), then they (providers) say things like, ‘Don’t you know what to do, don’t you understand?’ then they hit her thigh, or brashly move her aside.” — **Birth companion, community 2**

“They should send us inside, allow us to stay and take care of our daughters. Security should look after us without demanding money.” — **Birth companion, community 1**

- Demand for informal payments during and after childbirth (more pronounced in two facilities)
- Not allowing birth companions to accompany women during labor and childbirth
- Reports of physical and verbal abuse of women
- Support staff mistreating birth companions
- Treating women as if they have low worth in general—used to justify mistreatment by providers toward women and birth companions in some instances

Women's Agency in Seeking and Demanding RMC



Agency Constructs



Critical Consciousness

Includes awareness of aspects of care and self-worth; necessary for setting goals to seek or demand respectful care



Can: Self-efficacy

Perceived ability to act, perceived control, and self-efficacy



Act

Engaging in behaviors that could bring in desired outcome or envisioned goal of receiving respectful or good care




Resist

Exercising self-control, social control (to navigate social norms) and continued action despite resistance to ensure pursuit of goals

Critical Consciousness: A Precursor to Agency






“When a patient is in intense discomfort, they should at least check on her regardless of the team.”
— **Woman, community 2**


“It becomes the duty of the doctor and nurse to reassure her, saying, ‘You can do this, you have to bear the pain.’ It’s crucial for someone, either a doctor or nurse, to be by her side.” — **Woman, community 2**

“Everyone is admitted and looked after during delivery. What more can we ask for? This is respect that we get.”
— **Woman, community 4**



What Women Consider Good Maternity Care

- **Primary concern: perception of “good care”** is limited to clinical outcome : a normal delivery and positive outcome
- **Secondary concerns—when probed women express preference for:**
 - Information in a timely fashion
 - Encouragement and empathetic communication
 - Clean, hygienic conditions
 - Informed consent especially before a C-section
 - Not being shouted at
 - Attention and care for pain management
- **A rights-based perspective of receiving maternity care was not expressed**



“But some patients when they scream loudly, they say a lot of harsh things to them. Like they hit them on their thighs, verbally abuse, and say things like didn’t you think of this when you were conceiving, if you can’t handle the pain then you shouldn’t have conceived. .”

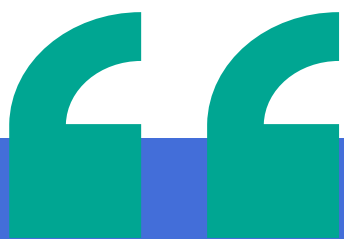
— **Woman, community 3**

“When a patient is already in pain, she expects doctors and nurses to try and understand her situation. They should inform her about the time it might take, whether it's half an hour, an hour, or two hours. ”

— **Woman, community 2**

Pain management as part of maternity care

- **Pain management stands out as a primary concern and point where mistreatment happens for majority of women :**
 - Lack of attention or negligence
 - Verbal abuse
 - Expectation of empathy from providers – often was unfulfilled
- **From provider perspective, pain management was not included as a specific need or point of respectful treatment**
- Within the Respectful Maternity Care Charter, the right to freedom from harm or ill-treatment mentions provision of compassionate and gentle care and assistance to women experiencing pain or discomfort.



*“We are just asked to stay outside and not allowed to enter. We are just given a list of medicines in writing which we have to bring and give to the staff. We just stay outside.” — **Man, community 2***

*“The government has rules, like the birth companion is allowed to stay in the hospital. They are paid Rs 200–300/day by the government and given food at the hospital.” — **PRI, community 4***

*“The doctor, nurse, ANM, ASHA—everyone should treat the woman with respect and talk to them with empathy. Then only, they will show interest to come there. Some women are very sensitive, if the doctor raises their voice, they get scared and will not come next time for treatment here.” — **ASHA, community 1***



What Communities Consider RMC

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- **Men in communities**
 - Consider good care to include kind communication, a clean environment and a normal delivery
 - Feel excluded from the process due to their limited role
- **Birth companions’** expectations are similar to women’s
- **Community influencers**
 - **ASHA workers** emphasize privacy, consent and link mental well being to clinical outcomes
 - **PRI members** mention communication by providers and empathetic/caring behavior
- **Community influencers** are aware of grievance redressal mechanisms at facility and community level but don’t mention as respectful care

Community Understanding of Disrespect and Abuse

“When did they treat you with care ? (laughs), they don't even listen carefully. There are very few doctors and nurses who empathize with our pain.”

— **Woman community 1**

“If we give them what we have they demand more money, even if we say we are poor. It's a problem for us. Everyone asks for money, even security personnel.” — **Birth companion, community 1**

“When a woman is screaming in pain, the nurse will try to console and comfort her. But if she does not listen to the nurse then the nurse will shout at her.”

— **PRI Member, community 4**

- **For women**
 - Shouting/verbal abuse
 - Hitting/physical abuse
 - Lack of empathy, uncaring behavior
 - Not allowing birth companions
 - Demands for bribes
- **For Community influencers**
 - Long waiting time
 - Negligence
 - Discrimination

“They say things like ‘You screaming illiterate,’ ‘Go out of here then,’ even to us.”

— Birth companion, community 2

“For my daughter’s delivery, they treated her very badly, and she felt very sad. We have seen hell. ...They won't show us the newborn babies even if we ask, and we’re scared to ask health care people because we think they might do something with our mothers and babies.”

— Birth Companion, community 1

“While the mother is giving birth to the baby, she won’t be able to do anything by herself. Mother-in-law will only do things for her and will take care of her.”

— Birth companion, community 3

Birth Companion’s Understanding of Disrespect and Abuse

- **Birth companions were more likely to identify harsh behaviors than women:**
 - Characteristics of birth companions: older, more experienced women (mothers and mothers-in-law)
 - They believe disrespect and abuse are the price of a healthy birth
 - They said women have little agency during childbirth

Women's Agency – Critical Consciousness of RMC

“If the patient is educated, they can say, or if they have some knowledge, then they can speak, but I think only some people can voice their opinion.”

— **Woman, community 3**

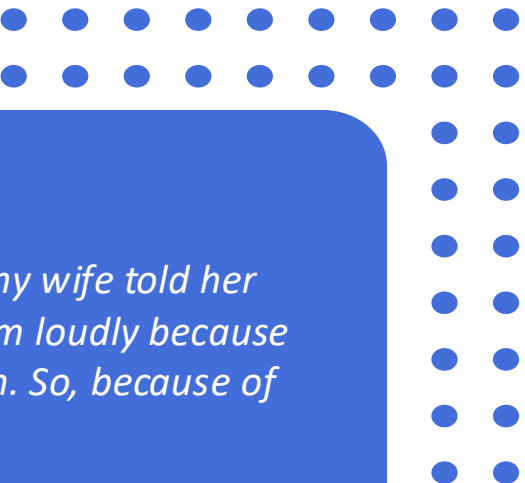
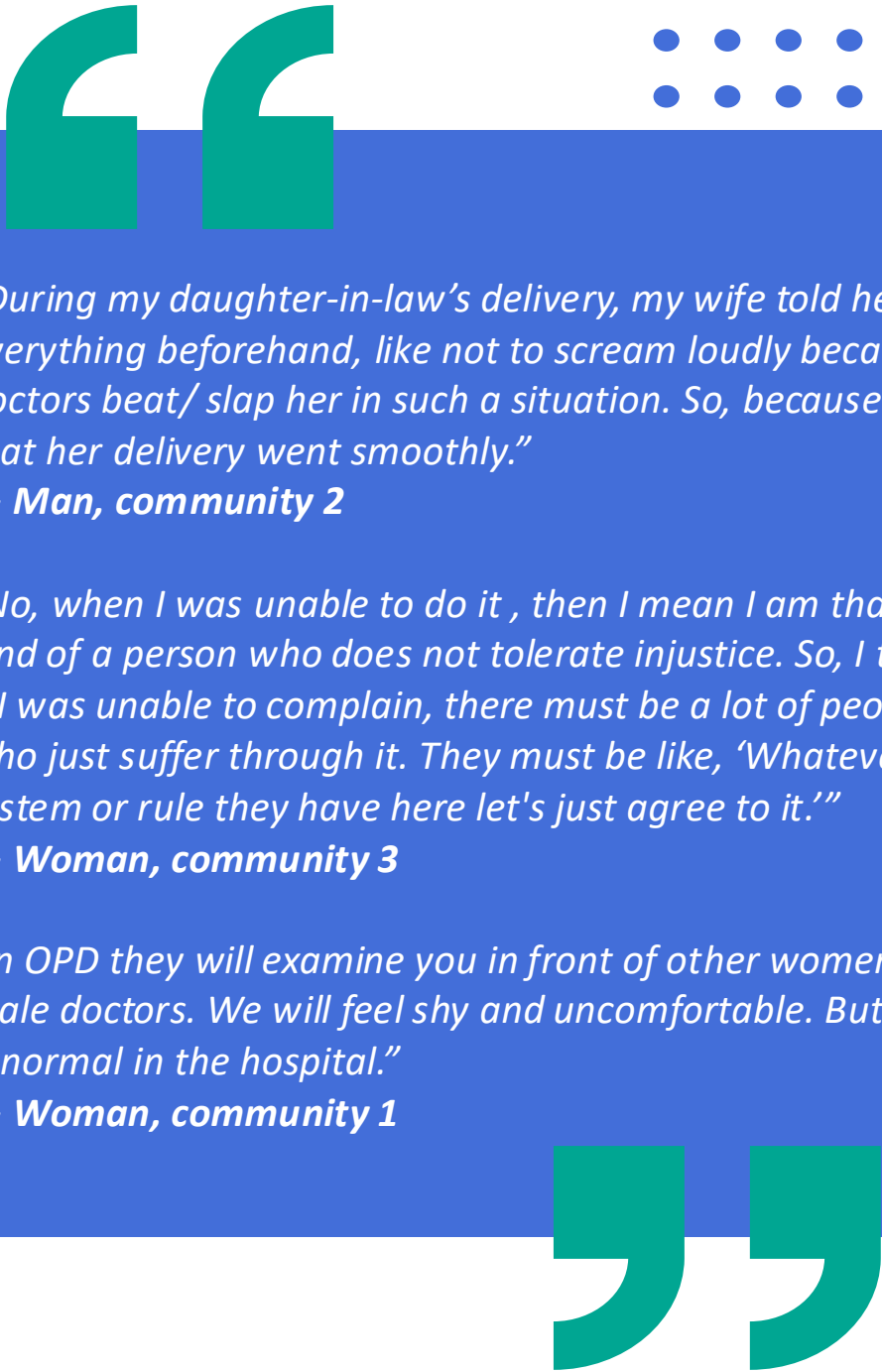
“We considered private hospitals as well, but they were asking for 20,000 INR for normal delivery. They informed us that a cesarean might be needed at the last moment, and they couldn't guarantee a normal delivery. My mother had all three of her deliveries at Facility 2, and she said, ‘It is the best!’ They don't focus on fees and costs, so they prioritize normal deliveries. My delivery was normal and went well.”

— **Woman, community 2**

- Overall, there is limited awareness of RMC and its components; the focus is on receiving clinical care with no complications
- Expectations of care do not involve RMC or the rights of women and newborns
- General lack of awareness and knowledge of grievance redressal
- Can articulate what constitutes harsh treatment and behaviors but don't immediately identify them as such

Self-Efficacy





“During my daughter-in-law’s delivery, my wife told her everything beforehand, like not to scream loudly because doctors beat/ slap her in such a situation. So, because of that her delivery went smoothly.”

— **Man, community 2**

“No, when I was unable to do it , then I mean I am that kind of a person who does not tolerate injustice. So, I think if I was unable to complain, there must be a lot of people who just suffer through it. They must be like, ‘Whatever the system or rule they have here let's just agree to it.’”

— **Woman, community 3**

“In OPD they will examine you in front of other women and male doctors. We will feel shy and uncomfortable. But that is normal in the hospital.”


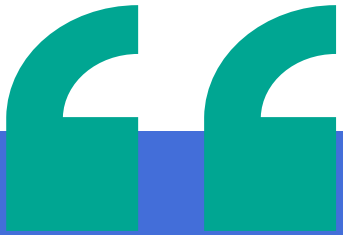
— **Woman, community 1**

Women’s Agency – Self-efficacy

- **A perceived lack of ability**
 - To question treatment by care providers and behaviors of providers
 - To act/complain against harsh treatment by providers
 - To raise grievances
- **A perceived ability or control**
 - To have support of birth companions depending on providers and institutional policies
- **Expression of low self-worth determining treatment:** Women express that their gender and socio-economic status determine the treatment they receive; they cannot ask for anything different

Act






“No one else, in my home I only take decisions. I thought and decided to go (facility 2) for the delivery.”
— **Woman, community 2**

“That was inevitable (choice of the facility) because that is the only hospital near us, and we can afford it.”
— **Woman, community 1**

“I made the decision myself because during that time you need someone who can give you courage. My cousin sister-in-law is courageous, which is why I took her along. However, during the actual delivery, she was asked to stay away and wasn't allowed to be near the bed.” — **Woman, community 2**



Women's Agency – Act

- **Choice of facility: mixed findings**
 - Often in discussion with elders and men as collective family unit
 - In some cases, solely by women—sometimes due to affordability and location of facility
 - Most women who chose a government facility were assured of having normal delivery; generational choice or relatives also delivered in same facility; heard of good care experience from others; had previous delivery experience at same facility
- **Choice of birth companion**
 - Mostly left to women to choose
 - Women chose depending on their level of experience, knowledge, and comfort with the person

Women's Agency – Act

“For birthing, the doctor will ask us to lay down on the bed. That is not in our hands.”

— *Woman, community 1*

“(When asked if women will complaint/question provider’s behavior in the vignette) ‘Saanvi will say nothing in return. She will be quiet or cry. Because to talk against them scares us more.’”

— *Woman, community 4*

- **Clinical care**
 - Women’s choices and preferences are mostly neglected
 - Family members and community members do not participate
 - Some women said they asked for information—most who did were educated or primigravida
 - Feelings of helplessness re: raising grievances; there was a barrier to action of raising grievance

Beliefs, Attitudes, and Norms



Women and Community: Beliefs around Maternity Care

“They scold a patient when it is something that is harmful for the baby. It is okay to scold for the baby’s sake. We have seen something like this.”

— *PRI Member, community 4*

“If something wrong is being done.. I feel like we should say something...But I am afraid...they might leave my daughter or stop treatment.”

— *Birth companion, community 1*

“Some people avoid going to hospital because they worry that the doctors might not treat them well, verbally abuse, or sometimes even hit them. But if there are instances of doctors behaving this way, it’s often because of how some patients treat them. After all, doctors are human too.”

— *Woman, community 2*

- **Providers are working for the good of the women;** their behavior, including mistreatment, is part of working toward that outcome
- **Public facilities and their providers always try for a normal delivery;** in a private facility they aim for a c-section
- If you **pay for services, you can demand better treatment**
- **Providers and institutions are overburdened**

Women and Community: Attitudes toward Disrespect and Abuse

“If the patient listens to them, then nothing will happen to her. Those that don’t listen to them, they are saying for her baby’s benefit, and if she doesn’t think that and does what she wants, then she will be scolded.”

— *ASHA, community 3*

“We are not paying for the treatment, It is free here. So, you have to bear with all the shit.”

— *Woman, community 1*

“If something wrong is being done, I feel like we should say something. ... But I am afraid...they might leave my daughter or stop treatment.”

— *Birth companion, community 1*

- **Positive childbirth outcome for the child and mother** is the most important aspect of care; “going back home with a healthy baby”
- **Complaints against harsh behavior will not improve the situation** and may result in sanctions against the woman or her family
- Some types of mistreatment are not worth complaining about, since complaining can result in worse care or neglect
- Most women said that availing public health services entitled providers to treat them harshly and that they accepted such treatment

Women and Community Norms on Respectful Care

*“It's important not to rush to complain because they are doing a lot for us. They don't have just one patient to take care of; they have many patients. **Good people don't complain.**” — Woman, community 3*

*“If rich people are there, they behave nicely with them but when village people come, they talk harshly.”
— Man, community 2*

*“If the mother can't cope and doesn't follow the doctor's guidance, sometimes the doctor might resort to hitting. ... If she can't endure the pain, it could even lead to the baby's heartbeat stopping. The doctor's intention behind this approach is for the patient's benefit.”
— Woman, community 2*

- **Descriptive norms**
 - Providers will sometimes use harsh behavior toward women during childbirth
 - Support staff ask for bribes from women/family
- **Injunctive norms**
 - Women and families should not complain about harsh treatment
 - Women should defer to the authority of doctors

Women and Community Norms on Respectful Care

“They should take care of the patient properly and should not scold them. Even if it is Sunday, it's their responsibility. Poor people, because of financial problems, go to government hospitals, not to the private.”

— *Woman, community 1*

“The doctor would explain things to them multiple times, but they struggled to understand, and eventually, frustration led to them being scolded and sometimes even hit. ...They have so many patients to cater to and they are also human.”

— *Woman, community 2*

“Patients like us don't understand medical terms because not all of us have studied medicine. In this case, I think they should talk in a simple language that a common man can understand.”

— *Woman, community 3*

- **Norm around acceptance of disrespectful behaviors came out in the context of specific conditions, as to when women would accept mistreatment**
 - Socio-economic status of women
 - Language barriers between the provider and mothers and birth companions
 - Women cause trouble for the doctors
 - Doctors and facilities are overburdened

Hierarchical Cultural Models and Meta-Norms

“When I conceived, I was 22 years old. During labor I told the nurse that I am in a lot of pain, please help me or give me some medicine. Then the nurse and doctor shouted, ‘Why did you get married so early, did I ask you to get married? Now you are crying for help, shut your mouth.’” — Woman, community 1

“It’s a risky time, and we have the chance to support someone in that time. The doctor will do his job, and the patient will bear the pain herself; what can we do anyway?” — Birth companion, community 2

“Because we need their help. We are used to such behavior as we don’t pay.” — Woman, community 2

- **Around women and their families seeking respectful care from health care providers:**
 - Doctors hold a high position in society
 - Women, especially young women, defer to others
 - Socio-economic status determines people’s position in society and the treatment they receive, generally, including women during childbirth

Women and Community on Raising Grievances

“Everyone thinks that it is normal. Then no one knows where to complain and to whom they should complain.”

— **Woman, community 3**

“My mother said, ‘Leave it, it is very common, arguments happen in the hospital, and we have to ignore it. Because we are not going to stay here forever, it is just a matter of five days.’ So, I was helpless and did not think much of it.”

— **Woman, community 1**

“I was furious (and wanted) to complain about the informal payments, but I was scared of the consequences. They might not help us to shift from one ward to another and clean our bed.”

— **Woman from FGD, community 1**

- **Knowledge**
 - Unaware of mechanisms for reporting grievances
- **Norms**
 - Fear of sanctions (getting worse care or none at all) if grievances are raised
- **Outcome expectation**
 - Grievance will not result in any change



Agency of Women - Summary

RETURN
TO ROADMAP



“Everyone is admitted and looked after during delivery. What more can we ask for? This is respect that we get.” — Woman, community 4

Woman: “They scolded me a little during delivery because I was not allowing them to give me stitches.”

Interviewer: “Did you react in any way?”

Woman: “I didn't say anything.”

Interviewer: “Why?”

Woman: “Because it was my fault, right? I wasn't taking the stitches properly, so I didn't say anything.”

— Woman, community 2

Dimensions of Women's Agency



Critical Consciousness

- Limited understanding of RMC
- What is disrespect and abuse? Only in terms of limited aspects of care
- Expression of low self worth/self esteem determines acceptance of mistreatment



Can/Self-efficacy

- Perceived inability to question or raise complaints
- Some control in receiving support from birth companion

Dimensions of Women's Agency



Act

- Making decisions and choosing facility and birth companion
- No choice or preference in provision of care or raising grievances



Resist

- Inability to act or demand care due to fear of sanctions in the form of neglected care or abandonment

“She will say nothing in return. She will be quiet or cry. Because to talk against them scares us more.”

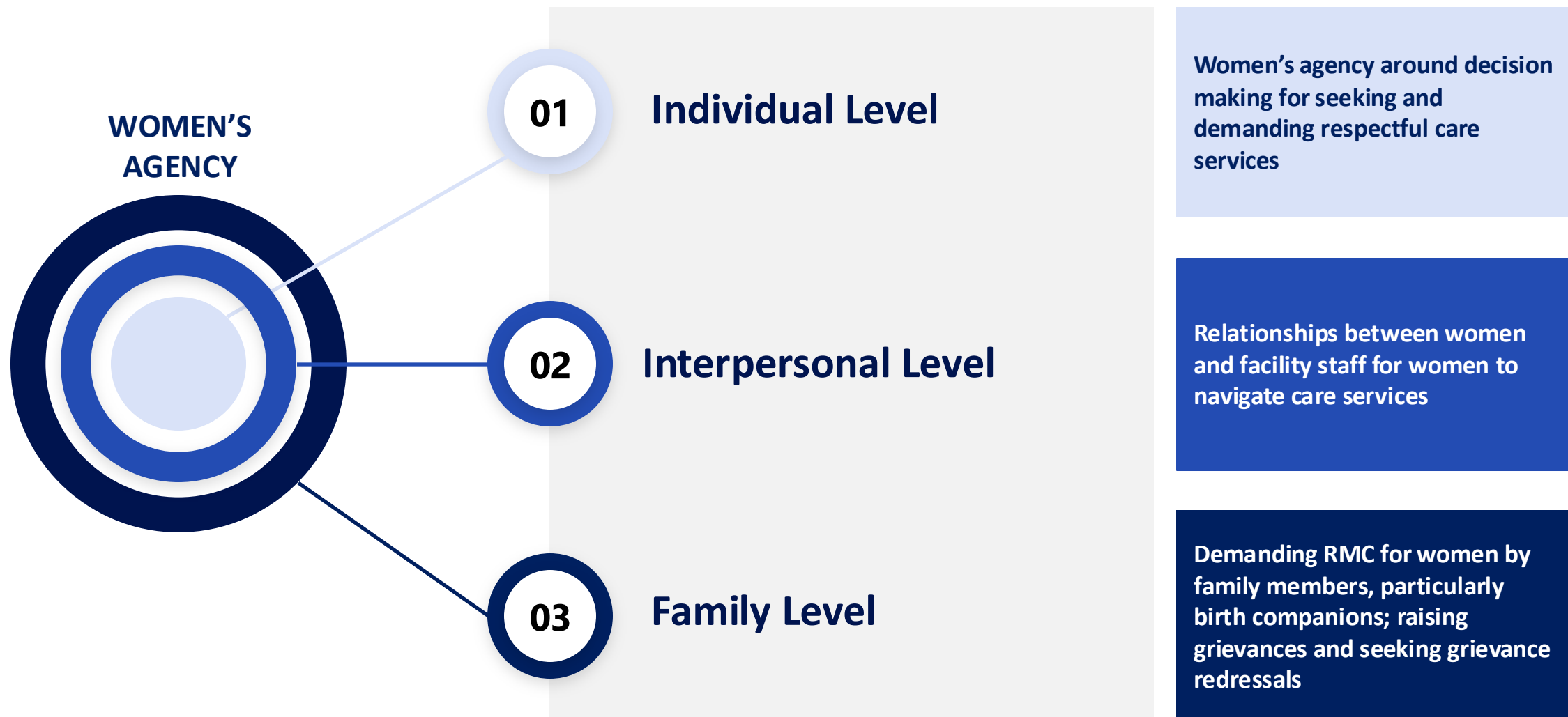
— Woman, community 4, when asked if women will complain or question provider's behavior:

“My mother said, ‘Leave it, it is very common, arguments happen in the hospital, and we have to ignore it...it is just a matter of five days.’ So, I was helpless and did not think much of it.” — Woman, community 1

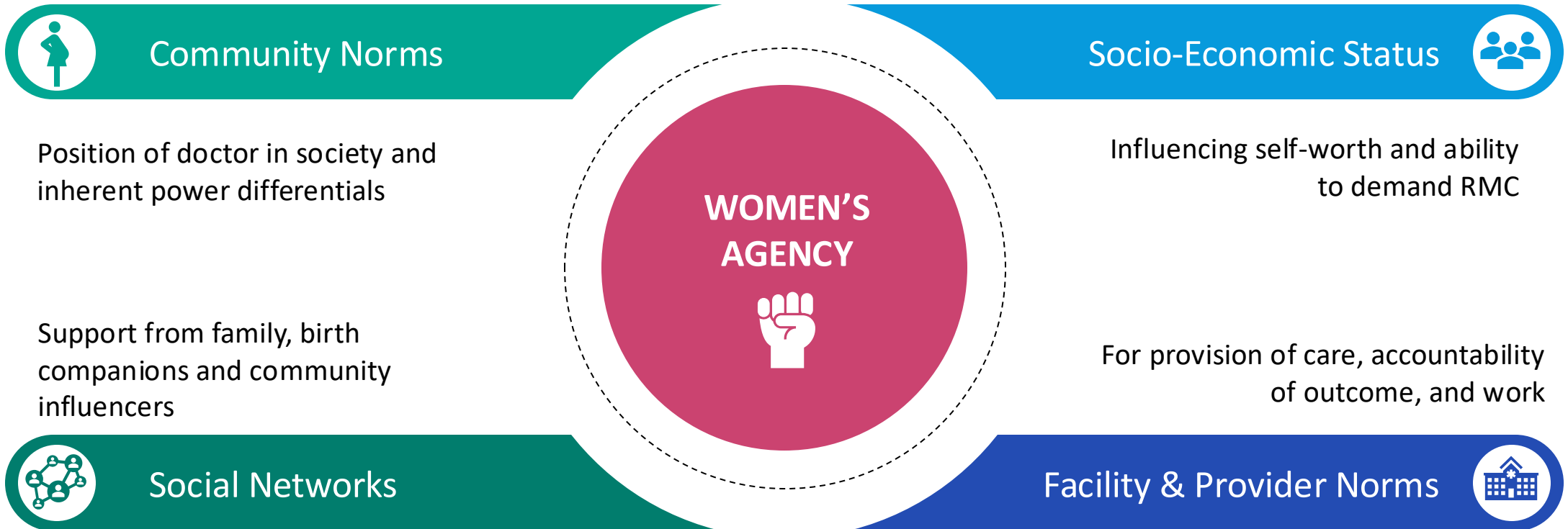
“It was my decision (to choose this facility for childbirth). Many friends in my circle have delivered in this hospital and they believe it's the best place due to the excellent treatment. That's why we chose here.”

— Woman, community 2

Spaces for Manifesting Agency



Relationship between Social Networks and Structures: Implications for Intervention



Implications of Findings for Intervention

“Yes, a lack of knowledge could be a factor because the patient may not be aware of her rights. If the patient knew her rights, she would speak up. Patients often have a fear that if they assert their rights, the doctor may mistreat them.” — Senior leadership, case facility 2

“The doctor should explain all the things about medicines, delivery process, and make the patient understand. Otherwise, they can explain to the family members.” — Woman, community 1

“The woman should be given freedom and the right to decide. Like you had asked us earlier if her consent is taken before deciding the place for her delivery, then she should be given complete freedom to choose.” — Man, community 2

- **Capacity building of birth companions**
- **Capacity building of ASHAs and community influencers to advocate for women’s agency** in making informed decisions about pregnancy and childbirth
- **Increase knowledge and awareness using rights language** around RMC focusing on:
 - Shifting expectations of care from clinical service to a comprehensive, respectful, and patient-centered care
 - Increase awareness of grievance redressal mechanisms at different levels and how to access these mechanisms

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9500 Gilman Drive, Mail Code 0507 La Jolla, CA 92093

Email: info@agency4all.org

Web: agency4all.org

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