



Averting maternal death and disability

**Human rights, constructive accountability and  
maternal mortality in the Dominican Republic:  
a commentary**

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## 1. Introduction

Human rights norms could be readily used to characterize and categorize the chilling scenes of humiliation, neglect and abuse described by Miller et al. in their report on institutional births and maternal mortality in the Dominican Republic [1]. Laboring women have a right to be treated with basic human dignity, to get the quality of care that enables them to give birth safely, and that offers their children the best chance at a healthy start in life.

But can human rights be mobilized to do anything to change this situation? Amid grim accounts of conditions in public sector facilities, the report describes a process that gives reason for hope: here we see the early stages of a process that, whether explicitly and consciously or not, uses many of the techniques of a rights-based approach to reducing maternal mortality.

At the heart of rights-based approaches lies a notion of accountability. All too often, accounta-

bility is used to mean simply blame and punishment. Here I use the phrase ‘constructive accountability’ to make clear that a rights-based approach to maternal mortality reduction is not primarily about enacting a system to find fault and pronounce punishment; rather it is about developing a dynamic of entitlement and obligation between people and their government and within the complex system of relationships that form the wider health system, public and private. It is about building health systems that function for the benefit of people [2].

A classic approach to human rights reporting uses the human rights that have been enacted into law—for example, rights to life and to health; to health care and to non-discrimination—as standards against which to judge treatment of pregnant and laboring women in the health system [3]. Important as that assessment is, to actually change conditions so that the public health system respects, protects and fulfills human rights, we ultimately need to use the impetus provided by human rights law to move beyond the legal realm into the realm of good, evidence-based, rights-conscious medical and public health practice.

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Miller et al. do not, of course, give full details of the political and technical/scientific process by which the Dominican government came to pass the new regulations codifying the norms shown there in Table 2, but they appear to have been formulated based on a view that high quality delivery services are an essential element of women's human rights. Constructive accountability—and the progressive realization of human rights—begins with putting such norms into place. From there, we can highlight important dimensions of the constructive accountability process demonstrated by the report in Miller et al.

## 2. Using norms in a continuous feed-back process

The '*Norms for attention to women in labor and delivery*' and '*Norms for managing obstetric emergencies*' are dated 2001. The assessment explicitly linking the team's observations to the standards set by the new norms was apparently conducted within months of their enactment. Dissemination of the assessment report led to a more careful review of specific maternal deaths, which, in turn, identified some individual physicians whose behavior and practices were egregious enough to justify sanctioning and loss of licensing. Of course, individual punishment (and knowledge that professional standards will be enforced) has an appropriate place in a constructive accountability system. The important point here is that individual sanctioning has *not* been used to scapegoat a doctor, pacify the public, and cover up wider, deeper problems. Instead, it has become one element in trying to implement an ongoing process of systemic change.

Indeed, a new dynamic of entitlement and obligation will require change on all sides. Providers in the health system clearly need to change their views of themselves, acknowledging that their fundamental obligation in law and in accordance with professional standards, is to deliver quality care to patients. But that dynamic will only develop when patients—the people the system is meant to serve—are confident in their entitlement and have effective mechanisms to assert it.

Some patients in maternity hospitals clearly found their treatment to be deeply humiliating: "The nurses and cleaners are animals with clothes on" [1]. But the longer Report of the Strategic Assessment published by the Ministry of Health (SESPAS), USAID and The Population Council in February 2002, also hinted at just how complex the problem of changing expectations and developing a sense of entitlement can often be. After a description of brutal delivery practices at a referral-level hospital, which included roughly hustling the newborn away from the mother with hardly a word, the authors describe their interviews of four newly post-partum women sitting in wheelchairs outside the nursery (one still not having seen her child or received any report of the baby's condition):

We asked each of them how they felt about their experiences; all replied that they were quite satisfied: "This is the best place to have a baby." Some had traveled long distances to have their baby in this "special place." [4], p. 25.

Human rights education meant to develop people's understanding of their entitlements and confidence in their right to assert them, is one of the objectives that women's groups and civil society groups often assume for their work. But such change also needs to be supported by practices in the facility. For example, posting a patients' bill of rights, and similar techniques are used by facilities in many parts of the world, from clinics in India to the teaching hospital at Columbia University in New York City. Providing a mechanism to enforce those rights is also an essential obligation of government.

But such specific steps to introduce and strengthen a dynamic of obligation and entitlement need not come only by fiat from above. Miller et al.'s description of one well-performing facility makes clear that good management practices at that level can make an enormous difference as well. Criterion-based audits and a monitoring group that includes community members are among the tools useful for establishing ongoing constructive accountability mechanisms at the facility level [5].

### 3. Participation of government and other stakeholders; transparency of results

In striking contrast to most human rights reports, Miller et al. is co-authored by officials from SESPAS, the government department responsible for the hospitals it evaluates. The willingness of the Dominican government to bring these issues to light, including in an international medical journal, as it takes steps to address them, must be acknowledged with real appreciation. Rights-based change requires constructive relationships between government, health professionals, and civil society. In the political and economic dynamics of today's world, donors and lenders, who sometimes use their economic power and leverage to influence—even distort—these relationships, also need to be sensitive to and supportive of the dynamics of rights-based change.

Initial reports of the strategic assessment were disseminated in workshops that included representatives of governmental and non-governmental groups, who together helped prioritize problems and then nominated members for the assessment team. It would be naïve to assume that these relationships among NGOs, government and professional bodies are without tension and moments of disappointment, even anger. But the commitment to an ongoing public, transparent process of assessment, change and re-assessment is critical.

### 4. Reflecting on structural as well as individual problems

Miller et al. make clear that the individual behavior of health providers is deeply embedded in a system that does not support them with appropriate training, supervision, assignment of tasks or salary. The analysis of rights violations and accountability lapses as being both individual *and* structural is a crucial prerequisite for making changes that will have lasting impact.

The analysis of the imbalance between overwhelmed referral facilities and the underused, understaffed primary facilities exposes a complex of structural deficiencies intertwined with individ-

ual preferences (no doubt complicated in their origin) that will require long-term commitment to correct.

### 5. Going forward

The very publication of the article by Miller et al. in this journal is an important part of the constructive accountability process. Of course, the analysis can go deeper. There are unanswered questions: who are the women who have suffered such sub-standard care and borne the brunt of unacceptably high maternal mortality in the Dominican Republic? Is inequity in the health system falling along critical social fault lines, so that it needs also to be addressed as an issue of discrimination as well? What role have donors played? What role have health sector reform policies played? What needs to be done at the local level in each facility and at the structural level in the system as a whole to ensure that the norms are followed?

The process of strategic assessment and follow-up described in Miller et al. is the beginning. The seriousness with which the government appears to be taking the issue is an important start. Now all actors have a role in ensuring that this process moves forward, that the facts elicited in assessments lead to appropriate measures for the progressive realization of the right to life and to health for the people of the Dominican Republic. Many of us will watch the process, hoping that the Dominican Republic will become the next success story for reducing maternal mortality—and that it will use a transparent, participatory, rights-based approach to do so.

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