

Parallel worlds: an ethnography of care in an Afghan maternity hospital

Article

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1 **Parallel worlds: an ethnography of care in an Afghan maternity hospital**

2 **Abstract**

3 Aspirations of quality, equitable and respectful care for all women in childbirth have,
4 so far, been unrealised. Sub-optimal care remains the norm in many settings despite
5 decades of substantial investment, the introduction of evidence-based policies,
6 procedures and training programmes. Improving the standard of institutional care for
7 childbearing women in Afghanistan is an example.

8 This ethnography of a large public Afghan maternity hospital explored the
9 experiences, motivations and constraints of healthcare providers. The aim was to
10 identify barriers and facilitators in the delivery of care. Participant observation, semi-
11 structured interviews, and focus group discussions were used to gather diverse
12 perspectives on childbirth and care between 2010 and 2012. The influences of the
13 sociocultural setting and political economy on facility-based care are discussed in this
14 paper.

15 Under the surface of this maternity hospital, social norms were in conflict with the
16 principles of biomedicine. Contested areas included the control of knowledge, equity
17 and the primary goal of work. The institutional culture was further complicated by
18 pressure from powerful elites. These unseen values and pressures explain much of
19 the disconnection between policy and implementation, education and the everyday
20 behaviours of healthcare providers. Improving the quality of care and equity in
21 Afghan public maternity hospitals will require political will from all stakeholders to
22 acknowledge these issues and find culturally attuned ways to address them.
23 Furthermore, the notion of competing world-views on healthcare has relevance
24 beyond Afghanistan.

25 **Research highlights**

- 26 • Afghan biomedical practice is being shaped by history, society and
27 politics
- 28 • Connections, status or financial gifts were required to access quality care
- 29 • Professional knowledge and clinical skills were generally guarded not
30 shared
- 31 • Social expectations and pressures were stronger than notions of equity
- 32 • Political elites had power and influence over healthcare providers

33

34 **Keywords**

35 Afghanistan; critical ethnography; sociocultural values; respectful care; equity; quality
36 of care; political economy; patronage

37 **INTRODUCTION**

38 Despite three decades of global commitment, activism and investment in maternal
39 health, women are still dying needlessly in low, middle and high-income countries
40 (Shaw et al., 2016; Victora et al., 2016). As governments, international donors and
41 healthcare implementers focus on the sustainable development goals many
42 challenges remain such as achieving good standards of care for childbearing women
43 in public health facilities (Koblinsky et al., 2016). Ensuring that the poorest and most
44 vulnerable women in society access the services they need and are treated with
45 kindness is currently little more than an aspiration in most settings (Barros et al.,
46 2012; Graham et al., 2016; Mumtaz et al., 2014).

47 Evidence-based policies and procedures now generally form the basis for healthcare
48 provider education and clinical protocols globally (Renfrew et al., 2014). The day-to-

49 day practice of care workers, however, is mediated by more innate values and
50 priorities (Andersen, 2004; Jaffré, 2012). Understanding the diverse and complex
51 social worlds that define healthcare providers in each unique setting is a vital step in
52 understanding some of the most intractable issues in 21st century healthcare (Panter-
53 Brick & Eggerman, 2018; Pitchforth et al., 2010).

54 In Kabul, state sponsored public health provision did not commence until the early
55 20th Century when Turkish and Indian doctors were employed to set up a hospital
56 and clinic. Health clinics for women did not commence until the 1940's although a
57 French couple opened an unofficial midwifery school in the 1930's. A Western-styled
58 health system including a medical university grew throughout the 20th Century,
59 although it faced opposition and functioned alongside traditional beliefs and practices
60 (Gregorian, 1969; Hunte, 1980). The fall of the Taliban regime in 2001 brought new
61 opportunities and impetus to rebuild and strengthen the health system devastated by
62 decades of conflict.

63 Since then, the Afghan Ministry of Public Health (MoPH) and international community
64 have made the reduction of maternal and newborn/child mortality a priority (Jhpiego,
65 2018; Ministry of Public Health, 2005, 2012). Addressing the dearth of female
66 healthcare providers has been a key strategy. Kabul medical university resumed the
67 education of female doctors and new national midwifery curricula were developed
68 incorporating competency-based learning approaches and a job description based on
69 the International Midwifery Confederation educational framework (ICM, 2002). The
70 new standardised midwifery education programme replaced a hotchpotch of short to
71 medium term courses run by international agencies throughout the country. Over
72 4,600 midwives were trained between 2004 and 2014 (Currie et al., 2007; United
73 Nations Population Fund, 2014). Although the training is highly valued, translating the
74 potential of these professional women and their skills into quality care for all Afghan

75 women and their unborn babies has been an elusive goal (Guidotti et al., 2009;
76 Jhpiego, 2013; Kim et al., 2012; Rahmani & Brekke, 2013).

77 Recent reviews conclude that Afghanistan has made progress in improving maternal
78 and child health, especially given the low starting point, poverty and ongoing
79 insecurity (Akseer et al., 2016; Bartlett et al., 2017). Amongst the challenges noted
80 are the unacceptably high maternal mortality ratio and poor quality of public hospitals
81 (Central Statistics Organisation et al., 2016; Ministry of Public Health, 2017; Tappis et
82 al., 2016).

83 This study explored the culture of care and the perspectives of Afghan doctors,
84 midwives and care assistants on healthcare delivery in one maternity hospital. The
85 aim was to understand the disconnection between good standard educational
86 programmes and the low-level care that women in facility-based childbirth often
87 received.

88 **Methods**

89 This study used a critical ethnographic approach to illuminate the values and
90 meanings underlying staff behaviours as well as the multiple realities and power
91 differences (Hammersley & Atkinson, 2007; Thomas, 1993). RA, a British nurse-
92 midwife researcher with broad cross-cultural experience and eight years in
93 Afghanistan conducted the research. She was familiar with the hospital having
94 overseen student midwives' clinical placements there some years previously but
95 wanted to understand care, and challenges with standards of care from the
96 perspective of the healthcare providers. The research was conducted from a
97 constructionist philosophical stance, "an epistemological approach which assumes
98 that there are no stable, pre-existing phenomena... but seeks to address questions of

99 how those phenomena are created through social processes” (Green & Thorogood,
100 2018, p.385).

101 A busy public Kabul maternity hospital was chosen for this study with permission
102 from the MoPH and the hospital director. The hospital received mainly poor women
103 who could not afford private hospitals. Officially public hospitals are free, however,
104 unofficially out of pocket expenditure is the norm (Bartlett et al., 2017). Data
105 collection including interviews, focus group discussions (FGD) and participant
106 observation occurred during several field trips organised between 2010 and 2012.

107 Since RA had only basic Dari a young Afghan woman was recruited as an
108 interpreter, trained and orientated to the study (Temple & Young, 2004). Information
109 sheets in Dari and Pashtu were placed in prominent areas throughout the hospital
110 prior to data collection. The logistics of observation were discussed with senior
111 medical and midwifery staff, and RA, her interpreter and the study were introduced at
112 several staff meetings.

113 Participant observation included all areas of the hospital during both day and night to
114 ensure data sufficiency. During observation field notes were taken to capture the
115 setting, staff practices and interactions (Wallace, 2005). These were typed up and
116 expanded as soon as possible afterwards. Informal talks with individuals and groups
117 of staff members helped to build a rapport and provided initial insights into the
118 pertinent issues and tensions (Brewer, 2000). Semi-structured interviews with 23
119 staff members then explored topics in more depth (Sherman Heyl, 2001), using a
120 mixture of opportunistic and purposive sampling. Interviews were conducted with
121 senior doctors and midwives, resident doctors, newly qualified midwives and care
122 assistants to ensure that a broad variation of views was represented (Sharkey &
123 Larsen, 2005). Questions included: ‘Tell me about care in this hospital’; ‘What part of

124 your work do you enjoy the most?'; and 'What are the most difficult things about
125 working in this hospital'? Most interviews were semi-structured, however, some staff
126 did not need prompting to share their experiences, ideas or frustrations. It was
127 important to calibrate observations of care with the wishes of Afghan women
128 regarding childbirth rather than Western notions of what is desirable. FGDs (van
129 Teijlingen & Pitchforth, 2006) were, therefore, held with two groups of women from
130 different socioeconomic backgrounds and communities to discover their experiences
131 and wishes regarding childbirth. The first FGD consisted of six female members of
132 one extended family; the second FGD consisted of ten unrelated women aged 23-56
133 who were members of a self-help group in a very poor area of Kabul.

134 Forty-one background interviews with senior officials in the MoPH, medical and
135 midwifery educators, programme directors, community leaders and non-Afghan
136 anthropologists and linguists provided insights into the wider health system,
137 sociocultural, political and historical context of care. Background interviews were
138 ongoing throughout and were part of the iterative process. They continued to produce
139 new perspectives and this provided a check against forming premature judgements
140 on the nature of hospital culture and life.

141 Interviews were digitally recorded if consent was given; alternatively, notes were
142 hand-written and expanded shortly afterwards. Interviews were conducted in Dari or
143 English. RA transcribed all interviews. As a quality control measure (Kirkpatrick & van
144 Teijlingen, 2009), recorded Dari interviews were transcribed and translated by an
145 Afghan researcher. Data were analysed thematically (Braun & Clarke, 2006). Each
146 interview was coded, then similar codes were grouped into categories (Holloway &
147 Galvin, 2017). Categories were checked against the data, linked with other
148 categories and redefined into higher order concepts (Forrest Keenan et al., 2005). To
149 achieve a systematic analysis that also maintained the contexts, each data set was

150 analysed separately prior to analysing across the data as a whole. The data from
151 observation, background interviews, semi-structured interviews, FGDs and from each
152 discrete cadre formed part of the final analysis. Conflicting perspectives or opinions
153 were included and discussed as they represent the complexity of social life and
154 interactions.

155 RA conducted the majority of the analysis, however, co-authors (EvT and KR) read
156 and coded several interviews. During data analysis the developing themes were
157 discussed with Afghan colleagues as well as two linguists and cultural experts to
158 ensure that these resonated with wider Afghan values and culture. This was
159 important in endeavouring to produce “culturally competent health knowledge” (Tsai
160 et al., 2004). The developing analysis and concepts were also discussed with the co-
161 authors. This article discusses the impact of sociocultural norms and the political
162 economy on healthcare providers and the care of women in facility-based childbirth.

163 Ethical approval was granted by the MoPH Institutional Review Board and
164 Bournemouth University. Written and verbal explanations regarding the aims of the
165 research were given to staff members prior to interview. As the researcher was a
166 foreigner introduced by the MoPH, it was vital to ensure that participants understood
167 that they were able to refuse an interview (Christakis, 1992; Nuffield Council on
168 Bioethics, 2002). Ongoing informed consent was obtained from each participant. In
169 one case, an interview with a care assistant was immediately brought to a close as
170 some discomfort was sensed. Because of Afghan politeness and her low status
171 within the hospital hierarchy it was possible that she felt unable to say no to a request
172 for an interview. After this, no formal interviews were conducted with care assistants
173 but opportunities were taken for informal conversations with others in corridors or
174 during work. This ensured that they knew their opinions were valued but gave them
175 the power to initiate conversation or to walk away.

176 Findings

177 Initial observations revealed familiar features – hospital staff in uniforms, women in
178 childbirth, busy corridors, visiting relatives, noises, smells, routine procedures and
179 morning reports. Behind the tangible, however, were other ‘realities’, which, in
180 addition to the ‘biomedical hospital world’, influenced the behaviours and priorities of
181 the healthcare providers. Social pressures and the political economy defined the
182 purpose of hospital work, controlled medical knowledge, access to care and the
183 agency of individual staff members. Furthermore, these other ‘realities’ elucidated
184 issues that have persistently undermined efforts to improve the quality of care.

185 1. The control of knowledge

186 Midwives received a competency-based education designed to enable them to
187 manage most complications of pregnancy and childbirth. Using their new skills in the
188 clinical areas, however, was a challenge. A junior midwife explained she had not
189 been allowed to care for women having their first baby, perform an episiotomy or
190 manual vacuum aspirations.

191 The old midwives tell us, ‘this is not a midwife’s job, this is doctors’ work’. They
192 say: ‘Here, what midwives do is only cleaning, arranging the ward and checking
193 the blood pressure of patients’.

194 One midwife complained that not only were midwives discouraged from using their
195 skills, senior midwives deliberately undermined her confidence by suggesting she
196 had made mistakes, and would be reported and punished.

197 Healthcare providers explained that if they tried to share their knowledge they faced
198 suspicion and opposition. A resident doctor started teaching colleagues about
199 neonatal resuscitation having recently attended a “Helping Babies Breathe” course

200 (Arlington et al., 2017). Some residents were interested to learn, whilst others
201 ridiculed her – accusing her of wanting to ‘show off’, to promote herself. An
202 experienced midwife, who wanted to improve standards, was reprimanded by senior
203 midwives for training her colleagues.

204 ‘You can’t train, who are you? You are a midwife not a teacher’. They don’t like
205 me to do training, she explained, because they think if I do training I will be
206 promoted...they don't think how good it is that the knowledge of staff is
207 becoming higher.

208 The residency programme for newly qualified doctors provided clinical training
209 designed to equip them as consultant obstetricians and gynaecologists. Each
210 resident was assigned a trainer but many complained that unless they were related
211 to a senior doctor they were left alone to develop clinical skills, practising on women
212 in childbirth (Arnold et al., 2014). A foreign doctor with many years’ experience
213 mentoring doctors in Afghanistan explained:

214 In teaching hospitals senior doctors are called trainers but many lack a sense of
215 responsibility to train... some regard the resident doctors as competitors, that if
216 you are too good at training the resident may take away your private patients.

217 With some exceptions, knowledge and skills were not considered resources to be
218 shared for the benefit of all but a resource to be controlled, kept to oneself and one’s
219 family.

220 **2. Equity or patronage**

221 Increasing ‘equitable access’ to healthcare is a strategic priority of the MoPH
222 (Government of the Islamic Republic of Afghanistan, 2011, p.21). A woman in one

223 community FGD explained, however, that when poor women came to the hospital the
224 type and quality of care they received depended on the attitude of individual staff.

225 If a woman is poor and the doctor is compassionate they will help and use the
226 hospital medicines but if the doctor is not kind but cruel, like a stone, then the
227 woman's relative will be left at the hospital gate and the woman will be forgotten
228 on the hospital's bed, and if something happens to her no action is taken.

229 Interestingly, in this quote, there is no notion of equity as a right but rather good care
230 being dependent on the personal attributes of healthcare providers i.e. being
231 compassionate. "If something happens..." implied that if a poor woman suffered a
232 complication or died healthcare providers would not be held to account. A non-
233 Afghan midwife who had experience of many Afghan maternity hospitals confirmed:

234 Here [in the health system] I think sadly - there's inequity, if women are poor
235 and uneducated I think they are treated badly...

236 The quality of care was also dependent on family ties. If the woman in childbirth was
237 related to or had a family connection with one of the hospital staff they would expect
238 to receive better care than women without connections. A non-Afghan surgeon with
239 many years in the health system explained, "the one overriding factor (in who gets
240 good or bad care) is connections. You've got to be related or know someone". A
241 woman in the other FGD explained:

242 Nobody feels responsible, so if you don't have a *wāsīta* [an intermediary,
243 middleman, advocate or go-between] the staff will not pay attention or care for
244 you.

245 Some staff explained that they cared for women like their own family or that this work
246 was their service to Allah. Several healthcare providers complained that if they gave

247 extra care to a woman with complications the relatives of other women would scold
248 them vehemently, accusing them of neglecting their relative.

249 Observations revealed a broad spectrum of care practices. Staff members generally
250 worked hard, often overwhelmed by the numbers of women in childbirth. Kindness
251 and warmth between staff and women in childbirth was observed, however, most
252 women laboured alone, distressed and unsupported while at times healthcare
253 providers sat together talking.

254 The strength of Afghan kinship ties and obligations is unequivocal; the duty of care
255 towards strangers is more tenuous. The healthcare provider role requires caring for
256 non-family members. A non-Afghan nurse manager with 30 years' experience in
257 Afghanistan explained:

258 The attitude of staff is generally that the patient who is not a member of my
259 family or clan is not interesting for me. If they give me money, yes this is
260 interesting, so I will help a bit.

261 An anthropologist, who had lived with Afghan families, explained that even in
262 families, care is connected to respect and respect is linked to your position in the
263 family hierarchy. "Status demands respect" she explained, "and respect demands
264 care". A historian and cultural expert concurred:

265 Respect in Afghan society is only due to equals or those above you in status. If
266 there is no embedded cultural idea of respect for those of lower status then
267 there is no obligation to show care. Patients by virtue of the fact that they are
268 seeking the aid of the hospital automatically classify as below the care provider.

269 Status, related to family importance and connections, educational background,
270 economic situation and possibly ethnicity influenced access to care and the quality of

271 care for women in childbirth; likewise, status affected the opportunities of healthcare
272 providers. A newly qualified midwife explained the difficulties she experienced
273 securing her job in the hospital. She had to sit a MoPH exam where only the top
274 students were employed. I asked her if connections or *wāsita* also affected job
275 opportunities?

276 Researcher /first author: So does it help if you know someone in the Ministry?

277 Midwife: Maybe... (lot of laughing from her and the interpreter) yes, it's a
278 custom in Afghanistan!

279 The official way to secure a job was to achieve the highest result in an exam.
280 Unofficially, however, the applicant had to know someone in the ministry or hospital
281 to be employed there.

282 Resident doctors and midwives explained that the same people were often chosen to
283 attend workshops and training courses. "Here it is the special people who get sent
284 every time", a midwife complained. During observation a senior doctor became very
285 animated about the need for a fair system and career pathway for staff.

286 We need a system where there are fences and people are unable to step to the
287 right or to the left but have to keep following the way step by step. We do not
288 have such a system at present.

289 This senior and highly motivated doctor had been overlooked for promotion for many
290 years. Numerous Afghans explained that no one could hold a senior position, in a
291 hospital or government ministry, without having powerful connections. As a
292 community leader confirmed, "Political support is necessary for senior positions, not
293 just knowledge".

294 Connections to important, powerful people were vital for everyone in this maternity
295 hospital. Without such patronage hospital staff as well as women in childbirth were
296 disadvantaged. Although there were exceptional staff members who cared for
297 everyone, the over-riding factor in receiving quality care was not need but status;
298 who one was and to whom the family were connected. Secondary to this, was the
299 ability to pay for services.

300 **3. The purpose of hospital work**

301 Many midwives and doctors talked of wanting to “serve the needs of their patients
302 well”. Staff explained that they “became happy” when seriously ill women recovered
303 because of their care. Others said their own mothers encouraged them to treat the
304 ‘patients’ well. Some doctors and midwives were endeavouring to improve standards
305 and were distressed with the deficiencies in care.

306 Women in the community, however, portrayed a maternity system that often lacked
307 basic clinical care and kindness. A young woman in the community FGD said:

308 There is no sympathy, or good behaviour. I delivered my first child in the
309 hallway of the hospital. Here there is no monitoring and nobody answers your
310 concerns... I had a very bad pain and couldn't understand anything.

311 A community leader, and a foreign doctor with many years' experience in the country,
312 concurred that throughout Afghanistan a job is considered to come with privileges,
313 including the opportunity to use a position to benefit one's family. The benefit could
314 be gifts or money given by, or requested from, women in childbirth or their families.
315 Senior positions provided the opportunity to ensure family members were awarded
316 places on training courses, promoted or appointed to jobs, even in preference to
317 more appropriately qualified applicants. The more senior the position held, the higher

318 the family expectations and pressures. A community leader posed the question – are
319 staff working in the hospital “to serve or to be served? To serve the patients or have
320 their needs served by the patients?” He explained that because patients benefit from
321 healthcare providers’ years of study, knowledge and skills, the staff expected some
322 remuneration in return. A woman in a FGD explained:

323 Believe me, when I went to the hospital to deliver my baby, in each step they
324 asked for money and I had to pay them, even when I wanted to leave.

325 A foreign nurse with extensive experience in Afghanistan explained that during the
326 Soviet occupation (1979 –1989) everyone was guaranteed a job. Large numbers of
327 government employees were consequently paid for attendance rather than doing
328 their job. If employees were required to do something then they would expect
329 additional payment. This, she said, was potentially connected to the expectation of
330 *shīrnī*. (*Shīrnī*, meaning 'sweets'/'sweetener', refers to the customary practice or
331 obligation to 'treat' close friends, family and colleagues to a gift or meal on, for
332 example, getting promoted, but can refer to a bribe). In addition it could partly explain
333 the unwillingness to take on extra work in an already busy hospital. A senior midwife
334 said that she tried to encourage other midwives to feel responsible for checking
335 women in childbirth to justify their salary.

336 You have to do good work and earn your salary, she told a midwife. ‘No!’ The
337 midwife said – ‘I earn my salary coming to this hospital’. They have old ideas
338 from a previous time, the senior midwife explained, but now we want to change
339 their ideas.

340 Doctors and midwives represented the investment of families: fathers, brothers,
341 husbands, grandmothers or mothers who had permitted or supported their studies. In
342 this collectivist society a healthcare provider’s first priority was to honour that

343 investment and their family obligations. Some were obliged to study medicine or
344 midwifery (Arnold et al., 2014) and this may partly explain issues with motivation.
345 Economic necessity meant that supplementing salaries could represent the
346 difference between family survival and destitution. In the ongoing turbulent Afghan
347 context, the protection of family networks is also vital for survival; disloyalty to family
348 jeopardises that protection. A nurse midwife who had worked in the country for many
349 years explained:

350 Because there is no formal system of protection against misfortune that is why
351 the informal power structures are so important.

352 A senior doctor explained, however, that unborn babies suffered as staff, spent time
353 generating *shīrnī* from the relatives of women in childbirth rather than regularly
354 checking fetal hearts, a vital element of high quality intrapartum care. This confirmed
355 the observation that generally, regular checking of women in labour and fetal hearts
356 was not done and fetal hearts were only listened to following internal examinations. A
357 woman in a discussion group concurred:

358 In Kabul's hospitals there is no system of investigation or monitoring. After first
359 examination they leave women in hallways of the hospital and nobody will take
360 care of them...

361 A doctor explained that taking *shīrnī* had become a habit for some regardless of
362 need. In addition, she alleged, there was a "hidden system" [of taking bribes]...
363 based on relationships, involving senior people.

364 This system [of taking money] is very dangerous for this hospital. Junior staff
365 members have a relationship with senior staff and it goes up, up, up... it is the

366 main cause of maternal and neonatal death [because staff do not have the time
367 to monitor women and babies].

368 Several participants indicated that powerful people from outside the hospital were
369 involved. One participant explained that an attempt to expose the practice had
370 resulted in a cover up and staff members threatened. She explained that the same
371 system existed in all Kabul maternity hospitals. Moreover, women suspected that
372 medical interventions were not always done for their benefit.

373 This issue is everywhere...they force you to have surgery and they will open
374 your belly. Natural birth is very low these days...they are doing surgery to
375 receive more money or to learn on poor people how to perform surgery.

376 Several healthcare providers gave examples of the fraudulent use of clinical
377 interventions to generate additional income: it was beyond the remit of this study to
378 examine these claims. The concept of healthcare providers being there to primarily
379 serve the needs of patients, however, failed to resonate with the experiences of
380 women in the community, background interviewees or observations.

381 **Discussion**

382 This study demonstrates the depth and complexity of issues that affect the provision
383 of care in this Kabul maternity hospital. It highlights that suboptimal care cannot
384 solely be attributed to a lack of knowledge, training, evidence-based policies or
385 procedures but is connected, in part, to the internal values and priorities of staff, the
386 societal and institutional culture. Although healthcare providers generally look the
387 same in hospitals across the globe, this study reveals they have different ways of
388 understanding the world. They may work in a 'caring' profession but perceive the
389 purpose of work from innate social norms and values, which, for example, can result

390 in guarding their skills rather than sharing them. A sense of responsibility to strangers
391 might clash with kinship obligations, the institutional culture, and the wider social
392 environment. Furthermore, public health institutions may not only provide care, they
393 may also be lucrative sources of income for political elites.

394 Speakman and colleagues (2014, p8) claim that recent health initiatives led to a
395 “rapid acceptance of global best practices” among Afghan stakeholders in midwifery
396 education. Our findings, however, illuminate some inherent problems; whilst the
397 institutions, programmes and systems of biomedicine have been adopted, the day-to-
398 day functioning of the hospital reveals the persistence of divergent values and
399 competing power structures. It reveals a system of biomedicine that is contextually
400 specific having been shaped by culture, history and politics. Recent developments in
401 education, policies and programmes have increased staff expectations but also
402 frustrations at the gulf between the ideal and the constraints of their world.

403 Competing discourses can be seen in the control of knowledge. From a biomedical
404 perspective access to knowledge is important to determine best practice, hence,
405 knowledge is a resource to be shared for the benefit of all (Beauchamp & Childress,
406 2013). In a more status-oriented society not sharing knowledge or skills is a way of
407 maintaining respect, superiority and power. The latter was highlighted by several
408 interviewees and confirmed by Foster (2009, p.37), a non-Afghan surgeon, who
409 reported that senior Afghan doctors did not entrust their knowledge to others but
410 rather accused young doctors of “stealing their skills”. Traditional stories from the
411 region expound the wisdom of keeping some knowledge to oneself. The Persian poet
412 Sa‘dī Shīrāzī (d.1292) advised his listeners “Never empower a friend so much, that if
413 he becomes your enemy, he is able to defeat you” (Loewen, 2008, p.69).
414 Furthermore, this monopoly on certain knowledge or skills (Arnold et al., 2014) may
415 be used to generate additional income in the private practice of doctors or midwives.

416 The importance of connections and patronage in accessing healthcare has been
417 documented in low and middle-income countries (Andersen, 2004; Rivkin-Fish,
418 2005). In his anthropological examination of maternal mortality in obstetric
419 emergency services in West Africa, Jaffré (2012, p.6) explained that “globally, entry
420 into services is made through ‘acquaintances’”.

421 It is not only Afghan women in childbirth who are disadvantaged if they lack a *wāsita*,
422 but also the midwives and doctors caring for them who may miss out on employment
423 and promotion opportunities. Ethical principles and the importance of attitudes that
424 promote equitable access are emphasised in the midwifery curriculum (Ministry of
425 Public Health, 2009). The MoPH reproductive health policy states that “poor and
426 underserved groups” are to be prioritised and inequities decreased (Ministry of Public
427 Health, 2012, p.3). Our study found, however, that inequitable access and treatment
428 was still the usual experience of women in childbirth. As an assessment of the
429 midwifery workforce reported, Afghanistan is rich in policies - the issue is
430 implementation (Jhpiego, 2013).

431 Afghanistan is not unique. Although the laws in many countries are conceived to
432 serve the ideal of equality, Hofstede et al. (2010, p.54) noted that “there are few
433 societies in which reality matches the ideal”. Low, middle and high-income countries
434 still struggle to achieve equality or equity in healthcare (Barros et al., 2012; David &
435 Collins, 2014; Mumtaz et al., 2014). Farmer (1999, p.1492) contends that: “Even as
436 our biomedical interventions become more effective, our capacity to distribute them
437 equitably is further eroded”.

438 It is impossible to make generalisations on the primary focus or purpose of work for
439 the heterogeneous healthcare providers in this study. The strong connection to family
440 needs, obligations and demands, however, was evident in staff of all cadres and

441 seniority. In their analysis of national cultural differences, Hofstede and colleagues
442 (2010, p.90) noted that globally the vast majority of people live in societies “where the
443 interest of the group prevails over the interest of the individual”. Furthermore,
444 individuals in these collectivist societies grow up to think of themselves as part of a
445 ‘we’ group (or in-group), the major source of their identity and security to which they
446 owe life-long loyalty. Minkov (2007) labelled this “exclusionism” where favours,
447 privileged treatment and sacrifices are reserved for the in-group, while others, (the
448 out-group) may be treated with indifference, rudeness and hostility.

449 Values are acquired through socialisation and although the more superficial facets of
450 a culture may change, values are the most stable element (Hofstede et al., 2010).

451 Although Afghan doctors and midwives are taught the principles of equity, these
452 might not resonate with their experiences or the values of their society. Moreover,
453 adopting these principles at work might place them in opposition to colleagues, the
454 prevailing institutional culture and the powerful elite. The importance of adhering to
455 social expectations in Afghan society was demonstrated by Eggerman and Panter-
456 Brick (2010) who conducted 2022 interviews with Afghan children age 11-15 and
457 their adult caregivers. Cultural values such as service to family were found to be the
458 bedrock of resilience, that underpinned self-respect and dignity, providing hope in a
459 violent, war-affected setting (Eggerman & Panter-Brick, 2010). The authors found,
460 however, that cultural dictates and social expectations also created a sense of
461 entrapment where personal aspirations had to be sacrificed and failure resulted in
462 psychosocial distress. Similarly, midwives, care assistants and doctors in our study
463 were frustrated by the injustices they experienced because of the pervasive nepotism
464 and their own powerlessness within the system. They were also distressed that
465 women in childbirth were deprived of the care they needed. Healthcare providers
466 were aware that public health institutions should provide care for all, however it

467 appeared that more compelling needs and demands usually surpassed the needs of
468 poor, uneducated, unconnected women. Interestingly, the assumption of relatives
469 that if a woman was receiving extra care it was because of connections not clinical
470 need further highlights how patronage is ingrained in Afghan society.

471 Jaffré (2012, p.6) also concluded that “the medical organisation is permanently
472 duplicated by an interconnected system”. “It is the same everywhere” he states, “the
473 behaviours of health personnel always mix technical norms with habits and local
474 customs” (p.8). A notable difference in our study was that the ‘interconnected system’
475 was complicated by economic hardship, the legacy of over three decades of conflict,
476 ongoing instability, and pressure from powerful people inside and outside the
477 hospital.

478 Service users in multiple studies have confirmed the need for out-of-pocket
479 expenditure in Kabul hospitals (Howard et al., 2014; Rahmani & Brekke, 2013). The
480 Afghanistan Reproductive Age Mortality Survey (Bartlett et al., 2017) reported that
481 the cost of delivery care, especially in government hospitals (which should be free) is
482 concerning. Our study suggests that these findings represent more than individual
483 staff supplementing their income. In 2016 health and education services in three
484 Afghan provinces were examined in an attempt to understand why qualitative
485 improvements have been so much more difficult to achieve than quantitative ones
486 (Afghanistan Research and Evaluation Unit, 2016). The roles of government officials,
487 local elites, armed opposition and the effect of political settlements in each province
488 were examined. It was concluded that political settlements have a major impact on
489 service delivery. Furthermore, ‘strongmen’ linked to the ruling elites in Kabul could
490 have serious impacts on service delivery and quality, “because of their attempts to
491 exploit them [hospitals and schools] as a source of patronage and revenue”
492 (Afghanistan Research and Evaluation Unit, 2016, p.3). A report commissioned by

493 the Minister of Public Health detailed the magnitude of corruption within the health
494 system (Independent Joint Anti-Corruption Monitoring and Evaluation Committee,
495 2016). This gives support to the claim of a study participant, that income generation
496 in public maternity hospitals was not confined to 'poor individual staff' but included an
497 efficient system involving senior figures.

498 The dominance of patronage networks in Kabul's public maternity hospitals reflects
499 the persistence of patronage networks at all levels of Afghan society (Sharan, 2011).
500 In addition, Schmeidl (2016) contends that because the international community
501 failed to adapt the process of democracy to the local, social and historical context
502 state-building has been undermined, and neo-patrimonialism has flourished.

503 Although current literature acknowledges that social-cultural barriers can affect the
504 quality of care, the danger is that the view of those barriers can be limited and
505 western centric focusing on traditional practices, gender and the status of women in
506 societies (Filby et al., 2016). While our study acknowledges these issues, it contends
507 that there are deeper layers of culture and meaning that offer more substantial
508 insights into the reasons that inputs, (such as the education of healthcare providers
509 and the presence of evidence-based policies and strategies), fail to produce the
510 desired outputs.

511 The findings suggest that social expectations and political pressures influenced
512 decision-making and the quality of care as Afghan healthcare providers were
513 confronted daily with the clash between world-views and values. One world-view
514 focused on the woman in childbirth and what was best for her as identified by
515 scientific research. Another world-view focused on personal survival, living life
516 according to the dictates of society and family, the deeply held 'inviolable norms'

517 (Weber, 1946, p.296) and negotiating the highly politicised work environment. These
518 competing discourses or ‘parallel worlds’ constantly undermined the quality of care.

519 From a global perspective one can see that foreign aid brings with it the need to
520 produce fast results to satisfy international donors and governments (Zürcher, 2012).
521 The pressure for results, however, can leave no time to explore underlying
522 constraints and the values that control behaviour in the workplace. There are also
523 often inherent assumptions in international development strategies regarding the (a)
524 motivation and agency of individual healthcare providers; and (b) all health systems
525 having the same common foundation of biomedical principles and ethics (Deb Roy,
526 2018; Mumtaz et al., 2015).

527 For the outsider, working alongside Afghan colleagues, the intangible world that
528 profoundly affects every facet of hospital life might be completely unknown. For the
529 Afghan this world is so known it is unremarkable. Barfield (2010, pp.31-32), using the
530 concept of ‘habitus’ (Bourdieu, 1977) explains that for Afghans the “material
531 habitus...is so taken for granted that it is invisible, even when of critical importance”.
532 Our findings suggest, as do those of Wood (2000, p.226) that we cannot understand
533 the way people work, their motivations and priorities or, therefore, make
534 improvements “without calculating for the overriding context”.

535 Currently the MoPH with international partners are endeavouring to improve the
536 quality of maternity care through a Helping Mothers and Children Thrive (HEMAYAT)
537 project including Respectful Maternity Care (RMC) initiatives (Jhpiego, 2018;
538 Pajhwok, 2016). Our findings suggest that, in addition, the conflicting discourses and
539 political pressures on staff at all levels in Afghan public health and government
540 institutions need to be acknowledged. Moreover, it is Afghan insider cultural

541 knowledge, ingenuity and courage that are vital to address these powerful worlds that
542 presently undermine high quality respectful care.

543 As Panter-Brick and Eggerman pointed out (2018, p.234) “an even handed view of
544 medical systems is one that understands why diverse ways of framing healer-patient
545 relationships co-exist and how this is related to historical, social and political
546 contexts”. It is critically important for stakeholders to understand that diverse,
547 conflicting ideologies and political economies may have a profound impact on
548 healthcare institutions, the people who work there and consequently on standards of
549 care. Unless we examine the social and political context in which healthcare is
550 delivered we are deemed to stay “conflict-blind” (Afghanistan Research and
551 Evaluation Unit, 2016, p.6) and solely focus on technical explanation and solutions
552 for the persistence of low quality services.

553 **Strengths & limitations of the study**

554 Conducting cross-cultural research as a non-Afghan western woman presented a
555 myriad of inherent pitfalls. It was vital that every decision from study design to
556 fieldwork and analysis was accompanied by reflexivity regarding the researcher’s
557 own socio-historical perspectives, underlying judgements and assumptions. Afghan
558 associates, cultural and linguistic experts were vital sounding boards throughout the
559 research process. They helped to refine the study design, clarified misconceptions
560 and provided deeper cultural insights. It was also important to consider the impact of
561 a foreigner’s presence on staff members’ behaviours during observation, and how to
562 establish a common humanity with the complex individuals behind the polite
563 exteriors. Another limitation was the use of an interpreter as her social status, age,
564 gender, interpersonal communication and language skills inevitably had an impact on
565 the data. Every effort was made to orientate, support and facilitate her with the

566 interpretation process. It is inevitable, however, that some cultural nuances and
567 richness will have been missed.

568 Although the quality of care in facility-based childbirth is currently receiving significant
569 attention this study presents a more unusual perspective. It examined care and the
570 caregivers in particular through a constructionist approach that encompassed not
571 only the biomedical and clinical but also the broader social context. It explored the
572 way that society, history and politics have shaped and continue to shape healthcare
573 provision in a uniquely Afghan manner.

574 As each cultural setting is unique the specific findings from this study cannot be
575 generalised. This research has relevance in many settings, however, as it
576 demonstrates the potential of inductive qualitative studies to look beyond technical
577 explanations and solutions for poor quality care. It reveals that understanding the
578 context of healthcare is pivotal to understanding behaviour; it challenges
579 conventional assumptions about individual staff agency and common strategies to
580 improve the quality of care.

581 Another strength of this study was the multiple methods that helped crosscheck the
582 findings. In addition, obtaining information from diverse groups of people provided
583 rich insights of Afghan society and the multiple interrelated issues that profoundly
584 undermined healthcare provision.

585 **CONCLUSION**

586 At the heart of biomedical principles is the woman in childbirth and what is best for
587 her according to scientific research (van Teijlingen, 2005). Survival strategies in a
588 still volatile insecure setting like Afghanistan depend on allegiance to family and
589 cultural dictates, and this translates into the working environment. This research

590 revealed a direct link between the values and social obligations of Afghan healthcare
591 providers, the political economy, and the quality of care. Diverse, conflicting world-
592 views defined the experiences of both women in childbirth and the staff who cared for
593 them. Equity of access and evidence-based practice were generally eclipsed by more
594 powerful values and obligations. Some staff worked with passion and strove for
595 equity. They appeared better motivated and able to balance the conflicting demands
596 but generally they faced hostility and opposition, even from the relatives of women in
597 childbirth.

598 Clashes between values in healthcare settings can be found in low, middle and high-
599 income countries. To assume that equity of access and knowledge for the benefit of
600 all is a universally accepted value in healthcare ignores the complexity of human
601 societies. This research suggests that the primary allegiance of healthcare providers
602 will be to the values of their society and to personal survival. Ignoring the impact of
603 social and political pressures on healthcare provision undermines the possibility for
604 designing effective interventions. Furthermore, it can result in complicity in the
605 ongoing neglect or mistreatment of the most vulnerable.

606 In the Afghan context there are questions for civil society, the Ministry of Public
607 Health, government and international stakeholders about the value of women's lives
608 and the parallel worlds that undermine Afghan maternity services. Further research is
609 needed into the good practice displayed by some staff to understand why they are
610 different and if this could be a starting point for change in others. More research is
611 required into the parallel worlds of health managers; the social and political pressures
612 that effect policy implementation. At grass roots level, action research could be used
613 to implement promising ideas from staff at every level as micro-actions of change.

614 Local solutions and courageous leadership are required to improve the quality of care
615 in maternity hospitals and address these challenging issues. Ultimately initiatives
616 must be based on Afghan culture and ingenuity in grappling with divergent values
617 and providing support to healthcare providers.

618 More generally, our findings suggest that aspirations of quality, equity and respectful
619 care for women in childbirth need to be tempered with a major paradigm shift by
620 donors and the global health community. It is not sufficient to see healthcare through
621 a one-dimensional biomedical lens. Healthcare is value-laden. Achieving quality and
622 equity requires not only technical know-how, policies and an enabling environment, it
623 also requires the adoption of the underpinning values that may be at variance with
624 the prevailing societal norms and political pressures, even in high-income countries.
625 The next level of quality improvement in maternity services, therefore, requires
626 digging deep (Panter-Brick & Eggerman, 2018) with 'insiders' to expose the multiple
627 worlds that undermine quality. This must be followed by international support for
628 context specific ways forward.

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