

**Afghan women and the culture of  
care in a Kabul maternity hospital**

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fulfilment of the requirements of  
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degree of  
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## Abstract

### **Rachel E. Arnold: Afghan women and the culture of care in a Kabul maternity hospital**

Female Afghan healthcare providers are vital to reduce the number of women dying in labour. Since 2001 the numbers of female providers have been substantially increased. Ensuring quality care for women in childbirth, however, remains a more elusive goal.

The aim of this qualitative ethnographic study was to analyse the culture of care of a Kabul maternity hospital and explore the barriers and facilitators to quality care. My particular focus was the experiences, thoughts, feelings, and values of the doctors, midwives and care assistants. Six weeks of participant observation, 23 semi-structured interviews with hospital staff, 41 background interviews and 2 focus group discussions with women in the community, between 2010 and 2012, were used to gather diverse perspectives on childbirth and care in Kabul maternity hospitals.

A thematic approach was used to analyse the data. Five themes were identified: the culture of care; motivation; fear, power and vulnerability; challenges of care; family and social influences. Three themes are explored in depth in this thesis. They are discussed in the following order: the culture of care, challenges of care, and fear, power and vulnerability. The influence of family and social norms on healthcare providers was integral to understanding hospital life; it therefore contributes to each chapter.

Women in childbirth laboured alone with minimal monitoring, kindness or support. For staff, the high workload was physically and emotionally demanding, resident doctors struggled to acquire clinical skills, midwives were discouraged from using their skills. Family expectations and social pressures influenced staff priorities. A climate of fear, vulnerability and horizontal violence fractured staff relationships. 'Powerful' hospital staff determined the behavioural agenda.

This study offers multiple insights into healthcare provider behaviour. It reveals complex interrelated issues that affect care in this Afghan setting but its relevance is far broader. It is one of few international studies that explore care from the perspective of healthcare providers in their cultural and social environment. It reveals that understanding the context of healthcare is pivotal to understanding behaviour and the underlying obstacles to quality care. Furthermore, it challenges conventional assumptions about individual staff agency, motivation, and common strategies to improve the quality of care.

# Table of Contents

<b>Copyright Statement</b> .....	<b>ii</b>
<b>Abstract</b> .....	<b>iii</b>
<b>Table of Contents</b> .....	<b>v</b>
List of Figures .....	x
List of Tables.....	x
<b>Acknowledgements</b> .....	<b>xi</b>
<b>Author's declaration</b> .....	<b>xii</b>
<b>Abbreviations</b> .....	<b>xiii</b>
<b>Glossary: Foreign words and expressions</b> .....	<b>xv</b>
<b>Chapter 1 - Introduction</b> .....	<b>2</b>
1.1 Thesis outline .....	4
<b>Chapter 2 - Setting the scene</b> .....	<b>6</b>
2.1 Afghanistan .....	6
2.2 Social setting.....	9
2.2.1 <i>Families</i> .....	9
2.2.2 <i>Women's roles</i> .....	9
2.2.3 <i>Patriarchal society</i> .....	10
2.2.4 <i>Women and Islam</i> .....	13
2.3 Recent history: Conflict, women and modernisation.....	14
2.3.1 <i>The 20<sup>th</sup> Century</i> .....	14
2.3.2 <i>Communist influences and Soviet occupation</i> .....	15
2.3.3 <i>Civil war</i> .....	16
2.3.4 <i>Women as refugees</i> .....	17
2.3.5 <i>The Taliban</i> .....	18
2.3.6 <i>The Karzai government</i> .....	18
2.3.7 <i>Legacies of conflict</i> .....	20
2.4 Afghan women today .....	21
2.5 Afghan women from a Western perspective .....	22
2.6 Afghan women and healthcare .....	24
2.6.1 <i>Traditional healthcare and modernisation</i> .....	24
2.6.2 <i>Conflict and the healthcare system</i> .....	25

2.6.3	<i>Women's health initiatives post-Taliban</i> .....	25
2.6.4	<i>Maternal mortality and the shortage of female healthcare staff</i> .....	26
2.6.5	<i>Caring behaviours</i> .....	28
2.6.6	<i>Personal connection with study</i> .....	29
<b>Chapter 3 - The literature review</b> .....		<b>30</b>
3.1	Procedures.....	31
3.2	Why the behaviour of healthcare providers is important.....	33
3.2.1	<i>Afghan perspectives on behaviour and the uptake of services</i> .....	34
3.2.2	<i>Behaviour and the uptake of services in similar societies</i> .....	35
3.2.3	<i>Behaviour and maternal mortality in Afghanistan</i> .....	39
3.2.4	<i>Behaviour and maternal mortality in similar societies</i> .....	42
3.3	The nature of the phenomenon.....	45
3.3.1	<i>MoPH standards for healthcare provider behaviour</i> .....	46
3.3.2	<i>Disrespect, neglect, and abuse in Afghanistan</i> .....	47
3.3.3	<i>Disrespect, neglect, and abuse in other societies</i> .....	49
3.4	The analysis of healthcare provider behaviour.....	53
3.4.1	<i>Perspectives of healthcare providers in Afghanistan</i> .....	54
3.4.2	<i>Perspectives of healthcare providers in other societies</i> .....	55
3.5	Research aims:.....	60
3.5.1	<i>My main research question was:</i> .....	60
3.5.2	<i>The secondary questions were:</i> .....	60
<b>Chapter 4 - Methodology</b> .....		<b>61</b>
4.1	Philosophical perspective.....	61
4.2	Study design.....	63
4.2.1	<i>Culture</i> .....	64
4.2.2	<i>Ethnographic style</i> .....	65
4.3	Methods.....	67
4.3.1	<i>Study site</i> .....	67
4.3.2	<i>Impression management</i> .....	69
4.3.3	<i>Gaining access</i> .....	69
4.3.4	<i>Data collection overview</i> .....	70
4.3.5	<i>Background interviews</i> .....	71
4.3.6	<i>Observation</i> .....	72
4.3.7	<i>Afghan society and interviews</i> .....	76
4.3.8	<i>Selection</i> .....	77
4.3.9	<i>Interviews</i> .....	78

4.3.10	<i>Triangulation</i>	80
4.3.11	<i>Community focus groups</i>	80
4.3.12	<i>Audit trail</i>	82
4.3.13	<i>Risk assessment</i>	83
4.3.14	<i>Data analysis</i>	83
4.3.15	<i>Interpretation and translation</i>	86
4.4	<i>Reflexivity</i>	89
4.5	<i>Ethics</i>	92
4.5.1	<i>Ethical approval</i>	92
4.5.2	<i>Information sheets and consent forms</i>	93
4.5.3	<i>Consent</i>	93
4.5.4	<i>Anonymity and confidentiality</i>	95
4.5.5	<i>Care of participants</i>	96
4.5.6	<i>Ethics in a cross-cultural situation</i>	97
4.5.7	<i>Ethics and interpreters</i>	98
4.5.8	<i>Ethical dilemmas</i>	98
<b>Chapter 5 - A culture of care</b>		<b>101</b>
5.1	<i>Experiences and observations of care</i>	102
5.1.1	<i>Admission</i>	102
5.1.2	<i>Service rooms</i>	104
5.1.3	<i>Privacy, respect and communication</i>	105
5.1.4	<i>Monitoring of labour and clinical care</i>	107
5.1.5	<i>Interpersonal support and care</i>	109
5.1.6	<i>Delivery rooms</i>	111
5.1.7	<i>Newborn care</i>	113
5.1.8	<i>Verbal and physical abuse</i>	114
5.1.9	<i>Postnatal care</i>	115
5.2	<i>The importance of bribes and wāsita</i>	117
5.3	<i>Fear and distrust</i>	121
5.4	<i>Exceptions</i>	123
5.5	<i>'Good care' for Afghan women and families</i>	124
5.6	<i>Discussion</i>	128
5.6.1	<i>"A well-qualified doctor to check us and do our care in a good way"</i>	129
5.6.2	<i>"You have to know someone in the hospital" – wāsita or money</i>	130
5.6.3	<i>"Patients are very sensitive, ask doctors to have good behaviour"</i>	132
5.6.4	<i>Summary</i>	135

<b>Chapter 6 - Challenges of care .....</b>	<b>136</b>
6.1 The high workload.....	136
6.2 Connections or 'wāsita' .....	141
6.2.1 <i>Wāsita and the acquisition of skills</i> .....	141
6.2.2 <i>Wāsita, jobs, training and exam success</i> .....	146
6.2.3 <i>Wāsita and perinatal women</i> .....	148
6.3 Skills and status .....	148
6.4 Family obligations .....	151
6.4.1 <i>Choice of a career</i> .....	151
6.4.2 <i>The need to survive</i> .....	152
6.4.3 <i>Obligation to care for family members</i> .....	154
6.4.4 <i>Caring for strangers</i> .....	155
6.5 Management, authority and care .....	156
6.5.1 <i>Senior hospital management</i> .....	156
6.5.2 <i>Afghan Ministry of Public Health</i> .....	158
6.5.3 <i>Healthcare providers and management</i> .....	159
6.6 Discussion.....	160
6.6.1 <i>The high workload</i> .....	160
6.6.2 <i>The influence of Afghan society</i> .....	161
6.6.3 <i>The influence of family</i> .....	162
6.6.4 <i>Skills, reputation and family</i> .....	164
6.6.5 <i>Knowledge - protecting personal and family interests</i> .....	166
6.6.6 <i>Strengthening family connections or wāsita</i> .....	168
6.6.7 <i>The influence of management</i> .....	170
6.6.8 <i>Summary</i> .....	170
<b>Chapter 7 - A climate of fear .....</b>	<b>172</b>
7.1 "They don't respect us" .....	172
7.2 Fear of humiliation and shame.....	175
7.3 Fear of blame .....	176
7.4 Fear of losing their job.....	180
7.5 Punishment and intimidation .....	182
7.6 Private fears: precarious lives .....	185
7.6.1 <i>Fear of moving to conservative areas</i> .....	186
7.6.2 <i>Fear of childlessness or the absence of sons</i> .....	186
7.6.3 <i>Fear of violence</i> .....	187
7.7 Fractured relationships.....	190



7.8	Discussion.....	196
7.8.1	<i>Respecting and caring</i> .....	196
7.8.2	<i>Humiliating and shaming</i> .....	198
7.8.3	<i>Blaming others</i> .....	199
7.8.4	<i>Living with violence</i> .....	202
7.8.5	<i>Summary</i> .....	207
<b>Chapter 8 - Discussion: Care, power and vulnerability .....</b>		<b>209</b>
8.1	Power and vulnerability.....	210
8.1.1	<i>Villains or victims?</i> .....	211
8.1.2	<i>Maintaining power</i> .....	214
8.1.3	<i>Perinatal women and power</i> .....	216
8.1.4	<i>Power and the family influence</i> .....	216
8.1.5	<i>Types of power</i> .....	218
8.2	Implications for care .....	222
8.2.1	<i>Care defined</i> .....	222
8.2.2	<i>Approaches to improve the quality of care</i> .....	223
8.2.3	<i>The quality chasm</i> .....	225
8.2.4	<i>Change and the quality of care</i> .....	227
8.2.5	<i>Humanisation</i> .....	228
8.3	Discussion of research process .....	230
8.3.1	<i>Strengths and limitations</i> .....	230
8.3.2	<i>Ethics</i> .....	232
8.3.3	<i>Researcher reflections and issues</i> .....	233
8.3.4	<i>Social context</i> .....	235
<b>Chapter 9 - Conclusions and recommendations .....</b>		<b>238</b>
9.1	The culture of care .....	239
9.2	Institutional culture: a microcosm of Afghan society .....	240
9.3	The perspectives of healthcare providers .....	241
9.4	Powerful staff and quality care .....	242
9.5	The role of management.....	243
9.6	Afghan women’s wishes and vulnerability .....	244
9.7	<b>Recommendations for improving care</b> .....	<b>244</b>
9.7.1	<i>Recommendations for practitioners</i> .....	245
9.7.2	<i>Recommendations for policymakers</i> .....	246
9.7.3	<i>Recommendations for educationalists</i> .....	248
9.7.4	<i>Recommendations for researchers</i> .....	248

9.7.5 Recommendations for non-Afghans in healthcare .....	249
<b>Epilogue.....</b>	<b>250</b>
<b>References .....</b>	<b>251</b>
<b>Appendices .....</b>	<b>I</b>
<b>Appendix A Overview of background interviews .....</b>	<b>II</b>
<b>Appendix B Overview of observations/ Kabul hospital .....</b>	<b>V</b>
<b>Appendix C Overview of semi-structured interviews .....</b>	<b>VII</b>
<b>Appendix D Community FGD2 (Demographics) .....</b>	<b>IX</b>
<b>Appendix E Risk Assessment .....</b>	<b>X</b>
<b>Appendix F Ethical approval IRB Kabul .....</b>	<b>XIX</b>
<b>Appendix G Information sheets for study introduction, interviews, community focus groups, and consent forms.....</b>	<b>XXI</b>
<b>Appendix H Sample <i>Darī</i> &amp; <i>Pushtu</i> information sheets .....</b>	<b>XXVIII</b>
<b>Appendix I BJOG Article .....</b>	<b>XXX</b>

## List of Figures

Figure 1: Literature review overview .....	33
Figure 2: Data collection overview .....	70
Figure 3: Chapter 5 Overview .....	101
Figure 4: Chapter 6 Overview .....	136
Figure 5: Chapter 7 Overview .....	172
Figure 6: Chapter 8 Overview .....	209
Figure 7: Chapter 9 overview .....	238

## List of Tables

Table 1: Summary of interview participants .....	71
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## Author's declaration

I declare that this study, "Afghan women and the culture of care in an Afghan maternity hospital", has been composed by myself and it is entirely my own piece of work. It has not been submitted in any previous application for a degree. All quotations have been distinguished by quotation marks and sources of information have been specifically acknowledged.

Rachel E Arnold

17<sup>th</sup> July 2015

## Abbreviations

AFN	Afghani (national currency of Afghanistan)
AMA	Afghan Midwives Association
APGAR	Health assessment score for newborn children ( <b>A</b> ppearance, <b>P</b> ulse, <b>G</b> rimace, <b>A</b> ctivity, <b>R</b> espiration)
BP	Blood Pressure
BSc	Bachelor of Science
CHC	Comprehensive Health Centre
EmOC	Emergency Obstetric Care
FGD	Focus Group Discussion
FIGO	Fédération Internationale de Gynécologie et d'Obstétrique = International Federation of Gynecology and Obstetrics.
HBB	Helping Babies Breathe
HIV	Human Immunodeficiency Virus
IGO	Intergovernmental Organisation
IMPAC	Integrated Management of Pregnancy & Childbirth
IRB	Institutional review board
IRC	International Rescue Committee
IV	Intravenous cannula
LNGO	Local Non-Governmental Organisation
MCH	Mother and Child Health clinics

MMR	Maternal Mortality Ratio
MoPH	Ministry of Public Health
MSc	Master of Science
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organisation
OBGYN	An obstetrician/gynaecologist
OPD	Outpatients department
PhD	Doctor of Philosophy
PTSD	Post-Traumatic Stress Disorder
SAFE	Skilled Attendance for Everyone
TBA	Traditional Birth Attendant
ToR	Terms of Reference
TRAction Project	Translating Research into Action
UN	United Nations
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

## Glossary: Foreign words and expressions

### Pronunciation:

<i>kh</i>	– as in Scottish ‘loch’
‘	– ‘ain’ (glottal stop); ‘gotta go’
<i>ā</i>	– long ‘a’ (alif): ‘ought’
<i>ī</i>	– long ‘i’ (‘been’)

<i>chāddur, chadrī</i> (also <i>burqa</i> )	Literally ‘curtain’; ‘veil’; the full length veil worn by adult women in public to conceal bodily form, face and hair
<i>daktar sāhib</i>	‘Mr Doctor’; the customary, honorific, way of addressing a senior medical official
<i>Darī</i>	One of the two official languages of Afghanistan, the main Persian dialect spoken in Kabul and many other areas Afghanistan. <i>Darī</i> is a colloquial dialect of Iranian <i>Farsī</i> , which slightly differs in vocabulary and grammar
<i>dāya</i>	Village midwife (usually a close relative of family); a traditional birthing attendant
<i>Farsī</i>	Afghans use the Iranian <i>Farsī</i> when writing, especially in official documents
<i>karāchī</i>	Hand-drawn cart
<i>khāla</i>	‘Aunt’; honorific title for any older women; commonly used for low-grade women workers in hospitals (e.g. cleaners; part time care assistants).
<i>madrasa</i>	Religious schools/seminaries
<i>mahram</i>	Male escort required under Islamic law to accompany any adult women who leaves the family home. The <i>mahram</i> is always a close relative.

<i>mullāh</i>	Religious teacher, instructor
<i>mujāhid</i> (plural, <i>mujāhidīn</i> )	An individual who has participated in a religious war or <i>jihād</i>
<i>pardah</i> (see also <i>burqa</i> , <i>chāddur</i> )	‘Curtain’, the tradition of not allowing adult women to be seen by male outsiders
<i>Pushtu</i>	One of the two official languages of Afghanistan, spoken primarily in southern and south-eastern Afghanistan.
<i>Pushtun</i>	Ethno-linguistic tribal people from southern and south-eastern Afghanistan and the Afghan-Pakistan frontier. Pushtuns of the Durrani tribe from Qandahar. They were the ruling race of the country from 1747-1978.
<i>Qurbān Sāhib</i>	An honorific title used by inferiors to superiors, which implies they are prepared to perform any service their superior requires.
<i>sharī‘a</i>	The Islamic legal system founded on the <i>Qur‘an</i> , <i>Hadith</i> (Traditions) and <i>Sunna</i> (example of Muhammad). In Afghanistan the Hanafi school ( <i>mazhab</i> ) of Islamic law is the official legal code.
<i>shīrnī</i>	Literally 'sweets' and by association, 'sweetener': (a) The customary practice or obligation to close friends, family and work colleagues to 'treat' them on receipt of e.g. promotion. This is usually in the form of giving a gift or hosting a meal (b) a euphemism for a bribe.
<i>wāsita</i>	An intermediary, middleman, advocate, go-between
<i>zan</i>	An adult woman



***“The children of Adam belong to each other,  
From creation they all come from one jewel.  
If one day, one of the members suffers,  
The rest of the members do not stay quiet.  
If you are undisturbed at the suffering of others,  
Then you should not be called a human”***

(Abū-Muhammad Muslih al-Dīn bin Abdallāh Shīrāzī [Sa‘īdī Shīrāzī])<sup>1</sup> (Loewen 2010b)

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<sup>1</sup> From: Sheikh Mushrifuddin Saadi, *Gulistan in Kulliyat-e Sheikh Saadi* [The works of Sheikh Saadi], ed. Muhammad Ali Furoghi (Tehran, 1986), 77.

English translation: Loewen, A., 2010. A Thousand Years of Persian Jewels: Classical Persian Poetry. In: Loewen, A. and McMichael, J., eds. *Images of Afghanistan: Exploring Afghan Culture through Art and Literature*. Oxford: Oxford University Press, 43.

## Chapter 1 - Introduction

It is a daunting task to represent the lives of other people particularly as an outsider to their world. It is especially daunting when those 'others' are Afghan women, about whom so much has been written since the Taliban seized power in 1996. Formerly it was predominantly anthropologists who investigated the lives of Afghan women. They, for example, studied marriage in Afghan tribal society (Tapper 1991) or "The performance of emotion amongst *Paxtun* (*Pushtun*<sup>2</sup>) women" (Grima 1992). More recently Afghan women have been portrayed from a gender or human rights perspective (Rostami-Povey 2007b; United Nations Assistance Mission Afghanistan and Office of the United Nations High Commissioner for Human Rights 2010), a trauma perspective (Lopes Cardozo et al. 2005; Omidian and Miller 2006), or as the focus of the international health community's efforts to reduce the high maternal mortality ratio (Bartlett et al. 2005; Save the Children 2008). My research is unusual because it draws on all of those domains as it explores and analyses the culture of an Afghan maternity hospital, the women who give birth to their babies there, and the healthcare providers, who are responsible for care. The decision to include insights from such diverse fields was made during the course of the study. It gradually became apparent that to understand the culture of this hospital and the behaviour of the women within it, it was vital to gain insights into Afghan society, families, the experiences and values that underpinned these women's lives.

As a nurse/midwife with seven years' experience working in Afghanistan, in urban, refugee and remote rural locations, I have witnessed the dire reality of pregnancy and childbirth for Afghan women. My first encounter with Afghan women having their babies and healthcare providers was a year spent in a small maternity department in Kabul during the Taliban regime. My remit was to improve standards: my challenge was how to initiate change that did not depend on my presence but would continue after I had left. I learnt that much

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<sup>2</sup> Ethno-linguistic tribal people from southern and south-eastern Afghanistan and the Afghan-Pakistan frontier. Pushtuns of the Durrani tribe from Qandahar were the ruling race 1747-1978.

could be achieved through a good working environment, with respectful, positive relationships. I also saw that imparting knowledge, mentoring, providing equipment and instigating systems was not sufficient to achieve quality care for all. There was a gap between what could be achieved and what was actually achieved. Warm, humorous, friendly doctors and midwives could, at times, be brusque, detached and inattentive to labouring women. They could drink tea with friends rather than help a mother whose baby was showing signs of severe fetal distress. They could go home after night duty before the day staff arrived, leaving labouring women in the care of untrained care assistants. I realised that I did not understand the staff, that I was missing vital insights into who they were and what 'made them tick'. The desire to understand Afghan healthcare providers and find the keys to improving the quality of care they give increased as I saw that the post-Taliban maternal health interventions were also failing to improve caring behaviours and motivation.

My research was based in a maternity hospital in the capital, Kabul between 2010 and 2012. It explored the world behind the numbers, uniforms and the familiar generic appearance of a busy bio-medical institution to elucidate the constraints, hopes, fears and values of the women who worked there. It was important to listen to the voices of women who used these services to situate the study in context. Women in the community were, therefore, asked what was important to them when they had their babies.

My primary interest has always been to improve the capacity and motivation of Afghan healthcare providers to care for women and their babies: I am striving to understand how that can be achieved. The focus on healthcare providers does not negate the needs of perinatal women. I am convinced that the only way to achieve quality care for Afghan women in childbirth and for their babies is through a workforce that is skilled, enabled and motivated.

Challenges with interpersonal communication, motivation and the quality of care within health services are not unique to Afghanistan, neither are they new

(Mernissi 1975; Auerbach 1982; Abrahams et al. 2001; Baker et al. 2005). The recent focus on reducing maternal mortality through the Safe Motherhood Initiative and the Millennium Development Goals has shown that numbers of healthcare providers, infrastructure and protocols alone are not enough to achieve the desired reduction in maternal and perinatal mortality (Freedman et al. 2007; United States Agency for International Development 2014). There are human behavioural issues that first need to be understood, and secondly addressed (Jewkes et al. 1998; Bowser and Hill 2010; Jaffré 2012). As Hammersley and Atkinson (2007, p.7) state:

“Human actions are based upon or infused by social or cultural meanings: that is, by intentions, motives, beliefs, rules, discourses and values”.

## **1.1 Thesis outline**

Chapter two ‘setting the scene’ provides the background to women’s healthcare and recent initiatives to reduce maternal mortality. In addition, I explain the social, cultural and recent historical events that have shaped and continue to influence the identities of Afghan women today.

In Chapter three I describe my review of the literature and how the literature helped me to define and refine the focus of the research and identify gaps in knowledge that this study would address. The aims of the research are presented at the end of the literature review.

Chapter four commences with the process of constructing the philosophical framework for this study, my justification for the methodological choices, the process and procedures of the study, and my approach to ethical issues. A cross-cultural study, especially one that uses an interpreter, presents many challenges to the quality and trustworthiness of the data. I explain how I approached these issues and endeavoured to ensure quality at each stage.

'A culture of care' is the fifth chapter and the first of three findings chapters. The general culture of care in Kabul maternity hospitals was described by Afghan women, who had their babies there, by participants with experiences in the Kabul hospitals and from my observations of care. Afghan women shared their feelings about care and explained how they would like to be cared for.

Chapter Six, 'challenges of care,' is the second of the three findings chapters. Care in the hospital is analysed predominantly from the perspectives of the healthcare providers. Doctors and midwives explained that there was a gap between how they were taught to care and the care that they were able to give. They pointed out that factors both inside and outside the hospital contributed to this gap in care.

Chapter Seven, 'the climate of fear,' is the final findings chapter. The underlying tensions and dynamics between the doctors, midwives and care assistants/cleaners are analysed exposing their vulnerability and the precarious nature of life for Afghan women.

The following chapter, 'care, power and vulnerability' is the main discussion chapter in which I discuss both the study findings and the research process. I contend that the care of perinatal women was profoundly affected by tensions between the personal power and vulnerabilities of healthcare providers. The nature of power within the hospital is explored and linked to the writings of Max Weber and Michel Foucault. The implications for the quality of care in this hospital are examined. The strengths and limitations of the research process are discussed and finally I reflect on the choices and power of the researcher.

In Chapter Nine I present the conclusions of the thesis and I provide recommendations for practitioners, policy-makers, educationalists, other researchers and intergovernmental organisations (IGOs) and non-governmental organisations (NGOs) working in maternity care in Afghanistan.

## Chapter 2 - Setting the scene

As this is an exploratory cross-cultural study, I need to place perinatal women and healthcare providers in their social, historical and cultural context. Several years living and working in Afghanistan gave me the basics of language and culture. In common with many foreigners, the demands of work prevented me from gaining an in-depth understanding of Afghan culture. As I considered undertaking this study I started to develop and enrich my cultural understandings through conversations with Afghans and non-Afghans, and through reading the literature. This has been (and is) an ongoing process, resulting in this chapter which presents an introduction to the physical, social, historical, and healthcare setting that are the background to this study, and to the lives and identities of Afghan women today.

### 2.1 Afghanistan

Afghanistan is one of the poorest and least developed countries (Jackson 2009). In 2011, the poverty headcount ratio at national poverty levels was estimated at 35.8% of the population (World Bank 2015a). According to the World Health Organization in 2011, 36.9% of the population fell below the minimum level of dietary energy consumption (World Health Organization 2015c) and in 2012 the life expectancy at birth was estimated at 60 years (World Health Organization 2015a). In 2013 the prevalence of stunting in children under-5 years was estimated at 40.9%, while 9.5% of children in the same age group were classified as wasted (World Health Organization 2015b). Afghanistan comprises many ethnic groups including Pushtun, Tajik, Hazara, Uzbek, Aimak, Turkoman, Baloch, Nuristani and Farsiwan. Few are indigenous but transverse Afghan borders with, for example, Pushtuns living in Pakistan, Tajiks in Tajikistan and Turkomans in Turkmenistan (Dupree 1997).

Afghanistan is a landlocked country of mountains, deserts, and fertile valleys. It is prone to earthquakes and recently suffered from several years of extreme drought. The summers are hot and dry, winters cold usually with heavy snowfall

in the mountains. Small remote villages cover the extensive mountainous terrain and during harsh winters their communities are cut off by snow for several months without access to healthcare facilities except by foot, donkey or horse. In one northern province it took over a week to carry a sick person to the provincial capital where I was based. For reasons, which include poverty and the conservative culture, many families do not even attempt these journeys when women develop complications in labour (Khan 2005).

More than three decades of conflict destroyed most of the country's infrastructure and reversed advances in industry, education and healthcare. The cost has not only been the loss of life, property and agricultural land, but also the loss of physical and mental wellbeing (Waldman 2002; Lopes Cardozo et al. 2004), of educational opportunities and employment. Conflict has also left a legacy of fear and ethnic tensions (Johnson and Leslie 2004; Jackson 2009; Aziz 2011).

This study was located in the capital, Kabul, situated on a high plane, surrounded by mountains on the edge of the Hindu Kush. Recent fighting reduced this ancient city and tourist destination predominantly to ruins. Since the fall of the Taliban, Kabul has grown into a jumbled mixture of old and new. What was left of the traditional buildings and architecture is disappearing fast as property prices have soared and development mushroomed without effective planning or control.

There are signs of wealth and development with opulent, brightly decorated three and four-story houses, hotels, shopping centres and wedding halls capable of seating more than one thousand guests. There are also signs of poverty as groups of *burqa*<sup>3</sup> covered women sit begging in the middle of busy pot-holed dusty roads with small children and babies; unemployed men stand on street corners with shovels in hand hoping for a day's work. Disabled men,

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<sup>3</sup> *Chāddur*; *chadrī* (also *burqa*) – lit 'curtain'; 'veil'; the full length veil worn by adult women in public spaces to conceal bodily form, face and hair.

small boys and girls take advantage of Kabul's gridlocked streets to solicit alms from passing motorists or sell small items, such as chewing gum or magazines. Men with wooden trolleys or *karāchīs*<sup>4</sup> sell everything from fresh fruit and vegetables to colourful women's headscarves, hardware and second-hand clothing. The majority (80%) of Kabul's population live in informal settlements, many on the sides of the mountains, without water and electricity (World Bank 2005).

The social cohesion of Kabul has been affected by recent conflicts, the transitory nature of many of its occupants and the high demand for land and housing.

"Kabul is a cauldron", Dupree (2004, p.327) stated, "filled with a complicated mix: native and long-time resident Kabuli, displaced from every corner of the nation, repatriated refugees, returned Afghan expatriates...skilled professionals, traders, farmers, artisans, educated, semi-educated and non-literate".

There are still areas of the city where extended families live in proximity, but less so than in the past. The World Bank (2005) estimated that the population of Kabul grew 15% per year between 1999 and 2002 and continues to grow at approximately 5% per year. This puts a strain on resources, employment, housing and healthcare services.

Insecurity affects people's lives in Kabul, in addition to suicide bombers and attacks on government and foreign establishments, robberies in residential areas are common, and organised gangs kidnap Afghans for ransom (Rubin 2007). Families are anxious if their wives or daughters are not back by dark. Office hours are adjusted in winter so that women are home by nightfall.

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<sup>4</sup> *Karāchī* – hand-drawn cart



During the course of this study Kabul increasingly looked and felt like an occupied city with well-armed security forces patrolling the streets and intersections, heavily fortified compounds, military convoys, and many roads permanently closed because of security concerns. Recent years have seen increased hostility against foreigners and foreign troops (Clark 2009) but Afghans are also worried about the withdrawal of these forces. The city was divided along ethnic lines during the civil war and in the absence of any reconciliation process (Benish 2009; Niamatullah 2009) there is fear of renewed ethnic violence.

## **2.2 Social setting**

### **2.2.1 Families**

“The family is the single most important institution in Afghan society” (Dupree 2002, p.978). Hunte (1980) explained that relationships between family members, both immediate and extended, are of exceptional importance. The functions of this tight-knit system include the enculturation of children, the selection of spouses for its young people, and the choice of occupations (Hunte 1980). Dupree (1997, p192) commented that the extended family consists of a network of social, economic, and political rights and obligations, which act as a substitute for the government in most areas. Kinship for Afghans means a “reciprocal set of rights and obligations which”, Dupree (p181) explained, “both satisfy and in other ways limit an individual’s status and role”.

### **2.2.2 Women’s roles**

Traditional Afghan society had clearly defined roles for men and women: the men protected and provided for the family and worked outside of the home; women’s roles were within the home, running the household, bearing and nurturing children, and entertaining guests (Hunte 1980). Tapper (1991), exploring politics, gender and marriage in tribal society, found that gender roles were not seen as complementary but that both men and women emphasised the superiority of men over women. Within rural communities women generally

work within the confines of the village and fields managing crops or livestock (Dupree 2004). These rural Afghan women, Dupree (2004) explained, who live in small kin-orientated groups often experience more freedom of movement than urban women living in areas with non-kin groups. Despite conflict and upheaval, approximately 74% of Afghans live in rural areas (World Bank 2015b) where traditional roles and responsibilities still dominate family and community life. Each ethnic group has its own social traditions and customs regarding the roles of women and, as will be explained below, recent history as well as different family traditions have affected women's roles, obligations and freedoms: they are neither static nor homogenous.

Grandparents were the main educators of children, Dupree (1997) recorded in 1973, as many rural villages did not have schools. Even when there were schools, many families did not consider education for girls to be necessary. Although many more girls have attended school since 2001, Smith (2009) found that there are still reservations regarding education for girls. She noted that girls who received a basic education were generally withdrawn from school once they reached puberty: many were then married prematurely to protect the family honour. Literacy rates are low with only 45% of men and 18% of women able to read and write (United Nations Educational Scientific and Cultural Organisation 2014) The lack of educated women has made the recruitment and training of female healthcare providers difficult.

### **2.2.3 Patriarchal society**

Afghanistan is a traditional, patriarchal and primarily tribal society (Ahmed-Ghosh 2003; Burki 2011), although anthropologist Dupree (1997) contended that this is modified by matriarchal influence. The matriarchal influence is stronger in some ethnic groups than others but can be seen in the authority and power of mothers-in-law. Typical households consist of several generations living together, and family bonds are normally extremely close (Dupree 2004; Rostami-Povey 2007a). Sons usually remain in the family home when they marry and when a bride is taken to her husband's home, all decisions regarding

her life and duties are transferred to her husband's family (Tapper 1991; Dupree 2004). Women and children tend to be assimilated into the concept of property (Moghadam 2002, p.20; Burki 2011).

Afghanistan is a collectivist society where most decisions are made by the family for the benefit of the whole family (Dupree 1997; Entezar 2007). The younger female family members have few choices. Decisions regarding school attendance, whether they do further study, or work outside the home will invariably be made for them. Decision-making within families is complex. Senior male or female family members are the main decision makers but even brothers can stop sisters from attending school. Parents arrange the majority of marriages but, in her study of marriage practices, Smith (2009) found that despite general adherence to cultural norms there is diversity and some desire for change.

Women, in Afghan families are seen as guardians of the family honour. Writing on cultural heritage and national identity in Afghanistan, Dupree (2002, p.978) explained that "honour is the rock upon which social status rests" Loewen (2010c, p.167) stated that

"the quest to gain and maintain one's reputation and the fear of losing it are fundamental driving forces in traditional Afghan culture".

Women are considered a threat to the status and reputation of their family, especially its men. Brides must be virgins, wives must remain faithful to their husbands and produce sons: even unfounded rumours of sexual impropriety can destroy the family honour (Loewen 2010c). Society judges each family by the conduct of the females:

"the more secluded the women are, the more honourable the man is as this shows that he can protect his property" (Loewen 2010c, p.169).

This is the reason that women must be protected and controlled, often segregated from public life in the social and religious system called *pardah*<sup>5</sup> that is practised in much of South Asia (Papanek 1973). If these women are allowed to leave their homes they will be protected from the gaze of unrelated men with the traditional *burqa* and usually accompanied by a male relative or *mahram*<sup>6</sup>. Some women in urban areas have more freedom to leave the home and travel without a *mahram*, to study and work. Underlying male/female relations, Loewen (2010c, p.169) explained, is

“a culturally installed fear, that a woman is inclined to err and thus threaten her ‘owners’ honour”.

In his cultural analysis based on the framework of Geert Hofstede, Entezar (2007) explained the sex-role system underlying Afghan society. In this male-dominated society Entezar (2007), an Afghan/American, asserted that a woman’s primary function is to produce sons; daughters, however, may also be married to settle feuds between families. According to Entezar (2007, p.115), Afghan literature, poetry and language generally reinforce negative beliefs regarding women, who are seen as “cunning, satanic, unfaithful, emotional and dishonest”. Tapper (1991) presented an alternative discourse, however, contending that even in traditional rural families women are not without power, but have the possibility to contravene social norms and male dominance, the ability to pressurise and the power to shame.

Domestic violence, according to Entezar (2007), is widespread in Afghanistan; humiliation and physical abuse are used to control women. While this is widely reported (Global Rights: Partners for Justice 2008; United Nations Assistance Mission Afghanistan and Office of the United Nations High Commissioner for Human Rights 2010; Wyatt 2011; Sarwary 2012), and corroborated by the

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<sup>5</sup> *Purdah* (see also *burqa*, *chāddur*) – ‘curtain’, the tradition of not allowing adult women to be seen by male outsiders

<sup>6</sup> *Mahram* – male escort required under Islamic law to accompany any adult women who leaves the family home. The *mahram* is always a close relative.

personal stories of colleagues, it is important to note that violence within families is complex. Mothers-in-law and other women condone or even act as perpetrators of abuse against other women or children (Afghanistan Research and Evaluation Unit 2007; Global Rights: Partners for Justice 2008; Smith 2008). Violence is not ubiquitous, however, and there are husbands who respect, support and care for their wives and daughters.

As can be seen from this introduction the representation of Afghan women is a contested area, with some writers emphasising the violence and abuse, others the power of women. Throughout this thesis I have attempted to portray the heterogeneous and often disparate nature of womanhood within Afghanistan in order to dispel notions of a generic Afghan woman.

#### **2.2.4 Women and Islam**

Hunte (1980) commented over three decades ago that it was difficult to overemphasise the pervasive quality of Islam in Afghan society. Islam remains deeply rooted in Afghan society and at the centre of daily life (Rashid 2002). An estimated 99% of Afghans are Muslim - 80% Sunni Muslims, 19% Shi'a Muslims (Dupree 1997; United States Agency for International Development 2015). Days and nights are punctuated by the call to prayer from each local mosque and official working hours are shortened during Ramazan, the month of fasting. The Afghan language is pervaded with references to Allah's will, presence and blessing. Every area of private and public life is ordered by religious practice, including the public observance of prayer five times a day, fasting and celebration of the religious festivals, and the enunciation of the Qur'an at the opening ceremonies of professional conferences and workshops. Islam is an integral part of life for both educated and uneducated Afghan women. During the working day in offices and hospitals individual women can be seen unrolling their prayer carpet, covering their head and praying.

Although traditionally Afghan women do not go to the mosques to pray, religious practices and beliefs are intrinsic to key family events such as

marriage, pregnancy, birth, sickness and death. The advice and input of *mullāhs*<sup>7</sup> (religious leaders) is sought during illness, often before that of healthcare providers. Hunte (1980) recorded, for example, that the call to prayer is whispered into the ear of newborn babies by the birth attendant, male family member or a *mullāh* shortly after birth. During weekends and holidays women and children often visit the tombs of saints, religious leaders and martyrs in graveyards to request assistance, especially in cases of sickness and infertility. Hunte (1980) described many traditional customs and protective measures, some magico-religious, used by women and traditional birth attendants (*dāya*<sup>8</sup>) to protect their unborn child from malevolent forces during pregnancy and the postnatal period. Newborn babies are tightly wrapped in cloths with amulets and eye beads attached to protect them from evil spirits or the evil eye. Women can occasionally be seen with herbal and religious medicines in maternity hospitals.

## **2.3 Recent history: Conflict, women and modernisation**

Originally I did not intend to include a section on conflict, women and modernisation. The women in my study, however, lived through parts of this era, and for them this does not represent history but a record of the experiences that they and their loved ones faced. The older staff members were born in the 1940s and 1950s when the king was ruling. Many younger staff who were born in the late 1970s and 1980s would have known nothing but conflict through their childhood, education and young adulthood or life as a refugee. Any attempt to understand who they are today, must, of necessity, incorporate some of the major events of their lives and society.

### **2.3.1 The 20<sup>th</sup> Century**

Ahmed-Ghosh (2003), suggested that Afghanistan may be the only country in the world, where, during the last century, rulers have been made and unmade by struggles related to women's status. Attempts to change the roles and rights

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<sup>7</sup> *Mullāh* – religious teacher, instructor

<sup>8</sup> *Dāya* – village midwife (usually a close relative of family); a traditional birthing attendant

of Afghan women have consistently faced (violent) resistance. The late 19<sup>th</sup> and beginning of the 20<sup>th</sup> century saw several attempts at the modernisation of Afghan society with some focused on improving women's lives. King Amir Abdur Rahman (1880–1901) forbade child marriage and forced marriages, supported inheritance and divorce rights for women but also imposed the death penalty for adultery (Dupree 1998). His son Habibullah, returning from exile in Syria and Turkey, was influenced by their new ideas. He established the first hospital and college. He also promoted the education of women and the royal family increasingly adopted Western values and dress (Ahmed-Ghosh 2003). Opposition by tribal and religious leaders grew and Habibullah was assassinated in 1919. Habibullah's son Ammanulah imposed European attire on government employees, encouraged women to dispense with the veil, promoted secular education and he opened the first girls' school in Kabul (Burki 2011; Ruttig 2013). These modernising activities alienated the Pushtun tribes and clergy. Queen Soraya, Ammanulah's wife, publically campaigned for women's rights to education, employment and divorce, which, according to Burki (2011), challenged religious and cultural beliefs as it was seen as un-Islamic. The notion that women had "rights" was a threat to the status quo (Burki 2011). Opposition to Ammanulah grew as he introduced laws setting a minimum age for marriage, allowing girls to choose their husbands, and encouraging wives to take legal action if mistreated (Burki 2011). Pictures of the King's wife unveiled during a state visit to Europe in 1929 led to his denunciation by opponents and that year he fled the country (Lee 2010). Many gender equality and marriage laws were reversed and the following decades saw more cautious reforms as women became nurses, doctors and teachers during the 1940s and 1950s (Ahmed-Ghosh 2003).

### **2.3.2 Communist influences and Soviet occupation**

During the 1970s Afghan women in Kabul became increasingly westernised. There were, however, violent anti-government demonstrations, clashes between Islamists and Leftists and a small minority of Islamists threw acid at bare headed women in mini skirts (Dupree 1998; Lee 2010). For the first time, Dupree (1998) claimed, Afghan women demonstrated on the streets. A Soviet

Union backed socialist government (the People's Democratic Party of Afghanistan) came to power in a coup d'état in 1978 and once again instigated rapid social and economic change. Mass literacy programmes, compulsory education, the minimum age of marriage set at 16 for girls, as well as land reforms met with violent resistance from tribal and religious leaders (Moghadam 2002; Ahmed-Ghosh 2003). Opponents of the government were purged and many Islamist leaders fled to Pakistan where they formed several militia or *mujāhidīn*<sup>9</sup> groups (Lee 2010).

The Soviet occupation (1979–1989) precipitated a prolonged civil war between the Soviet-backed government and the Islamist *mujāhidīn* (Lee 2010). “Life for Afghans was bitter”, said Lee (2010, p.25), particularly in rural areas where villages suspected of supporting the *mujāhidīn* were shelled and their irrigation systems destroyed. Consequently millions fled to Pakistan. In areas under government control, however, women, especially in Kabul, became more visible in society. Large numbers of women enrolled at university and others were employed in government agencies, the national airline, driving buses, the military, and the media (Moghadam 2002; Burki 2011). Some women even held positions of leadership over men according to Moghadam. An educated Kabuli resident told me (during the Taliban regime), that the Russian occupation had been the best years of her life. She had been a teenager at school, anticipating going to university and seeing increasing opportunities for women.

### 2.3.3 Civil war

Once the Soviet troops withdrew, however, the government gradually collapsed. The *mujāhidīn* took power in Kabul in 1992 claiming to “restore religious, ethnic and humane standards” (Amnesty International 1995, p.19). Urban women witnessed an overnight reversal of their status (Burki 2011). The constitution, “which guaranteed fundamental rights for women”, was suspended in 1992 (Amnesty International 1995, p.18), women were ordered to veil their whole

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<sup>9</sup> *Mujāhid* (plural, *mujāhidīn*) – an individual who has participated in a religious war or *jihād*



body and *sharī'a*<sup>10</sup> law instated (Moghadam 2002; Jackson 2009). A brutal civil war between the *mujāhidīn* groups ensued in which Kabul was virtually destroyed through what appeared to be the deliberate shelling of residential areas, mosques, schools, the university and hospitals (Amnesty International 1995; Ahmed-Ghosh 2003). Kabul became known as 'the city of widows' as many families were left without an able-bodied man (CARITAS 2004). Women who had never worked outside the home were faced with finding work or starvation. A report, based on in-depth interviews of refugees, '*Women in Afghanistan: A human rights catastrophe*' (Amnesty International 1995), documented gross human rights abuses (women were the main victims) that were committed with impunity by the *mujāhidīn* groups. Women, girls and boys were raped, tortured, arbitrarily killed, forcibly taken away, and sold into prostitution. Educated women were particularly targeted, especially those working in education, welfare or women's organisations (Amnesty International 1995).

#### **2.3.4 Women as refugees**

Intense fighting and insecurity, particularly during the civil war, resulted in the world's worst refugee crisis at the time. An estimated 6.3 million Afghan refugees sought refuge predominantly in Pakistan and Iran (United Nations 2002). Many highly qualified professionals, including senior medical staff, emigrated to Western countries (Foster 2009). Dupree (2004) explained that in the Pakistan refugee camps women and girls faced greater restrictions than they were used to at home. Exile also altered family dynamics and gender relations as many middle-class men lost status when economic pressures forced them to accept menial work to support their families (Rostami-Povey 2007a), or to allow female family members to work outside the home (Hyder et al. 2007). Some women learnt new skills and secured jobs but others could not adapt (Dupree 2004). Hyder and colleagues (2007) found that the pressures of adjusting and the changes in status contributed to family violence. Women were

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<sup>10</sup> *Sharī'a* – The Islamic legal system founded on the *Qur'an*, *Hadith* (Traditions) and *Sunna* (example of Muhammad). In Afghanistan the Hanafi school (*mazhab*) of Islamic law is the official legal code.

especially repressed in Pakistani refugee camps. The camps were highly politicised spaces controlled by *mujāhidīn* (Jackson 2009). Women who became too visible or vocal were harassed or attacked (Dupree 2004).

### **2.3.5 The Taliban**

The Taliban (students of Pakistani religious schools or *madrasas*<sup>11</sup>), disillusioned with the lawlessness of the *mujāhidīn*, seized power in 90% of Afghanistan between 1994 and 1996 (Lee 2010). They rigorously enforced an even stricter interpretation of Islamic law through their religious police who patrolled the streets beating and arresting violators of these laws: public executions became common (Lee 2010). Men were beaten if their beards were not long enough or if they were wearing Western clothes. Women were beaten if they were not fully covered or were seen without a *mahram*. The education of girls was forbidden and women were banned from working apart from in health related jobs. Prostitution was the only option left for some of the urban widows (Tang 2011). Rostami-Povey (2007b), however, described the tenacity of some women during this time who developed strategies to exercise autonomy such as hiring men to act as their *mahram*. This enabled them to leave their homes, run schools and work for their communities. The Taliban initially restored “a kind of order” (Burki 2011, p.55), personal and national security after decades of lawlessness (Lee 2010), however, they were also responsible for ethnic atrocities, abductions, and the suppression and abuse of women (Jackson 2009).

### **2.3.6 The Karzai government**

The Karzai government that came to power following the US-led mission to remove the Taliban (2002), attempted to consolidate power by accommodating the interests and values of both the international community and the elite networks of regional leaders, including former *mujāhidīn* leaders, who were

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<sup>11</sup> *Madrassa* – religious schools/seminaries

given government positions (Jackson 2009; Sharan 2011). For women this syncretism (or attempted amalgamation of fundamentally opposing philosophies) resulted in improved access to education and healthcare, equal rights under the 2004 constitution and legal protection from violence (Khan 2014). At the same time, however, traditionalists have resisted change and laws have not been enforced (United Nations Assistance Mission Afghanistan and Office of the United Nations High Commissioner for Human Rights 2010). A review of the gains in women's rights and gender equality over the last decade (Afghanistan Research and Evaluation Unit 2013) concluded that while the international community remains committed to gender equality in words, it has failed to adequately fund or hold stakeholders accountable. As the international troops were withdrawing there seemed to be a willingness to compromise women's rights in peace negotiations with the Taliban (Afghanistan Research and Evaluation Unit 2013). While not wishing to detract from 'women's rights', I would argue that the discourse around those rights can be narrow, framed in Western concepts such as individualism and gender which are alien to the majority of Afghans. The change that Afghan women and men desire is far broader.

For Afghan citizens there is "a deep yearning for life to be better" (Johnson and Leslie 2004, p.104). Studies have highlighted that their prime concerns include alleviating poverty, access to healthcare, education and employment, an effective and accountable government, security and the reduction of corruption (Jackson 2009; The Asia Foundation 2012). These aspirations mostly remain unfulfilled despite more than a decade of 'reconstruction' and poverty is still pervasive (Rubin 2007). Afghanistan has received a paucity of aid. Waldman (2008) compared this to other post-conflict countries, where in the first two years following the conflict Afghanistan received USD 56 per capita, compared to USD 679 in Bosnia and USD 233 in East Timor. In 2001 donors committed to give USD 25 billion to Afghanistan, of which only USD 15 billion had been delivered by 2008 (Waldman 2008). It is not possible within the remit of this study to discuss the politics of the reconstruction process but Johnson and Leslie (2004) contend that the imposition of liberal capitalism and Western values is unlikely to benefit the poor.

### **2.3.7 Legacies of conflict**

In a nationwide mental health survey of 799 adults, Lopes Cardozo and colleagues (2004) revealed that a high proportion of the population had been exposed to traumatic events during the conflicts. They found that 67% of respondents showed symptoms of depression, 72.2% symptoms of anxiety, 42% symptoms of post-traumatic stress disorder (PTSD) and 84% reported feelings of hatred. These results were high, the authors commented, even when compared to other communities traumatised by war, and women had significantly poorer mental health and social functioning than men. Afghanistan also lacked the resources to support or treat those with mental health issues. In 2001 (Central Asia Crisis Unit) the World Health Organization (WHO) reported that Afghanistan had an extreme shortage of mental health professionals, with eight psychiatrists and 20 psychologists for a population of approximately 25 million.

Several researchers (Lopes Cardozo et al. 2004; Omidian and Miller 2006; Miller et al. 2008) have observed that extreme poverty and worries about daily survival such as inadequate food, poor living conditions, unemployment and domestic violence might have more impact on psychosocial wellbeing than war-related experiences. Furthermore Miller et al. (2008) questioned the use of the Western construct of PTSD, recommending instead a focus on culturally meaningful symptoms, reducing daily stressors and improving social support.

Despite the tragic consequences of three decades of conflict, Hassan (2009) argued that for some women the conflict also brought empowerment. She explained that the fragmentation of society and the breakdown of traditional support systems forced women to develop new coping strategies and abilities; especially through women's organisations working amongst refugee groups. From modest beginnings where women's groups focused on practical needs, healthcare and handicrafts, women developed leadership skills and self-confidence. Some are now women's rights activists, and political leaders (Hassan 2009). Rostami-Povey (2007a) who interviewed 152 participants in

Iran, Afghanistan, Pakistan, Britain and the United States portrayed the divergent nature of women's experiences, agency, struggles for gender rights and survival strategies both in exile and reintegration.

Afghans who remained in Afghanistan through the fighting were disadvantaged by the poor quality of and prolonged disruptions in education compared to those who studied in other countries. Some returnees, however, struggle to adapt to the culture of their homeland having grown up as refugees in neighbouring countries (Saito 2009), and some are unable to speak their mother tongue fluently, having studied in another language. In addition, returnees can face resentment from those who stayed behind (Rostami-Povey 2007a). Saito (2009) found that it was primarily single educated women returnees who faced social ostracism by fellow Afghans. Healthcare providers were amongst the returnees.

Some Afghans have experienced nothing but conflict and instability in their lives. Women in urban areas, Kabul in particular, have faced almost constant upheaval and change. Not only did war and conflict bring physical devastation, trauma and loss but the ideology of each new government and regime had a direct impact on women's lives: some gave new freedoms; some removed life as they knew it. Women have been powerless to prevent that change. The lesson of history, Burki (2011) concludes, is that cautious, incremental efforts to improve women's status stand the best chance of improving women's lives in the long term.

## **2.4 Afghan women today**

There is no quintessential Afghan woman. Even within broad groups such as rural women from conservative backgrounds or educated professional urban women there are great variations, both in how women live and how they want to live (Abu-Lughod 2002). Burki (2011, p.57) explains, for example, that

“Since King Amanullah, the gender policies of a Westernised elite in Kabul have been completely disconnected from the issues and concerns of rural women”.

The unique dynamics, culture and history of each family, the attitude of a girl's father and brothers towards women, education and healthcare plus the cohesion and stability of the wider community in which they live will define the parameters of each woman's life.

Not only is there a large divergence in the roles, freedom and respect that women experience within the family, there has also been a large divergence in how Afghan men and women have been portrayed. Some researchers have focused on the patriarchal and oppressive nature of male dominated Afghan society; the control, violence and abuse of women (Moghadam 2002; Rawi 2004). Some have emphasised the respect, closeness and security of traditional values and ways of living, whilst acknowledging the stress that conflict and migration placed on family relationships (Dupree 2004; Rostami-Povey 2007a). My Afghan female colleagues represented that diversity: there were those who were married against their will at a young age, those whose freedom depended on the salary that they provided to their family, and those who lived in fear of their violent husbands. Conversely, there were those who, because of the support and encouragement of fathers and grandmothers, were able to study and follow their chosen career, despite opposition from their extended family.

## **2.5 Afghan women from a Western perspective**

As a Westerner, it is important for me to acknowledge that the involvement of Western governments and agencies in Afghanistan has often been driven more by political and economic considerations at home than by pure altruism (Rashid 2002; Coll 2004). In 2002 Barakat and Wardell advocated against singling-out women for humanitarian assistance, in isolation from their social, cultural and family context. They suggested that this approach might have more to do with

international political agendas than meeting the felt needs of Afghan women. The presence of foreign troops is perceived by many Afghans as an invasion (Rostami-Povey 2007a), and is compared to the Russian occupation. The plight of 'oppressed women who need rescuing' Khan (2014) suggested, is a discourse that has been used to maintain popular support for Western forces' continued presence in Afghanistan. Western feminist movements, while vocal and generous in their support of Afghan women have been accused of 'imperial feminism' as they have tacitly and uncritically supported US military, political and economic strategies (Abu-Lughod 2002; Khan 2014). As an Afghan woman explained to Rostami-Povey (2007b), for American feminists the *burqa* was the most important issue, for Afghan women it was access to education, healthcare and employment. Even amongst humanitarian non-governmental organisations (NGOs) who implemented programmes to improve the lives of Afghan women, evaluations have demonstrated that the opposite has sometimes been achieved (Daulatzai 2006; Kandiyoti 2009; McCarthy 2012). The emphasis on women's rights has ignored the social pressure on men to maintain their traditional role of controlling the women in their home, or follow parents' wishes to marry against their will (Azarbaijani-Moghaddam 2009). Providing employment exclusively for women has made it harder for men to find work, undermined their dignity as the traditional providers of the family, and increased tensions within the home (Dupree 2004; Daulatzai 2006).

As an outsider, I have felt both admiration and alarm at the large proactive programmes that Western nations have 'rolled out' to solve the Afghan problems, the complexity of which we have failed to understand. I have been disturbed by the ethnocentric assumptions that can underlie our efforts to improve the lives of other people. Although I do not consider the inactivity and passivity of cultural relativism to be the solution, I have also felt a reticence to interfere in somebody else's culture and world until it is understood. As Abu-Lughod (2002, p787) suggested, "Afghan women might want different things than we would want for them".

## 2.6 Afghan women and healthcare

### 2.6.1 Traditional healthcare and modernisation

Modern medicine is relatively new to Afghanistan. Hunte (1980) explained, that prior to the late 19<sup>th</sup> century, healthcare was provided by traditional and family-based medicine: the major female health practitioner being the ‘*dāya*’ or traditional birth attendant. In 1931 the first Afghan midwifery training school was opened in Kabul against a background of suspicion and opposition towards Western modern medicine, the education of girls and increased freedom for women (Hunte 1980). Hospitals for women as well as mother and child health clinics were gradually established, especially in urban areas. As Hunte (1980, p.2) pointed out, they did not displace the traditional means of healthcare

“but rather resulted in a pluralistic medical situation in which a number of health related alternatives are available to the population”.

Foreign nationals were involved in the development of modern medicine in Afghanistan. King Amir Abdur Rahman (1880–1901) invited two physicians, a registered nurse, a surgeon dentist from Britain, and some hospital assistants from India to visit Afghanistan (Hunte 1980). A Turkish gynaecologist, Turkish doctor and a German nurse taught students at the first nurse-midwifery school. 15 students graduated in 1935 (Hunte 1980).

From the late 1930s to the late 1960s schools of nursing and midwifery mushroomed throughout the country although, Herberg (2003) found most schools were run by private institutions and there were no standards to guide education or practice. During the 1970s the Afghan Ministry of Public Health (MoPH) began closing the private nursing schools, a standardised curriculum was introduced and a Nursing Unit was established to oversee nursing. By 1978, with the help of four international nurse educators, a school for graduate nurses had opened with the aim of upgrading nursing from within. Following the Soviet invasion in 1979, however, the programme was stopped (Herberg 2003).



### **2.6.2 Conflict and the healthcare system**

The Afghan healthcare system and infrastructure was all but destroyed during the height of the conflict and many doctors and health workers fled the country (O'Connor 1994). Those staff who remained managed with meagre medical supplies, sometimes without salaries. At times they were unable to leave hospitals due to the fierce fighting. Pakistan sheltered millions of refugees for more than ten years (O'Connor 1994). Many international health organisations were based in Pakistan and provided medical care and ran training programmes for community health workers and *dāyas* (Miller et al. 1995). A few international organisations remained in Afghanistan: some focused on victims of the conflict. Other organisations attempted to establish or support Mother and Child Health (MCH) clinics and immunisation programmes in the few areas that could be accessed (Tawfik 1994; Kaartinen and Diwan 2002), and to implement the Safe Motherhood Initiative (Mawji 2000). My experience, during the Taliban regime, was that operations were severely limited due to insecurity. Limited funding, supplies, and frequent edicts from the regime<sup>12</sup> made the provision of healthcare for women, even within Kabul almost impossible. By 2002 a national assessment (Management Sciences for Health 2002) estimated that 60% of Afghans had no access to basic healthcare.

### **2.6.3 Women's health initiatives post-Taliban**

Following the fall of the Taliban in 2001, the relative peace and influx of international donors, IGOs and NGOs presented the long awaited opportunity for a major reconstruction of the public health system (Waldman 2002). Improving mother and child health was one of the top priorities (Ministry of Health Transitional Islamic Government of Afghanistan 2003/1382). This received further impetus with the findings of several studies on maternal mortality (Amowitz et al. 2002). A retrospective cohort study of women who had died between 1999 and 2002 in four districts of Afghanistan was released in November 2002 (Bartlett et al. 2002), and revealed a maternal mortality ratio

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<sup>12</sup> For example: an edict in 1998 ordered all Kabul hospitals to transfer female patients to one hospital. Women were discharged from other hospitals regardless of condition. The designated hospital was barely equipped or staffed.

(MMR) of 1600 per 100,000 live births. Over three-quarters (78%) of deaths were judged to have been preventable. The four selected districts ranged from urban to remote rural and there were important differences between these areas; the remote rural district of Badakhshan had the highest MMR ever reported globally of 6,500 deaths per 100,000 live births (Bartlett et al. 2002; Bartlett et al. 2005).

#### **2.6.4 Maternal mortality and the shortage of female healthcare staff**

International efforts to reduce maternal mortality identified the importance of ensuring a 'skilled attendant' and 'skilled attendance' at every birth (Donnay 2000; World Health Organization 2004; Koblinsky et al. 2006; Freedman et al. 2007). The proportion of births attended by a skilled attendant became an international indicator for monitoring progress in achieving the fifth Millennium Development Goal: to reduce the MMR by three-quarters between 1990 and 2015 and achieve universal access to reproductive health by 2015 (United Nations Statistics Division 2008). In Afghanistan, however, there was a severe shortage of female healthcare providers, especially midwives. *An Afghan Health Resources Assessment* (Management Sciences for Health 2002) estimated there was a national total of 467 midwives. A key strategy, therefore, was to increase the numbers, quality and distribution of midwives especially in rural areas. A nationwide midwifery-training programme was developed and implemented by the MoPH, international donors and NGOs. Midwifery schools were reopened, new schools established (Currie et al. 2007) and an accreditation system developed to ensure the quality of midwifery education (Smith et al. 2008). The number of Afghan midwives tripled between 2003 and 2006 (Currie et al. 2007) and skilled birth attendance increased from 14% in 2003 to 34% in 2010 (United Nations Children's Fund 2003; Afghan Public Health Institute/ Ministry of Public Health (APHI/MoPH) et al. 2011). Women returned to Kabul medical university and newly qualified female doctors enrolled in obstetrics and gynaecology residency-training programmes in Kabul's maternity hospitals (Arnold et al. 2014). The community midwifery programme has been particularly acclaimed for training young women from rural areas as midwives (Turkmani et al. 2013; Zainullah et al. 2014). This has been achieved

with the support of local communities with the anticipation that these women will then return to serve women in their local community where there have previously been no skilled birth attendants. The *State of Afghanistan's Midwifery 2014* (United Nations Population Fund) states that 4,600 midwives have been educated in the MoPH accredited training programmes since 2003.

Current estimates of the impact of recent initiatives on the maternal mortality ratio in Afghanistan have been based on the *Afghanistan Mortality Study* (Afghan Public Health Institute/ Ministry of Public Health (APHI/MoPH) et al. 2011). This study reported an MMR of 327 (95% confidence interval 260-394) in the seven years preceding the survey. Incorporating newly available data the Maternal Mortality Estimation Inter-Agency Group estimated the Afghan MMR to be 460 (World Health Organization et al. 2012). Although a fall in maternal mortality is likely following the recent interventions, the dramatic improvement has been disputed (Carvalho 2015). Rasooly and colleagues (2013) argued, however, that the results are consistent with changes in key determinants of mortality such as increased age at marriage, lower fertility, increases in the numbers of women delivering in a health facility or with a skilled attendant.

Despite recent reductions to the number of women dying from pregnancy related causes, the *State of Afghanistan's Midwifery* (United Nations Population Fund 2014) emphasised that only 23 per cent of the estimated need for skilled birth attendance is met by the existing workforce. Furthermore,

“...even if graduation rates are doubled, efficiency improved and retention doubled...only 31% of estimated need will be met in 2030”.

Improving efficiency and retention rates, however, requires an in-depth understanding of the unique features of the working environment and the workforce.

### **2.6.5 Caring behaviours**

Despite very significant improvements in Afghan women's healthcare over the last decade there are fundamental elements within the hospital culture that have been resistant to change. I have, for example, often heard healthcare providers shouting at and on one occasion seen a labouring woman being slapped. On another occasion the baby of a woman who was in the second stage of labour was showing signs of distress. The doctor was called but when she failed to come I went to find her. She was chatting with a friend. The doctor ignored my concern about the baby and refused to rush to assist this woman to give birth. The doctor did not demonstrate a sense of responsibility or concern for this unborn baby or this baby's family. A non-Afghan colleague and I found a woman alone and crying in the delivery room some years ago, we discovered that she had just given birth to a stillborn baby. When we asked if someone could go and comfort her, a junior student midwife was sent. The student stood beside the bed and briefly told the bereaved mother not to cry. The student did not touch the woman or offer any other support; she appeared uncomfortable and quickly disappeared. It felt as though offering comfort in words, touch or through being with a grieving woman was strange and unwelcome, not only to the student but also to the other staff who carried on with their tasks and ignored the woman. An Afghan colleague's wife gave birth to her first baby in a Kabul hospital; she went home but started bleeding. Her husband tried to persuade her to go back to the hospital but she refused. It was a special Afghan holiday and she said that no one would want to see her. She stayed at home and died. I do not know what my colleague's wife experienced in the hospital, but whatever had happened she did not believe that the staff would want to see her again even although she had a problem. These incidents represent a few of the many that I have been involved with and many similar incidents that I have heard about from colleagues.

Numerous non-Afghan colleagues have remarked that healthcare providers did not appear motivated to care and that they seemed to lack a sense of responsibility, particularly in caring for poor, illiterate women. In addition they agreed that good communication, respect and kindness were rarely seen in

interactions between staff and perinatal women. The many informal conversations between colleagues produced multiple suggestions regarding the cause of these behaviours. To date, however, these suggestions have not been verified or disproved by research.

### **2.6.6 Personal connection with study**

This ethnographic study builds on more than a decade of involvement in the Afghan healthcare system. It also builds upon my respect for the Afghan people who have suffered so much. They continue to surprise me with their tenacity, humour and kindness - as they also continue to disturb me with their hardness and violence. I want to increase our knowledge and understanding of healthcare providers - the midwives, doctors and care assistants/cleaners (or *khālas*<sup>13</sup>) of this Kabul maternity hospital. My intention is to provide new insights that can be used to support and facilitate the healthcare providers in their vital roles, insights that could ultimately benefit the women who come to give birth to their babies in Kabul maternity hospitals.

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<sup>13</sup> *Khāla* – aunt; honorific title for any older women; commonly used for low-grade women workers in hospitals (e.g. cleaners; part time care assistants).

## Chapter 3 - The literature review

In this chapter I shall discuss the literature that contributed to the development of this research. Chenail et al. (2010) suggested that there are four main ways in which the literature contributes to qualitative research: through defining the phenomenon in question; identifying the research gap; supporting the methodological choices; and comparing and contrasting study findings with existing knowledge. This chapter covers the first two: I explain how the literature helped to define and refine the focus of my study and I identify the gaps in the literature that my study has addressed.

The primary focus of my literature search was the perspectives and behaviour of healthcare providers, Afghan and non-Afghan, especially those in societies with similarities to Afghanistan. I needed to ascertain if the behaviour of maternal healthcare providers was a significant study topic. I therefore examined the impact of healthcare behaviour on the uptake of services and maternal mortality. I then investigated this issue in more detail to define the phenomenon, and what was known, regarding contributing factors in healthcare provider conduct.

As I read and reflected on my experiences in Afghan health services and wider society, I realised that to study healthcare providers in isolation would create a false impression. It would reduce them to generic hospital staff and separate them from the world that gives them meaning and purpose. It was vital therefore to explore and incorporate fundamental elements of the context of their lives and work, such as Afghan womanhood, family, society and recent history. The literature associated with this secondary focus is presented in 'Setting the scene' and in the discussion sections of the findings chapters.

As a qualitative study, the literature review has been ongoing. The literature in this chapter generally represents what I knew before data collection. More recent literature will be brought into the discussions in the findings chapters.

My research questions and aims were developed and clarified from this initial literature search. These are presented at the end of the literature review.

### **3.1 Procedures**

Database searches were initially carried out using HINARI, the World Health Organization's 'access to research in health programme', as I was able to access this through the NGO that I was linked with in Kabul. Following this I used the Bournemouth University's search engine for an initial overview of the type of articles and the terms that were used. A more detailed search was then done through selected databases. More than 15 databases were searched including Academic search complete, CINAHL complete, Pub Med, Medline complete, Scopus, Global Health, WHO Reproductive Health Library, Web of Science, Science Direct, Interim, PsycINFO and PsycARTICLES. Initially, I located relevant literature regarding Afghanistan; I then widened the search to examine the literature from other contexts. Where there was a wealth of literature, my selection criterion, in addition to the quality of the article, was to select literature from similar contexts to Afghanistan where available, such as fragile/post-conflict countries, Islamic countries and low-income countries. In some instances, however, such as the neglect and abuse of women in facility-based childbirth, I deliberately selected examples from high, middle and low-income countries. My rationale was to demonstrate that these issues are widespread and not confined to low-income countries.

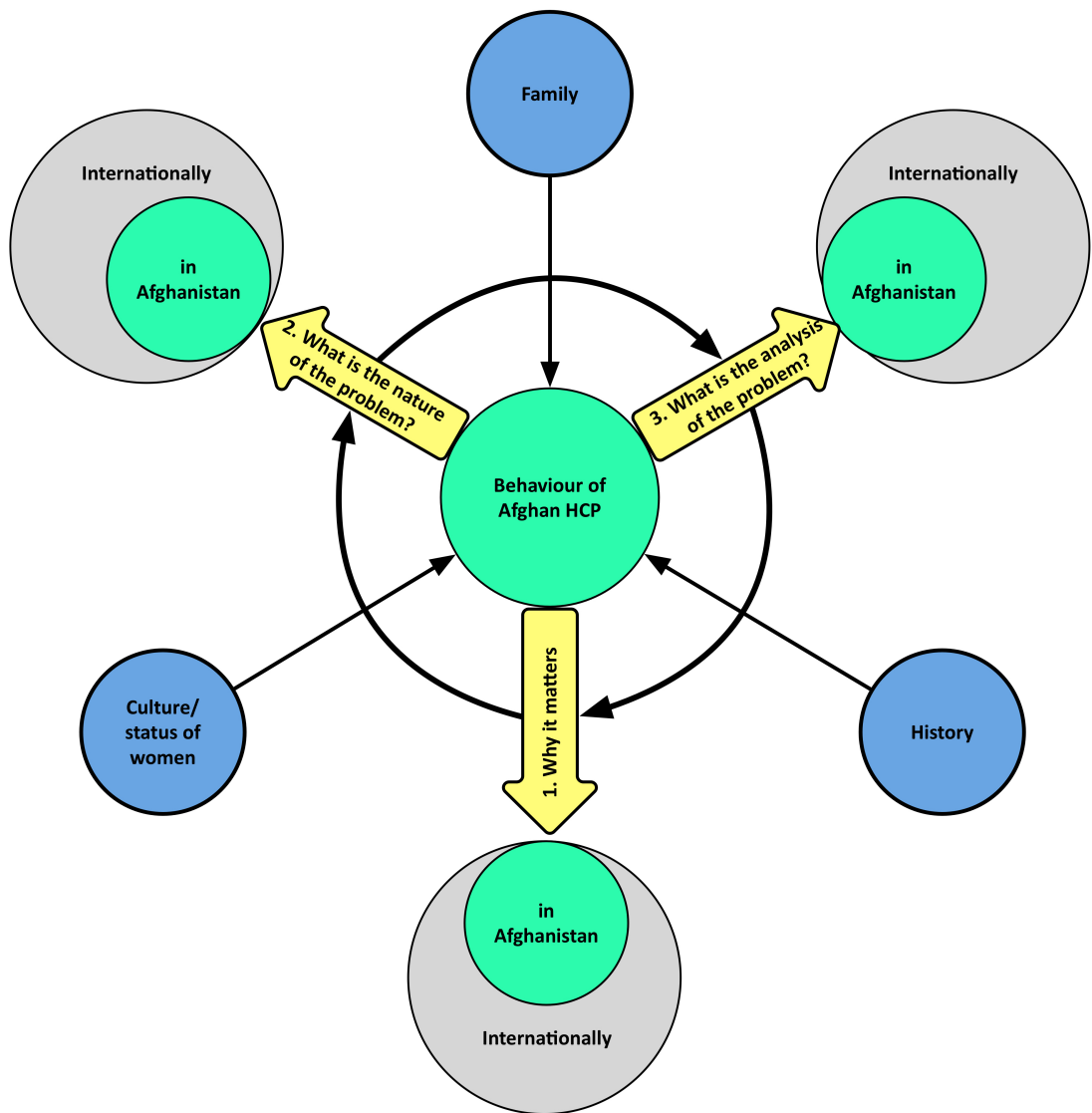
In addition I searched for grey literature in specific sites such as the Afghan Ministry of Public Health website: <http://moph.gov.af/en>; the Afghanistan Centre at Kabul University catalogue (<http://acku.edu.af>); the Afghanistan Research and Evaluation publications and library (<http://www.areu.org.af/?Lang=en-US>); the Afghanistan Analysts Organisation (<https://www.afghanistan-analysts.org>); and the Afghanistan Analyst website, a resource for researching Afghanistan including bibliographies and Doctoral and Masters' Theses (<http://afghanistan-analyst.org/dissertations-and-theses/>). Journals with a focus on the region such as the *Central Asian Survey Journal* were also searched.

In addition, I searched maternal health/reproductive health initiatives and advocacy websites such as Averting Maternal Death and Disability <http://www.amddprogram.org>; the Partnership for Maternal, Newborn and Child Health <http://www.who.int/pmnch/en>; Countdown to 2015 <http://www.countdown2015mnch.org>; White Ribbon Alliance <http://whiteribbonalliance.org>; Impact <http://www.abdn.ac.uk/iahs/research/impact/>; the International Confederation of Midwives <http://www.internationalmidwives.org> and the FIGO (Fédération Internationale de Gynécologie et d'Obstétrique = International Federation of Gynecology and Obstetrics).

Search terms were truncated where appropriate such as in Afghan\*, midwi\*, and Boolean Operators used such as AND, OR, NOT. Search terms such as Afghan\* AND health AND culture, also Afghan AND (doctor OR midwi\* OR nurs\* OR healthcare provider). In addition, Afghan AND (Doctor OR Midwi\* OR Nurs\* OR healthcare provider) AND (attitude OR behaviour) were also used.

The following Figure 1 illustrates the overview of the literature search. It includes the main questions that were explored in defining what was already known regarding the behaviour of healthcare and identifying the gaps in knowledge. It also includes the broader foci, (initially presented in setting the scene), that have set the study in context and assisted in the analysis and interpretation of findings.





**Figure 1: Literature review overview**

### **3.2 Why the behaviour of healthcare providers is important**

My initial literature search focused on the behaviour of healthcare providers particularly in Afghanistan, and post-conflict or low-income countries. Did staff behaviour have an impact on the uptake of services? Was being treated with respect or kindness important to Afghan women, or women from similar cultures? What was the significance of this topic with regard to maternal mortality? Holloway and Wheeler (2010) suggest that the initial literature review can help researchers decide whether to proceed with the study. It was

important to me, as a midwife, to discover if this topic was relevant to maternal mortality and likely to make a positive contribution to reproductive health policy and practice in Afghanistan.

### **3.2.1 Afghan perspectives on behaviour and the uptake of services**

Just before the Taliban took power (1996), Kaartinen and Diwan (2002) conducted a mixed methods study examining the utilisation of mother and child health services in a Kabul suburb and the perspectives and experiences of the women who accessed them. Traditionally the majority of these women gave birth to their babies at home. They and their families considered institutional birth a last resort if complications arose during labour. The women were frightened of being attended by a male doctor and fearful of invasive procedures such as “being cut”. They hoped the staff would behave like their own sisters or mothers, and be empathetic, patient, just, and communicate well. Kaartinen and Diwan (2002) reported, however, that these women said they often experienced unfriendliness and neglect.

A knowledge, attitudes and practice survey of 468 women of reproductive age in Kabul in 2004 (van Egmond et al.) showed that despite their proximity to health facilities only 32.7% of all births had occurred in a clinic or hospital. Many reasons were given for not giving birth in an institution including distance of health facilities, cost of an institutional birth, no permission from husband or family, fear of hospital, and poor services (van Egmond et al. 2004). Of the 16 barriers to utilisation of institutional deliveries the authors focused on women’s decision-making abilities (12% of women cited this), and did not provide more information on the poor services. It was also of note that the second highest barrier to institutional birth (16.9%) was that it was too expensive (van Egmond et al. 2004). As Afghan public hospitals are officially free, clarification of this point would have been helpful. In the first such study of recent years, Hansen and colleagues (2008) examined the perceptions of clients regarding the quality of primary care services in Afghanistan. Using data from a previous study, 5,597 exit interviews of patients from 617 health facilities regarding perceived

quality and their overall satisfaction were analysed. Estimations of quality were determined by interactions with health workers, rather than health facility characteristics such as cleanliness, equipment and medical supplies. The three highest determinants of perceived quality were the thoroughness of health workers in taking histories, conducting physical examinations and their communication with patients. Women also reported that the quality of care in basic health centres was higher than at district hospitals.

A qualitative study in the province of Badakhshan examined the intended and unintended consequences of the midwifery-training programme (Akbar 2011). Rural women explained to Akbar that they were treated in a derogatory manner by local hospital staff. This was highly influential, she explained, in their preference for giving birth at home with a traditional *dāya*. The lack of privacy, doubts about the effectiveness of care, and the humiliating experiences they endured in the hospital discouraged these rural women from using the services of midwives (Akbar 2011). Although references were limited, the literature indicated that the manner in which Afghan women were received and treated by healthcare providers influenced the acceptability and utilisation of those services.

### **3.2.2 Behaviour and the uptake of services in similar societies**

A qualitative study of Lebanese women's childbirth experiences and perspectives found that while women rarely questioned medical interventions despite their discomfort and embarrassment, they were vocal in expressing the importance of good interactions with their carers (Kabakian-Khasholian et al. 2000). A diverse group of 117 women were interviewed by Kabakian-Khasholian and colleagues. They came from rural, remote rural and urban areas and represented different levels of education and class. Although they had different opinions regarding the presence of their husbands or family members at the birth, and whether they preferred a midwife or doctor to care for them, women of all groups agreed that their satisfaction with care was 'highly dependent on their interactions with care providers.' The women appreciated

kind doctors and midwives who treated them humanely, praised or encouraged them, listened to their concerns and answered their questions. It appears (although the authors do not clarify) that private providers cared for all of the women in the study. The competitive nature of private care helps to explain some of the caring behaviours described but this does not detract from the importance women placed on the psychosocial aspects of care, especially when choosing their healthcare provider.

Exit interviews from health services of 1913 persons in rural Bangladesh (Aldana et al. 2001) found that politeness, respect and privacy was more important to them than the technical competence of the staff (characterised for example by physical examination or explaining the nature of the problem). Although this quality assessment study examined general health services it was one of a few larger studies in the region that, in addition to endeavouring to ensure rigour and reliability throughout the process, included multiple questions regarding client expectations, quality, satisfaction and the behaviour of providers. Aldana and colleagues highlighted differences between professional and lay notions of quality and the need to address both. They recommended more in-depth research on determinants of client satisfaction in respective cultures.

In the context of a high maternal mortality ratio and 64% home birth rate, a qualitative study in Rakai district, Uganda, explored the psychosocial factors that influenced decisions regarding the place of birth (Amooti-Kaguna and Nuwaha 2000). Eight focus group discussions (FDG) were held with groups of men and groups of women. Semi-structured interviews were held with 211 women who had given birth to a baby during the preceding year. The use of male moderators in this study might have affected the women's willingness to express themselves though the authors considered that the women talked openly. "Fear of being ridiculed by health workers" explained Amooti-Kaguna and Nuwaha, was one reason the women did not utilise public health units for antenatal care or childbirth. Some midwives were perceived as "rude, proud, negligent and vulgar" and were quoted as "using demeaning words to the

women”(p.208). Mothers who had not attended antenatal clinics or who had had many previous pregnancies were particularly abused by some young midwives. Mothers felt uneasy giving birth in the health unit due, they said, to health worker harassment or rudeness. They preferred traditional birth attendants (TBAs) who were said to be kind, caring, culturally acceptable and always available. Abrahams et al. (2001) reported from South Africa that staff-patient interactions made clinic attendance an unpleasant experience that discouraged women from attending. D’Ambruso and colleagues (2005) reported that humane, professional and courteous treatment was very important for women in Ghana. Health professionals’ attitudes were a critical element of care. They did not only affect women’s satisfaction and future use of maternity services but also affected whether they would recommend those services to others. Women in Ghana recounted both positive and negative encounters with staff. Some women experienced kindness, reassurance, politeness, help with caring for their babies and prayers, others cried when they relived their experiences of being threatened, shouted at, humiliated and unsupported as they gave birth. Despite the shouting and unfriendly behaviour, a number of women said that they would recommend the facility to women experiencing problems in childbirth because “to have your baby and be alive is the most important” (D’Ambruso et al. 2005, p.6). Studies from many other settings including Cambodia, Zimbabwe and Benin reported that unfriendliness, lack of respect, shouting, rudeness, beatings and neglect of pregnant women by healthcare providers was not acceptable to women and that such behaviour discouraged them from accessing maternity services or using a skilled attendant for antenatal care and childbirth (Grossman-Kendall et al. 2001; Mathole et al. 2004; Matsuoka et al. 2010).

Kempe et al. (2010) highlighted the importance of authority for women in Yemen. In a country where women are routinely disempowered, the authors noted that women’s personal empowerment at birth was very important to them. According to Yemeni childbirth tradition it is important that the labouring woman has power and authority during childbirth that their questions are answered and requests met. This is central to the experience of becoming a mother. The majority of Yemeni women gave birth at home, maternal mortality ratios were

high and the government was endeavouring to increase the use of professional care during childbirth (Kempe et al. 2010). This study revealed, however, that the higher the level of training of professional staff, the less respect and consideration the women experienced. It was the TBAs who shared authority, cared with empathy, created solidarity and support amongst women as they laboured at home. The authors concluded that attracting women to institutional care required a better understanding of people in the community, the involvement of traditional carers and fundamental changes to make health service provision culturally appropriate.

Women in focus groups and semi-structured interviews in Uganda could explain the merits of having their babies at the health facilities but for varied reasons including lack of transport, poor quality of care and rude staff, 61% gave birth outside the health facilities where 40% of births were supervised by TBAs (Amooti-Kaguna and Nuwaha 2000). The authors concluded that it was not health education for women that was needed but a change in staff attitudes to make the health units more user-friendly, improve the quality of care and increase the proportion of women giving birth with a trained health worker. The focus on cultural barriers, poverty and ignorance when discussing the underutilisation of services, Thaddeus and Maine (1994) contended, obscured the role that institutional inadequacies play.

These studies indicate that it is not sufficient to just provide clinical services; they must also be socially and culturally acceptable. Women's choices regarding ante-natal attendance, place of birth, the use of biomedical or traditional healthcare services are strongly influenced by their experiences of healthcare providers, or the reputation of health facility staff. The effect on the uptake of services, it could be argued, has an indirect effect on maternal mortality and morbidity.

Next, I wanted to ascertain if there was evidence of a direct link between healthcare provider behaviour and maternal mortality.

### **3.2.3 Behaviour and maternal mortality in Afghanistan**

There was scant literature regarding the interpersonal aspects of care in Afghanistan and no direct link with the outcomes for women who have their babies in hospitals or clinics. It was noted, however, in the Afghan National Reproductive Health Strategy (Ministry of Public Health 2006, p.17) that almost 70% of families who sought care reported that they encountered third level barriers or a delay in receiving adequate care at the facility (Thaddeus and Maine 1994) because of cost or poor quality service. Several studies also raised concerns about the quality of care in public maternity hospitals with the consequent risk of adverse events for mothers and babies.

In their observational investigation of a Kabul maternity hospital, Williams and McCarthy (2005) described factors that influenced the quality of care in 2003: the absence of infection control, lack of equipment and the management of perinatal women. The condition of women in labour was monitored inconsistently and infrequently, critically ill women were often neglected because more mobile women diverted attention from them and labouring women often gave birth unattended. There were inaccuracies in the authors' rationale. They suggested that female providers became deskilled during the Taliban regime when they had been forced to leave their jobs, however, my experience was that the Taliban had allowed women to continue to work in healthcare. The causes of what they termed "woeful patient management practices" Williams and McCarthy (2005) suggested, were a lack of knowledge, training, equipment, supplies and inexperienced healthcare providers caring for high-risk women. Although these were likely contributing factors the authors did not mention staff attitudes, behaviour or motivation. It is worth noting that when I commenced my study several years after this report, despite the provision of equipment and essential supplies, training programmes and upgrading for healthcare providers in all Kabul maternity hospitals, management practices were essentially unchanged.

In 2006 Guidotti and colleagues (2009) analysed perinatal outcomes and clinical practice factors in four government maternity departments/hospitals in Kabul. The average stillbirth rate of 38 per 1,000 births when compared to the average stillbirth rate of 12.5 in eight other developing countries, the authors suggested, showed the magnitude of the challenge in maternal and perinatal health. The high rate of fetal deaths during labour and prior to discharge (18.7 per 1,000 births) called into question the quality of care in these four hospitals. Guidotti and colleagues suggested that their findings could indicate unattended and prolonged labours, delays in treating antepartum haemorrhage and inadequate management of pre-eclampsia. It was not possible, however, to ascertain the reasons behind the high rates of perinatal deaths. The authors concluded that the quality of care was suspect and might have contributed to these deaths.

A study of caesarean practices and outcomes in one Kabul hospital (Kandasamy et al. 2009) found a stillbirth rate two-fold higher than some population-based values reported from Sub-Saharan Africa and parts of Asia (Lawn et al. 2005) where large proportions of the population do not have access to emergency obstetric care. A high number of the Kabul hospital stillbirths were normal birth weight infants who died during labour or birth. These types of stillbirths, Kandasamy et al. (2009) explained, are usually defined as preventable deaths: they highlight the need for better monitoring of labour and improved childbirth care.

These studies demonstrated the need to identify and explore constraints in the provision of quality care in Kabul maternity hospitals so that improvements can be made to the monitoring and management of labouring women and their babies. Although these studies made no direct link between maternal mortality and the behaviour of staff, the high rate of stillbirths and infant deaths raise the suspicion of unattended labours with the consequent dangers for women and unborn infants.



Purdin et al. (2009) described the notable impact of a reproductive health programme by The International Rescue Committee (IRC), amongst Afghan refugees in Pakistan, where over a four-year period the maternal mortality ratio improved from 291 to 102 maternal deaths per 100,000 live births. This was an extremely conservative community where women were not seen in the market, were allowed limited access to health services and did not speak of pregnancies. Based on the Averting Maternal Death and Disability programme and building blocks framework (Averting Maternal Death and Disability 2006), Emergency Obstetric Care (EmOC) centres were established with 24-hour coverage. Community health education activities built awareness of safe motherhood and danger signs during pregnancy, and the health information system was improved. Purdin et al. (2009) explained that building relationships of trust with community and religious leaders and involving them in designing a socially acceptable programme had been as important as the provision of clinical care. Of the many contributing factors, the authors concluded that the consistent presence of dedicated staff was the most important factor in the increased utilisation of EmOC services, and that privacy and a friendly environment had also increased utilisation and client satisfaction. Although this reproductive health intervention was not facility-based and was situated in Pakistan, it was significant because it highlighted the importance of socially acceptable programming to an Afghan population in increasing the uptake of services. In addition, while it is not possible to analyse the impact of one aspect of this multifaceted programme, it is highly likely that the culturally sensitive and respectful approach was a factor in the approximately two-thirds reduction in the maternal mortality ratio.

Conversely, in her unpublished thesis, Akbar (2011), a young Afghan woman, was highly critical of the community midwifery programme in Afghanistan and was sceptical of the benefits. She contended that maternal mortality was framed as simply an issue of physical access to care, and that the programme and curriculum had been developed in isolation from the local context. The political pressure to demonstrate success and quick results, she argued, discouraged in-depth investigation, and that the realities and beliefs of the intended beneficiaries had been ignored. Amongst programme weaknesses,

Akbar (2011) noted the absence of a mechanism to integrate the local women's thoughts, expectations and difficulties with midwives. Akbar explained that healthcare facilities were unresponsive to women's needs, intimidating and uncomfortable spaces for them. The current intervention could not reduce maternal mortality significantly, Akbar contended. I concur with much of Akbar's criticism of the midwifery-training programme, of which I was a part. Her criticism, however, encompassed biomedical practice, staff behaviour in the local hospital and her frustrations regarding politically driven development policies for which the midwifery programme cannot be considered responsible. Her study painted a powerful picture of the gulf between rural women and urban biomedical maternity services but did not explore the perspectives of the healthcare providers.

#### **3.2.4 Behaviour and maternal mortality in similar societies**

Thaddeus and Maine (1994) conducted a multidisciplinary literature review from the 'developing world' examining the interval between the onset of an obstetric complication and its outcome. Their conceptual framework classified the obstacles to the utilization of high quality, timely obstetric care as the three phases of delay: the first delay being the delay in deciding to seek care; the second delay, the delay of reaching a medical facility; and the third delay, the delay in receiving adequate and effective treatment. In discussing the first delay they concluded that:

“If a facility has a reputation for unfriendly staff, rude service providers and humiliating treatments then the prospective patients may delay the decision to seek care until the seriousness of the condition necessitates overcoming all barriers” (Thaddeus and Maine 1994, p.1096).

Once labouring women arrive at healthcare facilities, Thaddeus and Maine noted, there may be delays in providing adequate care. “Blaming the patient for seeking care late” conceals the fact, Thaddeus and Maine (1994, p.1104) argued, that “the healthcare system often fails the patient”. These delays were

symptomatic of inadequate care, shortages of staff or essential supplies, and late or incorrect clinical management. The large majority of these deaths the authors explained, were either entirely or probably preventable. In their analysis of factors affecting the quality of care, however, Thaddeus and Maine (1994, p.1105 Fig. 4.) omitted to discuss the effect of the humiliation of patients or rude, unfriendly staff, despite having mentioned this in the quotation above. The Prevention of Maternal Mortality Program initiated the review. They integrated some of the findings into their programmes in Ghana, Nigeria and Sierra Leone, but staff behaviour was not mentioned in their interventions.

In *The Lancet* maternal survival series, Ronsmans and Graham (2006, p.1195) concurred that “a large proportion of all maternal deaths takes place in hospitals.” Some women arrive in too poor a condition to be helped, some could have been saved if they had received timely and effective interventions, and other women admitted for normal birth subsequently develop serious complications and die.

“The latter two types of cases raise concerns regarding the quality of care in health facilities and numerous studies have shown that delays in recognition and treatment of life-threatening complications, as well as substandard practices, contribute directly to maternal deaths” (Ronsmans and Graham 2006, p.1196).

Several studies have examined the delays and substandard practices that can lead to maternal deaths. Weeks et al. (2005) interviewed 30 women who had experienced a ‘near-miss’ maternal mortality in a Ugandan hospital. The low uptake of services, difficulties of obtaining care and maternal mortality, Weeks and colleagues concluded, were closely connected to women’s powerlessness, their subservient role within Ugandan society, poverty, economic dependency, and the poor attitude of some health workers. Women were grateful for the care that had saved their lives. Misdiagnoses, administrative delays, the massive workload and the attitude of some health workers who, for example, went to eat rather than perform an emergency caesarean section, however, all contributed

to these 'near-miss' maternal mortalities. Wagaarachchi and Fernando (2002) concluded that substandard care influenced the outcome of 79% of maternal deaths in a tertiary hospital in Sri Lanka although the lack of documentation made it difficult to quantify the nature of substandard care. Taking all factors into consideration, Wagaarachchi and Fernando judged that 73% of these deaths might have been preventable.

Ronsmans and colleagues (2009) examined the relationship between skilled attendance, and maternal and perinatal mortality in Matlab, Bangladesh. Multiple data sources covering an 18-year period were analysed. The uptake of skilled care at birth in this conservative rural area had dramatically increased over the study period. Ronsmans and colleagues found that maternal mortality was low among women who did not seek skilled care but nearly 32 times higher among women who sought professional help, although this was declining towards the end of the study. The authors discussed possible explanations for these figures. Where the uptake of skilled birth attendance is low, they explained, women might delay seeking care until they are in such a poor condition that the midwife or doctor is unable to save them. Ronsmans and colleagues also suggested that the lack of timely and adequate care once women have reached a health facility might also explain the high mortality rate, as there was some evidence of substandard practice.

In 1999 the Dominican Republic reported a relatively high MMR of over 100 deaths per 100,000 births despite the fact that approximately 97% of women gave birth in a health facility with a trained attendant (Miller et al. 2003). Miller and colleagues conducted a rapid predominantly qualitative strategic assessment to identify the causes of the high maternal mortality ratio and define policies to address them. The study team found that the majority of 'National Norms' for labour and childbirth were not followed. There was a lack of adequately trained staff and while women with uncomplicated labours were over-medicalised, women with complications were ignored or under-managed. The qualitative study reported that care was lacking in all facilities and that the birthing process was dehumanised. Providers in the busiest facilities suffered

from compassion fatigue, were demoralised and overworked, and some maternal deaths were attributed to the negligence and apathy of the physicians (Miller et al. 2003).

“The overall constraint to improving maternal health was one of attitude, the attitude of clinical staff toward patients, of persons in authority toward clinicians and of women’s low expectation of a system that instead of serving them places them at risk” (Miller et al. 2003, p.101).

Following their analysis of rigorous research from the last decade, d’Oliveira and colleagues (2002) argued that violence against women in childbearing or abortion services contributed to maternal morbidity and mortality as it affected health service access, compliance, quality and effectiveness (d’Oliveira et al. 2002). As Miller et al. (2003, p.89) concluded

“Institutional delivery alone is not enough to decrease MMR, it is also the quality of emergency obstetric care that saves lives”.

### **3.3 The nature of the phenomenon**

Once I was convinced that the behaviour and attitudes of healthcare providers was a significant area to explore, I needed to define the nature of the phenomenon. Firstly I examined health policies in the Afghan MoPH and the midwifery curriculum to ascertain what standards and values healthcare providers were required to uphold in their work. Secondly I examined the literature on disrespect and abuse. My initial interest had been the apparent lack of kindness, communication, compassion and responsibility amongst healthcare providers. I realised, however, that the phenomenon as described in the literature was broader. Initially I had been reluctant to use the terms abuse, disrespect and violence, but this had excluded a significant body of literature not only documenting abuse but also providing some insights into the healthcare provider perspective. My second phase of literature searching,

therefore, included literature on abuse, violence and disrespect in facility-based childbirth.

### **3.3.1 MoPH standards for healthcare provider behaviour**

The working principles of the MoPH as stated in their national health policy 2005-2009 and health strategy 2005-2009 (Ministry of Public Health Afghanistan 2005, Annex E) included “treating all people with dignity, honesty and respect...and equitable access, giving priority to those in greatest need”. One of the health strategies in the logical framework is “to develop a culture of quality assurance covering service provision, clinical care and management” (p46), with the intended output or effect of “health providers showing interest in changing their attitude towards patients/clients for the better”. The core values in the Afghan National Reproductive Health Strategy 2006–2009 (Ministry of Public Health 2006, p.2) included: Human Rights, “promotes the rights of all people”; Gender, “by addressing discrimination against women”; Equity, with “priority attention to the poor”; and Culture, “uses a culturally sensitive approach”. The document then states the operational principles of reproductive health system “Quality of Care - All interventions should be made available with the highest standard of quality... safety ... and evidence-based best practices”. The Ministry of Public Health was therefore clear in its policies regarding the high standard of behaviour that was expected of its staff.

The midwifery curriculum gave a high priority to respect and interpersonal communication skills and emphasised the importance of high quality culturally sensitive care (Ministry of Public Health 2009). As each skill was taught interpersonal communication was emphasised. Student midwives were taught to always introduce themselves to the women and explain what they were going to do. Students were assessed for communication skills as well as technical skills. In an overview of the progress of Afghan midwifery since 2002, however, Currie and colleagues (2007, p.233) explained one of Midwifery’s remaining challenges:

“Afghan midwives need to learn more about treating clients with respect and kindness as well as the ethical issues of responsibility and accountability. Observations in maternity units of midwifery and medical staff indicate a lack of caring behaviours”.

Documents from Kabul Medical University were not available. There was no single curriculum and no specific module on ethical behaviour and professionalism.

### **3.3.2 Disrespect, neglect, and abuse in Afghanistan**

The literature is sparse in documenting disrespect and abuse within Afghan healthcare facilities. This could be because disrespect and abuse are rare or it could reflect the difficulties of the last 30 years of conflict, during which time the provision of even basic healthcare was challenging (O'Connor 1994). One insight is provided by Kaartinen and Diwan (2002), who documented that the women in one district of Kabul said that hospital staff were often unfriendly and shouted at them. One woman explained that she had been left alone with her legs in stirrups whilst the staff drank tea. She was screaming and scared that she would lose the baby. When the staff came, they complained that people of her ethnic group get married too early and have too many children (Kaartinen and Diwan 2002). The use of inexperienced and young interviewers would, however, have inhibited the women's responses and the interviewers would have been unlikely to have the ability or cultural mandate to probe into what is considered a very private topic. The interview team were also connected to the Mother and Child Health clinic so this might have biased some findings, although there is no reason to doubt the women's accounts of childbirth.

Following multiple interventions to improve standards of care in a Kabul maternity hospital, despite improvements in other areas, an assessment of care gave the healthcare providers 0% for information, education and communication with perinatal women (Standards Based Management Performance and Quality Improvement Team 2005). In Kabul hospitals annual

assessments measure the quality of health service using the Health Sector Balanced Scorecard. Eight domains are examined – ‘Human Resources’ includes staff management, supervision, job satisfaction and training; ‘Quality and Safety’ – examines the enabling environment, quality and staff-patient interaction. Progress has been made in many domains, however, there is room for improvement in areas such as health worker skills (which included interpersonal skills) and communication (Johns Hopkins University Bloomberg School of Public Health and Indian Institute of Health Management Research 2008). Unanswered questions remain regarding why the gaps in service delivery exist and how these can be addressed.

In her reflections, Currie (2007) a non-Afghan midwife who had worked with the Afghan MoPH to strengthen and expand midwifery education for over six years, recalled finding a woman who had been neglected by hospital staff. The woman had been admitted nine days previously with eclampsia and a cerebrovascular accident. She was, Currie (2007) pointed out, the classic example of the third delay (Thaddeus and Maine 1994), where care was accessed but appropriate treatment was not given.

Akbar (2011) interviewed women in two villages and in Faizabad the provincial capital of Badakhshan. The urban women spoke of change, the sense that giving birth at home with a *dāya* was no longer appropriate: women who had given birth at home were now taking their daughters and daughters-in-law to hospital. The village women, however, spoke of their discomfort about going to hospital, especially the loss of the strict privacy that surrounds pregnancy and childbirth. Akbar (2011) observed the humiliation of village women in the provincial hospital as they were treated with condescension, shouted at for the number of children that they had and ignored when they cried out in pain.

Sub-optimal care appeared to occur in various forms within Afghan maternity facilities; however, there was a lack of substantial documentation. I realised that participant observation would be an important component of this study to



enable me to understand the nature of care prior to conducting interviews and group discussions.

### **3.3.3 Disrespect, neglect, and abuse in other societies**

The literature contains many accounts of disrespect, neglect and abuse in reproductive health services. The examples below have been selected to demonstrate the breadth of contexts and the multiple ways in which healthcare providers fail to provide respectful quality care.

In the UK, the *Changing Childbirth* report in 1993 recommended a major reorganisation of maternity services that would put women at the centre of their care through choice, continuity and control (House of Commons Health Committee 2003). Women in a qualitative study by Baker et al. (2005), however, perceived that they had suffered from a lack of control, few choices and little influence over decision-making. The majority of the 24 women interviewed had been given inadequate information regarding what was happening to them and several talked of being coerced or bullied into procedures against their wishes and what their bodies were telling them (Baker et al. 2005). According to the authors, over half used negative terms to describe the midwives' attitudes, such as rude, harsh, judgemental, insensitive, intimidating or threatening.

Abuse and neglect were the dominant features of South African women's narrative accounts of labour and childbirth (Jewkes et al. 1998). In their study of the health seeking practices in maternity services, women described being shouted at, beaten, threatened with beatings and ordered to clean the floor - some women gave birth on their own. Women complained that the midwives were inhuman and uncaring. The most distressing part of their experience the women said was the neglect, the perception that the staff did not care. In-depth interviews with 19 Benin women explored their experiences of pregnancy and childbirth (Grossman-Kendall et al. 2001). Women considered themselves lucky if kind midwives cared for them. Other women described their midwives as

impatient, intolerant and scornful of women who complained of the pain. They also described midwives beating those who did not comply during childbirth (Grossman-Kendall et al. 2001). The women's testimonies described many dimensions of care that did not meet their expectations and was socially unacceptable to them. In Benin society, for example, age and having children traditionally brought respect. Grossmann-Kendall and colleagues noted that the mistreatment of older women with many children by young midwives, many without children, transgressed social mores. The older women found this particularly humiliating and barely understandable. The authors also explained that women considered caesarean sections as an act against nature, an evil of modern life and were suspicious that caesareans were performed to generate money. One woman had been forced to stay in the hospital for a month after the birth until her family paid the bill (Grossman-Kendall et al. 2001).

Swahnberg et al. (2007) interviewed and explored Swedish women's feelings of being abused during their lifetime in the healthcare system. The women, who had attended a gynaecological clinic, described their feelings of powerlessness when the staff did not listen to their concerns, take them seriously or believe them. They felt ignored even when they tried to stand up for themselves and no one responded, and they perceived that they were being treated 'as a thing without feelings'. One woman, for example, told the doctor to stop a procedure as the anaesthetic was not working but he did not answer and continued (Swahnberg et al. 2007). The callousness, rough, brusque or threatening treatment evoked feelings of discomfort and terror in the women. The core theoretical construct Swahnberg and colleagues (p.165) identified from these women's feelings was one of "being nullified", of losing autonomy and human dignity. Women reported intense current suffering even although the abusive event had, for some, occurred years earlier. Kenyan women who had their babies in Kenya's largest public hospital described "egregious rights violations", abuse and humiliation that endangered their lives and the lives of their babies (Center for Reproductive Rights and Federation of Women Lawyers Kenya 2007, p.7). The authors noted that women's experiences in this healthcare facility were said to have lasting psychological and physical repercussions, which shaped their subsequent decisions regarding healthcare use.

Several studies noted the lack of information for women, and the hostile reactions or ridicule which they received if they showed initiative or questioned the healthcare providers (Jewkes et al. 1998; Kabakian-Khasholian et al. 2000; Swahnberg et al. 2007). For women in Benin daring to ask a question was considered an act of bravery (Grossman-Kendall et al. 2001). Women in South Africa said that they were frightened of the healthcare providers and the random nature of the abuse. Midwives used fear, scolding, and punitive measures to exert control (Jewkes et al. 1998).

With the increasing reports of non-respectful, non-dignified care of women in facility-based childbirth the notion of safe motherhood has been expanded beyond maternal mortality and morbidity to promote the human rights of women. Advocacy groups such as the White Ribbon Alliance, for example, produced a Charter linking human rights with the needs of childbearing women and providing a platform for improvement (The White Ribbon Alliance 2011). Human rights groups have conducted many large-scale investigations into the reasons behind high maternal mortality and morbidity ratios in some hospitals, including the neglect, abuse and discrimination experienced by women and girls having their babies in healthcare facilities.

In South Africa, a Human Rights Watch report (2011) documented negligent and abusive behaviour by healthcare providers in healthcare facilities where maternal mortality rates had risen. Family members reported an apparent lack of concern by doctors and nurses in examining or treating relatives admitted with complications. The delays of several hours or days contributed to the deaths of babies and mothers. There was evidence of discrimination by individual healthcare providers against women who were HIV positive or foreigners, such as Somali women. Poor communication and a lack of translation for refugees meant that medical procedures were performed without informed consent, and women complained that they had received no explanation about cause of death of their babies.

In nineteen years, (1987-2006) the maternal mortality ratio in the United States of America was reported to have doubled. In addition, because there were no federal requirements to report maternal deaths, the authorities conceded that maternal deaths might be twice as high as reported (Amnesty International 2010). Ethnicity and economic status were found to have affected women's access to healthcare and the quality of care received. Amnesty International reported that African American, Latina, Native American and Alaskan Native women were at particularly high risk of discrimination, poor care, death or complications. An absence of translation services further disadvantaged women with limited or no English, resulting in difficulties accessing care and exclusion from decisions regarding their care.

A 10-month Human Rights Watch investigation in Uttar Pradesh, India, between 2008-2009, examined the reasons behind the continuing high maternal mortality ratio in that state, despite government initiatives to improve the quality and uptake of facility-based childbirth (Human Rights Watch 2009). The investigation found that many Comprehensive Emergency Obstetric Care facilities lacked the skilled personnel and essential supplies to manage obstetric complications. Women were therefore transferred between several facilities, often dying before effective treatment could be accessed. Despite government guarantees of free childbirth care, Human Rights Watch found that women faced unlawful demands for money from hospital workers for routine care such as cutting the baby's cord and for emergency treatment, such as blood transfusions, or an emergency ambulance. This imposed a severe burden on poor families and was a barrier to accessing care. Although hospital authorities denied that bribery occurred, the families of women in South Africa said they had to provide money, 'a cold drink' (bribe) or food for the nurses in exchange for medicines and treatment (Human Rights Watch 2011). Giving birth alone, verbal, physical and sexual abuse, and cases of detention in facilities for inability to pay have been documented in Kenya (Center for Reproductive Rights and Federation of Women Lawyers Kenya 2007).

Several articles and studies have sought to categorise the different types of suboptimal care. D'Oliveira and colleagues (2002) discussed four forms of violence: neglect; verbal violence including threats, scolding and intentional humiliation; physical violence including denial of pain relief; and sexual abuse. These forms of violence, the authors argue, support assertions regarding the dehumanisation of care and are a serious violation of human rights. As part of the USAID-TRAction Project, 2010, Bowser and Hill (2010) reviewed the evidence of disrespect and abuse in facility-based childbirth in low, middle and high-income countries. They examined the scope, contributors and impact of disrespect and abuse. They also included promising interventions. Their report revealed the multifaceted nature of non-respectful care. Seven categories of disrespect and abuse were identified: physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific client attributes, abandonment of care, and detention in facilities.

It was clear from the literature that disrespect, neglect and abuse was widespread and diverse. Furthermore, the varied forms of suboptimal care put women and their babies at risk, caused distress to women, deterred them from seeking professional help during pregnancy and childbirth or when faced with complications, and could result in the preventable deaths of women or their babies. In the next section I examine the root causes of suboptimal care.

### **3.4 The analysis of healthcare provider behaviour**

It is important to understand why people act as they do if behaviour is to be addressed. What was the analysis of healthcare provider behaviour from the literature? What drove healthcare providers to neglect the physical and emotional needs of labouring women? Why did skilled healthcare providers fail to use their skills effectively but instead humiliate and abuse perinatal women? Fonn and Xaba (2001, p.13) suggested that:

“It is very unlikely that health workers set out to treat patients badly. Thus there must be reasons why the end result of the provider-client relationship often turns out to be negative”.

Freeman et al. (2007) advocated a new focus for global safe motherhood initiatives. They explained the need to strengthen the organisational systems that facilitate health service delivery. Human interactions are the drivers of this system, they suggested, and managing them effectively “needs a continual open-minded search to understand...what drives people – e.g., providers, patients, managers - to act as they do” (Freedman et al. 2007, p.1389).

### **3.4.1 Perspectives of healthcare providers in Afghanistan**

Some of the limited insights into Afghan healthcare providers come from Akbar (2011) who observed and interviewed student midwives, trainers and some staff in the local hospital in a northern province of Afghanistan. She suggested that most doctors and midwives joined the profession because of family pressure, to avoid an early, unwanted marriage or lack of other options for educated women, not because of a passion for it. The biomedical midwifery-training programme, she argued, did not adequately prepare students to relate with respect to local women as it lacked any reference to local culture, childbirth customs or to the *dāyas*. Skills training on plastic models gave the impression of voiceless, unresponsive docile bodies and did not prepare the students for ‘real life’ and for urban and rural women who had strong opinions on reproductive health services and their reasons for using or not using them. Akbar (2011, p.83) claimed that the hospital staff felt less accountable for women who came from remote villages, and that the poor treatment of rural women was motivated in part by the preconception that rural women were dirty, ignorant and uncivilised (p.73). She does not explain, however, what this claim was based on.

Conducting research in Afghanistan has been challenging through three decades of conflict (Warshaw et al. 2006). Health focused research has been growing over the last decade, especially maternal mortality (Bartlett et al. 2005),

mental health (Lopes Cardozo et al. 2004; Miller et al. 2008), EmOC evaluations (Dott et al. 2005; Guidotti et al. 2009), family planning and HIV (Todd et al. 2008; Todd et al. 2011), and the midwifery programme (Currie et al. 2007; Smith et al. 2008). So far there has been no ethnographic study examining the culture of care in an Afghan hospital or in particular elucidating the perspectives of maternity healthcare providers on their role or the barriers and facilitators to quality care. Against a background of high maternal mortality, the need to increase the quality of care in EmOC facilities, and the pivotal role of the healthcare providers, an investigation of their perspective was long overdue.

My research will help to address this gap in knowledge as I have examined the culture of a Kabul maternity hospital and explored the thoughts, experiences, and values of healthcare providers and the barriers and facilitators they encounter as they care for labouring women. In addition, insights from women in the community will inform providers and policy makers how to make services more acceptable to Afghan women and their families. It is hoped that insights from this study will inform future initiatives aimed at improving the quality of care for women within Kabul maternity hospitals.

### **3.4.2 Perspectives of healthcare providers in other societies**

Finally I examined the literature regarding the analysis of healthcare providers behaviour in other settings, the root causes and contributing factors of suboptimal care.

South African health workers said that: the length of the waiting queue, if they had been up at night with a birth, and how supportive the doctors were affected the care that they gave (Fonn and Xaba 2001). They explained that a lack of positive role models discouraged them from working to a high standard, and that they took out their frustrations with their supervisors on women. As they reflected on their professional training, health workers explained that it had been 'Eurocentric,' and did not take into account the social setting of women.

The health workers said that they had been discouraged from asking questions and as a result they were intolerant of women who asked them questions. Chokwe and Wright (2011) conducted a phenomenological study investigating the experiences and perspectives of clinical care by learner midwives in South Africa. The authors concluded that if uncaring behaviours are modelled it is difficult for learner midwives to internalize caring and make it part of their daily practice.

Although the study by Jewkes and colleagues (1998) could be considered 'old' it is valuable for its broad analysis of abuse. In addition to the perspectives of nurses/midwives and the women accessing South African maternity services, other contextual factors are explored including the impact of professional training on identity and nurse-patient relationships, the influence of social context and the recent history of apartheid on the behaviour of staff. Jewkes and colleagues found that public health services were characterised by conflict, clinical neglect, verbal and physical abuse. The nursing staff were insecure performing their clinical roles, they lacked support in an environment with poor clinical outcomes and felt they were unfairly blamed when problems arose. In addition, there was an underpinning ideology of patient inferiority. Nurses perceived themselves as victims of abuse from the patients and used these perceptions to justify their actions in trying to exert "control" over the environment.

Mohammad-Alizadeh et al. (2009) explored the views of Iranian health providers on primary reproductive health services to understand and address the barriers to high-quality services. Focus group discussions with midwives and with other family health providers were used to explore staff roles, supervision, in-service education and ideas for increasing standards of care. Working with clients was the most satisfying part of their duties but many organisational factors beyond their control caused frustration and dissatisfaction (Mohammad-Alizadeh et al. 2009). Health providers explained that duties were not assigned according to their individual education and competencies. The midwives, including one with a BSc degree, complained that they were



becoming de-skilled because of the other tasks they had to perform. They estimated that 60% of their time was spent in record writing due to inefficiencies in patient record systems; as a result they said the clients were neglected. Health providers felt unsupported and unvalued by managers who highlighted the negative aspects of their work without considering the underlying causes. "Above all," Mohammad-Alizadeh et al. (2009, p.726) concluded, "the findings indicate a strong need for individual staff members to feel valued, supported and to develop their roles". This study was of particular interest because of cultural similarities between Iran and Afghanistan. In Afghanistan, such a wide mix of ages and educational backgrounds in focus group participants (from 26 - 51 years and four years of university education to none) could result in the most senior member of the group being the dominant contributor and opinion leader, suppressing other opinions. This may also have resulted in possible bias in the Iranian study.

A mixed methods study by Hassan-Bitar and Narrainen (2011) explored the challenges and barriers that maternal healthcare providers faced in the Occupied Palestinian Territory. In a difficult and resource-constrained environment midwives were at the bottom of the professional hierarchy. They wanted respect and an acknowledgement of their important role but were stressed by an "insane" workload, the lack of supplies, and a lack of professional support or guidance (Hassan-Bitar and Narrainen 2011, p.155). Midwives and nurses reported that they were humiliated because managers and doctors shouted at them in public. They also faced the frustration of women's families over the lack of resources, lack of beds or the absence of the doctor. Supervision focused on mistakes, gaps in work and punishment. Staff evaluations were given without explanation or the chance to improve. The need for supportive rather than punitive supervision was also important to healthcare providers in Tanzania (Manongi et al. 2006). One assistant clinical officer explained that "supervision is not kindly and lovingly done", instead people come with... paper and pens... "asking questions like a policeman" (Manongi et al. 2006, p.5). The lack of transparency and fairness in promotions and salary increases demotivated staff.

Much of the literature on healthcare providers came from the human resources and motivation perspective (Fort and Voltero 2004; Dieleman et al. 2006; Willis-Shattuck et al. 2008). It clarified that the motivation of individuals, “their willingness to exert and maintain an effort towards organisational goals” (Franco et al. 2002, p.1255) has a direct impact on the quality, efficiency and equity of health services (Franco et al. 2004). Although motivation was not the focus of this study per se, Franco and colleagues stated that poor motivation can show itself in a lack of courtesy to patients, a lack of attention to procedures, such as examining patients correctly, or the failure to treat patients in a timely manner.

As part of their review into disrespect and abuse in facility based childbirth, Bowser and Hill (2010) noted many contributing factors such as provider prejudice based on race, ethnicity, age, financial and educational status. Professional training distanced providers from the women in their care; under-resourced health systems, understaffing, and lack of professional development opportunities were seen to affect provider motivation. The authors highlighted gaps in the evidence around respectful care including the lack of validated tools to measure the prevalence of disrespect, the need to analyse contributing factors and the need to study the impact of disrespect and abuse on the utilisation of skilled birth care. Although “the analysis of contributing factors” could include the perspective of healthcare providers, the predominant emphasis was on the measurement and impact of abuse, rather than in-depth analysis and understanding of context.

D’Ambruso and colleagues (2005, p.9) emphasised that, in addition to the views of women, it was important to examine the perspectives of providers as “two parts of the whole”. My review of the literature indicated that there has been less examination or analysis of the perspectives of healthcare providers globally, compared to the experiences and perspectives of perinatal women. As the authors of a report from the CHANGE programme on assessing the caring behaviours of healthcare providers stated:

“Less emphasis has been placed on the views of maternal care providers perhaps because it is assumed that there is a universal provider point of view on the importance of caring as well as curing” (Moore et al. 2002, p.3).

The insights into the roots of staff behaviour highlighted a number of common issues including the need for respect, constructive supervision and support. In each context there were also unique constraints, frustrations and contributing factors. For example, Palestinian midwives and nurses were stressed, managing their own frustrations at the overwhelming workload and lack of supplies, as well as the frustrations of women’s families; black nurses in South Africa affected by the legacy of apartheid struggled to assert their identity and power over women in childbirth; midwives in Iran were becoming deskilled because they were required to perform many non-midwifery tasks and roles. It was likely that the Afghan healthcare providers would also have their own unique challenges and perspectives that affected their care of childbearing women.

Following my initial literature review I refined the research questions that would guide my study.

### **3.5 Research aims:**

#### **3.5.1 My main research question was:**

What is the current culture of care within the Kabul maternity hospital?

#### **3.5.2 The secondary questions were:**

What are the perspectives of the healthcare providers on care within the hospital and their role as care givers?

What barriers and facilitators have an impact on the quality of care given by the healthcare providers in the Kabul maternity hospital?

What are the experiences and desires of Afghan women regarding care within Kabul maternity hospitals?

The aims of this study were to analyse the culture of care within a Kabul maternity hospital and to identify facilitators and barriers in the delivery of quality care. My particular foci were the perspectives and behaviour of the healthcare providers – how healthcare providers saw their role, care within the hospital and the needs and values that motivated and controlled them.

## Chapter 4 - Methodology

### 4.1 Philosophical perspective

Constructing a philosophical framework for this study has not been straightforward (Crotty 1998). This has been an ongoing journey in analysing my own assumptions, reflecting on my initial standpoint and frequently acknowledging yet another layer of complexity. My starting point was a frustration with the linear analysis of the many Afghan problems in the post 2001 rush to rebuild the country. As a Western midwife I felt caught between two conflicting reactions. On the one hand, there were feelings of relief and admiration for the energy and efforts to reduce maternal mortality in Afghanistan through programmes like the midwifery training of which I was a part. On the other hand, I experienced a deep disquiet about the assumptions behind these interventions and the lack of reflection and adaptation to cultural factors in the drive to achieve fast results.

My research question explores the experiences, meanings, and values of healthcare providers. I wanted them to tell me about their world without imposing my own meanings and assumptions. A qualitative approach was appropriate to the research question. Many elements of the constructionist view with its claim of a social construction of meanings and reality resonate with my philosophical stance. Research conducted from a constructionist worldview, Creswell (2013) highlights, explores the complexity of views in the context of historical and cultural norms. This was the breadth necessary to analyse the culture of care and behaviour of the healthcare providers. Despite my familiarity with Afghan hospitals I sensed that there was an underlying world of meanings, realities and values for the staff that was different from mine. I could not understand their behaviour without understanding this underlying world. For example, were there different norms in how childbearing women were treated? Was this acceptable in Afghan society? Our constructions of the world have implications as they are bound up with power relations, Burr (2003) contends. This study aimed to explore the social reality of this hospital predominantly from

the perspective of the healthcare providers and how they understood and attached meaning to their situation.

I considered it inappropriate for a Western woman to be critiquing the lives and situation of Afghan women, as it was for them to speak about their lives and decide their priorities. In addition, the hospital was largely a female setting, so the issues that I initially saw were not gendered issues of male dominance or oppression but on the contrary, of women (healthcare providers) being uncaring or unkind to other (pregnant and labouring) women. Since power and oppression were situated within the hospital between women, and because I saw other elements of wider Afghan society also, my first thoughts were that a gender perspective would distort the results. A gender perspective seemed the obvious lens but the wrong lens through which to view and frame this study as it would narrow it down to the exclusion of other important elements.

Part of the difficulty in constructing a framework for this research has been related to my discomfort at my role as researcher – not wanting to take an imperialist approach and claim superior knowledge about what should be done (Said 2003). At the same time there has always been an element of critical enquiry in this study – the desire to bring about change for the betterment of Afghan women and their families. My purpose was not simply to describe ‘what is’ but a deeper exploration of meanings, values and motivation (Thomas 1993). For critical thinkers, Thomas (1993, p.34) claims,

“...the ontological assumption is that there is something else there that will take us beneath the surface world of accepted appearances and reveal the darker oppressive side of social life”.

As an outsider, acknowledging that world beneath the surface is the first step. I want to honour the trust of the healthcare providers who shared their stories, insights, fears and frustrations so that I would share them with others. As a researcher and outsider I have a voice and the possibility (and responsibility) to

say what they cannot say. Hence this knowledge does not belong to me; first it belongs to the Afghan Ministry of Public Health as they bear ultimate responsibility for the quality of healthcare women receive and also for the management and support of their staff. Secondly, it belongs to the international health community as they strive to improve the quality of care and reduce maternal mortality globally. With Freire (1972), I conclude that, I cannot liberate the oppressed, it will take men and women of great courage to liberate themselves.

So this study has elements of a feminist approach, as it explores a world of women, speaks of women and structures of domination that affect their lives. Ultimately it is, however, from more of a critical framework that I choose to speak of these women, not because of their gender, but because they are human beings.

## **4.2 Study design**

The focus of my study was Afghan healthcare providers within their social and cultural context, to explore “their behaviour, feelings, experiences” and understand “what lies at the core of their being” (Holloway and Wheeler 2010, p.3). A qualitative inductive approach (Denzin and Lincoln 2005) was appropriate to this study as it allowed me to access the world of the healthcare providers, the reasons behind behaviour and the meanings that they gave to their world. Qualitative research, with its person-centred holistic perspective (Holloway and Wheeler 2010) through extensive interaction (Avis 2005), enabled me to observe, reflect and look for patterns rather than narrowing down the field of study that could lead to the exclusion of vital issues. The explanation of social processes “from the perspective of those participating in the study” is the distinctive feature of qualitative research according to Avis (2005, p.13). Carrying out research in a cross-cultural setting brought additional challenges (Li and Karakowsky 2001; Tsai et al. 2004). A qualitative approach provided the flexibility (Avis 2005) and sensitivity to adapt the focus of the research as my

understanding and insight increased, to be guided by the healthcare providers priorities, as well as my own.

#### **4.2.1 Culture**

Ethnography is the study of culture. 'Culture' in this study refers to culture as defined by Tylor in 1874: "that complex whole which includes knowledge, belief, art, morals, law and custom and any other capabilities and habits acquired by man as a member of society". Helman (2000, p.2) explains culture as:

"a set of guidelines, both explicit and implicit, that individuals inherit as members of a particular society...that tell them how to view the world, experience it emotionally and how to behave in it in relation to other people..."

Worsley (1984, p43) claims that culture tells us not only who we are and what is what but what is to be done, "it supplies a project, a design for living". It was that "design for living" that was of particular relevance as I sought to understand the behaviour of healthcare providers. In discussing the concept of culture Geertz (2000, p.5) uses Max Weber's analogy of man "suspended in webs of significance he himself has spun" The webs are culture, Geertz (2000) claims, and the analysis of culture is an interpretative "search for meaning". As a cultural outsider I was endeavouring to understand the significance behind what I saw from the perspective of the insiders - the underlying beliefs, meaning and values of the midwives, doctors and care assistants. It was these perspectives that would give insights into their behaviour.

Several cultures and sub cultures were included in this study. First, I was interested in the institutional culture of the hospital with, as Hofstede et al. (2010, p.6) describe,



“...the unwritten rules of the social game. The collective programming of the mind that distinguishes the members of one group or category of people from others”.

Second, there was the wider culture of Afghan society, the communities and ethnic groups into which healthcare providers were born and of which they were members. It was important to be sensitive to this intercultural diversity (Fetterman 2010), recognising that the healthcare providers were not a homogenous group. Third, as a white British woman and a midwife I also brought my own cultural worldview to this study. Throughout the process I endeavoured to reflect on the cultural lens through which I was seeing, interpreting and judging this world of others (Li and Karakowsky 2001; Fetterman 2010). As Denzin and Lincoln (2005) point out, all qualitative researchers see through the lenses of language, gender, social class, race and ethnicity. Finally, my interpreter was a valuable resource in exploring this world of meanings and significance. As a young Afghan woman she brought not only language, but also her insider knowledge of local culture and social norms.

#### **4.2.2 Ethnographic style**

This research is born in part out of a belief that as outsiders we need to learn from the experts – “the insiders” (Chambers 1983). In this 21<sup>st</sup> century there is not always the luxury of time for a true ethnographic study and this research is too brief to own the name ethnography. It is however in the spirit of ‘writing a people’, in looking for patterns and customs and of ‘ethnographic intent’ (Wolcott 1987), conducting a holistic analysis of the cultural meaning and values behind behaviours that I offer it. My aim is not only description but an exploration and striving to understand the multiple realities and power differences beneath the surface (Thomas 1993; Fetterman 2010). In keeping with the wider issues that face ethnographers and researchers (Atkinson et al. 1999; Denzin and Lincoln 2005), it has been important to reflect on how much the social world was disturbed by my presence, and the prior assumptions and bias which I brought to this study (Brewer 2000). In addition there are challenges of being systematic, rigorous and trustworthy (Brewer 2000), and to

assess what claims can I make about my representation of this community (Geertz 2000). The tensions inherent in ethnography today demand reflexivity on the part of the researcher and an acknowledgment of the limits of what can be known. Whilst Hammersley and Atkinson (2007, p.236) remind ethnographers,

“reflexive ethnography implies a commitment to the value of understanding human social life”.

Hammersley and Atkinson (2007, p.230) emphasise that ethnography is more than a set of methods, rather it represents “a particular mode of looking, listening and thinking about social phenomena”. As an outsider I wanted look at not only the institutional context of care but also the socially constructed learnt behaviour, values, relationships and unwritten rules of behaviour amongst the healthcare providers. There were aspects of their behaviour that I did not understand. I realised that this was possibly not simply a professional issue but also related to the wider social, cultural and historical context. As an exploratory study the ethnographic perspective gave flexibility, as Sharkey and Larsen (2005, p.169) explain, to ‘follow the data’ and refine my study strategy as I became more aware of the underlying issues and dynamics. ‘Thick description’, a major characteristic of ethnography (Geertz 2000), provided me with the opportunity to bring a broad eclectic mix of factors together in the process of analysis and interpretation. These factors included not only the words of the participants but also tacit knowledge and unarticulated, contextual understandings (Altheide and Johnson 1998) as explained by key informants or from previous personal experiences. An ethnographic approach provided the means of access to the insider perspective (Sharkey and Larsen 2005) or ‘emic’ (Harris 1976) view of care. It gave me the opportunity to enter the world of the healthcare providers and listen to their thoughts and concerns. The observation of behaviour within the hospital setting and background interviews added a further ‘etic’ (Harris 1976) perspective on this culture of care. I needed to be able to understand what healthcare providers told me, and the things they did not tell me, in the broader context of Afghan society and culture. The use of

both approaches, as Robertson and Boyle (1984) suggest, added further focus to observations and new directions for interview questions. It also highlighted discrepancies between what was said and what was done (Deutscher 1973; Gobo 2008). Minichiello (2008, p.11) explains that using more than one method can help “discover contradictions and ambivalences within what on the surface may seem to be a simple reality”. In addition, every opportunity was taken to engage in conversation with groups of healthcare providers during tea breaks or during a lull in work. O’Reilly (2012) calls them ‘opportunistic group interviews’, taking advantage of naturally occurring groups and gently guiding the conversation. Fetterman (2010) highlights the need for sensitivity in issues of control and ethical behaviour in informal interviews, when to seize the moment to ask the unanswered question, and when it is best not to pry further. As Hammersley and Atkinson (2007, p.3) describe, it was a process of:

“collecting whatever data are available to throw light on the issues that are the emerging focus of the research”.

Two FGDs were conducted with Afghan women in the community. These group discussions not only added further perspectives to this study but also served as a benchmark on what is acceptable care within Afghan society.

## **4.3 Methods**

### **4.3.1 Study site**

The site chosen was one of the main obstetric referral hospitals for Afghanistan; it is close to the city centre, surrounded by chaotic congested roads, military headquarters, shops and street vendors. As with all Afghan maternity hospitals, the hospital staff, including the senior managers, were almost exclusively female. It is a place of first and last resort. Many normal births occur here as local families choose this hospital for childbirth, as it is one of the few ‘women only’ hospitals in Kabul<sup>14</sup>. It also admits a large proportion of critically ill

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<sup>14</sup> Some maternity units are part of general hospitals with male patients on the same site.

labouring women from all over the country when complications are beyond the scope of other health facilities. Kabul tertiary maternity hospitals run residency programmes for newly qualified female doctors and are the clinical training sites for midwifery training programmes. Once graduated, these midwifery students and resident doctors are deployed throughout the country. The influence of these institutions and their culture of care is not confined to Kabul, therefore, but it is likely to be replicated throughout Afghanistan. In rural communities healthcare providers are, in part, accountable to the local community. This does not exist to the same extent in Kabul because of the fragmentation of society following three decades of conflict and migration. The challenge and importance of providing high quality care for women in these key national facilities was a factor in selecting the study site.

Several large maternity hospitals in Kabul city were considered as study sites. "Access", however, as Hammersley and Atkinson (2007, p.43) state "is not simply a matter of physical presence or absence" and is "far more than the granting or withholding of permission for research to be conducted". I knew that a letter of official permission from the Afghan MoPH might give me physical access but would not necessarily guarantee cooperation and facilitation within the hospital. As van Teijlingen et al. (2010) stated in 'Lessons learnt from undertaking maternity care in developing countries', gate-keepers are particularly key and can act as barriers or facilitators. Experience had taught me that the internal politics of these institutions and gatekeepers, both formal and informal, could seriously undermine my research. I therefore asked the advice of colleagues who had insider knowledge of these hospitals. I made my final decision based on their recommendations of which hospital would be more research friendly.

My original study design involved data collection at two Kabul maternity hospitals to increase the generalisability (Holloway and Wheeler 2010) of the research findings. The logistics of preparing the study protocol, translation of documents, recruitment of an interpreter, and security issues all within the PhD timeframe, however, precluded the inclusion of a second site.

### **4.3.2 Impression management**

“Respect for the culture of the group under study” is an important protocol, which, Fetterman (2010, pp.46-47) explained manifests itself in “apparel, language and behaviour”. Over the years I adopted many features of an Afghan woman’s dress and behaviour out of respect for the communities where I lived. It was now important to consider, as Hammersley and Atkinson (2007) termed it, my “impression management” (a concept developed by Goffman in 1959) for this field work. I had to decide if I would wear the ‘normal’ educated Afghan woman’s clothes or a uniform and white coat like the healthcare providers. As my priority was to relate to the healthcare providers and it was mandatory to wear a uniform in some clinical areas I needed a uniform. Deciding on the uniform colour was not easy. Midwives wore royal blue scrubs, doctors wore pale green, and the care assistants wore maroon. I was interested to see that this was not consistent and some of the midwives wore green. I tried without success to find a totally different colour that would not align me with any particular group – in the end I chose an aqua green.

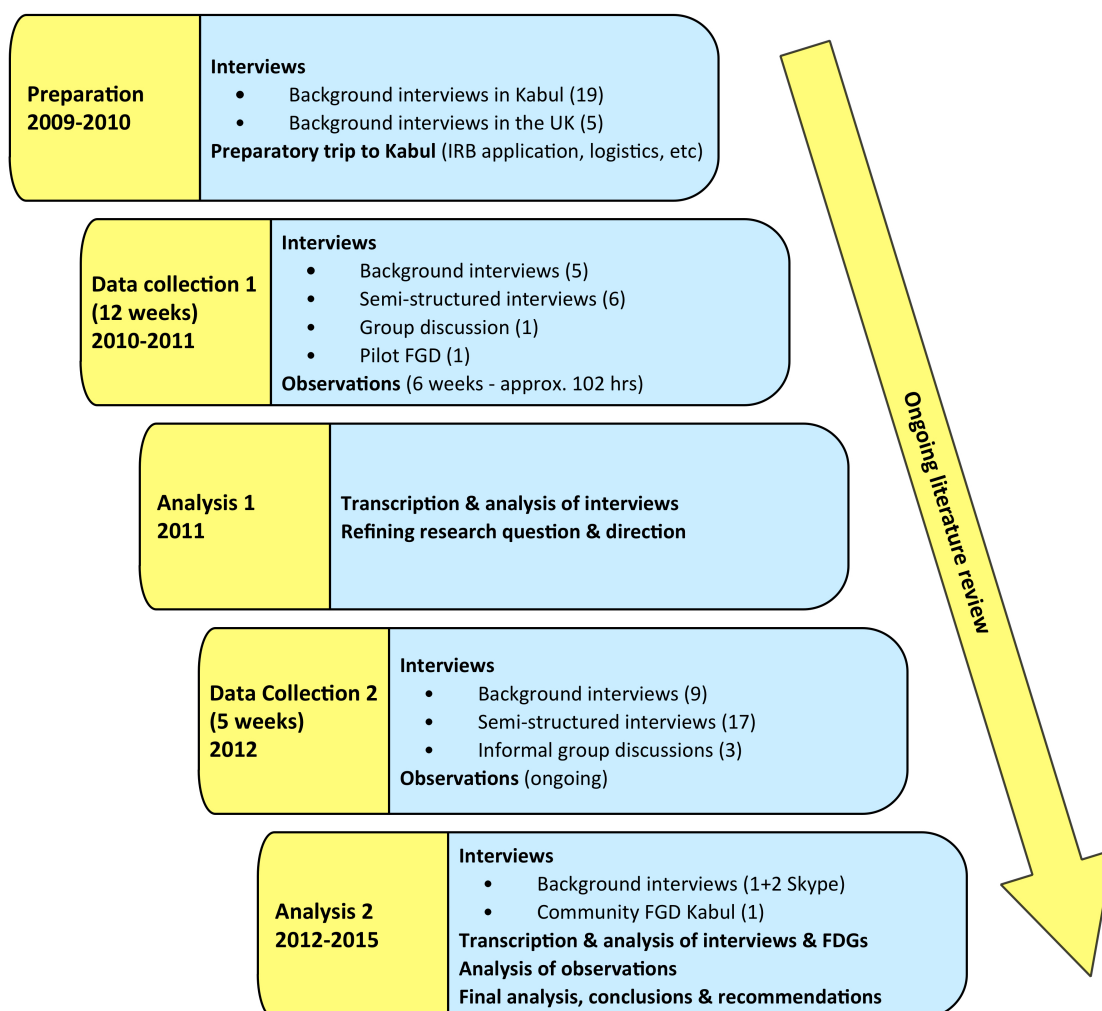
### **4.3.3 Gaining access**

Prior to the commencement of data collection, I had several meetings with the hospital director, herself a female obstetrician and gynaecologist. I explained the purpose of my research, what I would be doing in the hospital and requested her assistance. The director selected a senior member of the medical staff to facilitate my study. This senior doctor having ascertained my plans immediately prepared a rotation plan for me with the areas that I wanted be in and the number of days. She gave me permission to display information sheets in key places around the hospital to inform staff of my presence and the purpose of my time in the hospital. In addition, she formally introduced me at the doctors’ morning report the following day, although unfortunately seemed to forget my request to introduce myself. The following morning she introduced me at the midwives’ morning report where I was finally given the chance to speak. At the commencement of my second field trip I met with the hospital director again. This time, however, I was allocated a powerful but unpopular senior

member of the hospital to assist me. Fetterman (2010, p.37), discusses the predicament of the researcher who, once inside, needs to “disassociate diplomatically” from intermediaries who could have a negative impact on acceptance within the community. I decided to conduct an interview with the unpopular staff member, asked for her assistance for a few days, but then distanced myself from her for my remaining time.

#### 4.3.4 Data collection overview

Figure 2 gives an overview of the data collection, methods and timeframe.



**Figure 2: Data collection overview**

Type of interview	Participants
Background interviews	19 Afghans 22 non-Afghans
Semi-structured interviews	1 hospital manager 5 senior doctors 6 resident doctors (year 1-3) 2 senior midwives 8 midwives (6 months – 10 years experience) 1 <i>khāla</i> (care assistant/cleaner)
Informal group discussions	Group of senior doctors Group of resident doctors Group of midwives and nurse Group of <i>khālas</i> (care assistants/cleaners)
Community focus group discussions	FGD1 (Pilot FGD), 6 female members of an extended family FGD2, 10 Afghan women (aged between 23-56) from a poor area of Kabul

**Table 1: Summary of interview participants**

Background interviews were ongoing throughout the study. There were two phases of data collection in Kabul. Phase one (November 2010 to January 2011), consisted of six weeks of participant observation followed by a few semi-structured interviews and a pilot community FGD. Initial analysis was carried out late 2011. The second phase of data collection (March – April 2012) consisted of five weeks of semi-structured interviews of hospital staff, further background interviews and observation.

#### **4.3.5 Background interviews**

Forty-one background interviews were conducted to gain insights into the health system and the wider social, cultural and historical context of care (See Appendix A Overview of background interviews). Senior ministers in the Afghan Ministry of Public Health (MoPH) gave oversights of women’s reproductive health and challenges within the Kabul hospitals. Participants from Kabul Medical University and the Ghazanfar Institute of Health Sciences who were

responsible for the training of medical students and midwives were interviewed. Afghan midwives and doctors shared experiences and reflections on general Afghan hospital culture. Non-Afghan health professionals, some with extensive experience in the Afghan healthcare system, shared experiences, reflections and cultural insights. Several Afghan and non-Afghan researchers offered cautions and recommendations regarding conducting research in Afghanistan. A community leader provided insights into culture, values and the current pressures on Afghan communities, a female Afghan doctor who supports women who are victims of violence explained features of violence in Afghan families and society. A non-Afghan anthropologist, an historian, a linguist and educationalist, several with more than 30 years' experience in Afghanistan, reflected on Afghan culture. The majority of interviews were conducted face-to-face in Kabul; a few interviews were conducted over Skype or in the UK. All of the background interviews were conducted in English, the majority were digitally recorded and handwritten notes were made for the remainder. Interview notes were transcribed as soon as possible afterwards.

The initial background interviews helped me refine the focus of my study and questions. I continued my 'conversation' with some of the interviewees, including the two cultural experts, clarifying points that they had made and asking for further insights on my findings. I sent the transcripts of interviews to some interviewees to ensure congruence with what they had said. Background interviews continued to produce new information and perspectives throughout the study duration. This reinforced my awareness of the multiplicity and complexity of factors that affected life within the hospital. It was also a check against forming premature judgements of the nature of hospital culture and life.

#### **4.3.6 Observation**

The observation of people in their natural social environment, Brewer (2000, p.59) suggests, is perhaps "the data collection technique most closely associated with ethnography". Fetterman (2010, p.37) claims that observation is "crucial to effective fieldwork". Originally I had thought that observation would



be unnecessary as I was familiar with the study hospital. On reflection, however, I realised the importance of participant observation over casual familiarity. My experience in this hospital had also been some years previous. A period of participant observation was, therefore, vital to ensure that my study was based, not on former impressions, but on the current culture of care. Participant observation provided a descriptive overview of the setting, context, organisation of care, allocation of workload, and caring behaviours. I was also able to observe interactions between staff, women in childbirth and their families, and observe interactions between the different staff members and groups. Observation brought me closer to the healthcare providers as I participated in their everyday life – helping, watching, listening, and talking to them about their lives and their work (Brewer 2000). This close involvement, Brewer points out, has an effect on the attitude of the researcher and that personal experience becomes part of the data. My attitude at the commencement of the study was one of an outsider influenced by many experiences in the Afghan health services, not all of them positive. Immersion in the setting, Fetterman (2010) pointed out, is vital to develop an empathetic understanding or ‘emic’ perspective of the insiders’ view through becoming a thoughtful observer, listener and learner in their world. The experience of immersion, resulted in copious field notes, conversations and events to reflect upon, and also as Fetterman (2010) suggested, the internalisation of some of the hopes, fears and frustrations of the healthcare providers.

As soon as I decided to spend time observing I started grappling with questions about the role that I would adopt. Whilst I am a nurse midwife I knew that it would not be appropriate to assume responsibility for labouring women, as this would take all my attention, time and energy. I decided, therefore, to participate in the setting by offering assistance to healthcare providers in whatever else needed doing. Observation was, however, more difficult than I expected. From the commencement of observation I saw that it would be impossible to ‘blend in’ as wards were small and overcrowded; and my interpreter and I were obviously outsiders. It was difficult to get involved in the clinical care of women as I was not familiar with hospital protocols and procedures, neither could I decipher

women's notes as they were written in a mixture of *Farsi*<sup>15</sup> and English. The approach that I took was to introduce myself to staff as I arrived in each new area and ask the senior person if they could show me around. This provided me with insights into the ward routines and the management of perinatal women. More importantly, it gave me an opportunity to engage in conversation with one of the staff, listen to her opinions, and hopefully dispel the initial awkwardness for us all. Introductions were inevitably followed by questions such as: How old was I? How many children did I have? Was I married? Why wasn't I married? My interpreter would have a similar line of questioning, hers ending with why she only had one child of five years old, and, wasn't it time she had another? Once that was out of the way we would settle into the ward routine.

Each day I quickly assessed the most appropriate course of action such as chatting to staff, helping with bed making, preparing swabs, spending time with perinatal women or settling into a corner of the room to simply observe. My role during observation, to use the typology of Gold (1958), fluctuated between observation, participant observation and full participation as a woman unexpectedly gave birth to her baby in the early labour room. Ultimately I settled into a 'marginal role' somewhere between 'participation and research'... or "familiarity and strangeness" as Hammersley and Atkinson (2007, p.89) describe it. At times I was involved in the hospital activities and drama, at other times I stood back and observed. Davies (2008) argues that the nature and quality of observation is more important than the degree of participation.

Six weeks were spent in this extremely busy, noisy hospital - observing life, interactions, frequent dramas and daily routines covering the full 24-hour period (See Appendix B Overview of observations). I conducted observation in the admission area, high-risk antenatal and intensive care ward, the rooms with labouring women, the delivery and the postnatal rooms. I deliberately varied the times of day and areas of the hospital to ensure data sufficiency (Wallace

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<sup>15</sup> Afghans use the Iranian *Farsi*, especially in official documents.

2005). All cadres of staff and support workers were included in my observations as all were involved in caring for perinatal women and their babies.

A few days in each area helped me familiarise myself with routines and increasingly focus on the details of the setting, the actions and interactions and to reflect on what I saw. It also allowed healthcare providers to become accustomed to my presence. Opportunistic group discussions developed in staff rest rooms, standing in corridors or during mealtimes. A few discussions were more extended and informative than others; these were included as 'informal group discussions'.

Participant observation is not only about engagement with the social world of others, as Emerson et al. (2001) note, it is also about producing written accounts and descriptions. To capture as many details as possible I recorded my observations, conversations and reflections in a notebook. As extensive note taking can be distracting and unhelpful during observation (Holloway and Wheeler 2010) I made brief notes at the time, then typed and expanded them as soon as possible afterwards to include as much detail as possible before it was forgotten. If there were points that I needed to clarify I would question my interpreter the next morning. I recorded the observations and events of the day on one side of the page and on the other side I recorded my thoughts, emotions, reactions and reflections. In addition, I included the reflections of my interpreter, the things that she had seen and heard and how she had felt. If we experienced a particularly interesting situation or discussion my interpreter and I would withdraw to a private area to discuss and digitally record our recollections. We attended the midwives' and doctors' morning reports and various joint meetings. This provided further insights into the pertinent issues under discussion and the nature of interactions between the doctors, midwives and care assistants. I frequently checked the details of what I thought I had seen or heard with my interpreter to avoid misunderstandings.

My observations continued until one specific event convinced me that my 'empirical understanding' (Wallace 2005) was unlikely to be clarified further by more observation and that I had reached the appropriate point to commence interviews with the hospital staff. My interpreter witnessed some verbally abusive behaviour between a midwife, women in labour and a healthcare assistant. She said she was shocked at the language and attitudes of the healthcare providers but she was also shocked that their behaviour had changed so noticeably as I walked out of the room. This incident told me that abuse was probably more widespread and severe than I had seen, furthermore, that the behaviours I had seen were almost certainly moderated by my presence. My observations had confirmed that perinatal women were often the recipients of sub-optimal care in various forms. As I did not want to measure the degree or frequency of sub-optimal care but to answer the question 'why?' In following a constructivist, inductive approach in this study, semi-structured interviews with hospital staff were the next logical step.

#### **4.3.7 Afghan society and interviews**

The strength of the ethnographic interview, Sherman Heyl (2001) claims, is the opportunity that it gives to hear from people directly about their experiences and how they interpret them. Until the last decade, however, Afghans have had very little exposure to social research (Warshaw et al. 2006) or to being asked their individual opinion. Afghans grow up and live in extended families where, even as adults, important decisions are made for individuals by the group and lifelong protection and advancement are found in group solidarity (Dupree 1997; Entezar 2007). Several background interviewees with research experience explained that the history of interrogation and 'informing' on others used by previous regimes brought an element of fear into interviews and particularly focus group discussions. During the brutal conflict neighbours had been encouraged to report neighbours and children were tricked into informing on their parents (Laber 1986). The introduction of radio phone-in programmes and reality TV shows since 2002 might have promoted the concept of individualism, however, beneath the surface Afghan society is far from an 'interview society' (Silverman 1993). Although it would be challenging to create safe spaces for

participants to talk openly in this context, I remained convinced that the healthcare providers were the ones best placed to give insights into their world.

#### **4.3.8 Selection**

Sharkey and Larsen (2005) state that the most important issue in sampling for qualitative research is to ensure that a wide variation of views is represented. I wanted to hear and represent as broad a range of healthcare provider perspectives as possible, so I included senior and junior doctors, newly qualified midwives and those long established in the hospital. Originally I planned to use purposive sampling during observation to select interviewees. The senior obstetrician who was facilitating my study unexpectedly presented me with a list of senior doctors who were 'willing to be interviewed'. I did not know the criteria that she had used in selecting these doctors or if they had been coerced into being interviewees. After consideration, however, I decided that I had no choice but to interview some of them. Hammersley and Atkinson (2007) note that gatekeepers and powerful figures may select interviewees out of a desire to facilitate or to control. I was not sure of the motivation of my gatekeeper but explained clearly to each of the doctors that they were not obliged to talk to me and that our conversation would be confidential should they agree to participate in an interview. The four doctors all consented to being interviewed and showed no reluctance in answering my questions. The interviews were brief (about 20 minutes on average) as the doctors indicated that they were extremely busy and could not spare more time. They shared useful insights into hospital life but said nothing that could be considered controversial.

My second dilemma in selecting interviewees was that in Afghan culture saying 'no' is considered rude (Cardenas 2010, p.112). Conversation is constructed in such a manner that one avoids saying no – either by saying 'yes' but inferring no, or, by saying 'yes' but then later coming up with a reason to avoid what was agreed to. Purposive sampling against this background could waste time as people may not come for interviews or participants could be put under

obligation to give interviews against their will, which would be unethical. I discussed this at length with my interpreter and initially decided to try self-selection. I spoke at several staff meetings explained the purpose of my study, my desire to hear their opinions and views. This invitation was met with great surprise by a group of resident doctors who had been told that interview participants had already been selected. After reassuring these doctors that I was interested in their thoughts and experiences, each gave a semi-structured interview. In addition, during observation, several healthcare providers talked at length to me - I subsequently asked some of them for interviews. Ultimately, opportunistic and purposive sampling was used to ensure that each occupation and different levels of seniority were represented.

It is relatively easy to approach and interview someone who is friendly and talkative, however, I was aware of the danger of causing bias in selecting only those I felt at ease with (Rogers 2008). To offset this natural tendency occasionally I deliberately talked to healthcare providers who appeared more distant and less friendly. I purposely approached one staff member who had been verbally abusive to a labouring woman to try and understand her perspective. She talked to me informally on a couple of occasions but was unwilling to be formally interviewed.

#### **4.3.9 Interviews**

Twenty-three semi-structured interviews or occasionally unstructured interviews explored the experiences, thoughts, feelings and perspectives of healthcare providers (see Appendix C Overview of semi-structured interviews for tables of participants). The interviews with midwives, doctors and health assistants lasted between 20 – 90 minutes. Healthcare providers were asked if they would give consent for interviews to be digitally recorded. I explained that this was to enable me not to miss or forget anything that they said, that the recording would be confidential and that it would help me type notes and think about what they had said. Interviews were digitally recorded if the interviewee gave permission, then later transcribed and translated. Where permission was not given, notes

were hand-written and expanded as soon as possible afterwards. An aide-mémoire was used as an interview guide with questions such as: Please can you tell me about care in this hospital? What part of your work do you enjoy the most? What are the most difficult things about working in this hospital? How do you feel about caring for women? Some interviews were unstructured as interviewees wanted to share a specific issue relating to their work. One midwife had worked in the hospital for more than 30 years; she explained the difficulties of keeping the hospital functioning through the war and her frustrations with present care. Another midwife had recently moved from another hospital, she related her struggles to instigate change and improve the standard of care. Interviews were used to 'sound out' previous findings and check my developing analysis and two participants were interviewed for a second time as they were particularly knowledgeable and informative.

Interviews were conducted in the hospital but away from the interviewees' work area. Holding interviews in the hospital was not ideal as some interviews were disturbed by the demands of their professional responsibilities. It was not possible to conduct interviews at a different location or time due to the restrictions that many families place on the movements of its female members. In addition, there were many demands on their time as women who work outside of the home are still responsible for childcare and household chores, and many female doctors also had their own private clinics.

At the commencement of data collection I was promised an interview room. The room, however, belonged to a male consultant surgeon and he needed it. He vacated the room for a few interviews and I then tried to find another venue. No space was under utilised in this crowded hospital so locating an interview room was often more challenging than finding interviewees. During the second phase of data collection the hospital was being painted and some areas closed. Interviews were, therefore, conducted in the best space available: empty wards, the library, vacated offices and once in the corner of a busy room with women getting ready to go home. The noise levels on one occasion resulted in a digital

recording that is hard to hear, although I think I was the only one disturbed by noise – the interviewee continued talking as though she did not notice.

#### **4.3.10 Triangulation**

The strength of a study that uses multiple methods is also the process of triangulation that crosschecks the findings. “Triangulation is at the heart of ethnographic validity” Fetterman (2010, p.94) explains, as information from different sources can be compared to check the quality of information, to eliminate alternative explanations and improve understanding of the phenomenon under study. Triangulation always improves the quality and accuracy of ethnographic findings Fetterman argues. Hammersley and Atkinson (2007, p.184) take a more cautious approach, suggesting that triangulation “is discovering which inferences from the data seem more likely to be valid”. Triangulation in my study could be said to come not only from multiple methods such as observation and interviews for instance, but also from the perspectives of diverse groups of people. These included Afghan women who gave birth to their babies in the hospital, healthcare providers and community leaders also non-Afghan healthcare providers and non-Afghans with other frames of reference and expertise. Although the findings did not always concur, I suggest that this adds to the richness of the data and reflects the complexity of human interactions and difference. Where differences were found I have noted or discussed them in my findings chapters.

#### **4.3.11 Community focus groups**

Hearing the voices of women users of maternity services and respecting their wishes has been a neglected area in Western countries (Oakley 1980; Graham and Oakley 1981). It was especially important for me to include the perspectives of Afghan women on their maternity services, as I needed to calibrate my observations of care with their wishes rather than my own Western notions of care. I wanted to learn what was important to them when they give birth to their babies in hospital and to hear their experiences. This would add a further vital dimension to my analysis of the culture of care.



Afghan society, according to the dimensions of national cultures described by Hofstede et al. (2010), is collectivist in nature (Entezar 2007). I decided that focus group discussions were likely to be the most comfortable and productive setting for interviewing women in the community. Minichiello et al. (2008) note that focus groups can be particularly appropriate in cross-cultural settings as they provide a safe and culturally familiar context. Kitzinger (2005, p.57), claims that

“...a defining feature of focus group research is using the interaction between participants to generate data”.

My experience of informal group discussions with Afghan women was that group dynamics often stimulated very lively interactions. A pilot community focus group discussion (FGD1) (van Teijlingen and Hundley 2005) was held during my first field trip at the home of an ex-colleague, with six female members of his extended family. It was conducted in *Darī*<sup>16</sup> and translated by my interpreter. A non-Afghan colleague helped to facilitate the group as a note taker. After initial introductions, the group of women were asked if they would give their consent for our discussions to be digitally recorded. I explained that this would be confidential, that the purpose of the recording was to enable me to remember what they had said and to type notes when I got home. The women gave their consent for the recording. The FGD discussion was digitally recorded and lasted for 93 minutes. This pilot focus group was helpful in identifying which questions generated the best discussions, to learn some of the important issues, and to give my interpreter experience in translating a group discussion in a safe environment. The data from the pilot FGD was included in my data. Several community focus groups were planned for my second field trip but by this time several major Taliban attacks in Kabul had targeted foreigners and Afghans working with foreigners. My supervisory team and I decided that it was unwise to hold prearranged focus group discussions with unknown groups of Afghans in unfamiliar areas of the city. It was important however, to ascertain

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<sup>16</sup> One of the two official languages of Afghanistan. The main Persian dialect spoken in Kabul and many other areas of Afghanistan. *Darī* is a colloquial dialect of Iranian *Farsi*, which slightly differs in vocabulary and grammar

what Afghan women and their families considered acceptable behaviour from healthcare providers to provide a benchmark in interpreting my observations. A recent Afghan graduate from Oxford University whose MSc was on 'Maternal health and the midwife training programme in Afghanistan' expressed an interest in my study. After several meetings, selection of a group, and agreement on the protocol, she conducted a focus group discussion (FGD2) with community women on my behalf (see Appendix D Community FGD2 (Demographics)).

The Afghan researcher and a note taker conducted a focus group discussion in a poor area of Kabul with eight women from a pre-existing self-help group. It was conducted in *Darī* and lasted 45 minutes. The women were aged 23 – 56 and they had experienced birth at home, in private and public hospitals, and in an Iranian hospital. The women were outspoken about their experiences in Kabul maternity hospitals and the changes they would like. At the end of the focus group two further women added their comments and ideas. The interviews were transcribed and translated into English by an Afghan midwife researcher. I also received verbal feedback from the Afghan researcher who had conducted the FGD.

This amendment to my study had the advantage that it removed the need for translation. The facilitation of a FGD by a young Afghan woman will have undoubtedly had an impact on the data depending on if the women felt more at ease talking to her than a foreigner, and the social divide between the facilitator, an educated Afghan woman, and the participants who were predominantly uneducated women. It is impossible to determine the exact nature of this impact, simply important to view the data in the light of this fact.

#### **4.3.12 Audit trail**

Throughout the research a study diary has been used to document personal reflections and the research journey. For example, study deliberations and key discussions with my supervisors and decisions were recorded. Moments of

insight and new perspectives from the literature have been noted and explored. It has been especially useful as a reflexive tool to analyse my thoughts, feelings and reactions particularly during data collection. It has been a tool in my ongoing analysis as I have used it to explore avenues of thinking and revisited 'old' ideas and thoughts.

#### **4.3.13 Risk assessment**

The preparation and approval of a risk assessment for my first data collection trip was protracted. Bournemouth University was concerned about sanctioning a field trip to Kabul because of the many security risks. They took advice from many sources. A joint meeting was held between university management representatives, my supervisors, the Dean of Health and Social Care and myself to discuss issues of concern. After a second revision of the risk assessment form authorisation was given (see Appendix E Risk Assessment for the completed Risk Assessment Form and approval).

#### **4.3.14 Data analysis**

Thematic analysis, as developed by Braun and Clarke (2006; 2013) was used to analyse the data. Data analysis commenced at the beginning of the study during observation and informal conversations with healthcare providers and was ongoing throughout. Hammersley and Atkinson (2007) note the importance of the process of familiarisation with the data. Personally transcribing interviews, hearing them multiple times ensured I became familiar with the data as I had time to reflect on ideas and time to listen to the intonation, emotion, and silence of the interviewees. I was surprised at the many details that I had not noticed at the time of interview: the emphasis, intensity and even humour of participants.

After transcription I coded the data section by section often using 'in vivo' codes (Holloway and Wheeler 2010) such as 'no-one appreciated us,' and 'we can easily be replaced.' Similar codes were grouped into a category such as 'not being valued.' Transcripts were re-read as patterns and relationships emerged

and categories developed. Selected interviews were read and coded by two of my supervisors. For example 'not being valued' was linked with the category of 'no powerful connections' and became the more conceptual category of 'vulnerability'. Categories were checked against the data and redefined where a more appropriate concept was identified (Forrest Keenan et al. 2005; Clarke and Braun 2013). The initial category 'powerlessness' was renamed 'vulnerability' as I realised that all healthcare providers had a degree of power over women having their babies and their relatives by nature of their insider knowledge but some were also vulnerable within the wider hospital hierarchy. This was an iterative or "recursive process" as I reflected on the data and at the same time collected more (Braun and Clarke 2006; Srivastava and Hopwood 2009).

I started analysis with pen and paper, printing out all interviews, cutting them up and grouping categories together in folders. After my first eight background interviews I realised that this approach was not going to be practical, that there was too much data. I continued to print and mark all the transcripts by hand but then computerised the categories by creating documents and folders including many 'in vivo codes'. I considered using a qualitative analysis programme, however, after discussion with my supervisors it was decided that it would take too long to learn the programme and that it would be simpler to analyse without.

This study used several methods and included diverse groups of participants. To achieve a systematic analysis that also maintained the contexts, methods and perspectives of individual groups, two strategies were employed. First, participants from the hospital interviews and background interviews were grouped in each data set according to profession and seniority, Afghan or non-Afghan healthcare professional, Afghan non-health professionals or representatives from the Ministry of Public Health. This ensured that issues of importance for the various groups could be identified. Secondly, each data set was analysed separately prior to analysing across the data (Braun and Clarke 2006). Data, therefore, from my observations, the community focus group discussions, background interviews, informal group discussions and the

hospital healthcare providers' interviews were analysed as discrete data sets. The categories from each data set were then compared and refined using a broad framework. The themes from all the data sets were amalgamated into the final overarching themes.

Tsai et al. (2004, p.10) stress the importance of including those who understand the culture and language of the participants in the data analysis process in endeavouring to produce "culturally competent health knowledge". As themes have developed I have continued discussions with two linguistic and cultural experts to ensure that these resonate with wider Afghan values and culture.

Five themes were identified in this study: The culture of care; staff motivation; fear, power and vulnerability; challenges of care; family and social influences on care. There is too much information to be discussed within the confines of this thesis, and therefore I have focused on three themes that encapsulate the most unusual and pertinent areas in answering the research question as a maternal health researcher: the culture of care; challenges of care; and fear, power and vulnerability. It was not possible to discuss every facet of the individual themes as they encompass most aspects of this institution. The more uncommon aspects have been selected and the ones that relate most directly to the care of women. Many factors that motivated and demotivated the healthcare providers were identified. Some of these factors will be mentioned, however, I decided that to examine motivation in detail would be to divert from the central focus of the culture of care. I originally thought that I would explore the influence of family and Afghan society on hospital care in detail. Reflecting on the data I realised that whilst the impact of family obligations on the behaviour of staff is of interest to those from more individualistic societies, the healthcare providers themselves mostly chose to talk about other issues. The foundational (core) value of family as an underlying driving force must be included as it indirectly and directly affects most aspects of this hospital culture. It will, therefore, be a thread that runs through the findings rather than a separate chapter. Fear, power and vulnerability profoundly affected work and relationships in the hospital. This theme was separated into two chapters. The first, the climate of

fear, focuses on the healthcare workers' experiences of fear and horizontal violence. The second, the final discussion chapter, develops the analysis of power and power struggles as the underlying driver for the fear, hostility and fractured relationships within the hospital. Finally, the discussion chapter returns to care and the implications of the analysis for improving care.

#### **4.3.15 Interpretation and translation**

The recruitment and orientation of an interpreter for this study was a critical decision. Temple and Young's (2004, p.171) remind us that "the translator always makes her mark on the research whether this is acknowledged or not". The gender, social status, educational background, ethnicity, age of the interpreter, and her interpersonal communication skills would all have an impact on our acceptance within the hospital, and the degree to which participants would share their thoughts and feelings with us.

In a context where the United Nations Development Programme (2011) estimated that only 5.8% of women aged 25 years and older have a secondary education, recruiting a female interpreter was challenging. Despite advertising for six weeks through the formal Kabul recruitment channels and my informal networks I failed to find more than a handful of suitable candidates. Status and respect are closely connected in Afghan culture (Loewen 2010c). Consequently, my initial thought was that in addition to excellent language skills, the ideal person would be a female doctor who was married with children. The best candidate, however, had good but not excellent language skills and did not have a medical background, but she was married with a child and appeared enthusiastic to master new skills. As part of the interview process I organised a mock group discussion with staff in the NGO office including senior staff and one of the cleaners to assess not only language but also attitude. This candidate was personable, respectful to all and demonstrated a natural compassion and warmth. Her initial orientation and training was intense as in addition to becoming conversant with the study and the research process she

required a basic medical vocabulary to enable her to converse with the healthcare providers with some understanding.

Kirkpatrick and van Teijlingen (2009, p.26) point out the need to achieve “conceptual equivalence rather than equivalence of word form” is an important factor in reducing translation bias. Having worked with interpreters of varying calibre for many years I was concerned to ensure that all concepts at the heart of my study were conveyed correctly. Prior to the commencement of observation, background interviews were held with two senior Afghan researchers from the Afghanistan Research and Evaluation Unit. After explaining my study, the semantics of the *Darī* and *Pushtu*<sup>17</sup> words that would most closely and correctly convey the key study concepts were explored and a summary compiled. This summary formed part of my interpreter’s orientation to ensure a high level of congruence between what I was endeavouring to express, what my interpreter understood and the words that she used to communicate with participants.

Although she did not fit my ideal at the time, in many ways I now consider the appointment of this Afghan wife and mother a serendipitous event. She brought many unexpected things to this study such as the ability to see what I could not see – the daily workings of a busy maternity unit through the eyes of an outsider. As a midwife who has worked in Afghanistan for many years I am, in part, accustomed to the attitudes of staff and their manner of dealing with women in childbirth. My interpreter, however, experienced the distress of women in labour as the distress of a close relative. She was shocked and outraged at things that I had become a little numb to, or ceased to notice. Very soon I realised that she had more to offer than simply language skills. At the end of each day we debriefed and reflected on our day. First, I wanted to ensure that she had not been distressed by what she had experienced. Second, I needed to hear what she had heard and seen, what she had noticed, and how she - a young Afghan woman and an outsider in this hospital culture - had felt.

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<sup>17</sup> One of the two official languages of Afghanistan, spoken primarily in southern and south-eastern Afghanistan.

In listening to her reflections I was able to calibrate my understanding of what is normal, what is acceptable, what is shocking – not through a Westerner's eyes, but from the perspective of a young Afghan woman. Her reflections became part of my study (Vara and Patel 2012).

In addition, my interpreter inadvertently helped to reduce the power differentials between the researcher, interpreter and participants (Kirkpatrick and van Teijlingen 2009). As wife and mother who did not appear to come from a wealthy or influential family she related with ease to the younger midwives, the uneducated *khālas* and also to the women in childbirth and their relatives. I assumed that her lack of medical knowledge would disadvantage our acceptance and respect, particularly with the doctors. The doctors though seemed disarmed by her presence and questions. She was no threat to their status. While she spoke to them with respect, she also appeared to speak to them simply as one woman to another. The responses that she elicited from some of the doctors were tempered by that more unusual dynamic.

Despite the benefits of this particular interpreter I had occasional concerns regarding the accuracy of the interpretation. Although not fluent in *Dari* I could understand some of the conversation and on occasion I noticed discrepancies in what was interpreted or parts of replies that had been missed. I questioned my interpreter immediately so that she was able to make the necessary corrections. Pitchforth and van Teijlingen (2005) point out the importance of measures to ensure the accuracy of translation. As a quality control measure all, bar one of the interviews that were digitally recorded, were transcribed and translated by an Afghan midwife researcher with a Masters degree from Bangladesh. I then compared the transcripts to the digital recordings of the interviews. Whilst there were some omissions on the part of the interpreter her interpretation stayed closer to the actual words of the participants than the midwife researcher. The midwife researcher had supplemented medical terms and explanations into the translation, which in some cases reduced the clarity and impact of the words used. I therefore added some of my interpreter's original words to the transcripts that I analysed.



## 4.4 Reflexivity

Reflexive considerations, states Davies (2008), have in recent years become central to the role of ethnographers. Marshall et al. (2010) explain that reflexivity strengthens transparency and quality in qualitative research as the researcher reflects back and forth on the research process challenging their own perceptions and influence on it. Finlay (2002), describes reflexivity as one tool that researchers can use to evaluate how inter-subjective elements influence the research process and that, although contested by some, can increase the integrity and trustworthiness of qualitative research. From the outset one of my biggest challenges was how to manage the inter-subjective elements of this cross-cultural study including the cultural and power differences between myself as the researcher, and the healthcare providers as the participants.

I had been critical of other healthcare research in Afghanistan where I saw cultural flaws in the study design but faced with my own study I realised that avoiding such flaws would not be easy. I knew the propensity of Afghans to tell foreigners what they think they want to hear, the challenge of identifying the right questions to ask in a cross-cultural context and the inherent difficulties of working through an interpreter. I needed to create a space in which healthcare providers felt safe to say more than they would normally say to an outsider, and, in which I could hear something close to what they were trying to say. Reflexivity regarding my own assumptions and background and the interrelated position of the participants has become an ongoing part of decision-making, study design, data collection and analysis.

The original focus of my study was compassion amongst Afghan healthcare providers. During the initial background interviews, I became aware that compassion was not an important value in Afghan society. Compassion was one of my values I realised and for that reason it had seemed the obvious focus. The choice of topic also contained an underlying judgement of healthcare providers who, from my Western perspective, were failing to demonstrate compassion. If my study was to be relevant to Afghan maternity services then I

needed to refocus on issues of consequence to Afghans and, to borrow a term from the phenomenologists, 'bracket out' my beliefs (after examining them) in order to genuinely and actively enter the world of the healthcare providers. As Sharkey and Larsen (2005, p.179) point out,

“ethnographic research is not just seeking answers to questions but, more radically, looking to ask the right questions”.

My study was, therefore, refocused to explore the broader culture of care especially from the perspective of the healthcare providers to learn what was of importance to them.

The orientations of researchers are shaped by socio-historical influences, values and interests as Hammersley and Atkinson (2007) state. As a British woman, a nurse-midwife with cross-cultural experience in many resource poor settings, I endeavoured to be self-aware of influences on my decisions and reactions. During interviews for example, I noted in my memos that I was finding it harder to approach doctors than midwives and care assistants - especially when looking for semi-structured interview participants. As a midwife I felt at ease in the company of midwives, however, my unease with these doctors was uncharacteristically strong. Doctors have a high status in Afghan society and midwives less so especially in the eyes of the medical profession. After years of working in the Afghan health system, I realised that I had absorbed some of those values and that this was affecting my data collection. Having identified this awkward personal dynamic I enlisted the help of my interpreter who, as a non-medical young woman, had a general respect for all healthcare providers - but less reticence than me at approaching even the most senior medical staff. With her help I overcame this internal barrier, was able to redress the balance by increasing the interviews and the informal time spent with the doctors.

I was not prepared for the impact of observation on my senses, the smells and sounds that brought back uncomfortable memories of past experiences in that

hospital and my inability to disconnect my professional senses and intuition regarding labouring women. Savage (2000), argues that participant observation has a visual bias in Western thought and that surprising little theoretical attention has been given to the “embodied subjectivities of the researcher” and the part that the senses play in the production of knowledge. Interpreting fieldwork, she explains, may involve moving between the past and present, between memory and lived experience and it is filtered through our cultural worlds. It was important for me to listen to my senses but also to analyse and check the veracity of what I thought I understood with healthcare providers or my interpreter.

As the only foreigner in the hospital merging into the background was not possible. I knew that people would be aware of my presence, would have ideas regarding my purpose. It was also likely that their ideas might not be based on what was written on the information sheets I had displayed. I realised that since I could not avoid the ‘Hawthorn effect’ (Roethlisberger and Dickson 1939; Bowling 2002), I could use it as an opportunity to learn. Frank (1997) suggests that:

“the challenge is not to eliminate ‘bias’ to be more neutral, but to use it as a focus for more intense insight”.

Hammersley and Atkinson (2007) argue that endeavouring to understand people’s response to the presence of the researcher might be as informative as how they react to other situations. I knew that the behaviour of staff would be affected by my presence but did not know in what way. As a foreigner introduced by the Afghan Ministry of Public Health (MoPH) my assumption was that the majority of the healthcare providers would try to behave in a way that they thought was acceptable to the MoPH and to foreigners. The data from my participant observation are therefore viewed through this lens.

The relationship between Afghans and foreigners has become increasingly ambivalent since the perceived 'occupation' by Western troops. Attitudes towards foreigners now include not only the traditional respect and hospitality towards 'guests' in their country but also suspicion, hostility and hatred. Although starting from a position of privilege, as an educated foreign woman 'introduced' by the MoPH I was aware that behind the polite exteriors diverse life experiences, preconceived ideas and assumptions threatened to impede our engagement or collaboration. Establishing trust depended on my ability to relate, listen, be vulnerable at times and find a common humanity. The rest was dependent on them.

## **4.5 Ethics**

### **4.5.1 Ethical approval**

The Afghan MoPH had its own experienced institutional review board (IRB). Whilst the normal procedure would be to first apply for ethical approval from one's own academic institution, I felt uncomfortable to apply for approval to Bournemouth University and then present this as a *fait accompli* to the Afghan MoPH for their approval. I felt that it was more respectful to give the Afghan MoPH the autonomy to decide the ethical appropriateness of research carried out in their country. After discussion with my supervisors it was agreed that my first application would be to the Afghan Institutional Review Board (IRB). Ethical approval for this study was obtained from the Afghan Ministry of Public Health IRB in September 2010 without comment or amendments. This approval was valid for one year and approval was granted in November 2011 for a further year commencing March 2012 (See Appendix F Ethical approval IRB Kabul). Ethical approval was obtained from Bournemouth University; the study was registered with Bournemouth University who regarded the ethical approval from Afghanistan as the final decision of approval. I have attempted to act ethically throughout the study. I have reported to the IRB during the study and sent a final report of my findings in 2014. I hope to return to Afghanistan when my PhD is completed and present feedback to the hospital, MoPH and other stakeholders.

#### 4.5.2 Information sheets and consent forms

Study information sheets, interview information sheets and consent forms (see Appendix G Information sheets for study introduction, interviews, community focus groups, and consent forms) were written for the hospital setting and for participants in the community FGDs. It was important that clear, concise and colloquial language was used to enable all participants from illiterate *khālas* to consultant obstetricians, to understand the study and be able to give informed consent (World Health Organization 2015d). The purpose of the study and the information sheets were initially discussed with two native speaking *Darī* and Pushtu researchers. Time was taken to ensure that the translators understood the range of participants and the type of language required to ensure that they did not change the text into the more formal written language. The information sheets and forms were then translated into *Darī* and *Pushtu* - the two main Afghan languages. Other translators then 'back translated' (Brislin 1970; Su and Parham 2002) each information sheet and consent form into English. I then compared the back translations with the original English versions to check that the translation was correct. Discrepancies between the *Pushtu* versions were discussed with the original translator and changes were made where required. The *Darī* back-translations were a very poor quality and I realised that the translator's written English was a much lower standard than his spoken English. I arranged a second back-translation with another translator, this confirmed that the *Darī* forms were correctly translated and only required minor adjustments. (See Appendix H Sample *Darī* & *Pushtu* information sheets)

#### 4.5.3 Consent

Information sheets were displayed in public places within the hospital so that staff could understand why I was in the hospital and the aim of the study. Before I began observation I was introduced to the doctors and midwives at their individual morning reports. As women who were having their babies in the hospital were not the focus of my observation it was not considered necessary to ask them for formal consent. My interpreter and I took time, however, to talk to any woman who asked questions and explain my study. We introduced

ourselves to the groups of staff we met in each new location, explained the reasons for our presence and answered questions.

Prior to each interview the prospective participant was given an interview information sheet with an opportunity to read it, ask questions and clarify anything that was unclear. After checking if they were happy to proceed they were asked to sign a consent form. For those participants who were illiterate the information sheets were read to them or summarised by my interpreter. The interpreter then recorded the verbal consent of illiterate participants on the consent form (Nuffield Council on Bioethics 2002, 2005). Interviewees were asked if they would give their consent for the interview to be digitally recorded. I explained that the purpose was to make sure that I remembered everything they said, to enable me to listen to their words and ideas again, think about them and type them accurately. Several interviewees did not consent to the digital recording and in these cases I made handwritten notes during the interview. I did not ask all interviewees for permission to digitally record their interview as I felt that because of their position it might inhibit what they felt comfortable to say. This was a subjective judgement and involved a couple of senior doctors and *khālas*. In these cases I took notes as we talked. All handwritten interview notes were expanded as soon as possible after the interview with the help of my interpreter (Emerson et al. 2001). Women in the community focus group discussions were also asked if they would give permission for the discussion to be digitally recorded. The women in both community FGDs gave their consent.

There are inherent problems in informed consent for the qualitative researcher, Holloway and Wheeler (2010) explain, due to the flexible nature of qualitative research. Consent in qualitative research is ongoing (Holloway and Wheeler 2010). It is impossible to predict the direction that interviews and discussions will take, making it especially vital that participants understand that they can withdraw from the research at any time. In a cross-cultural situation informed consent is particularly challenging. Silverman (2010) notes that in cross-cultural situations it might be difficult for participants to say 'no' to a researcher's

request. The *Darī* language, Cardenas (2010) explains, is clothed in layers of politeness and courtesy where denials, corrections, requests and judgements are communicated through a labyrinth of indirect speech. I was aware of the need for particular care in respecting the autonomy of the healthcare providers by not exerting pressure on them to talk to me or by engaging them in conversation for longer than they wanted. The training of my interpreter included a presentation and explanation of research ethics. This was important because my ethical behaviour, in part, depended on her. It was her language and communication skills that would help potential participants, with differing levels of literacy, to understand the study aims and their freedom to participate or not. She would also be better positioned to notice if the participant was uneasy, wished to withdraw from the interview, or did not understand something.

I endeavoured to be sensitive to the verbal and non-verbal signs of discomfort in those I talked with. I abandoned an interview with a *khāla* as I suddenly became aware of the large power difference between us. We had talked to the *khāla* about the study, asked if we could interview her and thought that we had obtained 'informed consent'. As we started the interview I felt she was uneasy. I realised that because of Afghan politeness and her low status within the hospital hierarchy she would have found it very difficult to say no to my request. Because I was not sure of the genuine voluntary nature of her participation, I immediately drew the interview to a close. After this I did not try to conduct any formal interviews with *khālas* but instead spent time sitting and chatting with them as they 'guarded' the hospital entrance door, made beds or stood together in the hospital corridors. In this way I knew that they could talk to me if they wished, but simply walk away if they were uneasy.

#### **4.5.4 Anonymity and confidentiality**

Ensuring anonymity and confidentiality within the Kabul public healthcare arena is hard given the limited pool of educated female staff and close extended family networks. 'Everyone knows everyone' is a good premise from which to

start deliberations on how to protect identities, reputations and institutional rivalries. The usual protections were put in place during this study. The names of participants and signed consent forms were kept separate from the transcripts of interviews. Interviews were kept on a password-protected computer and printed documents were locked away. My interpreter knew that she would lose her job if she divulged details of findings or the identities of our participants. It was helpful that she was not a health professional, although she still knew a few of the hospital staff. The Afghan woman who translated the digitally recorded interviews, was a senior midwife who knew a vast group of midwives throughout the country. Although she had a research background I emphasised the need to maintain confidentiality and anonymity. I was still slightly concerned about the potential for a breach in anonymity so I decided to withdraw one of the particularly sensitive interviews and used the original translation for my analysis. I also deleted a small section of another interview where I had inadvertently used the participant's first name.

When discussing my observations or informal conversations I have not always identified if a staff member was a doctor or midwife, this is because I did not always know, or did not record it. Both doctors and midwives wear white coats and although the different professions generally wore different colours this was not consistent. Rather than inadvertently misrepresent professional groups, where I do not know, I have used a generic term such as healthcare provider or staff member. Women in the community generally spoke of 'the doctors,' however; because of the difficulty distinguishing between the professions it is likely that sometimes 'the doctors' were midwives.

#### **4.5.5 Care of participants**

The principle of non-maleficence, meaning 'do no harm', (World Medical Association 1964; Beauchamp and Childress 2013) includes the commitment to never leave a participant in distress. It was impossible to know the direction our conversations would take and if painful memories or emotions would emerge. After more than three decades of conflict in Afghanistan I knew that there was a



potential for distress and wanted to have follow-up support in place (Rogers 2008). An Afghan ex-colleague introduced me to the director of an Afghan organisation that offered social/psychological counselling. It was agreed that participants could be offered free counselling if the need arose. In the event there were no participants who warranted referral. I put posters from this NGO in the hospital, however, as counselling is a new area in Afghanistan and this could be helpful for some hospital staff.

#### **4.5.6 Ethics in a cross-cultural situation**

Christakis (1992) in his discussion of Western medical ethics in non-Western settings, highlights the existence of alternative ethical systems and cross-cultural variations in such fundamental beliefs as the definition of personhood. He elucidates some of the complexities of research ethics when investigator and researched come from different cultural settings and have different ethical expectations (Christakis 1992). I was aware that despite the familiarity of the medical setting under the surface there were different values from my Western ones. To act ethically I would, therefore, need ongoing sensitivity to listen, question, reflect and adapt (Nuffield Council on Bioethics 2002, 2005; Ryan et al. 2011). The word 'confidentiality' in Afghan society, for example, appears to have a different meaning from Western society and the biomedical world. Some years previously an Afghan doctor explained that local doctors and nurses understand confidentiality as 'you don't tell the patient the bad news but you can discuss it with other people' (Ryan et al. 2011). It was important when I tried to explain confidentiality, therefore, to avoid using the word 'confidential' but rather to explain that we would not tell their colleagues or the hospital director what they told us. Murphy and Dingwall (2007) also contend that within ethnography there is an asymmetrical power relationship between the researcher, the researched and the representation of their community. The ethical responsibility inherent in the principle of non-maleficence, beneficence and confidentiality is particularly acute as I write of the healthcare providers of this Afghan hospital, and as my findings enter the public domain.

#### **4.5.7 Ethics and interpreters**

A commitment to ethical behaviour has to include all those involved in the study including interpreters. As I reviewed the applications for the position of my study interpreter I realised if I selected a non-medical woman as an interpreter the sights, sounds and dramas of a maternity hospital and delivery wards in particular could be frightening and even traumatising for her. I therefore decided to exclude applications from women who were neither medical nor mothers themselves. The interpreter I selected was a mother but was not a medical professional. During our time in the hospital I therefore endeavoured to be aware of potentially distressing events, sometimes reassuring her and explaining what was happening, sometimes simply walking away. At the end of each shift we reviewed the day together and I enquired if there was anything that she had found difficult. Of more immediate concern for my interpreter was her husband. It was important to reassure him that I was a respectable woman who would take care of his wife. I had to be flexible in my plans, as he would sometimes arrive early outside the hospital to take her home. We had to wait nearly two months until he agreed that his wife could spend a night in the hospital with me. Her safety had to be paramount.

#### **4.5.8 Ethical dilemmas**

Ryan et al. (2011) discuss the conflicting roles of the midwife-researcher such as where duty of care and maintaining the integrity of the research may be in conflict. Rogers (2008) observed that the qualitative research paradigm has brought with it new ethical tensions for researchers. The issue of witnessing sub-optimal or potentially dangerous care was recognised in my IRB application stating that if potentially dangerous care is witnessed

“It is clear that in accordance with the code of practice (Nursing & Midwifery Council 2008) my first duty of care would be to act without delay”.

Much of the care which I witnessed during observation was sub-optimal by Western standards: lack of communication between healthcare providers and the women they were caring for and a lack of privacy as internal examinations were performed in full view of other labouring women and staff. There was minimal protection from cross infection as bed linen was rarely changed even when soaked with body fluids from the previous woman, and there was a dearth of human kindness or support for frightened and distressed labouring women. These things were the norm. Putting the mother or child at risk was also a regular occurrence. Women with antepartum haemorrhage were discharged; the monitoring of vital signs and fetal wellbeing during labour was rare. Women who had just given birth were left alone with the placenta in situ whilst staff attended to other woman until they thought that the placenta had separated, and women appeared to routinely go home without postnatal checks.

Marshall et al. (2010) highlight that researchers have to negotiate moral complexities in clinical settings. The professional responsibility 'to intervene if the life of the mother or baby were at risk' had sounded straightforward, but as Ryan and colleagues (2011) point out it is the midwife-researcher who faces the challenge of translating those ethical principles into appropriate action. Trying to identify the point of intervention in the actual situation was extremely stressful. My normal professional responses, reactions and sense of responsibility had to be suppressed as I tried to maintain my researcher role. Most days I experienced a painful internal dialogue as I tried to think through the implications and correctness of action or inaction, at the same time, by simply standing by, I felt guilty of collusion with the sub-optimal care. The situation was made more obscure by language difficulties – because my interpreter was not medical she could not convey much of what was written in the notes. Being unable to understand the women's notes I could not access all the necessary information on which to base my decision.

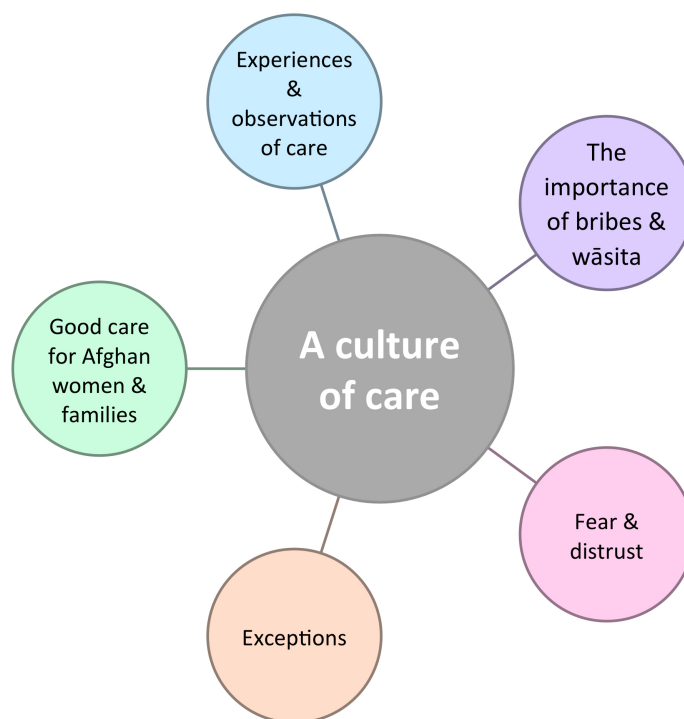
There were a couple of instances where I did intervene as I considered that the life of the mother was at risk, such as a very distressed woman with ruptured membranes, meconium and no progress in more than 36 hours. I questioned

the doctor in charge regarding her management and plan for this woman and then left the ward for a while. When I returned the woman had been taken to theatre for a caesarean section. There were other instances where despite care that was sub-optimal I knew that this was the accepted culture or practice, I realised that nothing would be achieved by my intervention. My decisions to get involved often constituted pointed questions regarding the care of certain women, which I hoped would prompt the doctors to review their management or to convince me that they were managing a particular woman appropriately, despite appearances.

There was another type of demand that I faced - the need to not abandon my humanity in the research process. I could not stand impassively observing, pretending not to hear or see as labouring women cried out in extreme distress with no family or healthcare provider support. I could not ignore their cries or replicate a model that was so contrary to my training and my personal values. After some thought I adopted a supportive role – in some instances sitting on the bed of the most distressed woman in the labouring room (usually a frightened young woman having her first baby) rubbing her back and talking her through contractions or supporting women through the second stage of labour. I thought about the impact of my actions on staff as I was unintentionally modelling something different but there was no observable impact. On a couple of occasions, however, labouring women were seen rubbing the back of other distressed labouring women. In examining some of the ethical challenges especially pertinent to qualitative research Houghton et al. (2010) conclude that priori prescription is not always possible, hence the need for ethical sensitivity and moral competence on the part of qualitative researchers. Charmaz (2008) refers to “emergent ethics” describing the tensions that qualitative researchers experience as they endeavour to apply general ethical principles in situations of ambiguity and human complexity. In this unanticipated role I found a way for my different identities as researcher, midwife and human being to peacefully co-exist.

## Chapter 5 - A culture of care

This chapter examines care in Kabul maternity hospitals from my observations, interviews with Afghan and non-Afghan health professionals, non-health professionals, and from the experience and perspectives of women in the community. I have included a few comments relating to general public hospitals if they are consistent with the study hospital and add important detail or clarification.



**Figure 3: Chapter 5 Overview**

I commence with an overview of the journey of perinatal women through the hospital system. To maintain the integrity and cohesion of the context, particular features of care are introduced in relevant areas of the hospital, where they were usually observed, or where the participants most notably described them. This does not mean that this was the only hospital area where these things occurred. Overarching themes are then identified and described, including a

section on notions of 'good care', largely from interviews with Afghan participants. The main aspects of care are then discussed.

## **5.1 Experiences and observations of care**

### **5.1.1 Admission**

Labouring women accompanied by family members usually arrived at the hospital in local yellow taxis, or private cars. Admission was through a small door into an assessment area. Large numbers of women were examined and many admitted daily through this department. Usually two doctors and three or more midwives were on duty. On one occasion during my observation an outpatient's department (OPD) doctor reportedly admitted 97 women during her night duty. There was no obvious triage system and women commented that staff did not distinguish between those who were in 'a bad condition' and those who were not.

"The examination area was curtained off and doctors sat behind a big desk busy filling in notes. A small crowd of women sat, stood or leant over the desk waiting to be asked questions, waiting to be noticed and helped. Some were tearful, arching their backs and rubbing their enlarged abdomens".

(Field notes day 1)

Women labour alone in this hospital. The staff explained that, due to the lack of space in the already overcrowded rooms and corridors, relatives were not allowed to stay with labouring women. For some women this could be the first time in their lives that they had been separated from their family. Relatives waited outside day and night. Large groups of relatives were often pressed around the door of the hospital waiting for news and waiting in case the doctor needed something for 'their patient'. A name was shouted, little pieces of paper were passed out and the relative rushed off to buy the medicines, IV cannulas and solutions, or examination gloves from one of the two pharmacy shops across the road. Sometimes the medicines did not get to the women.

“If our relative (in the hospital) needs something the *khālas* will call us from the door. We buy the medicines and give them to the *khālas*, but when we phone our relative sometimes they say they didn’t receive the medicines. They (the hospital staff) are stealing the medicines”.

(Community FGD2)

A couple of *khālas* guarded the hospital door. I was told that their job was to keep relatives out, apart from during the official visiting hour between 4pm and 5pm. At the door of the hospital there was an almost constant scene of arguing, pleading and even physical fighting as desperate relatives tried to gain access to visit their daughter, sister, or daughter-in-law.

“Some relatives were sitting on the bench just inside the door and a few women in burqas and big *chadrī* were trying to get in the door past the *khāla* who was on guard. Suddenly the *khāla* started screaming at a relative as she tried to push her out of the door. (She was a tiny lady but made up for it with aggression and intimidation.) Successfully evicted, the door was slammed closed; the *khāla* fell back into her seat and stuck her foot on the door to hold it shut”.

(Field notes day 3)

Emergency admissions were common during observation. The following field notes excerpt is an example of staff acting promptly and efficiently.

“There is a commotion at the door and I am told that a very sick woman with bleeding is coming. A midwife fetches the blood pressure monitor and others make preparations. Several people burst into the curtained area carrying a pale shocked looking woman. She is put onto a bed and one of the midwives, a *khāla*, and a couple of the relatives elevate the woman’s legs on a metal stool on the bed. It looks very precarious. Between her legs is a plastic sandal with the umbilical cord tied to it. Another midwife attaches the blood pressure cuff and inserts an intravenous cannula into each arm. I find a big blanket and cover her with it – she feels very cold. A young doctor arrives and asks the relatives questions – she takes blood and fills in the notes. Intravenous infusions are commenced. The young woman is barely conscious... The doctor disappears behind the curtain emerging a short time later with the placenta. Gradually colour returns to

the woman's cheeks and her blood pressure starts to register. The staff smile, – *'How did we do then?'* one of them asks me”.

(Field notes day 1)

The latter comment raises the question of the Hawthorne effect of the observer, although it is hard to know how much my presence affected their behaviour. It suggests that the participants might not have clearly understood my role, thinking that I was there to check up on their clinical skills.

On other occasions there were several women with emergencies in the OPD but no one was attending to them as in this example.

“There were no midwives or doctors when we reached the admission area, just a *khāla*. Several women were on beds alone behind the curtains, numerous women were standing around the desk. One woman complained to my interpreter that she had been there two hours and had not been seen by anyone. A woman was bleeding, she thought she had lost her baby, a young woman had pain over her old caesarean scar and her waters had gone. A shocked looking woman was rushed into the ward. Her husband lifted her onto the bed. *'She delivered last night and has lost a lot of blood'*, he explained. The doctors were nowhere to be seen”.

(Field notes day 13)

### **5.1.2 Service rooms**

Once women had been assessed they were either sent home or transferred to the service area of the hospital. This area consisted of small wards with between two to eight beds in each. It included an intensive care room, rooms for labouring women, high-risk antenatal women, postnatal women, a room for women with Hepatitis B, a room for women undergoing planned surgery and a private labour room. The labouring rooms were normally overcrowded. I counted as many as four women sharing a bed - lying, sitting, holding onto the frame and sometimes vying for space.



### 5.1.3 Privacy, respect and communication

When there was a change in staff the doctor who had commenced her duty performed an internal examination on every labouring woman. There was no privacy in the wards and no attempt to keep women covered up when being examined.

'A doctor was examining women in the labouring room. She ruptured the membranes of one woman in the bed under the window. As usual the woman was flat on her back with everyone in the ward able to see everything. This doctor was not unkind and was less rough than many; but still the woman was exposed for all to see'.

(Field notes day 15)

Women in the community explained that doctors do not talk to them, or ask them about their problems. They just want to examine them.

"...doctors don't ask us for permission but immediately start the examination without asking; '*How long are you pregnant?*' or '*What is your problem?*', or '*What kind of pain do you have?*' This is very common in Afghanistan".

(Community FGD2)

My interpreter had given birth to her baby in this hospital. She was upset when midwives examining women were rough and the women shouted out or screamed.

"They should first arrange their legs and tell them how to breathe, then slowly, slowly examine them. The woman has bad pains, labour pains are so bad, and then you give her another pain".

(Interpreter reflecting on day 4 of observation)

Although I am not fluent in *Darī* I understood some of the brief exchanges between healthcare providers and labouring women. The most common phrase was, “you need more time” following an internal examination. This meant that the woman had not progressed enough to be transferred to the delivery rooms. Often these were the only words spoken, no discussion or further explanation as to what had been found and what this meant. A midwife who had been involved in the midwifery-training programme commented:

“We have come a long way... but I think there is still a long way to go, trying to get the basics of respect, being non-judgemental... communicating differently, explaining what they are doing. And not just what I saw on Sunday – a doctor or midwife doing things to a woman who was screaming and screaming and no one was talking to her...it was very distressing to see that still going on.”

(Non-Afghan midwife 7 years in Afghanistan)

I did not observe staff talking to labouring women at any length, giving explanations or support. Several women described this void in interpersonal care.

“... there is no sympathy, no good behaviour, no monitoring and nobody will answer your concerns - I delivered my first child in the corridor of the hospital. I had a very bad pain and couldn't understand anything”.

(Community FGD2)

There were a few cases where perinatal women questioned the staff, or in this rare example, disagreed with the staff.

“A young woman asked for our help, she was sitting on a wooden bench with a big puddle of fluid on the floor beneath her. *‘I have been like this since morning’* she said *‘and no one is helping me, they told me to go home’*. She explained that she was seven months pregnant and lost her previous baby after her waters broke early. We took her to the consultation

area. When the doctor and midwife saw her they told her to go home, that she just had some discharge. 'No', the woman said, '*when I stand up I lose a lot of fluid*'. 'I know what this is' said the midwife '*I am a midwife!*'"

(Field notes day 18)

The midwife appeared angry that her diagnosis had been questioned. My interpreter explained that the implication was, "Do you know better than me? I am a midwife!" The young woman showed courage, perhaps because of her desperation to keep this baby and, perhaps in part, because she felt I would be her advocate.

#### **5.1.4 Monitoring of labour and clinical care**

The partograph has been part of the protocol for monitoring labouring women and their unborn babies in Kabul maternity hospitals for about a decade (World Health Organization 1994; Ministry of Public Health 2009). Healthcare providers are trained to use it and every student midwife has to demonstrate competence in completing it, understanding the significance of observations and when an intervention is indicated. Women in the community complained that once they had been admitted there was no monitoring:

"In Kabul's hospitals there is no system of investigation and monitoring. If you look thousands of times for a doctor they may never respond to your needs. After first examination they leave women in hallways of the hospital and nobody will take care of them".

(Community FGD2)

The staff appeared to congregate in one particular labour room and sit at the desk chatting while one doctor went from woman to woman examining them. Occasionally the doctor would call out a finding to be recorded in the notes. Often there were no staff members in the high risk or intensive care rooms. I did not observe midwives monitoring women in labour or fetal wellbeing apart from performing internal examinations and then listening to the fetal heart. One

woman commented that there was better monitoring during the night but generally women noted:

“There are enough doctors but they need a system of monitoring – that’s the problem there is no system and everybody does whatever they want”.

(Community FGD2)

It was not within the remit of this study to assess standards of clinical care, however, it was also not possible to ignore the clinical side of care. An incident on my pre-observation visit to the hospital illustrated that for me.

“A middle-aged woman and her daughter came into the office where I was talking with a senior midwife. The mother explained that her daughter was pregnant and bleeding but had been sent home by the outpatients’ staff. They lived in a distant place and the mother was adamant that her daughter should stay in hospital as she was still bleeding... The midwife picked up the phone and talked to somebody. From what I understood she arranged for the woman to be checked again. When we got home, however, my interpreter explained that the midwife said that if the young woman had been checked she should be sent home”.

(Pre-observation visit to hospital)

I did not know all the clinical details regarding this woman, however, at face value, sending a bleeding pregnant woman home to a distant location risked the life of this woman and her unborn baby. A non-Afghan midwife commented on clinical decisions.

“The clinical decisions are still very bad, For example, if a woman has fetal distress the staff are not thinking should we give oxygen, should we deliver the baby? They just want to do more internal examinations”.

(Non-Afghan midwife 7 years in Afghanistan)

### 5.1.5 Interpersonal support and care

In addition to the lack of clinical care and monitoring for perinatal women and their babies there was a lack of interpersonal support.

“A pregnant midwife in a green uniform sat at the desk – her hands hung between her legs and she seemed to be staring into nothing. Around her women were moaning and crying out – I’m dying! Please help me! Please help me! And calling for their mothers. Another midwife came in, her hands were in her pockets and she glanced at the women’s notes on the table unresponsive to the cries and distress of the room. She fiddled with the syringes in the cupboard, stopped with her back to the labouring women to chat with the pregnant midwife. A few minutes later she was gone”.

(Field notes day 15)

Many women said that doctors did not care and did not pay attention to them when they were in labour. Instead, they said, the doctors were busy doing other things, talking and laughing together, eating and telling stories. There were usually labouring women in the long corridor that ran through the hospital, holding on to the walls, or crouching on the floor and quietly moaning.

“I felt dizzy and became unconscious and fell on the hospital floor but nobody came to help me”.

(Community FGD1)

My interpreter and I came across several women in severe distress on the corridor floors. In the following example a women in advanced labour needed to purchase gloves so that the staff could examine her.

“It was her first baby and she appeared to be in advanced labour. She was a long way from the labouring rooms, but told us that she needed to get to the door of the hospital to find someone to buy her examination gloves so that the doctors could examine her. She did not have any relatives waiting outside she explained. We found a wheelchair and took her back to the

labouring room. There the staff explained that the hospital did not have enough gloves so women were asked to provide them. There were some sterilised gloves in a cotton sleeve on the table – ‘*it’s fine*’, they said, ‘*we’ll use them for her*’. A short time later she was examined, found to be fully dilated and transferred to the delivery room”.

(Field notes day 18)

If this woman had a relative outside then the normal system would have been for her to send a message via a *khāla* to ask them to purchase gloves. It was not clear which women the gloves on the table were for but apparently not for this particular woman. This incident raised questions regarding hospital supplies and also highlighted the vulnerability of women without any relatives waiting outside the door.

The experience of labour was particularly distressing for young women having their first baby. They did not seem to know what to expect or what was happening to them. They were alone without a family member and many were very distressed as this account from the focus group illustrates:

“I decided to go to hospital for my first baby because my mother passed away and there was no one to take care of me... I was worrying and I went to the doctor and asked her ‘*Daktar Sāhib*<sup>18</sup>, *why don’t you check me?*’ The doctor started shouting at me and said ‘*Every single minute you are asking me to examine you. We want to eat breakfast*’. I kept quiet and decided to go back to my bed. While I was walking I fell down on the ground. The other women shouted ‘*Hurry up you are going to deliver your baby*’. But before getting to my bed my baby was born in my trousers, there was no need for a doctor. The women screamed for help and the doctors came and took my baby. After that I will never go to hospital”.

(Community FGD2)

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<sup>18</sup> *Daktar sāhib* – ‘Mr Doctor’; the customary, honorific, way of addressing a senior medical official.

As I spent time with the labouring women I became aware that they appeared to be very withdrawn. I reflected on this in my memos:

“The women don’t seem to interact with each other but live deep in their own internal world, staring through hollow eyes awaiting their fate... I hardly recognise them when they have had their babies, they look so totally different, like they have come to life. It is almost like they cease to exist in this fight for survival, in the powerlessness of their humiliation, this lack of agency and humanity. Maybe for this time a part of them ceases to exist, it hides, it recedes to their innermost hidden self – how else could they face the degradation and shame”.

(Memos from observation day 5 & 15)

#### **5.1.6 Delivery rooms**

Once women reached the second stage of labour they were transferred in a wheelchair to the delivery rooms. There were three main delivery rooms each containing a row of three or four delivery beds. The bottoms of the delivery beds were kept folded away and the women had to lie on the top half. They wore their own *chadors* and clothes but were exposed below. As with the service area, women received intermittent clinical attention, their babies were born, and women were sutured, however, the women were generally devoid of support, encouragement or kindness. This excerpt from my field notes shows the terror of a young woman with no support who was about to give birth to her first baby. It also shows a midwife’s perspective who considered that shouting and distress were a woman’s lack of self-control and not her (the midwife’s) responsibility.

“Four women were alone in the delivery room. In the corner bed was a young woman having her first baby. She was in the second stage of labour and appeared terrified shouting that she was going to die, shouting for help, for an operation. My interpreter and I were leaving for the day and so I found a labour room midwife and asked if she might be able to support this woman. ‘*Some people control themselves and some people don’t*’ the midwife told me. After some discussion it was obvious the midwife was not going to support the woman”.

(Field notes day 10)

The next day my interpreter told me, that as we had walked out of the room the midwife said to her colleague, “Wait until they have gone and I will sort her out” My interpreter explained that this had been a threat. (We stayed with the distressed woman until she gave birth.) I noted in my memos that this midwife qualified two years ago and had been warm, friendly and humorous in previous conversations. This was not the response I had expected. There were many occasions when the ‘human element’ appeared to be missing:

“A pale looking distressed woman was wheeled into the delivery room by a *khāla*. She was ready to have her baby but all of the delivery beds in this room were occupied. The *khāla* disappeared with the wheelchair and the woman was left standing on her own in the middle of the room at the foot of the delivery beds. As the pain of a contraction overcame her she sank to the floor holding on to a stool, the only thing available. The staff continued with what they were doing, everybody ignored her. The stool was then needed, so a staff member took it telling the distressed women to ‘*stand up the floor is not clean, there’s blood on it*’.”

(Field notes day 10)

A non-Afghan midwife recounted being in the delivery room attending a birth when she witnessed another childbirth:

“I heard the sound of someone pushing a baby out behind me; it was a lady with twins. There were three staff the other side of the room looking at her. One slowly ambled over saying that she couldn’t help because she didn’t have any gloves on, so she held a bucket out and the baby plopped into the bucket. The other midwives just stood there...”

(Non-Afghan midwife 6 years in Afghanistan)

A lack of attention and care from hospital staff was recounted by several women in the community such as this woman who gave birth to twins in a Kabul hospital:



“My twins were delivered but with little care, I was told by a hospital that my child’s problem was caused by lack of oxygen. This one who is with me is two years old and can walk, the other one is in bed and cannot sit or walk...it is due to the doctor’s carelessness”.

(Community FGD1)

### **5.1.7 Newborn care**

The care of newborn babies was an issue of concern to several non-Afghan midwives, for example:

“My colleague was shocked. On four occasions during a week in the hospital, she found sick, cyanosed babies that were under blankets who would have died if she hadn’t found them and revived them. I thought maybe she was exaggerating, but then I was in the hospital and found the same...and neither the health professionals or the mums were checking the babies wondering how they were”.

(Non-Afghan midwife 6 years in Afghanistan)

On a few occasions when senior midwives were present I saw babies being put to the breast immediately after birth but otherwise I did not see babies receiving much attention. Babies were not weighed when I was present and it seemed unlikely that their condition at birth was accurately assessed.

“The scales in the labour room have things piled on top of them. I have not seen one baby weighed during the whole of my observation. The birth register also shows a preponderance of 3kg babies all with Apgar scores of 8-10”.

(Field notes day 13)

If a baby was born in a poor condition, they were bundled up and rushed along the corridor to the nursery to be resuscitated. About that time, a programme called ‘Helping Babies Breathe’ (HBB) was introduced by an NGO. Equipment was provided and some staff were trained in care of the newborn and

resuscitation. I did not see staff resuscitating babies in the delivery room but I was told by several staff that the course was very helpful and had given them confidence in the resuscitation of newborn babies.

### **5.1.8 Verbal and physical abuse**

Women in the community said that the staff were not polite and used 'bad words' to them:

*"Doctors tell us they are tired of lots of births, they say 'Please stop getting pregnant'...they use bad words to us and slap us – they say 'When you had sex with your husband you should have thought about the pain you have now'".*

(Community FGD2)

In general labouring women did not speak to the staff. The staff gave instructions to the labouring women that were often shouted, especially in the labour room. The staff used various expressions to make the mothers push harder during second stage such as:

*"If you don't push and help us now, maybe your baby's situation will not be good. It won't be my fault, the blame will be on your head".*

(Field notes day 11)

*"Maybe the baby is being strangled, maybe it will die, why are you not pushing!"*

(Field notes day 9)

A non-Afghan midwife in a background interview explained she had witnessed perinatal women being slapped.

“I saw a *khāla* walk up to a woman. She slapped her thigh really hard and told her off for bleeding onto the bed”.

(Non-Afghan midwife 6 years in Afghanistan)

Physical abuse occurred not only in the form of healthcare providers slapping perinatal women but I also witnessed several incidents of fundal pressure being applied to precipitate the birth of a baby with fetal distress. In some cases this was performed quite violently. A non-Afghan midwife told me that there had been attempts to stop this dangerous practice. Injections of oxytocin and misoprostol are on occasions administered to labouring women. This practice was officially banned but unofficially used to quicken the progress of labour. A doctor explained in the following example that hospital staff members often use it for their relatives.

“Controllers bring relatives and tell the other staff that ‘*she is my cousin, please pay attention to her*’. She then uses oxytocin or misoprostol for the woman. If the uterus ruptures the doctor is blamed, if she delivers safely the midwife takes the credit”.

(A doctor)

Some women in the community described being given an injection after they had given money and that the baby was then “born successfully”. It is possible that this was an injection of oxytocin or misoprostol. It was not within the scope of this study to examine these clinical issues, however, more work needs to be done in evaluating this aspect of clinical practice.

### **5.1.9 Postnatal care**

Once women had their babies they were quickly transferred to a postnatal room as women were often waiting for a delivery bed. The hospital tried to keep women for six hours after birth. The four postnatal rooms were generally crowded with no room to walk between some beds. Sometimes several women and babies had to share beds. During the day relatives came bringing flasks of

tea and food to women who had given birth. The older women swaddled the newborn babies tightly in the traditional Afghan style, sometimes organising and helping other women with their babies and sharing food with them. The rooms filled and emptied fast, sometimes, I observed, without any postnatal checks on the condition of mother or baby.

“Several women were getting impatient to go home. A midwife came into the ward to discharge them – she asked a few questions and then in an instant they were gone. I didn’t see her palpate an abdomen, take a blood pressure or look at their blood loss”.

(Field notes day 14)

On another occasion the mother of a postnatal woman asked the midwife if they could take their relative home. The midwife explained that they must stay for another hour. No sooner had the midwife left the room than one of the families started packing, quickly followed by the other families in the room. After speaking to them I followed them down the corridors to the outside door. No one stopped them and no one questioned them.

“Within about 15 minutes all of the newly delivered mothers and their babies had gone and a new set of women had taken their beds. The *khālas* wheeled the newly delivered women into the room unperturbed or surprised it seemed by all the empty beds!”

(Field notes day 16)

From the *khāla*’s lack of reaction it appeared that this was a normal event. The women left hospital without being checked or officially discharged and were presumably happy because they could go home when they wanted. The staff had less work and the beds were quickly vacated for the next group of women. One midwife explained that it was vital for women to be checked after birthing and prior to going home but that this did not happen.

“After women deliver they *have to* check their blood pressure, their bleeding, everything - but they are not checking these things. When women deliver at night, in the morning they say... they say ‘*go home*’... this is the care of this hospital”.

(A midwife)

## 5.2 The importance of bribes and *wāsita*<sup>19</sup>

Officially care in Afghan public hospitals is free. Unofficially there were two factors that increased the likelihood of a woman receiving care and attention. First it was important to know someone in the hospital who would make sure the woman was looked after, and secondly it was necessary to give money to staff. Women in the community focus group explained the system.

“In this country if you don't pay a bribe or don't know someone nobody will do anything for you (all the participants agreed with her). Believe me, when I went to the hospital to deliver my baby, in each step they asked for money and I had to pay them, even when I wanted to leave”.

(Community FGD2)

The practice of having to know someone, or *wāsita*, was so important, a key informant explained, that families will take a relative to a hospital that does not have the necessary speciality (such as taking someone with an orthopaedic problem to an internal medicine hospital) because they ‘have *wāsita*’ there. The person with whom the family has a connection is then expected to ensure that the ‘family member’ receives the appropriate treatment. This system also depends on money the women explained:

“If you have *wāsita* and give them enough money (under the table) then they will look after you and pay attention to you. If we don't pay enough money they may not take care of you. If you ask them to help you they will

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<sup>19</sup> *Wāsita* – an intermediary, middleman, advocate, go-between

say they don't have time, and finally the patients will deliver on their own. I don't know what is the benefit of hospitals?"

(Community FGD2)

A female doctor who works in the community explained that many Afghan women give birth at home, even in Kabul. The main reason she said was the cost of having a baby in hospital.

"In Kabul there are many issues that deter women from delivering in hospital but the majority of women don't go to hospital because of poverty".

(Female doctor, reproductive health programme)

A doctor in the Ministry of Public Health clarified that, despite the official policy, men and women had to pay for care in public hospitals:

"We say that the service in government hospitals is free but actually it is not free but much more expensive than hospitals that charge".

(Doctor Ministry of Public Health)

Women said that they were asked for money for care, to 'speed up' the labour, if they were cold and wanted a blanket, or if they wanted the heater put on in their room. Several women commented that it was not just a case of giving money; it had to be *enough* money. *Shīrnī*<sup>20</sup> was the term that staff used to ask for money after the birth of a baby. *Shīrnī* was a 'gift' to celebrate the birth and to thank the staff member who had assisted. Healthcare providers insisted that *shīrnī* was given without coercion; perinatal women and their families often complained that they had been under pressure to give. A female doctor

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<sup>20</sup> *Shīrnī* - literally 'sweets' and by association, 'sweetener': (a) the customary practice or obligation to close friends, family and work colleagues to 'treat' them on receipt of e.g. promotion. This is usually in the form of giving a gift or hosting a meal (b) a euphemism for a bribe.

described how a family member had been asked for money in a Kabul maternity hospital.

*“I brought a relative to the maternity hospital and stayed with her until the baby was born. The midwife, who knows me, asked my relative for money in front of me. ‘I did my best for you, I wasted two hours for you, you should give me some money.’ My relative gave some money to the midwife, but the midwife replied ‘This is not enough money, you should give me more because I spent my time with you’”.*

(Female doctor, reproductive health programme)

From their experiences, some women in the community concluded that money could ensure their babies were born safely, other women had paid large bribes but had still given birth on their own or experienced complications. Women knew that in addition to bribes they were being asked to pay for medicines, medical supplies, and blood for transfusion “that should be free”. These women were frustrated that even giving money did not guarantee good care:

*“Money is not important if we get our health and good care. The issue is that even if you give them money they don't provide us with good service. If you pay and don't get good services it's more painful. We want to be treated and get better not be in a worse situation when discharged – our money gone and our relative's health even worse”.*

(Community FGD2)

A group of non-Afghan women, who had lived more than 30 years in Afghanistan, explained that bribery had occurred in the past but it was rare, shameful and more hidden. It became widespread during the communist regime and was now considered normal. During the pilot community FGD, I asked what happens to poor women when they go to hospital to have their babies. The women said that some staff were kind and would care without being given money but some staff would not care.

“If a woman is poor and the doctor is compassionate they will help and use the hospital medicines but if the doctor is not kind but cruel (like a stone) then the woman’s relative will be left at the hospital gate and the woman will be forgotten on the hospital’s bed. If something happens to her no action is taken”.

(Community FGD1)

The comment that “if something happens no action is taken” appears to imply that if a poor woman suffered complications or died, the healthcare providers would not be held to account, because their family would not have the money or powerful connections to take staff members to court. Poor women, they concluded, were at the mercy of the healthcare providers. A non-Afghan midwife commented that poverty equated to bad treatment and that this inequity was not only present in maternity hospitals but in wider Afghan society.

“But here I think *sadly* – there’s *inequity*, if women are poor and uneducated I think they are treated badly. These are very deep, deep, cultural norms...you know a poor women is not treated well”

(Non-Afghan midwife 7 years Afghan midwifery)

Most people who have money, or even a little money will not go to the government hospitals an Afghan researcher said. If they can they will take their family to a private hospital or even to Pakistan where the care is (perceived to be) better. A hospital midwife confirmed this explaining that many women in the hospital were the wives of ‘day labourers’<sup>21</sup>, men who have *karāchīs* (small trolleys) with goods for sale on the side of the road, or, perhaps the wives of taxi drivers. During observation I met several women who had been admitted in a critical condition having been brought by their families from distant Afghan provinces. The relatives of one woman who had suffered eclamptic fits told us they had travelled for two days and sought help at two previous health facilities before reaching Kabul. The woman’s baby had died and she was barely

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<sup>21</sup> These are men who have no permanent employment but stand on street corners in groups waiting for someone to hire them for the day as manual labourers.



conscious. From their clothing and demeanour and also a staff member's comments I concluded that they were very poor. Families like these are at risk of poor care one Afghan researcher commented, as they generally know no one who can be their advocate and they do not understand *Darī*, (which is spoken by the majority of hospital staff). I asked an historian and cultural expert – “Who is worthy of respect in Afghan society”? He explained:

“In tribal societies respect is only due to equals, or those above you in status. In Afghanistan one always refers to those above you with a title of respect but never those below you. Where there is no embedded cultural idea of respect for those of lower status there is no obligation to show care since care and respect are linked”.

(Non-Afghan historian and cultural scholar)

### **5.3 Fear and distrust**

Women in the community distrusted doctors' motives, clinical judgements and their skills. They had relatives who had had complications from instruments 'left inside them' during operations, and relatives who had been left unattended for days when they needed a blood transfusion. A common phrase that they used was 'doctors are careless with patients'. They thought that the doctors who attended them did not know what they were doing.

“Surgeries were done by young girls (unmarried women) who are students. They don't have experience and don't know much - they are just practising”.

(Community FGD2)

Distrust of hospital staff resulted in perinatal women possibly misinterpreting correct clinical practice, as in this example where the doctors had probably used the appropriate suture material:

“The way they are stitching is unprofessional, I can tell you, they used shoelaces - it was black string!”

(Community FGD2)

Women in the community gave several examples of families who were told that their relative needed a caesarean section or they would die. Poor families, the women said, had little choice but to accept the doctors' word, as they could not afford to 'lose a mother'. Although their comments included experiences in private hospitals as well as public facilities, the general opinion was that decisions were made for the benefit of the doctors, rather than the women and their babies.

“This issue is everywhere...everywhere they force you to have surgery and they will open your belly, natural birth is very low these days... They are doing surgery to receive more money or to learn on poor people how to perform surgery”.

(Community FGD2)

A woman in the community said she was frightened and felt unsafe when she saw how other women were being treated:

“When I saw the behaviour of doctors I got scared and thought they are getting women ready for the butcher, for slaughtering.”

(Community FGD2)

In Afghan culture, a background interviewee explained, it is very offensive to liken someone to an animal. This choice of analogy, therefore, likening women to animals about to be killed by a butcher, is particularly strong and shocking. It conveys fear and the sense that these women in childbirth have been reduced to powerless creatures that are less than human. An Afghan female doctor who worked outside of the hospital told of a discussion at the Ministry of Public Health regarding a woman who had recently died in one of the Kabul maternity

hospitals. The woman had given birth but then had a postpartum haemorrhage. She was discovered dead in her bed.

“You know it was really shocking for me to realise how much the mothers are afraid of the hospital staff, afraid to say ‘*help me, something is wrong*’.”

(Female doctor reproductive health programme)

A sense of vulnerability pervaded the accounts of care within Kabul maternity hospitals, not only from the women themselves, but also from other interviewees who were familiar with Afghan hospital environments.

“You come to the hospital...and hang up your humanity and your dignity at the door”.

(Non-Afghan nurse 14 years in Afghanistan)

As this hospital was one of only a few referral centres for the whole country other options were very limited. Provincial hospitals and private hospitals referred women to this hospital when they were unable to manage the complications. Some women would have travelled for more than a day and arrived in a poor condition. Even for the women from the local community, once in labour at the hospital it was not easy to leave. For the majority of women there was nowhere else to go, regardless of the standard of care or the attention that they received.

## **5.4 Exceptions**

A few doctors and midwives told me that care was very good in the hospital, that everyone was cared for equally well and that there were no problems. Other staff said that they treated women like they were their own family. From my observations and previous experience I can say that there are many healthcare providers who work hard to ensure that women give birth safely. Women in the community and interviewees said that some staff members were

helpful and kind to the women in labour. The overwhelming evidence from interviews and observation, however, was that high standards of care and sympathetic attentive staff were the exception. A woman in the community concluded that you were a lucky person if a kind healthcare provider attended you.

“Of course there are midwives and cleaners who are working with their heart and helping patients – it is someone with good luck who is receiving services from such a midwife or *khāla*”.

(Community FGD2)

A non-Afghan healthcare provider also cited examples of staff who were motivated and kind in his speciality but as explained here, this was not the norm.

“Sometimes you see staff who try to be kind and do their best...but usually they don't have a high position. No, to have a career you have to act in another way. It doesn't pay to be compassionate”.

(Non-Afghan healthcare provider, 16 years in Afghanistan)

This interviewee explained that those who show compassion and kindness are usually the ‘small nurses’, those with little status who were closer to the clients. It was not a quality that advanced one’s career, as it was contrary to the accepted behaviour within hospitals. An Afghan midwife commented that when she worked well other staff would try to stop her as it put them in a bad light.

## **5.5 ‘Good care’ for Afghan women and families**

One of the most important issues that I needed to clarify was the type of care that Afghan women wanted so that I would have a benchmark to interpret the behaviours within the hospital. How did Afghan women like to be treated? What was acceptable to them? I could not assume that this would be the same as my

benchmark. I did not want to judge what I saw in the hospital from a Western perspective but, as much as possible, from the perspective of how Afghan women would wish their healthcare providers to behave.

The women who participated in the two community FGDs came from different economic, social and ethnic groups but their experiences and wishes regarding care in Kabul maternity hospitals were very similar. Other Afghan interviewees including a community leader, and several husbands concurred on the type of care that was acceptable and unacceptable for Afghan families. Desires regarding care had three elements, one concerned the quality of clinical care, another the cost of care, and finally the interpersonal aspects of care.

Women knew that they should be monitored regularly to see how their baby was and if their labour was progressing but they complained that this did not happen. They felt that they did not receive good care partly because the doctors were careless in attending to the needs of women and partly because the knowledge and skills of the doctors were poor.

“We want a qualified doctor to check us and care for us, to do our treatment in a better way”.

(Community FGD1)

The women wanted doctors who would pay (serious) attention to them, who would do their best for them.

“There must be doctors who think deeply about their patient and take care of their patient with good checking and medical treatment”.

(Community FGD2)

The women wanted competent and motivated doctors but explained that they were unable to identify such doctors.

“There are good doctors and also bad doctors and we cannot distinguish (between) them”.

(Community FGD1)

These women acknowledged their vulnerability in the medical system. They were unable to protect themselves from harm, as they did not know who would take good care of them. They often had no choice in who cared for them. The only leverage that they had was to hope that money would motivate the hospital staff to ‘pay attention’ to them. Many interviewees and women in the community agreed that to get anything done in Afghan society they had to know somebody who would help them (*wāsita*) and they had to pay a bribe. There appeared to be some acceptance that ‘this is how things are done here’, but the women were frustrated that even paying bribes did not guarantee good care. In addition the women complained that they were forced to pay for medicines and supplies that should have been free. It was not possible for me to assess if medicines were being charged for or if families were being sent to the pharmacy to buy medicines that were present in the hospital. I rarely saw medicines being taken from the hospital cupboards though but frequently saw family members rushing off with prescription papers in hand.

The predominant issue the women discussed was interpersonal attitudes and the behaviour of healthcare providers. They wanted to be treated with politeness, respect and kindness by doctors who focused on the needs of their ‘patient’. “Patients need kindness”, several women said, and it was important “to ask doctors to have a good behaviour with patients”. “Patients are very sensitive”, they said and another explained that the behaviour of the staff could make pain better or worse.

“Patients can be healed with good behaviour, but bad behaviour doubles the patient’s pain”.

(Community FGD1)

Being treated with politeness and sensitivity was considered part of the healing process for women in both groups even though they came from different social, educational and ethnic backgrounds. Some women put a higher value on good behaviour and politeness than professional skills and knowledge.

“I think all doctors should learn about politeness and good behaviour for a year before their professional lessons. This is more important than professional skills and knowledge”.

(Community FGD1)

Many other Afghan interviewees stressed the importance of politeness and good behaviour in their traditional society. A doctor from the MoPH explained that people would rather pay than be treated impolitely.

“If hospital staff have bad behaviour then the patients won't come back but they will go to private clinics. Even although care in the private clinics is not good people are polite to them”.

(Senior female doctor MoPH)

‘Good care’ for these Afghan women contained several elements. They wanted to be cared for by well qualified healthcare providers, rather than being “practised on by inexperienced young women”. The women wanted the healthcare providers to check them, monitor how they and their baby were progressing and pay attention to them. They wanted to receive free medicines and services, although some said that the money was not so important. It was keeping their health that really mattered. Most importantly these women wanted the healthcare providers to be polite and treat them with respect and kindness. The type of care that these women had experienced, and the majority of care that I had observed, therefore, was not acceptable either to them, or to their families.

## 5.6 Discussion

The priorities of these Afghan women were very similar to notions of good care in other settings, such as the findings of a systematic literature review by Nicholls and Webb (2006) which asked the question “What makes a good midwife?” The 33 studies were from predominantly high-income countries; three were from ‘developing countries’. Good communication skills made the greatest contribution to being a good midwife. Being compassionate, kind, supportive, knowledgeable and skilful were also essential qualities. Small and colleagues (2014) reviewed the experiences of immigrant and non-immigrant women using maternity services in five countries. There were few differences between the groups: they wanted care that was safe, high quality, attentive and supportive together with being given adequate information.

Studies from several settings found that healthcare providers used their power over women in childbirth to control or maintain distance from them rather than to care for them. One stakeholder in the Dominican Republic commenting on the high maternal mortality ratio in institutional births reported that it was “an issue of culture and power” (Miller et al. 2003, p.100). South African midwives used violence, Jewkes (1998) suggested, to create a social distance and to assert their own power and knowledge. D’Oliveira and colleagues (2002) noted that the socialisation and training of healthcare professionals places doctors, nurses (and midwives) in a privileged and powerful position over those they are caring for. Healthcare providers in this study exerted power over women through their knowledge, skills and ability to withhold care. Women in the community revealed how vulnerable they were, as they did not know who were good doctors and unless they had the money to pay, it was “luck” whether kind or cruel staff cared for them.

This discussion focuses on the three elements of care that were important to these Afghan women and their families, the quality of clinical care, the cost of care and the interpersonal aspects of care.



### **5.6.1 “A well-qualified doctor to check us and do our care in a good way”**

Recent literature regarding maternal healthcare in Afghanistan has predominantly focused on the achievements of the last decade (Rahimzai et al. 2013; Rasooly et al. 2013; Turkmani et al. 2013; United Nations Population Fund 2014; Zainullah et al. 2014). Behind the numbers however there are still notable challenges in achieving quality care for Afghan women who access maternity services.

From the accounts of women, some healthcare providers and my observations, perinatal women received little monitoring or attention from admission to when they were ready to have their babies. It is likely that this lack of monitoring contributed to the high levels of perinatal mortality recorded in several studies (Guidotti et al. 2009; Kandasamy et al. 2009). The lack of monitoring would have prevented the timely identification of complications and subsequent effective interventions. A more recent chart review of caesarean births conducted by Kim and colleagues (2012a) reported that only 28% of women had been managed with a partograph. Out of 151 caesareans 17% of babies had died and 16% of women (n=27), of these, four women had been classified as non-emergency cases. In the 63% of emergency cases that recorded an abnormal fetal heartbeat, surgery began one to three hours later. A delay of 72 hours to birth was recorded in one case with an abnormal heartbeat. The partograph was only used in 13% of cases of fetal death. Kim and colleagues (2012a) concluded that multiple deficits in the quality of care no doubt contributed to the large numbers of maternal and fetal deaths. Clinical observation and a chart review was used by Evans and colleagues (2014) to assess the quality of caesarean births in Afghanistan. They examined the time between admission, identification of a complication, decision to perform a caesarean, incision and birth. The study, that included Kabul maternity hospitals, reported rates of stillbirth in the observed groups of 7% compared to the unobserved groups of 21%. The authors suggested that the Hawthorne effect may explain the shorter time intervals to birth in the observed group and that a lack of motivation may lead surgical providers to perform at less than their full capabilities when not being observed, but this was unsubstantiated.

These studies confirm that babies and women are dying from preventable deaths in Afghan hospitals and that the quality of care is still poor seven years after Williams and McCarthy (2005) drew attention to suboptimal conditions and care. Several authors' recommendations include encouraging the use of partographs, improving decision-making and documentation, surveillance systems and maternal death/near miss audits (Kim et al. 2012a; Kim et al. 2012b; Evans et al. 2014). Several of these 'solutions' such as training in the use of the partograph and in Emergency Obstetric Care have been implemented since 2003. Seven years on, there remains a lack of analysis into the root causes of poor clinical care and decision-making. It was particularly noticeable that midwives, who were all trained in the use of the partograph, were rarely seen checking women and completing it. A doctor suggested that they were "busy with other things".

### **5.6.2 "You have to know someone in the hospital" – wāsita or money**

When they went to hospital give birth to their babies it was vital, not only for women in Kabul, but also for women in the Afghan province of Badakhshan to know someone in the hospital. Akbar (2011) explained that in a patronage society, connections made a difference in the type of care women received. Women from remote villages were disadvantaged she explained, because they did not know anyone in the hospital. This made the experience "terrifying and intimidating" for the women who sought care and, in addition, the midwives and doctors were less obliged to care for women they did not know. The rural women told her that when they had their babies in the hospital they had been neglected and humiliated.

Howard and colleagues (2014) examined the perspectives of users and healthcare providers of reproductive health services. Out-of-pocket expenditure was particularly difficult for those accessing Kabul reproductive health services, even for those with a high income. Despite regulations stipulating that these services should be free money was needed for doctors' fees and medicine. Rahmani and Brekke (2013) conducted a qualitative study examining the

experiences and views of healthcare receivers and providers in Kabul and a rural village. There is a lack of detail regarding the methodology such as the selection procedures and how access was gained to various health facilities. With this proviso, however, many comments and perspectives concur with my findings such as the need to bribe and to purchase medicines that should be available in the hospital. These women also reported that if they did not know anyone in the hospital they might be “left and forgotten”.

In his anthropology of obstetric services in West Africa Jaffré (2012) explained that using connections to access care is a global phenomenon. Equal access to services did not exist, therefore, patients had to use various means such as acquaintances or money to ensure that the healthcare providers noticed them. Andersen (2004) studied the treatment of patients in a Ghanaian hospital. He concluded that differential treatment was closely linked to having the right connections and also to social status (Andersen 2004). In Ghanaian society a person of low status could not expect or claim respect or attention from someone of a higher status unless they were related or had some obligation. Miller and colleagues (2003), described the neglect, lack of dignity or respect for labouring women in the Dominican Republic. Healthcare providers viewed their clients as uneducated and partly to blame for the high maternal death rates. The neglect and abuse of women described by Jewkes and colleagues (1998) in South African maternity services was underpinned by ideologies of patient inferiority on account of their ignorance or illiteracy. Mumtaz and colleagues (2014) found that the low caste ultra-poor women in Pakistan were powerless, invisible and treated badly by healthcare providers because of their social inferiority. The women reported that staff ignored and abused them, they called the state hospitals “butchers” and said that “they would rather die at home” than seek such care. These studies demonstrate that Afghanistan is no exception and that there have been reports of similar findings in many countries.

The social and professional standing or status of individuals in Afghanistan is closely related to power and wealth (Entezar 2007). Status is also linked to the

family that one comes from and the honour of that family (Loewen 2010c). In a study of resilience amongst Afghan school children and their carers Eggerman and Panter-Brick (2010) found that poor people were not treated like human beings, not cared about nor respected. The majority of women accessing the Kabul hospital were of a low social status and in a country where status is an important component of society; lack of status compounded their vulnerability. It would be hard, and probably futile, for these women to request better care. As uneducated women it would be extremely difficult for them to question the doctors and midwives. Entezar (2007), in his analysis of Afghan culture based on the work of Geert Hofstede (2010)<sup>22</sup>, explained that there is a high tolerance of inequality amongst Afghans, that those of lower status would not expect to be treated in the same way as those with superior status. The only options for those of low status was to hope that were 'lucky' and received attention from a kind member of staff, to pay (bribes) for care, or to give birth at home.

The MoPH continues to espouse a policy of equity in healthcare and making the poor a priority (Ministry of Public Health 2012; Newbrander et al. 2014). The findings of this PhD study, however, indicate that because of the dominance of social norms such as *wāsiṭa*, and the importance of status, women who did not have connections and could not pay staff to provide care were neglected. The unofficial costs of giving birth in Kabul hospitals resulted in the exclusion of poor women of low status from healthcare services.

### **5.6.3 “Patients are very sensitive, ask doctors to have good behaviour”**

The description of “hanging up your humanity and dignity at the door of the hospital” was a fitting picture of childbirth in Kabul’s maternity hospitals according to the accounts of women in the community. It was a frightening ordeal for many of them as they were separated from family, humiliated and depersonalised.

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<sup>22</sup> In the 1970’s Hofstede commenced analyzing survey data on the values of people from more than 50 countries who worked for a large multinational corporation International Business Machines (IBM).

Although not fulfilling all the criteria of a 'total institution' as described by Goffman (1968) in his study of closed institutions, many similar depersonalising features were part of this hospital culture. Goffman portrayed the mortification or shaming of individuals as they entered the prison, were separated from the outside world, were not given information or control over decisions regarding their fate, lost their sense of personal safety and were forced to be deferential.

Dehumanisation Haslam (2006) explained, although typically associated with ethnicity, race, intergroup conflict and genocide such as the Tutsis in Rwanda, the Bosnians in the Balkan wars, has also been associated other domains such as the representation of women in pornography, with disability, technology, and medicine. Subtle forms of dehumanisation can enter hospital life as carers treat clients less like persons and more like objects Haque and Waytz (2012) observed. It allows people to experience fewer moral concerns for their actions towards others and can justify acts that would otherwise be considered harmful. Haslam (2006) proposed a model of humanisation based on what it means to be uniquely human and on human nature. The corresponding forms of dehumanisation represent others as animal-like and are therefore viewed with contempt, or as objects regarded with indifference. Todres and colleagues (2009) developed a conceptual framework for humanising care, both to illuminate and give direction to humanising care, and to guide an agenda for qualitative research. Their perspectives on what it means to be human were informed by the phenomenological tradition and their framework consisted of eight essential constituents of humanisation in regard to caring. Each constituent is on a continuum between humanisation and a form of dehumanisation such as "Togetherness – Isolation" or Agency – Passivity. Todres and colleagues noted that the extremes seldom occur. When Afghan women's experiences are held against these dimensions, however, and against their explicit wishes regarding sensitivity and kindness, the degree of dehumanisation in this setting becomes apparent. Separation from family, for women in this Kabul hospital, was the first loss of identity as they were isolated, wrenched away from everything familiar. The lack of information about the progress of their labour apart from the comment "you need more time," and the observation of "things being done to the woman in the bed" as she screamed

but was ignored, stripped women of their agency and dignity. The women complained that no one asked permission to examine them or asked them about “their problem or their pain.” This objectified them, reducing them to a body without any regard for the person inside, dislocating them from their personal world. Being examined in view of a room full of people in a society where most women are covered from head to toe in public, together with the verbal abuse of those who questioned the healthcare providers all contributed to a loss of agency, identity and dignity. The emotional distance between the women and the healthcare providers is further illustrated as a baby is allowed to drop into a bucket, and as healthcare providers sat motionless and unresponsive while women around cried out for help, for comfort, for reassurance in their pain. Women who were abused by staff in South African maternity services said that the most distressing part of their experience was the neglect (Jewkes et al. 1998). Dehumanisation according to Oliver (2011, p85)

“...is the almost unimaginable process by which human beings are rendered so radically ‘other’ that their lives count for nothing”.

The childbirth experiences of Afghan women in this Kabul hospital stood in stark contrast to their wishes. I would contend that these experiences should not be reduced to a list of clinical failings or features of disrespect or abuse; it is only as they are examined in the light of what it means to be human that the impact can be glimpsed.

The features of neglect, disrespect and abuse in this Kabul hospital could be aligned with the categories of the Bowser and Hill (2010), or the analysis of d’Oliveira and colleagues (2002). My aim was not to measure, categorise, or compare the experiences of these women but rather, to understand the underlying determinants. Although the issue of suboptimal, disrespectful care in facility-based childbirth is an area of concern globally (World Health Organization 2014), there is an inexplicable dearth of primary research investigating the healthcare provider perspective. The majority of studies

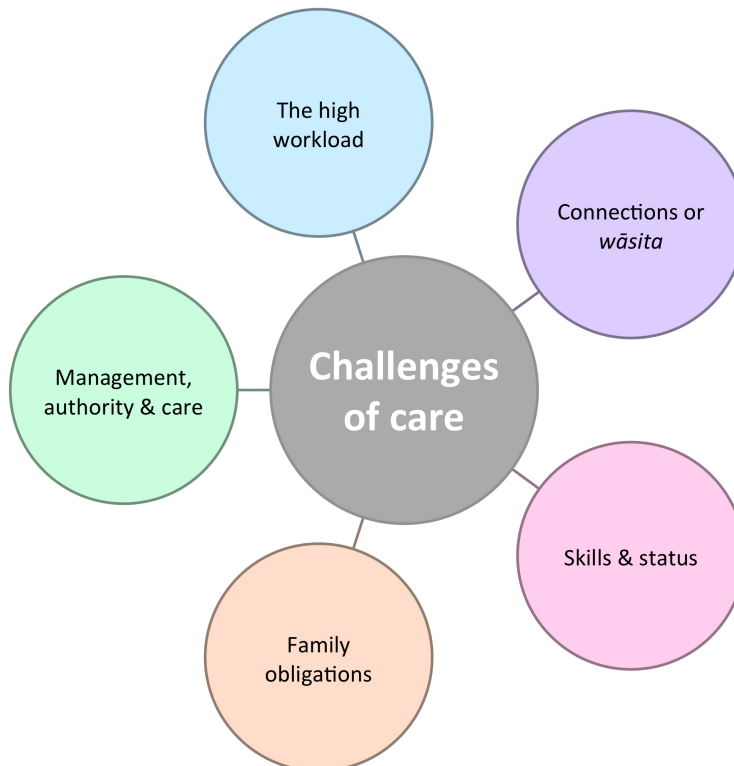
continue to focus on measuring and defining abuse, (Abuya et al. 2015) or alternatively, base initiatives on the review of Bowser and Hill (McMahon et al. 2014). A recent study by Milne and colleagues (2015) examined the perspectives of Nepalese healthcare providers on barriers to women giving birth in a maternity-care facility. Prior to data collection a comprehensive literature search was conducted encompassing the perspectives of skilled birth attendants. Only four primary research studies and one literature review were identified as relevant. The authors noted “the lack of research around skilled birth attendants” (Milne et al. 2015, p.4). The recent WHO statement on the ‘prevention and elimination of disrespect and abuse during facility-based childbirth’ advocates the need to measure and define abuse, to train healthcare providers and to emphasize the rights of women. It does not suggest, however, that the healthcare perspective may yield important insights or that different settings could have unique contributing factors.

#### **5.6.4 Summary**

The experiences of women in the community, family members and non-Afghan healthcare providers, combined with my observations, revealed many deficits in care. Once women had had their initial assessment many received minimal attention or monitoring until they were ready to give birth, unless they knew someone in the hospital or paid a bribe. The experiences of these women went beyond inattention to physical needs. The lack of human kindness, loss of identity, isolation and objectification dehumanised these women and their experience of childbirth. This ‘culture of care,’ they explained, was not acceptable to them. In the following chapters I will explore the factors that contributed to this culture of ‘care’ by exploring the challenges to care and the perspectives of the healthcare providers.

## Chapter 6 - Challenges of care

In this chapter I introduce the key constraints and challenges that impinged on the ability of the midwives, doctors and *khālas* to care ‘like they were taught’. I also analyse the provision of care primarily from their experiences and perspectives.



**Figure 4: Chapter 6 Overview**

### 6.1 The high workload

The most obvious constraint to high quality care within this hospital was the workload. Midwives, resident doctors and senior doctors consistently cited “the crowd of patients” as the main reason that they could not care for perinatal women according to the national MoPH standards. A trainer explained that the high workload affected standards of care:



“The main problem in this hospital is the number of patients; we can’t care for them well”.

(Senior trainer 11 years in hospital)

During observation I regularly saw up to four labouring women sharing a bed. In the postnatal rooms also, several women and their newborn babies shared beds, especially in the early morning before the midwives discharged them. The following excerpt from my field notes was an attempt to understand the numbers of women, beds and workload that staff were responsible for:

“The ‘service area’ had approximately 60 beds. It included labouring women, postnatal women and babies, high risk and intensive care rooms. During the night two resident doctors and three midwives cover this area. There is no guarantee how many women will be in each bed... today I counted 23 labouring women in a ward with 6 beds”.

(Field notes day 7 and 8)

Given the number of healthcare providers, number of beds and potential number of perinatal women, especially during the evenings and nights, it is reasonable to conclude that staff could not provide high quality care. It was inevitable that suboptimal care would occur.

“I checked the delivery register for numbers of births and counted how many births individual staff had managed. Over the last few days there were 51, 75, 66 and 63 respectively in 24-hour periods. In one 24-hour period four doctors and five midwives managed 75 births. One doctor assisted 13 women and one midwife supported 23 women in childbirth during her 24-hour duty”.

(Field notes day 7 and 8)

It was not unusual to find one midwife caring for three or four women in a delivery room, checking the progress of women about to give birth, then returning to other women to deliver placentas. There was often pressure for beds as *khālas* would rush in with a woman in a wheelchair who was ‘ready to

have her baby' but found that there was no bed available. As one midwife explained it was impossible to care for everyone:

“There are too many patients; we can't manage...whilst we are caring for one patient another delivers on the floor”.

(Midwife qualified 7 years)

The staff worked long hours with little time at home to recover or attend to household responsibilities. A senior midwife explained that all staff members have to come at 8am. When on night duty they have to stay until after 9am the following morning. “It is a very long time,” she added, “too long”. The staff members have the rest of the day at home but then have to be back at work by 8am the next morning. Friday was their only day off. If healthcare providers were working on Friday they had to wait until the following Friday for a day off. In the mornings the corridors were so crowded with staff it was generally hard to move; in the late afternoons, evenings and nights, while there were many labouring women it was often difficult to locate a healthcare provider. The contrast between mornings and other times of the day was striking.

The midwives, doctors and *khālas* were all women who would have responsibilities at home for husbands, children, elderly parents, and for entertaining guests - an important social obligation for Afghan families. A full-time job would not excuse them from these responsibilities. The lack of time at home was difficult for them they said. Many staff talked of the need for a shift system so that they could have more time to rest at home, to study, to attend to their household responsibilities and come to work refreshed.

“A shift system would be good. At the moment everyone has to work everyday. Staff will come with good energy if they have had time at home”.

(Senior obstetrician)

A shift system had been tried for a few weeks but had been stopped. The staff were not sure why, some said it was because the MoPH did not have the money to fund extra transport for staff. Others healthcare providers said it was the fault of senior doctors who refused to be in the hospital in the afternoon and attended their private clinics instead. A senior doctor from the management team explained that some powerful doctors had challenged her authority to run the system. The MoPH had verbally agreed to the shift system but would not put this into writing and consequently the shift system was stopped.

The high workload exerted an almost relentless pressure on staff and, I was told, caused a lot of stress, exhaustion and sickness. My field notes highlighted on several occasions that staff looked visibly tired. A senior midwife said that staff felt exhausted:

“During the night the doctors, midwives and even the *khālas* are so tired they are almost unconscious! Everyone is tired with stress, they are very, very tired”.

(A senior midwife)

During observation a trainer said that the high workload affected doctors' health.

“The senior trainer said that doctors' health was suffering because of the stress and workload. Many had arterial sclerosis, back problems, heart disease she explained, and they were all very tired, frustrated and depressed”.

(Field notes day 1)

Many of the healthcare providers admitted that they lost patience when they were tired and that they switched off to the cries of women in labour. Several doctors and midwives admitted that they were not caring as well as they would like to. They knew in their hearts that they should do better but explained that it was the number of women that made this difficult.

“We should be kind, we are not kind enough ...In our heart we know that we did the wrong thing...If I take care of 10 or 15 patients after that I have no energy so when a woman asks something I say, *‘Be quiet! You ask a lot of questions, I have no time!’*”

(4<sup>th</sup> year resident doctor)

Healthcare providers acknowledged that they knew how to care in theory but that it was impossible because of the high numbers of women who give birth in this hospital.

“If we had a few patients”, the midwife explained, “then we could care but with so many we can’t. This is our hope to care for patients better. We know how to care, like we were taught in the school, but we can’t do it here”.

(Field notes day 4)

A few healthcare providers said that the high workload was used as an excuse, and that care could be better despite the workload, as in this following example:

“If I ask *‘Why didn’t you do this?’* the staff say they couldn’t because there were so many patients but some of the time they are not so busy and could do everything well but they don’t”.

(4<sup>th</sup> year resident doctor)

Sometimes women arrived in a very poor condition having been in labour for many days. Families had often taken their relative to a provincial hospital first. If the staff there could not help, families were forced to travel up to several days more to Kabul. Often the unborn baby was dead by the time the woman reached the hospital. Sometimes the healthcare providers were unable to save the mother. The high proportion of women with complications put the doctors and midwives under pressure as a resident doctor explained:

“Every night we have 14, 16, 18, caesarean sections - they come from outside, from far away: rupture, ectopic rupture, total placenta praevia, active bleeding, concealed abruption, two or three previous caesareans, breech presentation...fetal distress, abruption. Sometimes it’s so difficult”.

(4<sup>th</sup> year resident doctor)

Another fourth-year resident doctor explained that the high number of women with normal uncomplicated labours took time and attention away from the women with complications. During one duty she spent several hours checking more than 30 labouring women, each saying “Please help me, please help me”. No one told her that there was a woman with severe pre-eclampsia ‘asleep’ in the next ward. By the time she got to her it was too late and the woman died shortly afterwards. A MoPH doctor confirmed the pressures on Kabul maternity hospital staff:

“The large population in Kabul puts a big demand on hospitals and most complicated cases from the whole of Afghanistan come to these Kabul hospitals”.

(Senior doctor MoPH)

So the heavy workload, high numbers of complicated cases and the long hours with reduced numbers of staff made the provision of high quality care extremely challenging for healthcare providers. There were further factors that impaired the ability of the staff to care, including difficulties acquiring the necessary clinical skills.

## **6.2 Connections or ‘*wāsita*’**

### **6.2.1 *Wāsita* and the acquisition of skills**

This hospital ran a four-year residency-training programme. Resident doctors bore responsibility for the majority of the work. First and second year residents were on duty in each area and called a third or fourth year resident if they

required help or advice. Only after this would the help of a more senior doctor be sought. A first-year resident explained that the clinical work was very hard for them because no one helped them develop their clinical skills, such as episiotomies or suturing.

“No one showed me how to do an episiotomy or how to suture, the trainers just say ‘*You’re a doctor, you can do it*’”.

(1<sup>st</sup> year resident doctor)

This resident explained that her theoretical knowledge was good but her ability in practical clinical skills was very low. As medical students they had come to the hospital hoping to start learning skills. Unless they knew one of the senior midwives or a senior doctor, they were not allowed to enter the delivery area but encouraged to go home. Also, as resident doctors they needed a relative or contact who worked in the hospital to help them develop clinical skills. Resident doctors without connections or *wāsita* generally had to teach themselves their clinical skills through a process of trial and error on perinatal women.

“So day and night we work by ourselves and teach ourselves. For example, if the first time I do something I feel it was not correct, then the next time I change it. I am a fourth-year resident now, but I don’t feel that I learnt from anyone, nobody took my hand and showed me ‘*do it like this, don’t do it like that*’”.

(4<sup>th</sup> year resident doctor)

Resident doctors were left on their own for hours at a time from their first night duty. Usually two resident doctors covered each hospital department overnight. One slept for three to four hours while the other worked, then they swapped over. One resident recalled that she had made serious errors in her clinical management of perinatal women with complications during her first night duty:

“On my first night duty the other doctor was a second-year resident. She slept for the first half of the night while I was alone; I made three big

mistakes. One mistake, I remember, was a woman having her first baby. She was premature, bleeding and the baby was breech. I gave her her notes and said '*Go to the ward!*' I didn't know that I should have prepared her for a caesarean section".

(2<sup>nd</sup> year resident doctor)

Although there were trainers who were responsible for training the resident doctors the majority, 80% one resident suggested, were reluctant to pass on their skills. The resident doctors explained that the opportunity to learn depended on 'who you know,' not on ability, motivation or on a training policy. Opportunity depended on having a '*wāsita*' in the hospital or a government ministry.

"What you can do depends on if you have *wāsita*. If you have a relative in here you can do more things, learn more things".

(4<sup>th</sup> year resident doctor)

Connections, or the lack of them, affected the clinical rotation of residents to different areas of the hospital. Resident doctors were expected to perform caesarean sections once they were third year residents, so it was important they gained experience in the theatre as soon as possible. A resident doctor explained, however:

"Just some doctors who have a relative in this hospital are helped, because I don't know anybody they didn't send me to get experience in the operating theatre for two years".

(4<sup>th</sup> year resident doctor)

The residents also explained that if trainers were called to an emergency they would mostly perform the necessary procedure, such as cervical suturing, themselves rather than teach a resident doctor how to do it. Another resident doctor was angry, because, she explained, despite four years on the residency programme she lacked the necessary skills to be a specialist:

“I was illiterate (lacking in clinical skills) when I came into this hospital as a first-year resident and will go from this hospital illiterate... I will leave this hospital after one more year and qualify as an obstetrician/gynaecologist. A specialist should know everything but I am illiterate... I am a fourth-year resident and I have still not repaired a cervical tear”.

(4<sup>th</sup> year resident doctor)

This doctor declared that she was as untrained and uninstructed in clinical skills as when she had commenced the residency programme. Once doctors completed the residency programme they had to find employment in other hospitals, clinics or private health facilities. Some doctors would work in remote areas with little backup, it was vital for them to become competent in clinical skills and decision-making during their residency. Another resident expressed her disappointment that the programme had not provided her with a thorough training as promised.

“There are some trainers who observe and support us a lot but it is mixed, it is not a standard system. When I came here they said ‘*We organise the training like this and this*’ and I was so happy. Now I am a fourth-year – nothing!”

(4<sup>th</sup> year resident doctor)

A senior doctor in the MoPH confirmed the importance of *wāsita*. Some doctors graduated from the residency programme unable to perform a caesarean section on their own, she said, because they did not have relatives in the hospital to teach them. A recently qualified doctor explained that there was a difference between what was written and what actually happened:

“The level of knowledge and skills was lower than I expected... I was not satisfied; we should have learnt more comprehensive skills as specialists. Maybe they are there on paper but in the real situation they are not taught”.

(Recently qualified OBGYN specialist)



Several women in the community asserted that the doctors were poorly educated. They felt that the doctors were just practising on them. The resident doctors' accounts of the residency programme showed that the fears of these women were well founded. Some doctors were not well trained and had no option but to 'practise' on perinatal women.

A discussion in the doctors' morning report one day provided a stark example of the lack of support resident doctors received in developing their skills. A woman had been found in the operating theatre with her abdomen open and no doctor in the room:

"A senior doctor stood up at the front of the room. She said that she had seen '*a bad situation, like a nightmare*', which she hoped she would never see again. She had found a woman in the theatre on the operating table 'cut open', the anaesthetic wearing off and no doctor in the room, just a nurse! A doctor who had been involved in the operation explained: '*When I was there everything was fine, although I know doctor X*' (the junior doctor involved in the operation) '*can't do everything*'. Senior doctor: '*Then why did you leave her there? Why don't you teach them? This is the problem, although you know something you don't want to teach anyone else*'".

(Field notes doctors' morning report day 14)

No one explained why both doctors had left the woman on the operating table or where they had gone. It was clear, however, that there was a problem with clinical training, and that some trainers were reluctant to share their skills and knowledge. I asked a resident doctor the reason many trainers did not teach clinical skills. She suggested that perhaps they were too tired because of the workload or that perhaps they had become demotivated and discouraged. Others suggested that some trainers lacked knowledge and skills. The fact that many trainers performed procedures themselves at times rather than teaching the residents, demonstrates that in those cases it was not a lack of skill but something else that prevented the transfer of skills. A non-Afghan interviewee, who had taught doctors in general hospitals, suggested that sometimes trainers

regarded the residents as competitors, concerned that if a resident doctor became too skilled they would take away their private patients.

In addition to the trainers who were reluctant to train others, a senior midwife and a resident doctor both said that they had faced opposition from senior staff and ridicule from some colleagues when they tried to run informal teaching sessions. “*Who do you think you are that you want to train us*”, some of the resident doctor’s colleagues had said, “*you are just showing off*”. A midwife had a similar reaction from her boss.

“I want to train the midwives but our boss says ‘*you can’t train - who are you? You are not a teacher!*’ Her behaviour was not good with me”.

(Experienced Midwife)

The midwife’s analysis of the situation was that the senior staff members were not interested in others gaining knowledge but worried that their positions might be threatened.

“They don’t like me to do training here, because they think if I do training I will be promoted. ‘*Oh it’s not good! No, don’t do this*’ they say, but they don’t think how good it is that the knowledge of the staff is becoming higher.”

(Experienced midwife)

### **6.2.2 Wāsita, jobs, training and exam success**

Midwives who worked in public health institutions had a job for life as long as they complied with the regulations of those institutions and did not commit any serious mistakes. The competition for jobs was tough. One newly graduated midwife explained – “To get this job I tried a lot and tolerated a lot of difficulties”. She explained that the system for getting a job in the hospital was an exam set

by the MoPH: the top students were employed in the hospital. I wondered if connections also affected job opportunities and so I asked her:

RA: "So does it help if you know someone in the Ministry?"

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

(Midwife qualified 1 year)

So, the official way to get a job in the hospital was to take an exam where jobs were awarded depending on the results. Unofficially, however, you had to know someone in the Ministry or hospital to be employed there. Several staff members confirmed that to get a job in the hospital it was essential to know someone important. Numerous Afghans in the community explained that no one could hold a senior position, in a hospital or ministry, without having powerful connections. As one community leader confirmed, "Political support is necessary for senior positions, not just knowledge".

Places on workshops and training courses were highly prized. In addition to the knowledge and skills that could be acquired each participant would be paid a 'per diem' or daily allowance. Doctors and midwives complained that the same people were sent on courses each time. The implication was that people with *wāsita* were given places.

Some years previously, while employed as the technical advisor to the Afghan midwifery training programme, I received a note from one of the senior members of the training institute asking me to pass a midwifery student who had failed her exam. Another non-Afghan colleague had similar requests from family members. It appeared that this was normal practice for the faculty: success in exams could be arranged if students had the 'right' contacts or *wāsita*.

### 6.2.3 *Wāsita* and perinatal women

*Wāsita* is so integral to Afghan society that even visiting relatives saw care through the lens of *wāsita*. They did not understand that some labouring women needed more attention and care than others. Several staff mentioned that relatives become unhappy with them when they gave a woman with complications more attention than their relative.

“Sometimes you have a sick woman, the doctors are coming to see her and you are giving her injections, but the other relatives are not happy and they are saying ‘*Oh she must have a relative in this hospital*’” (because she is getting more attention than their relative).

(Senior midwife/controller)

The relatives’ assumption appeared to be that the quality of care was solely dependent on relationships. This suggests that the *wāsita* system was pervasive. A background interviewee stated: “nothing happens without *wāsita*”.

## 6.3 Skills and status

The midwifery-training programme placed a high emphasis on the acquisition of clinical skills. Skills were initially taught in a skills laboratory where students practised on models. Once in the clinical areas each student was assigned a clinical preceptor and was assessed for competency in essential skills prior to graduation. The challenge for midwives was not the acquisition of skills but the use of those skills once they graduated.

There was a broad range of midwives within the hospital: midwives who had trained in the 1970s; midwives who had trained post 2002 under the competency based training programme; and midwives who had trained in private midwifery training institutes that had recently sprung up. Having worked in the midwifery training programme, I was interested to see the midwives who had qualified post 2002 using the extended skills they had been taught such as

manual vacuum aspiration (MVA), manual removal of placentas and cervical suturing. A newly qualified midwife told me that they were not allowed to use these skills:

“What we studied at the Institute we cannot do in this hospital, they do not allow us to work according to our terms of reference. This is very difficult for us and makes us sad about our choice of midwifery... breech deliveries for example. A new midwife who enters delivery room is told not to touch the patient to avoid failure”.

(Midwife qualified 1 year)

This midwife explained that she was only allowed to assist women having their second or subsequent baby. She was not allowed to perform MVA or help women having their first babies or do an episiotomy, despite having been taught these skills during her training. The senior midwives told her that this was not her work:

“The old midwives tell us ‘*This is not a midwife’s job, this is doctors work*’ they say. ‘*Here what midwives do is only cleaning, arranging the ward and checking the BP (blood pressure) of patients*’”.

(Midwife qualified 1 year)

Senior midwives not only discouraged newly qualified midwives from using their extended skills, the midwife said, they undermined their confidence:

“For example, if I did curettage on a patient and am confident that I have left nothing inside, when I arrive the next day the old midwives will say ‘*What did you do with the patient? The ultrasound scan shows there are pieces left inside*’. Their intention is to stress me”.

(Midwife qualified 1 year)

This newly qualified midwife said she was confident in her skills but the assertion of the senior midwives that she had made a mistake made her

anxious and question her own abilities. An experienced midwife explained that because midwives were not able to use their skills they became demotivated and some wanted to leave.

“We would like to put everything we have studied into practice. Because this does not happen people lose interest and this is the reason some midwives want to leave this hospital”.

(Experienced midwife)

An unexpected finding emerged when several midwives discussed the challenges of their work. Rather than cite the workload, long hours or low salaries, bed making was the most frequently mentioned difficulty. These educated young women explained that they felt humiliated and ashamed at being expected to do this 'menial task', especially if one of their relatives saw them. They protested that this was not a job for educated women.

“Making beds is the most difficult, hardest job for a midwife. They can use some of the illiterate workers for this...all the time a midwife spends making beds she could spend caring for patients”.

(Midwife qualified 8 years)

I was initially inclined to disregard the comments about bed making but then realised this was not one isolated opinion but something that clearly distressed them. Their analysis of the situation was that midwifery had changed and advanced but that the system did not reflect that.

“In the past midwives used to make beds and clean because the skills that are taught now, were not taught to midwives then. At that time there was no episiotomy, MVA ... now midwifery is much more modern and complicated”.

(Midwife qualified 7 years)

The combined effect of not being allowed to use the skills that they had been trained to use and having to perform menial unskilled jobs resulted in some midwives leaving the profession. Other midwives for economic reasons had no option but to stay, although some admitted they had lost interest in their work.

## **6.4 Family obligations**

The collective nature of Afghan society means that decisions such as taking employment outside of the home or the choice of a career are usually more related to the needs of the family than the wishes or interests of the individual. Afghan women, who work outside the home, often do so because it suits the needs of their family. Even for female doctors and midwives, the fulfilment of family expectations is vital for maintaining their ongoing freedom, an interviewee explained:

“My Afghan friend is a doctor with a high position in a UN agency but she would lose that freedom if she didn’t bring home the salary. She’s an economic asset to her family but she said that if she suddenly couldn’t work she’d be a nobody; she would have nothing”.

(Non-Afghan midwife 6 years in Afghanistan)

### **6.4.1 Choice of a career**

Interviewees and findings from previous studies concur that medicine has always been the pinnacle of educational goals for Afghans, possibly because it combines prestige with more potential for income generation than other careers (Hunte 1980). Places at Kabul Medical University are oversubscribed every year and only the best students are awarded positions. One obstetrician explained that sons and daughters are sometimes forced into medicine by their families because of the status this will afford the whole family.

“Most students and especially families want to be the best, to get into medicine and be proud of it. Even some students who don’t like this subject are forced by their families to select medicine as their career”.

(Recently qualified obstetrician)

Doctors have to leave the hospitals when their residency programme is completed and they do not have guaranteed employment. This specialist qualification, however, enables them to open private clinics or to secure jobs in other hospitals.

There are a limited number of careers for women that are acceptable for Afghan families. A career in midwifery is attractive because training is free, and because midwives work in a female environment that Afghan families prefer for their daughters and wives. If they are able to find a job in a public health facility midwives have a secure income and job for life.

#### **6.4.2 The need to survive**

There was one other group of women in the hospital who, while not directly involved in clinical care, were indispensable to the running of the hospital. Most commonly they were referred to as ‘*khāla*’, literally meaning Aunty. I was told that these women were all widows who had no option but to work outside the home when their husbands died.

“I had to get this job when my husband was killed in the war”, one of the *khālas* who guarded the main door explained. “I have two children, I had to work, I had no choice or how could we eat?”

(Field notes day 3)

Some *khālas* came from important families, or had been the wives of famous people, a midwife explained; the loss of their husbands had resulted in a profound change in circumstances for them. These women cleaned the



corridors, bathrooms, labour room beds, transported women in wheelchairs from one area to another and ran errands for the doctors, midwives, relatives of women in labour and women in labour themselves. They guarded the door of the hospital trying to keep relatives out and transported heavy loads of equipment. The *khālas* had to work one night in every three nights (two nights at home and then a night duty). Midwives worked one night in every four and resident doctors worked one night in every seven.

The *khālas* complained about the poor treatment they received in the hospital, explaining that it was difficult to get time-off for family problems and that their health was suffering from the hard work. Most of my conversations with the *khālas* occurred in the corridor, as they paused for a few minutes and shared a thought or problem. Sometimes a few other *khālas* would see us chatting and join in, as in this section from my field notes:

*“A khāla I had chatted to on several occasions joined us as we stood in the corridor. ‘If I didn’t have any obligations do you think I would work here?’ she said. ‘How should I work in this bad situation? When we came here we were healthy but now everyone has problems, arthritis and we are not healthy’. She had worked in the hospital for 18 years she told us”.*

(Ongoing observation March 2012)

Many *khālas*, like this one, were very thin and did not look healthy. One explained that she was the only wage earner in her family and responsible for her elderly parents as well as her children. “If I had the ability I would never come back to this hospital but I have eight children” she said. Another explained, “Everything is hard but I have to do the hardest”. For these women work was about family survival.

### 6.4.3 Obligation to care for family members

Doctor and midwives were obliged to care for family members or important people with connections to their family who came into the hospital (Arnold et al. 2014). This obligation took precedence, even if the healthcare providers were looking after other women, or if they were officially off duty or sick. Occasionally a doctor or midwife would be seen with a relative in labour, offering them drinks, allowing them to rest against them during contractions, or sometimes sitting in the staff room waiting for their relative to progress in labour. The obligation to family not only covered immediate relatives but also their extended family also. On one occasion a midwife with a streaming cold sat in an office for hours during the evening waiting for a distant relative to have her baby. I asked if the midwife could refuse to look after her relative, as she was obviously unwell. “She can’t refuse”, my interpreter explained, “She has no choice”.

An anthropologist who had lived with Afghan families for extended periods of time explained that she found it hard to distinguish between “care that comes from the heart and obligation - fulfilling your role”. She concluded that care was linked to respect, which was connected to your position in the family hierarchy. “Status demands respect and respect demands care”.

An Afghan female doctor who was responsible for a reproductive health programme talked about the pressures that female healthcare providers experience.

“Some doctors and midwives are under pressure from their family and too much work, every day work, every day... Working in the hospital is very hard physical work, all the day they are running, they deal with different patients, with different family backgrounds, different behaviours, then when they get home the children expect them to be nice, they have to meet the expectations of their husbands, their children, their husband’s family, the guest - all these things out of the capacity of one person to manage”.

(Female doctor reproductive health programme)

Background interviewees suggested that economic necessity and social obligation were generally more influential in the choice of career than compassion or altruistic notions of care. Even at work healthcare providers remained accountable to family and family needs.

#### **6.4.4 Caring for strangers**

While the strength of family ties and obligations within Afghan society was unequivocal, there did not appear to be similar obligations to non-family members. Several interviewees explained the divide between family and non-family as in the following example:

“There is no obligation to those outside of your family. You must take care of your family, your clan, and your close relatives. Whoever is not your family is not really your problem”.

(Non-Afghan health professional 16 years Afghanistan)

The healthcare provider role requires that doctors, midwives and *khālas* care for non-family members, and some of them saw this as their service to God and to other women. A cultural expert and linguist clarified that there is a fundamental detachment from those who are non-family, that outsiders are perceived as ‘other’, as almost not human.

“Afghan poetry is loaded with the dignity of human beings, but this clashes with the obligation to be loyal to your clan, your family. The stranger is almost not human”.

(Non-Afghan cultural & Persian literature scholar)

Several non-Afghans who had worked in the healthcare system for decades confirmed the detachment and disinterest that they had witnessed between healthcare providers and patients who were not family members.

*“The attitude of staff is generally that ‘the patient who does not belong to me, is not a member of my family or clan is not interesting for me. If they give me money, yes, this is interesting, so I will help a bit’”.*

(Non-Afghan nurse manager 30 years Afghanistan)

The tenuous obligation to care for those who did not belong to your family implied that care depended on the decision of individual healthcare providers, or the power of the hospital management to enforce standards of care.

## **6.5 Management, authority and care**

Interviews with senior management figures in the hospital and in the Afghan MoPH produced many perspectives on management and authority rather than one clear overview. Healthcare providers added their opinions on management, authority and care in the hospital. This section presents different perspectives and their nuances.

### **6.5.1 Senior hospital management**

One senior figure was candid about the challenges of providing quality care in the hospital. The problem was not a shortage of staff, on the contrary, she asserted that there were too many doctors for the number of beds. The problem was rather a lack of well-qualified professional doctors. She also explained that the hospital management lacked authority over staff. While we were talking, a doctor came into the room and gave her a small piece of paper with several official stamps on it. After she had gone the senior doctor showed me the paper. In English were the words ‘viral hepatitis’. “This is not real, I know she doesn’t have viral hepatitis but what can I do?” the senior doctor stated. In the following quotation she explained that it was not only the doctors who flouted the authority of the hospital management:

“Six months ago the hospital management decided to fire a *khāla*, because she had persistently bad behaviour. The MoPH was informed. A month later the *khāla* came back with a letter from the MoPH rejecting the complaints of the hospital management. The hospital was ordered to reinstate the *khāla*. ‘So she is here, working. What can we do? We do not have any authority’”.

(Senior doctor hospital management)

When I questioned her to ensure that I had understood the story correctly, she confirmed that it was because of relationships that the *khāla* was reinstated.

“Relationship is very, very important, relationship is over the law. Who they are is everything, which family they are from: relationship is everything”.

(Senior doctor hospital management)

This *khāla*, the senior doctor implied, must have had powerful relatives who ensured that the MoPH issued a letter overturning the decision of the hospital management. The hospital management was responsible for standards of care in the hospital but it appeared that an uneducated woman with connections, or *wāsita* could have their decision overruled. Several interviewees recounted similar incidents and confirmed that the power of hospital management was limited. The MoPH appointed hospital staff and the hospital management could not fire anyone without the support of the MoPH. An ex-parliamentarian explained how difficult it was, even for the hospital senior management, to bring about change.

“There’s no power to really change the system, even the management can’t decide. There are lots of relationships, hidden relationships which influence”.

(Politician)

Not only were the hospital staff controlled by and answerable to the MoPH but also a centralised bureaucratic system meant that the hospital management

had no financial autonomy, even for small repairs or items of stationery. Lengthy administrative procedures were necessary, a senior doctor reported, often resulting in long delays for urgent repairs to items such as broken toilets. She said she was frustrated with her job and the lack of authority. “I am tired of my job... you think about my job” she concluded.

### **6.5.2 Afghan Ministry of Public Health**

The Ministry of Public Health held the ultimate responsibility for care. Staff employment, financial control and permission for operational changes within the hospital depended on letters and edicts from the MoPH. Senior managers at the MoPH wanted to give more autonomy to hospital management teams but, a head of department, commented that the hospitals currently could not manage.

“The MoPH wants to delegate hiring and firing, planning and procurement, however, at the moment the hospital management do not have the capacity”.

(Senior manager MoPH)

Senior MoPH staff related many challenges in care within Kabul hospitals but claimed that in some situations they did not have the power to intervene or enforce changes. Several health professionals and a community leader were critical of the MoPH, accusing its staff of weakness, a lack of monitoring of hospital directors and not caring. Most evenings when I was in the hospital there would be a sudden flurry of activity and tidying up accompanied by the announcement that, “the MoPH are coming”. Two or three men would come to the ward office, talk to the person in charge and then leave. They came to check if staff were all present someone explained. My interpreter noted the irony and asked “why do they send men to an all female hospital when plenty of women work in the MoPH”? The visit by male representatives of the MoPH may have fulfilled an administrative purpose but cultural propriety ensured they would not visit the clinical areas or talk with women who were having their babies in the hospital. They could not check or enforce standards of care.

Healthcare providers looked to the Ministry of Public Health to solve their problems but some accused them of not caring. Several midwives mentioned the need for the MoPH to design health education programmes, as many women understood very little about pregnancy, childbirth and warning signs of labour. They criticized previous MoPH health education initiatives however as being out of touch with ordinary people.

### **6.5.3 Healthcare providers and management**

Several doctors who were endeavouring to improve standards of care in the hospital complained that their requests for appreciation letters had been ignored. They wanted the hospital management to encourage staff members who were working well but no letters had been written. A resident doctor said that management need to be proactive, to check who was working, address problems and set an example.

“No one cares or checks or enforces, we have a weak leadership. Once in four years a senior manager came to check - she took away the kettles because the electricity bill was so big! But she is never checking the delivery rooms to see what’s wrong, what’s right”.

(Resident doctor)

Management fail to inspect the wards and when they finally came, the resident complained, they focused on secondary issues, ignoring important things like care in the delivery room. I suggested that the hospital management might not have the authority to improve standards of care. The resident was adamant that a lot could be achieved, even without money or power:

“But with a pen you can write an appreciation letter. If you punish one or two people then everyone will be afraid and it will get better day by day. If you reward and praise two people for their achievement, then everybody will be motivated”.

(Resident doctor)

It is difficult to present a clear overview of the management system because there is more than one system of control and authority operating within the hospital and the MoPH. First, there was the official hierarchy with roles and responsibilities; second, there was the unofficial system based on relationships. The official management structure gave titles and responsibility but endowed very limited power. The system that relied on connections gave varying degrees of power to individuals from *khālas* to doctors. The unofficial system based on *wāsita*, or nepotism and cronyism, appeared more effective than official hierarchy. Some senior figures who bore the official responsibility for standards of care within the Kabul hospitals claimed they lacked the power to enforce high standards. Healthcare providers claimed that management was weak, and did not care or enforce standards. A resident doctor laughed as she explained, “You understand, Afghans need force!” Several Afghans and non-Afghans also used the same phrase: “Afghans need force!”

## **6.6 Discussion**

### **6.6.1 The high workload**

Miller and colleagues (2003) concluded that overcrowding led not only to a degradation in the quality of care in facility childbirth in the Dominican Republic but also contributed to compassion fatigue amongst care givers. In their analysis of violence against women in healthcare institutions d’Oliveira et al. (2002, p.1683) found that heavy workload and long hours can “demoralise and traumatise staff” which may result in staff taking out their frustration on perinatal women. High workloads have been cited as a contributing factor to substandard care in many contexts (Center for Reproductive Rights and Federation of Women Lawyers Kenya 2007; Hassan-Bitar and Narrainen 2011). A report on paediatric services in Kabul during the Taliban regime (Sogan et al. 1998) illustrates the current pressure on Kabul maternity hospitals. The authors noted that one maternity hospital had an average of 20-30 births each day, seven to eight caesarean sections per week. During data collection, in 2010 and 2011, the study hospital had between 50 to 80 births and 14 to 18 caesarean sections per day. This increase in numbers places pressure not only on caring for this



number of women but also the physical space and bed occupancy. The story of the resident doctor (see 6.1) who checked 30 women in normal labour while a woman with severe pre-eclampsia was in the next ward unconscious, illustrates that people can be too busy to prioritise. A lack of communication also contributed to this maternal death, as no one had told the doctor that there was a severely ill woman in the next ward.

The high workload in this Kabul hospital and the absence of a shift system, which would have utilised staff more efficiently and given them more time at home, undoubtedly contributed to deficits in the quality of care. To describe the culture in this study hospital adequately, it was important to explain the stress and pressures on staff due to the workload and the staff requests for a shift system. In selecting themes, however, I decided not to explore workload as a main theme. My rationale was that first; this was an administrative, structural issue between the MoPH and the hospital. It was an issue that stakeholders were aware of and I was unlikely to be able to contribute anything new to the deliberations. Second, I considered that there were other less obvious issues within the hospital environment that warranted more in-depth investigation, such as the impact of wider Afghan culture and families on the behaviour of healthcare providers.

### **6.6.2 The influence of Afghan society**

Some studies of life and work within hospital environments have emphasised the separate nature of biomedical institutions. Goffman (1968), for example, studied the social situation of mental patients. He described the separation of patients from the outside world, with the loss of identity and curtailment of the self within the closed institution. Helman (2000), however, stated that medical systems do not exist in a cultural vacuum, rather, they are an expression of the values and social structure of the surrounding society. The findings of this study agree with the ideas of van der Geest and Finkler (2004) that the hospital is a domain where the core values and beliefs of a culture are revealed. Van der Geest and Finkler (2004, pp.1995-1996) argued that hospitals the world over

are “deceptively familiar” but that this familiarity belies the “underlying social and cultural processes that are being played out in hospital settings”. In his ethnography of an orthopaedic hospital ward, Zamin (2004) demonstrated how many features of Bangladeshi society were reflected through the actions and lives of the ‘actors’ within the ward. Hospitals, he argued, are not an isolated biomedical sub-culture but a microcosm of larger society. Jaffré (2012), examined socio-technical practices in four hospitals in West Africa to understand the quality of care and maternal mortality “from below”. “It is the same everywhere”, Jaffré (2012, pp.8-9), claimed, the behaviour of health personnel was always a “mix of technical norms with habits and local customs”: generally staff behaved the same inside hospitals as they did on the outside.

Interviewees in this study concurred that challenges in care were not simply issues of staff management, policies or systems of training, but that life and work within the hospital was affected by the outside world, by the values and norms of Afghan society. The predominant influence was the family.

### **6.6.3 The influence of family**

The most important institution in Afghan society is the family (Dupree 2002) and fulfilling family obligations is a core value (Hunte 1980; Eggerman and Panter-Brick 2010). For the healthcare providers in this Kabul hospital, the task of fulfilling family obligations alongside their professional responsibilities was exacting. Many studies examining the perspectives or motivation of healthcare providers in low or middle-income countries have not cited factors relating to the tensions between family and work responsibilities (Fort and Voltero 2004; Franco et al. 2004; Manongi et al. 2006). It is possible that these studies were exclusively focused on the work setting and did not invite the inclusion of social factors. With quantitative studies especially, unless there were questions regarding family and social factors, the issue of family obligations would not arise. Mumtaz and colleagues, (2003) however, explored the gender-based constraints that community-based female health workers experienced in Pakistan, a nation with many cultural similarities to Afghanistan. They noted the

interconnectedness or 'seamlessness' of home and work for these women and the conflicts they experienced between family obligations and employment (Mumtaz et al. 2003). A study examining the determinants of job motivation among physicians in Pakistan also identified the importance of personal and social time for female physicians (Malik et al. 2010). Jewkes and colleagues (1998) examined the reasons behind the abuse of patients in two South African midwifery units. They noted that most nurses had to "juggle the complex burden of work and home lives" (p.1783). Andersen (2004) examined the differential treatment of patients from the perspective of health workers in Ghana. He found that the local staff members received requests for help from relatives both near and distant and that the staff could not refuse. Wood et al. (2013) examined factors influencing the retention of midwives in Afghanistan. They noted the difficulties for working midwives of family responsibilities such as caring for children or other family members, and that some midwives, because of family problems, washed clothes and prepared food at work (Wood et al. 2013). For Afghan healthcare providers in this research the "seamlessness" (Mumtaz et al. 2003) of their lives not only included domestic chores at work but also caring for relatives, strengthening connections to important people, increasing family income through bribes, and helping family members acquire new clinical skills.

The lack of obligation to non-relatives did not mean that there was no care for those outside the family but that the needs of family, rather than the needs of strangers, took precedence. In examining resilience in adversity, Eggerman and Panter-Brick (2010) interviewed 1,011 Afghan school children and their caregivers. They concluded that cultural values such as 'service' to family and community were important in giving hope. Failure to serve family and fulfil obligations was a source of shame (Eggerman and Panter-Brick 2010). The fulfilment of family obligations was, for many healthcare providers, the reason they were working in this Kabul hospital. A study conducted in Turkey by Alparslan and Doganer (2009) found, however, that healthcare providers who did not choose their job were more likely to experience burnout and depersonalise those they cared for.

#### **6.6.4 Skills, reputation and family**

Partamin et al. (2012) assessed the knowledge and skills of 82 doctors and 142 midwives in 78 facilities in Afghanistan; levels of competency were found to be similar between the two groups in decision-making and technical skills.

Although doctors and midwives were good in maternal care they were weak in managing newborn resuscitation and high-risk emergencies. The authors stressed that urgent attention must be given to the gaps in knowledge and skills as these address the three major causes of maternal death: pre-eclampsia/eclampsia; postpartum haemorrhage; and maternal sepsis. The high percentage of healthcare providers lacking the clinical skills to manage life-threatening emergencies is disturbing. Many of the doctors in the study by Partamin and colleagues would have completed their residency in this study hospital. Although many Afghans are said to be ambivalent towards the system of doing favours for family and helping those with whom there is a family connection, these figures demonstrate the grave implications of allowing a social system with notions of favours and benefits to dominate clinical training.

Hassan-Bitar and Narrainen (2011) reported that the scope of practice for midwives in Palestine was severely limited by doctors and by the Palestinian Ministry of Health. A qualitative study of Iranian nurses' experiences of professional power highlighted the ambiguity between the nurses' knowledge and the limits imposed on them by the hospital "physician-centred culture" (Hagbaghery et al. 2004). The nurses realised that the hospital system "did not tolerate their power" and that if they showed initiative and exerted their power it caused conflict and tension. As a result, Hagbaghery and colleagues reported, nurses acquiesced to the domination of the doctors and lost confidence in their own abilities. Similar acquiescence could be seen in junior Afghan midwives who submitted to the power of senior midwives who intimidated and frightened them, and did not want them to use certain clinical skills. An evaluation of the Afghan midwifery education programme conducted between 2008 and 2010, revealed that midwives had limited opportunities to practice certain skills and had consequently forgotten many of the clinical skills they had learnt (Health Services Support Project and United States Agency for International

Development 2009; Zainullah et al. 2014). A recent assessment of Afghanistan's midwifery workforce (Jhpiego 2013) noted that there was a wealth of policies regarding midwifery; the issue was implementation. The authors highlighted the specific challenge of midwives being unable to fulfil their scope of practice, based on essential competencies of a midwife<sup>23</sup>, despite extensive efforts by the Afghan Midwives Association. The resistance to change in this hospital, not only by doctors but also by senior midwives, demonstrates the challenge of translating the aspirations of international agencies into practice. Turkmani et al. (2013) suggested that professional jealousy among doctors was one reason that prevented Afghan midwives from using their competencies. They proposed that midwives could work with more experienced colleagues to enable them to retain their clinical skills. This PhD study indicates, however, that it is precisely these more experienced colleagues, the senior midwives, and not just the doctors, who were prohibiting the newly graduated midwives from using their skills. There was no clear indication as to why the senior midwives were prohibiting midwives from using many of their clinical skills. During the last decade the skills of existing midwives had been upgraded and extended through training courses so it was unlikely that senior midwives lacked the new competencies. It was possible, however, that these older women were less confident in using new skills and did not want to be shamed by the confidence of newly qualified young midwives. Whether deliberate or not, insisting that midwives made beds kept the more junior midwives in a subservient position.

D'Oliveira and colleagues (2002) point out that in societies with a rigid social class it is difficult for healthcare professionals to perform menial tasks. In Afghanistan reputation is not an individual matter and is taken very seriously.

A "good name, honour and reputation are no laughing matter in Afghan society" according to Loewen (2010c, p.167), and "the quest to gain and maintain one's reputation and the fear of losing it are fundamental driving forces in traditional Afghan culture".

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<sup>23</sup> From the International Confederation of Midwives 2010.

Individuals in the public eye carry responsibility for their family's reputation. To be ridiculed, to "lose face" or to be spoken of badly, therefore, is to bring shame on the whole family (Loewen 2010c, p.169). So after years of education these midwives were being denied the honour of using the skills that they had learnt but required to do the task of unskilled/illiterate low-status workers. In Afghan society this would result in a 'loss of face', likely to demotivate these midwives. As an additional consequence, some families might withdraw permission for their daughters or wives to work outside the home. *The State of Midwifery in Afghanistan* (United Nations Population Fund 2014) highlighted the need to improve retention rates amongst midwives. This study found that the shame of having to perform menial tasks and the denial of permission to use their clinical competencies resulted in some midwives leaving the profession and others being demotivated.

#### **6.6.5 Knowledge - protecting personal and family interests**

Entezar (2007) claimed that expert power and knowledge do not carry much weight in Afghan society: that whom you know is what matters, not what you know. While knowledge might not give the same degree of power as having important connections, the findings of this study dispute the assertion that knowledge is of limited importance. Several background interviewees confirmed my experience - that teachers are held in high regard in Afghan society. The reluctance of the resident doctor trainers to share knowledge and skills and the control of who was permitted to teach or use their skills in the hospital all point to knowledge as power. Knowledge in the hands of those in 'lower positions' seemed to be regarded as a danger to be controlled. Knowledge did not appear to be valued for its potential to improve the quality of care for perinatal women and their babies but was treated by some as an asset to be guarded and used for individual benefit. The most frequent complaint from resident doctors was about poor clinical skills training and the lack of support.

I asked a cultural and linguistic scholar, if he could explain this phenomenon. He explained that some ancient traditional stories and sayings expound the wisdom of keeping some knowledge to oneself

“There is a Persian legend about a young wrestler who was becoming a champion wrestler. One day the young wrestler challenged his wrestling coach to a match: he was much bigger and stronger than his coach. The two men wrestled but eventually his coach threw him down. The young student got up and declared: *‘It is not because of his superior strength that he won but because he taught me 355 wrestling techniques: but kept one for himself’*”.

(Non-Afghan cultural & Persian literature scholar)

It was a custom for a master to keep one wrestling technique to himself in order to ensure that he always remained the champion the interviewee explained. In addition, a famous Persian poet, Sa‘dī Shīrāzī (Loewen 2008) cautioned:

“Never empower a friend so much that if he becomes your enemy, he is able to defeat you”

The interviewee suggested that hospital trainers could be deliberately keeping skills to themselves to maintain their status and superiority. A non-Afghan surgeon (Foster 2009) was told the worst problem in Afghanistan was that “doctors never entrusted their knowledge to others” but said the young doctors were “stealing their skills”.

Afghan society, the interviewee also suggested, may have underlying beliefs in keeping with ‘the Image of Limited Good’. George Foster (1965) based his theory on studies of traditional societies and on his fieldwork in Tzintzuntzan, Mexico. Foster suggested that people in these societies view their social, economic and natural universes, such as land, wealth, friendship, honour, respect, status and power, as existing in finite quantities. Furthermore, it is not possible to increase the available quantities of these ‘good’ things so they have

to be divided. Following this argument he suggested that “an individual or family can improve their position only at the expense of others,” therefore an improvement in someone’s position is viewed as a threat by all others (Foster 1965, p.297). Although Afghanistan cannot be described as a peasant society or a closed society as Foster described the Tzintzuntan, many of his observations such as the personal threat if someone else’s position is improved and the subsequent lack of generosity towards others in sharing ‘good things’ such as skills or knowledge could be useful explanatory tools. There were many critics of Foster’s theory (Kaplan and Benson 1966; Kennedy 1966) who highlighted the inadequacies of his use of ‘peasants’ as a refined social type, the assumptions and the lack of methodological explanation and clarity in his theory development. They also suggest that many of the phenomena can be explained in simpler ways, such as a history of being deprived by others of land or property. Of particular interest is Foster’s concern with the implication of this orientation and behaviour with regard to the economic growth of the country.

Whatever the reasons behind the senior hospital staff not sharing their clinical knowledge and skills, and the midwives not being allowed to use their competencies, there were serious implications for the quality of care. Doctors who lacked vital clinical skills placed perinatal women and their babies at high risk of clinical errors, while women were also deprived of the skilled care that the midwives could have provided.

#### **6.6.6 Strengthening family connections or *wāsita***

The importance of having connections or *wāsita* is prevalent within Afghan politics, institutions and society (Dupree 1997; Entezar 2007; Eggerman and Panter-Brick 2010); it was prevalent within the hospital also. Having the right connections was more important than ability or motivation in securing jobs and receiving support and training. There were official training policies and recruitment procedures, however, helping, supporting and promoting family members, or people who were connected to your family, took precedence.



Interviewees concurred that senior management could not enforce standards of care with staff members who were connected to powerful families.

To Westerners *wāsita* can appear to be a type of nepotism or cronyism but according to historian and West/Central Asia consultant, doctor Jonathan Lee (personal communication, 10 April 2015), it is an acceptable cultural value in Afghanistan. Families actively seek to embed *wāsitas* in the state system to gain benefits and ensure the smooth passage of official papers through the bureaucracy. Afghans, he explained, tend to be ambivalent about the *wāsita* system, those who have *wāsita* tend to be less critical of the system than those who do not, since they are essentially locked out of this form of patronage.

The *wāsita* system is part of the wider culture of client-patron system, a system that was widespread in ancient civilisations such as Rome and in medieval societies (Loewen 2010a). In the client-patron system, a background interviewee explained, individuals of higher rank provide goods and services to a client further down the social order who then becomes obliged to the patron, morally, socially and sometimes financially. The relationship between the feudal lords and their vassals in medieval Britain was a client-patron relationship where the lord provided for those under his jurisdiction but in return expected homage, allegiance and service. Not only the poor, Loewen explains, but those with lesser power and wealth than others need someone superior who can provide them with power, privilege and provisions. Similarly, the patron or benefactor seeks protégés whom he can shower with benefits in order to receive loyalty, support and service. Loewen (2010a, p.177) explains that the client-patron relationship is one of reciprocity or mutual exchange, and tremendous obligations on both sides. The client-patron system continues to define much of Afghan society (Sharan 2011).

The importance of connections is not unique to Afghanistan but ubiquitous in many societies. Anderson (2004) found that differential treatment at the Ghanaian hospital was closely connected to social status and having the right

connections. According to Jaffré (2012), globally, entry into services is made through 'acquaintances', the use of family or friends networks. Female healthcare providers in Pakistan who had important family connections demonstrated greater confidence and received more respect from the communities than their counterparts (Mumtaz et al. 2003). In Western societies 'who you know' can also be of importance as the prevalence of 'old boy networks' essential for employment in certain institutions.

When Afghan healthcare providers did a favour for a relative or those with whom their family had a connection (such as securing a job, teaching a new skill or caring for someone in labour), this strengthened the obligation. These networks of obligations were the way to advancement. In the absence of a strong government and state benefits this system offers some security for the future.

#### **6.6.7 The influence of management**

The role and authority of management in this hospital was unclear and disputed. The hospital managers blamed the Ministry of Public Health for not giving them the authority or undermining their authority by supporting staff such as the *khāla* over them. Furthermore the hospital managers blamed staff for being dishonest and not working professionally. The MoPH claimed that hospital management lacked capacity and therefore could not be given more power. Healthcare providers blamed both the MoPH and hospital management for not enforcing standards or encouraging staff who were working well, for not checking and not caring. It is not possible to discuss administrative hospital management issues within this study. The issue of authority and power, however, will be discussed further in the following two chapters.

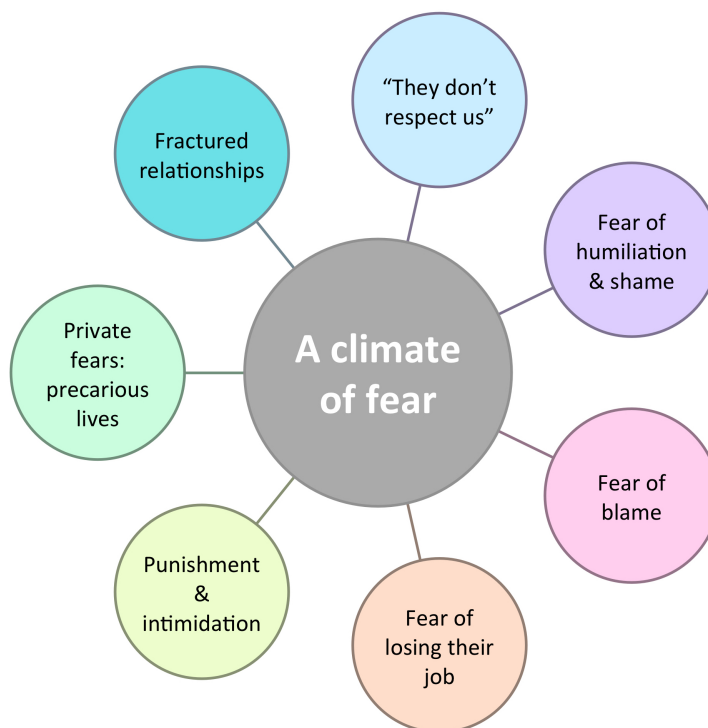
#### **6.6.8 Summary**

Healthcare providers struggled to manage the large number of women, including critically ill women, who gave birth in the hospital. Resident doctors

were responsible for women with complications but their trainers were reluctant to train and share their skills unless they were related or connected to a resident. The resident doctors were, therefore, not wholly competent and had to teach themselves by trial and error on labouring women. The midwives were discouraged as they were prevented from using their extended skills but obliged to do 'shameful' menial tasks like bed making. Family expectations and obligations put additional pressures on the doctors, midwives and *khālas*. The social system of *wāsita* resulted in unequal opportunity and put childbearing women at increased risk of complications. The façade of the hospital was familiar – it looked like a hospital anywhere. Beneath the surface, however, other systems had a profound influence in the behaviour of staff, the values of family, tribe, honour and loyalty - the traditional ways of surviving. In the next chapter I will explore the underlying fears and hostilities that dominated this hospital culture and the behaviour of the doctors, midwives and *khālas*.

## Chapter 7 - A climate of fear

In order to understand the culture of this hospital it was necessary to look beyond workload, systems and clinical care to understand how doctors, midwives and *khālas* experienced work and life within this institution. In this final chapter I explore the climate of fear, its sources and its impact on the working environment. I commence, however, with the unrealised hopes these women held, their longing to be respected and valued.



**Figure 5: Chapter 7 Overview**

### 7.1 “They don't respect us”

One of my first surprises was the number of staff members who talked about wanting to be appreciated. Several midwives described working conditions in the hospital through years of conflict. “They were terrible times”, one midwife said. Sometimes it was too dangerous to leave the hospital; sometimes they had walked long distances across the city to get to work. They had managed

without food, basic medical supplies, or electricity in the hospital and had burnt paper to provide light for births. They went for months without a salary. A midwife commented: “No one understood what we did or appreciated us”. Many staff members spoke of wanting to receive an appreciation letter, for example:

“We have this pain in our hearts. They never give us letters of appreciation, but they give us letters of complaints! ...I want the hospital director to encourage midwives by giving them appreciation letters rather than warning letters”.

(Midwife)

The type of language used, “this pain in our hearts”, indicated that this was more than a wish, but a deep need to be praised, recognised and appreciated. Healthcare providers spoke of being demotivated “when staff who work well are treated the same as staff who don't”. Warning letters were given if the hospital management were unhappy about the behaviour of a staff member, and, according to participants, three warning letters resulted in dismissal. Several midwives stated that when they first arrived in the hospital they were keen to work and help perinatal women but that now they had become discouraged and had lost their enthusiasm. One of the few nurses stated that most midwives in the hospital were not happy. When asked the reason for this she explained: “Because of the bad behaviour from the senior midwives, they don't respect us”.

Respect and appreciation were topics that staff talked about more than salary. An interviewee explained that the lack of respect was not only an issue for women at work, but also at home:

“Generally men in Afghanistan don't value women. This affects how the midwife behaves with others because she doesn't receive respect in her own family, especially from her husband”.

(Female doctor reproductive health programme)

Staff members also said that they were not valued:

“No one values us here because we are cleaners, but if I don't clean this hospital, who will?”

(A *khāla* group discussion 2)

I noted that although this *khāla* did not feel valued, she understood that she made a valuable contribution to the running of the hospital. There were other factors that contributed to staff feeling undervalued. Resident doctors and midwives explained that they had no voice in the hospital, that no one was interested in their ideas. “No one listens to our ideas – so we are silent because of that”, a junior midwife had complained.

A second-year resident doctor explained that when there was a complication with a woman, even if they were not in the wrong, the residents could not defend themselves to their trainer: “We put our hands over our mouths; we can't say anything because they are our trainers”. Teachers are highly regarded in Afghan culture (Foster 2009). Social respect and deference prevented residents from questioning, challenging or disagreeing with their teachers.

The lack of value and respect were also felt in the absence of basic commodities for staff.

“We don't have a room to change our clothes, nowhere to eat, no soap to wash our hands... And we haven't had any extra clothes for five years. Our lives here are not like human beings.”

(*Khālas* group discussion 1)

The *khālas* were employed to care for others, but did not feel that their needs were considered. They were responsible for keeping the hospital clean to prevent the spread of infection to perinatal women and their newborn babies, but were not provided with soap to protect themselves. There were several

examples of an absence of care for staff who fell ill. One midwife spoke of a sick member of staff who was not being supported; the implication was that she thought that there should be some help.

A doctor in the community explained that staff in the hospital suffered from a lack of time off and holidays. The *khāla* in particular complained that they were not allowed much time off. “If you are in a coma, (you can have time off – implied) but otherwise no holiday”. Others could not afford to take time off as they then lost their night duty pay and extra food allowance.

Many of the doctors and midwives spoke of their wish to study and their frustration that there was no support to do this. The resident doctors explained that they were not provided with the time or the materials to study. Midwives complained that they were criticised if they were found studying a book during work time. Several midwives wanted to study for a BSc in midwifery, to learn English or computer skills, but said they were not helped or encouraged. Their only value to the hospital one midwife felt was as workers - “All that is available (for staff) in this hospital is continuous working”. *Khālas* and resident doctors also spoke of wanting to be valued, respected and treated with kindness.

## **7.2 Fear of humiliation and shame**

Several midwives and resident doctors described the ordeal of the morning report where night duty staff handover to day staff. Midwives finishing night duty from each area of the hospital reported to the midwifery managers. The doctors who had worked all night reported to the resident doctors, trainers and senior obstetricians. The most senior doctors sat in the front rows of the room and would often cross-examine the doctors giving the report. Sometimes a senior doctor would give words of advice to all the doctors, at other times there were prolonged, animated discussions. The example below illustrates how hard it was for a first-year resident doctor to give her report, her fear of criticism and her discouragement over the lack of encouragement.

“You work hard all night and try to do a good job, but then you have to go to the morning report and your heart is beating fast; sometimes the trainers will criticise you for a small point. You try hard to do things right, but no one praises you or says ‘*Well done.*’ When you make one small mistake you are criticised. Everybody makes mistakes...I have never experienced this before”.

(1<sup>st</sup> year resident doctor)

The midwives had their morning report in the office of the head nurse; the format was similar to the doctor’s report. Midwives also faced the risk of humiliation during the report:

“...after our night duties, the next morning we are insulted by management. ‘*Why didn’t you do this, or do that?*’ They yell at us. They make trouble for us, but nobody hears our voice. At night we go without sleep but in the morning they don’t encourage us – they discourage us”.

(Midwife several years in this hospital)

For Afghans, any setting outside of their home and kinship group is considered public (Moghadam 2002). Being reprimanded in front of colleagues equates to public humiliation that would shame not only the individual doctor or midwife, but also their family; therefore, it is something that staff tried to avoid at all costs.

### **7.3 Fear of blame**

From my first day of observation in the admission area I was puzzled by the way that work was divided between doctors and midwives.

“The doctors were busy and stressed managing the women while the midwives were in the staff room sitting, drinking tea, and chatting. One midwife was washing children’s clothes in a big bucket on the floor then hanging them on the radiator and hot pipes. The doctors were doing the majority of the work, writing the notes and prescriptions, examining



women. The midwives appeared to do what the doctors asked them to do such as taking blood pressures, inserting intravenous cannulas, and taking blood. This was very strange, I noted; I am used to midwives working independently, only calling a doctor when they need them”.

(Field notes day 3)

Some weeks later, during an interview with a resident doctor I asked about my observations. She explained that some months previously a woman had been admitted to the admission area in advanced labour. A midwife examined her, found that she was ready to have her baby and transferred her to the delivery room where both mother and baby died. The woman had a heart condition, but no one knew as the woman’s notes had not been filled in and no doctor had seen her. The midwives were therefore criticised for her death. Because of this the midwives said, “We won't do anything”. From the brief outline of the incident it appeared unlikely that the death of this woman and her baby could have been prevented, though the midwives had been blamed. The result of this was that the midwives refused to do anything but carry out the doctor’s instructions.

According to several of the participants the propensity to apportion blame extended to the hospital management. It was unfair, they explained, that the hospital management accepted the version of events they were given by relatives or other staff and issued warning letters without giving healthcare providers the chance to explain what had happened.

If a midwife makes a mistake the hospital directorate immediately sends a warning letter. Instead of sending warning letters they can invite the midwife to the office, talk to her and advise her not to commit that mistake again...When a patient complains they do not ask us *‘is this complaint true and did you commit this mistake?’*

(Midwife several years working in a nearby country.)

In another incident, I found a baby in the postnatal wards who had aspirated and needed resuscitation. Such incidents requiring prompt, appropriate management are not unusual on postnatal wards. What struck me as unusual, however, was the reaction of the staff in the neonatal nursery. It seemed that they needed to decide whose fault it was:

“I rushed to the nursery with a deeply cyanosed motionless baby from the postnatal ward who had not responded to stimulation. The nursery midwife suctioned his mouth and nose, then aspirated his stomach and gave oxygen. By the time he started to recover a few other midwives and a doctor had gathered. ‘*He aspirated, it’s the mother’s fault!*’ they all pronounced”.

(Field notes day 14)

Staff were not only blamed by their colleagues and by the hospital management. Several midwives explained that perinatal women and their relatives also complained about them, accusing them of poor care.

“When women come to hospital they want one midwife to care for each labouring woman. It is not possible here. If we are busy with a woman with complications the other women become angry and say ‘*There is no care in this hospital!*’”

(Midwife 7 years experience)

I asked a doctor about the apparent need to apportion blame. She explained that everyone makes mistakes and that staff quickly learn to blame their colleagues as a way of protecting themselves.

“Mistakes happen, and from the beginning doctors learn to defend themselves: one way is to blame others. Sometimes, to save themselves, senior doctors will blame junior doctors”.

(Specialist doctor)

While public humiliation brings shame on one's family, accusations of poor care or of making a clinical mistake have even more serious implications. A participant explained that there was an internal investigating committee in the hospital, and small errors resulted in warning letters, notes in professional records, reductions in salary, or other punishments. If, however, the family of a perinatal woman involved in a case made a claim, then the doctor or nurse had to face the judicial system. The doctor or midwife was then likely to have to make a large payment to avoid prison. One doctor explained how frightened the doctors were of making a clinical mistake and its consequences:

“There is a big issue and a lot of fear about it at the moment. Because of this, some doctors have left, or are talking of leaving, as they are so anxious and stressed about it. Apparently last year there was a big case and two senior doctors were involved; I think a patient had died. It was only because they had relatives or contacts that they were able to get off, but now everyone is very anxious about it”.

(1<sup>st</sup> year resident doctor)

During my second field visit I found out that a court case was in progress involving hospital staff. An instrument had been left inside a woman following surgery; she had survived, but her family had made a claim. Two senior doctors and the scrub nurse, a midwife, were on trial. On my last day in the hospital the staff appeared to be in turmoil. I learnt that the court decision was expected that afternoon and strike action was being planned.

*“Everybody is very upset about this and people are crying”, a resident doctor explained – ‘If the judgement goes against them it has been decided that all the doctors will take off their white coats and strike in protest. They will accept and treat patients with ruptured uterus, but nobody else - they will close the hospital’. A group of doctors were seriously talking together in the resident doctors’ room. Every now and again another resident rushed in with the latest information. ‘They want money’ one of the residents explained – ‘USD 8,000 from each of them’.*<sup>24</sup>

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<sup>24</sup> Monthly salary of a midwife including night duty payments was the equivalent of USD 150, a senior doctor approximately USD 200

One of the trainers came in the door and made an announcement, telling the resident doctors to come and sign the protest form. A group of resident doctors gathered around her, some followed her out of the room. *'We are stressed every duty – if our patient will get a complication and we will be sent to the judge,'* one of the doctors said. *'Yes'* said another, *'today it happened to them: tomorrow it may happen to us'*. We talk about insurance, *'no they don't have insurance here they say'*".

(Field notes April 2012)

#### 7.4 Fear of losing their job

Finding a job in a public hospital, I was told, was not easy; therefore jobs were highly sought after. Whole families, sometimes extended families, depended for survival on the salary of one person. The loss of a job, with the low likelihood of finding another, could have devastating consequences. *Khālas* commented that the fear of losing their jobs kept them from talking about their problems even when they were asked.

“‘Sometimes people come from the Ministry’, one of the *khālas* said ‘they ask us about our problems but we are afraid to tell them. I have eight children and I am a widow – I have no other income. I pay AFN 5,000 for my rent and now my landlord says ‘bring me AFN 7,000<sup>25</sup>’.

RA: ‘What would happen if all of you (the *khālas*) went to the Ministry of Health and told them your problems?’

*Khāla*: ‘We are all afraid’, she said, ‘because we are all widows. We are frightened that they will throw us out. If we lose our jobs what will happen to us?’”

(Field notes April 2012)

If staff complained about their treatment or working conditions, I was told that they were given two options, to endure it, or find another job. There is a shortage of midwives nationally but it has not been easy to deploy midwives from Kabul to the rural areas (Zainullah et al. 2014). In recent years several

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<sup>25</sup> Approximately USD 140 at time of study; comparable to a *khāla*'s monthly salary

private midwifery-training institutes have opened in Kabul<sup>26</sup> adding to the numbers of midwives in the city. A senior management doctor also explained that there were currently too many doctors in the hospital. The healthcare providers, therefore, knew they could be easily replaced.

*“The management of the hospital says that ‘this is (like) a military hospital, if you have the ability, stay, if you cannot tolerate it, then leave. There are many jobless midwives and doctors in Afghanistan, I can fill your place’”.*

(Midwife qualified 3 years)

Several staff used almost identical words when they recounted what the hospital management had said to them. The analogy of the hospital being like a military hospital was frequently used. One resident doctor took it further explaining that they had to obey orders even against their own judgement:

*“‘We are like soldiers’ one of the residents said ‘and we are counting the hours until it is over’. Several other residents nodded and indicated they agreed with the statement. Her eyes looked full of tears...she seemed very troubled. ‘Why do you say you are like soldiers?’ I enquired. ‘We are like soldiers ready at any time...you have to, you have to agree, even if they say the milk is black you say, yes sir!’”*

(Informal conversation data collection 2)

An Afghan midwife involved in training students explained, “everyone is interested in keeping their jobs and keeping out of trouble”. ‘Keeping out of trouble’ required acquiescence to those in power.

Each group of healthcare providers talked of things they were frightened of: humiliation in the morning report; a woman in their care developing a serious complication and a subsequent court case; or losing their job. In addition, I

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<sup>26</sup> There were privately trained midwives in the hospital

realised from staff interviews that fear did not happen by chance but was reinforced by intimidation and punishment as explained in the following section.

## **7.5 Punishment and intimidation**

If the management was unhappy with a midwife's behaviour, an interviewee told me, the midwife was sometimes sent to work in the hospital laundry as a punishment. A midwife with over 30 years of experience in the hospital explained that this also happened in the past. One midwife complained that she had recently been sent to the laundry, following a very serious illness and at her own doctor's advice, she had asked the management if her hours could be reduced.

“During this time I was sent to the laundry to supervise the work there. I am a midwife, I did not train for three years to work in the laundry, they sent me there as a punishment”.

(Midwife)

The punishment had its desired effect. The midwife had rescinded her request to reduce her hours, despite the dangers to her health. “Now I am working normal hours”, she explained. The midwife gave me the names of several others who had also spent time in the laundry. A further midwife involved in training explained that punishment was used to maintain the status quo:

“New midwives want to change but when faced with the senior midwives they can't do it. If they start to treat patients nicely and not shout they get a lot of abuse from the older midwives. If they don't behave in the accepted way they face a hard time and can be sent to the laundry”.

(Afghan midwife from midwifery training programme)

So it was difficult for junior midwives to stand against the established culture and if they did they were punished. A newly graduated midwife confirmed that the younger midwives were frightened of the older midwives:

*“The old midwives frighten us and tell us ‘If you do something wrong on a patient we will report you to the authorities and they will punish you’”.*

(Midwife qualified 1 year)

Another midwife explained that the younger midwives picked up the habits of the older midwives very quickly. “Everything the senior midwives do the junior ones would like to do also”. It is not clear from her comment if midwives wanted to imitate the behaviour of older midwives out of fear, or because this would give them benefits.

It was not only junior midwives who were intimidated by the senior midwives. An experienced midwife who had recently moved to the hospital recounted the aggression she had encountered on her second day:

*“In the morning, when I had just come, one of the senior midwives was very cross and angry. She started shouting at me – ‘Why haven’t you cleaned the rooms? Why is your ward so dirty, why is it so unclean?’ The new midwife said ‘Qurbān Sāhib’<sup>27</sup> I only arrived yesterday, they have just introduced me – let me start my work, now I start my job, my duties!”*

(Midwife new to hospital)

Despite this being her second day the midwife was blamed for the condition of the ward she had been assigned to. She talked of having “a pain in her heart” at being given such a ‘welcome’. This midwife thought that the senior midwives were unhappy with her employment in the hospital. It was, I concluded,

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<sup>27</sup> *Qurbān Sāhib* - an honorific title used by inferiors to superiors, which implies they are prepared to perform any service their superior requires.

unreasonable to criticise and humiliate a new employee on her first working morning. The most obvious explanation was that the senior midwife was trying to establish her authority by intimidation. Other forms of punishment included marking staff absent for 10 days, resulting in a subsequent reduction in salary:

*“As I was talking to the khāla there was loud banging on the entrance door. Eventually she opened the door, there was a brief exchange of words and the door was slammed firmly shut. I asked about her role guarding the door and controlling entry to the hospital. ‘If we allow patients’ relatives through the door’, the khāla explained, ‘the controller will mark us absent for 10 days. She will write our names on a black list; if it happens again we will get a warning letter’”.*

(Field notes March 2012)

I then understood why the *khālas* were so fierce and unkind with relatives and so determined to keep them outside: their salary and job depended on it. If they received three warning letters they would be dismissed. A resident doctor explained that if they missed a night duty and could not find someone to replace them, they were marked absent for 10 days and their bad behaviour was noted in their records. This was particularly hard for staff when their children were sick at home. The pressure to conform and to comply was strong, especially as it was enforced by the threat of punishment.

Several resident doctors told me that older midwives had threatened them. The threats occurred if a doctor complained about the behaviour or practice of the midwives. In the following example, a doctor explained that midwives belittled the doctor’s status and experience and threatened to get her into trouble:

*“...The midwife will say to the resident doctor; ‘don’t be proud saying, I am a doctor. You have been a doctor just two years. I am a midwife, I have spent 30 years here: you must be quiet. If you say something, I will make a report about you and take it to the management’”.*

(A doctor)



When I asked what “make a report” meant, the doctor explained that the midwives would claim that the doctor had made a serious mistake resulting in, for example, a stillbirth and report the doctor. The doctor would then be silent, I was told, “because she was afraid of these midwives”. Doctors across the globe are usually the dominant health profession in maternity care provision; in this hospital, however, they were threatened or controlled to some extent by certain midwives who would generally be lower down the hierarchy.

On reflection, I realised that I had my own experience of intimidation. When I commenced observation I was told that during the evenings, nights and weekends a senior midwife or ‘controller’ was responsible for the hospital and when I arrived I must report to her. On my first weekend in the hospital I forgot to report to the controller. It was mid afternoon when my interpreter and I met the controller in the corridor. When she realised we had been in the hospital since the morning without her knowledge the controller became very angry. I knew this midwife from the past and immediately apologised for my mistake. She continued to berate my interpreter, however, and remained hostile and angry. She refused to be friendly.

## **7.6 Private fears: precarious lives**

As these doctors, midwives and *khālas* talked of their lives and work within the hospital, I understood that these women faced another set of fears; a change in their personal circumstances over which they had little or no control. I would estimate that most midwives and doctors were aged between 20 and 35 years. As an Afghan doctor and interviewee pointed out, most of them were “born in a war situation” and grew up through the traumas, fear and unpredictability of conflict. A trauma counsellor explained, “There was no family that did not lose someone”. The *khālas*, for example, were all women who had faced a sudden change in circumstances when their husbands had died or been injured. They had gone from living at home and being provided for, to undertaking menial work outside of the home in order to survive. Dupree (2004) pointed out that when women lost their husbands they lost status and at times had to live as

appendages or virtual servants in the households of extended families. In addition, worries about housing were mentioned by several staff. Those who rented their home had no protection against landlords who could suddenly increase rents or demand the property back. A *khāla* complained that her landlord was demanding more rent but she did not know how she could find the extra money. A midwife explained that her landlord had recently demanded that they vacate their home. She had not been able to find another despite several weeks of searching.

### **7.6.1 Fear of moving to conservative areas**

Several resident doctors said that their husbands wanted to return to their home provinces to live, to areas that were more conservative than Kabul. Women in Kabul can have more freedom if their family allows. In some conservative provinces women are rarely seen outside of their home and the scope of women's freedom is controlled by the community as well the family. There may be strong opposition to women working outside the home from some sectors of society (Moghadam 2002; Dupree 2004). One resident doctor admitted that the residency programme had been a good excuse to remain in Kabul. Another said she was frightened of working as a female doctor in a Taliban-controlled area. Although they were educated women, each said that their husband would decide: they would have to accept.

“My husband comes from a conservative province; he wants to go back there. I am afraid, I don't want to leave Kabul and go back to a place where there will be even more restrictions on me as a woman, but I know I will have no say in this”.

(4<sup>th</sup> year resident doctor)

### **7.6.2 Fear of childlessness or the absence of sons**

Several healthcare providers had been unable to have children. One midwife had been sent back to her family because she had not “given her husband any children”. She was desperately trying to find an organisation that would fund

infertility treatment and frequently stopped me to ask if I could help her secure funding.

Fertility, according to anthropologist Dupree (2004), was always the measure of an Afghan woman's prestige. Childlessness is a disaster she explains, a social stigma where, as in other societies, it is the woman who is blamed. A woman's position and security within her husband's family depends on her bearing children, especially sons. If a woman does not bear a son her husband may marry a second wife: shaming and humiliating the first wife.

I do not suggest that childlessness affected the work of staff but I use it to illustrate the many issues that have profound effect on the lives of healthcare providers, issues over which they are powerless to control.

### **7.6.3 Fear of violence**

Many interviewees mentioned the prevalence of violence throughout the recent conflicts and also in Afghan homes and society. Healthcare providers were not immune to this violence:

“One of the (female) directors of a Kabul hospital was recently dragged out of a taxi and beaten up, and this has happened to a lot of women”.

(Non-Afghan academic, 15 years Afghanistan)

No explanation was given as to why the director of the hospital and other women had been attacked. The most likely reason was that conservative Afghan men would be opposed to women traveling alone without a male chaperone or *mahram*: they would consider them to be immoral women (Samar et al. 2014). A female doctor explained that many healthcare providers also experience violence at home.

“My colleagues, some of them, no, the majority of them are living with violence at home. Yes the majority. Women in our society, really they are poor, they work like slaves for the men and for the family members of their husbands”.

(Female doctor, reproductive health programme)

Although none of the doctors, midwives or *khālas* admitted that they suffered violence at home, several told me of colleagues with violent husbands. An anthropologist, who had lived in an extended Afghan family for six months, confirmed that violence was regarded as normal.

“Quite some violence, physical violence is considered perfectly normal. It’s not an issue the violence, the not caring, sometimes the cruelty that is happening within families”.

(Anthropologist, several years experience in Afghanistan)

The anthropologist explained that it was not only husbands, but also brothers, uncles, mothers-in-law and sisters-in-law, who could be violent. Traditionally, when women marry they go to live with their husband and his family where they are under the authority of their husband and especially their mother-in-law. Large extended families of several generations commonly live under the same roof (Dupree 2004). Many women live together, the wives of several brothers, and sometimes several wives who belong to the same husband.

“Even in families women have rivalries and jealousy. They do not share fears and deep problems but have to lie and pretend in order to survive. I see a lot of fighting and competition for who is higher in the hierarchy of daughters-in-law”.

(Non-Afghan woman, 3 years with development NGO working with families and communities.)

Violence against children at home is also widespread (Smith 2008). A female doctor working to improve standards of maternity care explained that the childhood home environment affected healthcare providers' behaviour at work:

“If people have good memories from their families, if they had soft hearts, then they will be like them...but some of the staff, they experienced hard times in their life and no one took care of them, so they will work in that manner in the hospital”.

(Female doctor working with NGO)

I did not ask healthcare providers about violence at home but on occasion asked whether some staff have problems in their families that make it hard for them to care. Doctors and midwives were adamant that problems at home must not affect their work. Some did not answer the question, but several, like this midwife, confirmed that problems at home were usual:

“In Afghan families there are many problems, it's normal; problems with husbands, mothers-in-law, sisters-in-law... Afghan men are Afghan men, and we cannot change their behaviour”.

(Midwife 7 years in hospital)

While violence appeared to be accepted with resignation and no expectation of change, it made sense of the high priority placed on fulfilling family obligations.

During my data collection one educated Afghan woman shared her story with me. After her father died she had been forced into marriage, as her mother's new husband did not like her. She was married to a volatile and violent husband who frequently attacked her. He threatened to kill her during the course of this study. She lived in fear of provoking his anger if she was late home or if she received a 'nuisance phone call' and he imagined it was an admirer. If she ran away, he threatened that he would find her and kill both her and their children. And so she managed for the sake of her children: she could not see a way out.

Nothing in my conversations with Afghans or non-Afghans indicated that her story was unusual in this context.

## 7.7 Fractured relationships

During observation I experienced an uncomfortable encounter with an Afghan friend who pretended she did not know me:

“On my first day in the delivery area I unexpectedly met an ex-colleague who was now a resident doctor. I was delighted to see her and started exchanging the normal Afghan greetings. I was about to tease her and introduce her to my interpreter when I stopped. This was a cold awkward encounter and in a split second I sensed she was uncomfortable, that perhaps she did not want other staff to know that we knew each other. She was a longstanding Afghan friend. I was confused and could not understand her reaction. For the remainder of the day she avoided eye contact and totally ignored me”.

(Field notes day 11)

Previously I had worked with this friend in another hospital. We had been a good team then and I wondered what had changed, why she apparently did not want her colleagues to know we were friends. All I could surmise was that she did not feel as secure in this environment as in our former workplace, but I had no opportunity to ask her.

During an interview, whilst talking about care in the hospital, a midwife unexpectedly started talking about relationships between the staff. Her assessment was that relationships were not good.

“Behaviour is very bad here, not good, not good (*the midwife spoke quietly when my interpreter was out of the room*) – not good with patients, staff with staff, midwife with midwife, doctor with midwife, doctor with doctor”.

(Midwife – new to hospital)

During observation I frequently heard shouting in the corridors and behind closed doors. Sometimes staff shouted at relatives of labouring women who were in the hospital without permission, but often the shouting was between members of staff, most commonly the midwives. There was at times a lack of teamwork: a midwife who refused to help a resident doctor overwhelmed with labouring women; a *khāla* who refused to hurry and help a midwife transfer a woman about to give birth to the delivery room. Occasionally there were glimpses of the underlying dynamics such as comments between doctors over where one should sit for their morning report.

“One of the doctors said to another doctor – ‘*You had better move before they shoot you in the back!*’ (She was warning her not sit too far forward, in the place of the more senior doctors but to move towards the back of the room.) At this point I enquired if I should sit nearer to the back of the room also, but was reassured I would be all right as I was a guest, a visitor!”

(Field notes data collection 2)

I saw exceptions, some indications of close relationships between groups of resident doctors, groups of midwives. For example a midwife tried to encourage a sick midwife who was worried about her health, and a senior doctor who said she had remained at the hospital because of the support and friendship of another senior doctor. A junior midwife said that some of the older midwives were kind. In general, however, I was told that staff were not kind to each other, from the *khālas* to the management team. One of the staff members had serious health problems and I asked her how it was for her working in the hospital. She explained that not even her own colleagues were sympathetic or helped her but they were frustrated that she could not do her share of the work.

“Everyone is cross with me, they are not happy because I cannot do my work properly. When I explain my health problem to other staff they say; ‘*What should I do about it? It’s not my problem*’. No one is kind or helps me, they shout at me and say they will replace me if I don’t do my work”.

(Staff member)

There were consistent stories of unkindness from the hospital management. Two *khālas* said they had both been refused time off to care for close relatives in hospital.

“One *khāla* said her son had never completely recovered from major surgery because no one had been there to look after him. The other had requested permission to be with her mother who was very sick in hospital. ‘*Go and make beds*’ she had been told by senior management, ‘*your mother will get better,*’ but she didn’t, the *khāla* explained, her mother had died. The *khāla* broke down and cried”.

(Field notes April 2012)

The poor relationships between healthcare providers were compounded by inequity of opportunity. Midwives and resident doctors complained that although they needed training they were not sent on training courses. They resented the same people being chosen to attend courses every time. A resident doctor explained that they are desperate to learn and had repeatedly asked for training. She used an analogy of being like “wild animals”, untrained and dangerous towards the women in their care, not because they wanted to be but because of a lack of training:

“Many times we contact the training centre and say; ‘*train us because we don’t know what we are doing, we are like wild people, like wild animals, we do whatever we want with the patients, please train us.*’ They told me, ‘*Your turn will come.*’ I don’t know when”.

(2<sup>nd</sup> year resident doctor)

During the morning report a midwife attempted to discuss the difficulties of completing the partograph on every woman because of the high workload. A senior midwife replied at length in a loud voice emphasising that completing partographs was their responsibility. She refused to discuss the practical challenges of how they could manage this but concluded by telling the midwives that they were to blame for the workload.



“It’s your fault because you take everything on your shoulders – you tell the doctors, ‘*I will do this*’, (extra work like breech deliveries) and now you are complaining that you cannot manage!”

(A senior midwife)

This was an opportunity to improve care through discussing the practical difficulties of managing the workload. This senior midwife, however, appeared unwilling to listen to problems or work with her staff to find solutions. Her answer was to blame the midwives for wanting to use their extended skills and thus take on extra work.

Because decisions within the hospital were made on the basis of *wāsita* not on ability or need (see 6.2) the system was perceived to be unfair. Many staff members mentioned this lack of fairness in who attended workshops or who was helped to develop skills, and who was promoted. This inequity resulted in resentment amongst the ‘excluded’ staff, those who did not have powerful connections. During my first morning in the hospital, a senior doctor spent more than 30 minutes talking to me in the Out Patients Department. Formerly she had held a senior position but had been side-lined in recent years. She described many difficulties that staff faced. As she talked about the need for a fair, equitable system she became very animated: she was very anxious that I understood her point. She explained the need for a system that everyone had to follow and drew diagrams on a scrap of paper then acted out a demonstration of people having to walk the same road with no deviations.

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

(Senior doctor)

A ‘level playing field’ would be an appropriate idiom to express her concept, a system where ‘everyone had a fair and equal chance of succeeding’. Currently, she claimed, this did not exist.

One morning there was a heated discussion during the doctors' report regarding their impossible workload. They agreed that it had been the pressure of large patient numbers that had resulted in the instrument being left inside a perinatal woman and the subsequent court case (see 7.3). The doctors wanted to tell the MoPH that they could not manage but a senior doctor said they could not do this unless they worked together:

“You should support each other, not blame each other and say it was her fault. With one voice you should say to the MoPH, ‘*We cannot do this because it is impossible for us – we cannot take all this work on our shoulders*’. You have to learn from them (the doctors and midwife who had made the mistake), now they are going to court. If we are not in one hand here, how will the Ministry help us or support us?” (My interpreter later clarified that being “in one hand” meant working together.)

(Field notes doctor's morning report March 2012)

Poor relationships within the hospital undermined the ability of the hospital staff to support each other and work together for change, either for themselves, or for the women they cared for. They lacked the power to lobby the MoPH about the difficulties they faced if they could not speak with one voice.

On my last visit to the hospital I sat and talked to two *khālas* to whom I had not talked before. The area was quiet and they seemed happy to chat. They mostly led the conversation talking about the unfairness and unkindness they suffered in the hospital:

“From here to the Ministry are women and women are more cruel and violent to each other than men are to women”.

(A *khāla*, ongoing observation April 2012)

The assertion that women were more cruel and violent towards each other than men was one of the final statements of my data collection. It was one statement

that I did not expect and it left me with many questions regarding the experiences that had led to it.

Several interviewees shared insights into staff relationships within the hospitals:

“We are working with women (the healthcare providers) who themselves are in very submissive, subservient positions. I think when they come into their work setting there’s a lot of power issues going on between doctors and midwives, probably with bullying. Power games go on between professional groups and then that’s reflected in their caring in the clinical setting”.

(Non-Afghan midwife 7 years experience)

To understand relationships within the hospital, I talked to a female doctor who counselled victims of violence. She explained that when someone is abused by the people they depend on for protection, like fathers or husbands, their ability to trust can be destroyed:

“Violence, abuse and trauma has an effect on the trust system and can result in a state of fear, anxiety, a lack of trust in others, violence towards colleagues. These women can react at work. It is not necessarily to do with their colleagues but because they are being put down at home”.

(Doctor/trauma counsellor in Afghan NGO supporting female victims of violence)

Violence or abuse can affect the emotions, she explained, resulting in jealousy and numbness, even towards their own daughters and daughters-in-law. This counsellor said that female doctors had been amongst the women she had supported and worked with in psychosocial groups. She explained how violence was perpetuated within families and society:

“Women mostly suffer from violence when they have less power...from our experience there is a cycle of violence particularly women against women. They are victims and they in turn victimise others”.

(Doctor/trauma counsellor in Afghan NGO supporting female victims of violence)

## **7.8 Discussion**

### **7.8.1 Respecting and caring**

In an evaluation of the pre-service midwifery education programme (Health Services Support Project and United States Agency for International Development 2009), midwives reported that other health providers did not respect them and sometimes insulted them. In their qualitative study on retention of Afghan midwives, Wood and colleagues (2013) found that the lack of respect from other healthcare professionals affected the retention of community midwives.

The need to feel valued, respected and recognised has been found in many studies and diverse settings (Kirkham and Stapleton 2000; Fort and Voltero 2004; Manongi et al. 2006; Mohammad-Alizadeh et al. 2009; Brodie 2013). In their systematic review of motivation and retention of health workers in developing countries, Willis-Shattuck and colleagues (2008) concluded that recognition was highly influential in motivating health workers, some studies cited recognition by employer and community as one of the most important motivating factors. In a large study investigating the supervision of midwives in the UK (Kirkham and Stapleton 2000), midwives talked of their need to feel valued and respected. When they were praised, they said, their confidence was enhanced and they felt ‘spurred on’.

Mumtaz et al. (2003) found that female healthcare providers in Pakistan said repeatedly that because they were not appreciated or rewarded they were not motivated to work hard. Research into motivational determinants among

physicians in Pakistan (Malik et al. 2010) found respect to be one of the most important motivators for physicians; both male and female. Organisational support and constructive feedback regarding performance also had a critical influence on healthcare provider motivation (Franco et al. 2002; Fort and Voltero 2004; Manongi et al. 2006; Willis-Shattuck et al. 2008). Appreciation, constructive feedback and organisational support were not the working environment which Afghan healthcare providers described or I observed.

In 2004-2005 Kitt and colleagues (2006), became concerned about the health of staff in a Kabul maternity hospital. They noticed that few wore glasses, some had difficulty hearing the fetal heartbeat and others were frequently absent from work. They subsequently developed an occupational health initiative. Their initial findings showed that 52% of staff members had difficulty seeing, 22% reported hearing problems, 43% currently suffered from back pain, only 8% had received hepatitis B immunization (Kitt et al. 2006). These findings support the assertion of the healthcare providers that their health suffered as a result of the workload (see 6.1) and they also have serious implications for perinatal women if doctors and midwives have difficulty, for example, reading labels on medicines or identifying tissues during surgery. The lack of help to maintain their own health was seen by the healthcare providers as a system that did not value or care for them (see 7.1). The occupational health initiative was replicated in other maternity hospitals in Kabul although there was no evidence of it continuing by the time of my data collection.

The carers had many needs; they had physical problems, financial worries and responsibilities, a need to acquire skills and for more time at home. They had obligations and expectations from family, may have suffered psychosocial traumas, and they longed to be valued and respected. The majority of these needs were unmet. Hofstede (1984) discusses human needs and the quality of life in non-Western settings. From his study of employees of one organisation in 53 countries he argued that quality of life is culturally dependent. He contends that Maslow's hierarchy of needs (Maslow 1954) is ethnocentric, based on mid-twentieth century United States middle class values. Hofstede points out that it

is inappropriate to use this scale in non-Western societies, as their values are different. Maslow's scale and theory, Hofstede explains, does not include values of high import for collectivist societies such as harmony or family support. On the contrary, Maslow puts self-actualisation and autonomy on the top of an individualistic value system. Although I agree that the values and priorities implicit in Maslow's model are alien to Afghan society, I do suggest that it has one important contribution to make to this study; that when basic needs are not met it is hard to consider the needs of others.

### **7.8.2 Humiliating and shaming**

Hassan-Bitar and Narrainen (2011) explored the challenges experienced by Palestinian maternal healthcare providers. Palestinian midwives complained that they were humiliated by doctors, by managers who criticised and shouted at them in public and also by relatives of labouring women frustrated at the lack of resources, or the absence of a doctor.

Public humiliation is particularly distressing in Afghanistan, where gaining and maintaining a good name, honour and reputation are fundamental social driving forces (Loewen 2010c). Sexual impropriety or even the rumour of impropriety by a female family member is considered to destroy the family honour. Women working outside the home in Afghanistan must be extremely careful to avoid even a hint of anything that might shame their family (Moghadam 2002). Similarly, failure in studies or employment also dishonours the family. A colleague, who worked in the midwifery training programme, explained that the family of an Afghan student midwife threatened to kill the student because she had failed her final exam three times.

I am not an anthropologist and it is not possible to discuss the cultural concept of honour and shame within this thesis. It is important, however, to note that this social construct, that contains a complex set of values, norms and behaviours, is not unique to Afghanistan, but has been identified in societies from the ancient Greeks and Romans, countries of the Mediterranean region, and

present day traditional societies in both East and West (Neyrey 1998). Some would contend that, although expressed in different forms, the desire for praise and avoidance of shame is present in all societies (Cairns 2011). While the love of honour and praise has been described as the pivotal value of the Mediterranean world, the fear of blame or shame, and striving to avoid it, is of equal or even greater importance (Neyrey 1998).

Foster (2009) in his analysis of professional knowledge and surgical training in Afghanistan explains that the issue of honour and the need to avoid shame has very deep historical roots, which, he suggested, exerts more influence than the average Westerner is able to grasp. A background interviewee in my research explained that 'shame and honour' is the need to be honoured or praised by people and to avoid being shamed in the eyes of others. Present day honour killings, by family members, of female relatives who are considered to have shamed the family, demonstrate the lasting power and magnitude of this value (BBC News 2006a, 2006b; Sarwary 2012). Examining gender equality in health in Afghanistan, Samar et al. (2014) recorded a mother's desperation to avoid family shame by performing a makeshift caesarean section at home on her pregnant daughter who had been raped. Entezar (2007) claimed that humiliation is a strategy that is often used in Afghanistan to enforce authority and exercise power over others. A strategy that was used within this hospital to avoid shame was to blame and humiliate somebody else, as explained in the next section.

### **7.8.3 Blaming others**

In a study of the support needs of midwives in the UK, Kirkham and Stapleton (2000) highlighted the vulnerability of midwives and their need for protection in a professional and institutional culture where some were quick to blame and punish. UK midwives felt isolated, lacked confidence and were fearful of making a mistake that could result in them losing their registration. Turkmani and colleagues (2013) suggested that providing life-saving interventions without the support of a regulatory framework is a risky business for Afghan midwives.

Healthcare providers in Afghanistan face multiple risks if they are held responsible for a professional error, participants explained, including physical violence from the family. They may face a criminal court case; a prison sentence; or a demand for a large payment and possible financial ruin for the family. They would depend on family networks to negotiate on their behalf. In their evaluation of Afghan midwifery education, Zainullah et al. (2014) pointed out the importance of licensure and regulation of midwives not only to safeguard perinatal women, but also midwives. At the time of this study I was told there was no professional indemnity insurance, no institutional support and no regulation or representation for Afghan health professionals accused of misconduct. The lack of regulation for midwives was highlighted in a recent report on the *State of Afghanistan's Midwifery 2014* (United Nations Population Fund). The Afghan Midwives Association (AMA) has been leading the initiative to establish a regulatory body – The Nursing and Midwifery Council. The council was to be in place by 2014, although Speakman et al. (2014) point out that the extent of its powers and effectiveness remain unclear. Within medicine there were also initiatives to set up a regulatory body to oversee licensing, fitness to practice, and disciplinary procedures (Homayee 2010).

Similar to the behaviour of the midwives in the admissions area (see 7.3), one solution for avoiding blame regarding clinical errors is to practise defensively. There is extensive literature regarding defensive practice amongst healthcare professionals, particularly, but not exclusively, in high-income countries (Symon 2000; Studdert et al. 2005). It is not possible within the remit of this PhD study, however, to discuss this.

The culture of 'blaming someone else before you are blamed' engendered fear and my analysis uncovered that it did not create an environment where staff could work together, talk openly about problems, or learn from mistakes. In their occupational health initiative Kitt and colleagues (2006) reported high levels of psychological symptoms among Kabul maternity healthcare providers, 63.7% of whom admitted to feeling anxious or nervous much of the time, while 63.7% reported worrying about taking care of their family. The authors suggested this



was an indication of the fragile state of mental health and psychological stress in the hospital. I would suggest that if my findings also reflect the situation in other Kabul maternity hospitals, the culture of blame and lack of trust between colleagues would be a contributing factor in the high levels of psychological distress.

Evans et al. (2014) in their study of the quality of caesarean births in Afghan health facilities, suggested that maternal death and near miss audits would be a valuable strategy for analysing reasons for delays in detecting complications, making decisions and intervention. Findings from this PhD research suggest that against the background of fear, blame, punishment and no legal protection for staff, it is highly unlikely that clinical audits would prove successful. Foster (2009), a non-Afghan consultant surgeon who worked for 11 years in the Afghan public healthcare system, explained that doctors avoid open discussion and that a culture of secrecy prevents rational analyses of the root causes of error. A doctor in the MoPH told me that a maternal mortality committee existed, but that no maternal deaths had been reported. Sometimes family members came to the MoPH regarding a relative who had died in a public hospital, she explained, but when the MoPH endeavoured to investigate the records were missing.

The 'blame culture' has been identified as a major contributor to poor patient care together with the reluctance to report medical errors, Gorini and colleagues (2012) reported. In their experimental study 249 healthcare providers were asked to express their fear of blame or punishment in the scenario of having made a clinical error. The authors found that the fear of being blamed was higher than the fear of being punished in all participants from student nurses to senior physicians. The fear of being blamed they concluded was pervasive and deep-seated, and it engenders feelings of inadequacy and is a cultural barrier to incident reporting. An alternative approach to dealing with human error in healthcare was pioneered by Reason (2000) in the UK, utilising lessons from high reliability organisations such as aviation. Rather than blaming individuals, the traditional healthcare approach, he advocated a 'system approach' that

started from the premise of human fallibility, identified areas of weakness and put defences in place to protect against mistakes. It was anticipated that this 'no blame' approach, which endeavoured to change the system rather than blame individuals, would promote a culture of openness in reporting adverse incidents. The 'no blame' culture has been promoted in healthcare.

In his qualitative study of incident reporting amongst specialist physicians in the UK, Waring (2005) argued that the issue was more complex than the 'culture of blame' and advocated addressing the broader 'culture of medicine'. Reason (2000) acknowledged that the no-blame culture had serious weaknesses, as there was a need to confront individuals who wilfully engaged in unsafe behaviours and distinguish between culpable and non-culpable acts. Reason subsequently promoted the 'Just /Safety Culture' (GAIN Working Group E 2004). I would also agree with the critics of the 'no-blame' approach, who argue that whilst there is a need to reduce the fear of blame, there is also the need to balance 'no blame,' with institutional responsibility and individual accountability (Wachter 2013). A participant explained that a no-blame approach had been introduced in this Kabul hospital by an NGO endeavouring to improve the quality of care. It was not possible for me to ascertain if there had been an impact. For a no-blame culture or a 'just culture' to improve care for perinatal women, however, there must also be strong systems culture, led and enforced by management (AbuAlRub and Abu Alhijaa 2014). I saw no indications of that type of leadership.

In the context of a society that considers reputation of extreme importance, the lack of respect and hospital culture of humiliating, blaming and shaming I suggest contributed to a climate of fear, stress and dysfunctional, fractured, staff relationships.

#### **7.8.4 Living with violence**

In their analysis of a decade of literature on violence against women in healthcare settings, d'Oliveira et al. (2002), claimed that violence within

healthcare services often reflects a high prevalence of violence in the wider society. Jewkes et al. (1998, p.1783), studying abuse of patients in South African maternity services, explained that in addition to work pressures the nurses had to contend with increasing levels of violence in society including domestic violence. Against the legacy of apartheid, a group of predominantly black South African midwives felt that they were not respected but abused by patients, that they were vulnerable and unfairly blamed for problems in the busy midwifery unit that lacked reliable medical backup.

Violence against women and girls in Afghanistan is reportedly widespread and can include domestic abuse, rape, forced marriage, neglect, torture and killing by members of their family. Although there have been some legal gains since 2001, a report in 2013 (Afghanistan Research and Evaluation Unit, p.2) presented a mixed picture of the current situation of Afghan women, acknowledging that

“...gender-specific norms are among the most pervasive and resistant to change in any society...”

Progress has been made in health outcomes and education for women and girls, however, many efforts to promote reform have encountered political backlash from the more conservative segments of society. A report in 2014 (Human Rights Watch), concluded that with international interest waning, opponents of women’s rights had seized the opportunity to begin to reverse the progress that had been made since the end of the Taliban. The Elimination of Violence Against Women Law (2009) remains valid but enforcement is weak. Numerous parliamentarians have spoken out against legal protections for women and girls: some have called for this law to be repealed (Human Rights Watch 2014). There had been an increase in reports of domestic violence but this had not been accompanied by an increase in criminal prosecutions (United Nations Assistance Mission in Afghanistan 2013). Women in the public sphere face additional dangers. Numerous high-profile Afghan women, (female parliamentarians, senior police officers, activists, teachers and doctors) have

been threatened and assassinated in recent years (Kouvo 2014; Human Rights Watch 2014). Three leading Afghan midwives that I personally know have recently left the country following threats against them or their families.

It was not within the remit of this study to examine violence against women in Afghanistan; however, it became increasingly clear that to portray the lives of Afghan women without discussing the prevalence of violence within homes and society would be a misrepresentation. I do not suggest that Afghan women are defined by violence but rather that the fear of violence and the need to mitigate against it is a powerful driver in the lives of those who experience violence. Violence was not related to literacy or economic status, the trauma counsellor/participant confirmed, but it depended on the culture of each individual family. In a discussion with male colleagues a few years ago, the majority of these mostly educated Afghan men, considered that it was the right of husbands to beat their wives and admitted that they would beat their own wife if they believed it was warranted.

It could be argued that the private fears of healthcare providers are not part of the hospital culture of care. I would contend that to separate these women from their lives outside the hospital would be to create an artificial divide that does not exist. Furthermore, these insights reveal the precarious nature of women's lives, their lack of self-determination and the fears and trauma with which many live: factors that help to elucidate their behaviour within the hospital.

Lateral or horizontal violence has been identified within the midwifery and nursing professions (Roberts 1983; Leap 1997). Duffy (1995, p.9) in her critical analysis of horizontal violence in nursing defined it as:

“overt and covert non-physical hostility such as criticism, sabotage, undermining...scapegoating”.

An ethnographic study of the culture of midwifery in the UK, highlighted the lack of mutual support, the pressure to conform, and midwives feelings of vulnerability (Kirkham 1999; Kirkham and Stapleton 2000). Horizontal violence was seen in the culture of blame and scapegoating which reinforced the status quo. Bluff and Holloway (2008) reported on the influence of midwifery role models on student midwives in the UK. Of the two types of midwife that emerged, the prescriptive midwives followed rules and endeavoured to ensure that other staff did the same. They bullied, intimidated and humiliated midwives who were more flexible in their practice. In each of these studies nurses and midwives are portrayed as the oppressed, subservient group, sometimes oppressed by managers and superiors but predominantly by the more powerful profession of medicine within institutions that reflect male-cultural values (Kirkham and Stapleton 2000).

Horizontal violence could be seen in the fractured relationships between Afghan healthcare providers, the lack of support and kindness, the culture of blaming, intimidating, humiliating and shaming. In this hospital, however, the oppressors were not so clearly defined. This was an almost exclusively female institution<sup>28</sup>; senior management, obstetricians, resident doctors and midwives were overwhelmingly female. Despite the high social status of doctors, and their restrictions on the scope of midwifery practice, it was reported that senior midwives had threatened and silenced doctors. My analysis is that in this context rather than the medical profession the oppressors were female and that both midwives and doctors were oppressors; dependent on their location in the hierarchy and their state of power.

The concept of horizontal or lateral violence first emerged from the polemic of Fannon (1963) exposing the impact of colonialism on Algerian society. Colonialism not only brought physical violence and destruction, Fanon claimed, it also affected mental and psychological wellbeing and social cohesion. Unable to fight their oppressor, the colonised resorted to hostility, intergroup conflict

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<sup>28</sup> I occasionally saw a senior male obstetrician and visiting general surgeon, a male lab technician and junior administrator.

and murder. Lateral violence was described by Freire (1972) in the uneducated workers and middle class of Latin America whom he saw as oppressed and dehumanised. The destructive effects of horizontal violence have been identified in Aboriginal communities in Canada and Australia. It not only refers to physical violence but can also include social, emotional, psychological, economic and spiritual violence (Australian Human Rights Commission 2011). From his experiences in Aboriginal communities, Phillips (2009), explained that when an oppressed group have no way of getting justice from their oppressors they start to attack or hurt one another in an attempt to “feel powerful in a powerless situation”.

Horizontal violence has its roots in unequal power relations (Australian Human Rights Commission 2011). The unequal power relations in this Kabul hospital were not only linked to the institutional hierarchy but also to the social power of *khālas*, midwives, doctors and senior hospital managers. These female healthcare providers experienced unequal power relationships both in society and in their homes. In Afghan society they are considered inferior to men - the property of their husbands (Entezar 2007), and in many families they are seen as a threat. There is a perceived need for them to be controlled to prevent them tarnishing the honour of the family (Moghadam 2002). I do not suggest that all healthcare providers suffer abuse at home, or that violence is always committed by misogynistic men (Daulatzai 2006), as mothers-in-law and other women are often perpetrators of violence (Global Rights: Partners for Justice 2008). I do, however, maintain that, given the violent nature of Afghan society, it is likely that a significant proportion of healthcare providers had been, or were victims of violence. The trauma counsellor, for example, said that 36 doctors had been through the psychosocial courses on trauma and violence that they held for staff in several Kabul hospitals. During the course one doctor had admitted,

“I am shouting at my patients because I never stop working, I don't have time to think or reflect on my problems.”

A feature of horizontal violence noted by Fanon (1963) and within Aboriginal communities (Australian Human Rights Commission 2011) is jealousy towards those who succeed. Jealousy is a possible explanation for the midwife who complained that she was not allowed to teach, and the doctor who tried to pass on information from a workshop to her colleagues, but was accused of wanting to 'show off' or promote herself (see 6.2.1).

The hostility between staff, I would argue, not only created an unsafe, hostile environment in which to work but also affected the care of perinatal women such as seen in the unwillingness of staff to help one another at busy times, and the fear of blame which encouraged defensive practice. Their inability to "speak with one voice" undermined the doctors' ability to collectively pressurise the MoPH to address issues of workload and therefore safety in the hospital.

Beneath the outward expressions of horizontal violence in this hospital there was, I would suggest, a more fundamental injustice. For any society to consider women the property of men, (as was the case in the UK until fairly recently), is to objectify them, to dehumanise them. The failure to enforce laws protecting women against violence and the pressure from government lobbies to abolish those laws (Afghanistan Research and Evaluation Unit 2013; Human Rights Watch 2014) has revealed very deep beliefs about the status of women in Afghan society and the value of their lives. Those beliefs, I argue, denote that all women start from a position of dehumanisation irrespective of the perspectives of male members of their family. Their dehumanisation may be subtler than the suffering of the perinatal women, but the healthcare providers, as women, are also to some degree dehumanised by the society they lived in.

### **7.8.5 Summary**

Fear was a dominant feature of this hospital environment, and it provided an acute contrast to the respect and support that midwives, *khālas* and doctors longed for. Staff feared making a mistake, being humiliated, or being blamed. They also distrusted colleagues. For some healthcare providers these fears

would have intensified existing fears from their lives outside the hospital. This was a hostile, threatening environment where staff practised defensively and tried to “keep out of trouble” while other powerful staff, including doctors and senior midwives, intimidated and imposed the status quo, preventing positive change. In the following discussion chapter I will examine power and vulnerability in the hospital and the implications for care.



## Chapter 8 - Discussion: Care, power and vulnerability

In this final chapter I return to my original question regarding the culture of care and the gap between the presence of healthcare providers and the care that perinatal women received. Many barriers to the provision of care were identified in this study. Although these were 'new' to me it is unlikely that they were 'new' or unknown to the hospital managers or MoPH. This poses questions of why these barriers had not been overcome and what perpetuated the climate of fear and horizontal violence amongst healthcare providers?



**Figure 6: Chapter 8 Overview**

Firstly, I will examine how power struggles and vulnerability affected the hospital environment, staff relationships and the care of women, including the different types of power that were used to control staff and maintain the status quo. Secondly, I will explore the implications of these findings for improving the quality of care in this hospital.

## **8.1 Power and vulnerability**

More than one system of power existed in this hospital and almost exclusively female institution. There was the official legal or bureaucratic system of the senior managers who were responsible to the Ministry of Public Health. This included the hierarchies of medical staff and midwifery staff according to seniority.

In parallel to this system was a hidden second system, namely the power of social connections. As already discussed, those who had powerful family connections or *wāsita* were at an advantage in the acquisition of clinical skills, securing jobs and being selected for workshops (see 6.2.1 & 6.2.2). As a consequence, they were more skilled and less likely to make clinical errors. If they did make a serious mistake or were threatened with dismissal, powerful people would advocate for them or even intervene on their behalf.

Healthcare providers who did not come from an influential family or lacked connections to powerful people were vulnerable. Originally I thought of them as powerless, though women in the community explained that even the guard at the gate had power, as he knew the doctors and midwives. On reflection I concluded that no one working in the hospital was powerless as they had jobs, insider knowledge and income. The consequences of vulnerability were, however, that these staff members, especially resident doctors, were at an increased risk of making a clinical error as they had less support and fewer opportunities to develop their skills. If they made a mistake and a perinatal woman developed a serious complication they would not have a powerful

advocate to intervene with the judge, or pay a large fine on their behalf. Midwives and *khālas* were also vulnerable if they did not have powerful connections and were blamed for errors or threatened with dismissal.

Powerful staff knew that they could not be touched, could flout the rules, as in refusing to comply with the shift system, and could act with impunity. They could blame and humiliate others and challenge the authority of those in more senior positions (see 6.5.1 & 7.5). Those in senior positions were able to use their authority to benefit their families, for example, by arranging jobs for family members.

Knowledge, status and wealth were sources of power for the healthcare providers. Teachers, trainers and senior doctors with advanced clinical skills were respected and could attract more private patients. Wealth gave a degree of security and status. The scenario of senior midwives threatening doctors, however, suggests that the doctors' skills and status was secondary to the powerful connections of the midwives. So, while knowledge, status and wealth gave some power, family connections and client-patron networks appeared to be the most important social asset.

### **8.1.1 Villains or victims?**

From the commencement of my study I struggled with an almost Manichean desire to understand the healthcare providers; were they oppressed, or were they the oppressors: the villains, or the victims? Alternatively, were there two groups: healthcare workers who used the system for their own advantage, neglected and extorted women, and showed no kindness to perinatal women or colleagues; and healthcare workers who tried to care but were vulnerable and oppressed within the system? The advantage of obtaining data from many diverse sources has been the challenge to a narrow dualistic perspective. The analysis that concurs and resonates with my data presents a more complex picture as the following case of one *khāla* illustrates.

The *khālas* were non-educated women who suspected that they did not always receive the correct salary but were unable to check. As widows the economic survival of their family depended on their job; their fear of losing the job prevented them from complaining, regardless of working conditions. The *khālas* performed menial work and were at the bottom of the hospital hierarchy but they still had power. “All bad things are done by the *khālas*” a woman in the community focus group remarked. It was a *khāla* who might let relatives through the door to visit for a precious few moments, might relay requests for medicines to waiting relatives, might bring the medicines or food back to the labouring woman. The *khālas* were not ignorant of this power. Women in the community complained that their relatives bought medicines and gave them to a *khāla*, but on occasions, the medicines never arrived. So *khālas* were vulnerable to exploitation through their lack of education by powerful people within the hospital system but they were able to exploit those more vulnerable than them.

In his analysis of social power, Bierstedt (1950) argued that institutional authority does not necessarily equate to power; that informal institutionalised power may exert more power. The inability of senior hospital management to dismiss a *khāla* illustrates informal power: the power of connections in a client-patron society. Senior hospital managers had authority, status and responsibility for standards of care. *Khālas* in contrast did not have authority or status in the hospital hierarchy and were formally responsible to senior managers for their conduct. This example showed, however, that a particular *khāla* was able to negate the authority of senior management, because she had what could be termed ‘the Afghan trump card’, a connection with a more powerful person than this senior manager. As a consequence, this *khāla* was able to obtain a letter from the MoPH ordering the hospital management to reinstate her. I overlooked it at the time but recently noticed the clue in a midwife’s description of the type of women who work as *khālas*: “some of them were formerly wives of famous, popular people” (see 6.4.2). So although some *khālas* had lost their privileged life and been forced into menial employment when their husbands died, their family connections could still be effective when required. It would be incorrect to conclude that senior managers did not have power; several interviewees had explained that political power is vital for

anyone appointed to a senior position. The power of senior management, however, was limited and depended on the strength of their political alliances.

There was, I concluded, no clear dichotomy between vulnerable and powerful staff members. Each doctor, midwife and *khāla* was on a continuum between power and vulnerability. They all had some degree of power as well as vulnerability. Vulnerable staff still had power over the perinatal women and their relatives. The women were dependent on them for help, care and kindness. Doctors, midwives and *khālas* could choose to care and help or they could use their position to extort money, mistreat or neglect. The vulnerable staff members could also blame other staff members. Power was not absolute either. Even the powerful individuals had some vulnerability as illustrated by stories I heard during data collection about the two senior doctors who were in court over a clinical error, and the hospital director who had been pulled out of a taxi and beaten.

Furthermore, as the example above demonstrates, the position of individuals on the continuum was neither static nor stable. Factors inside and outside of the hospital, events often outside their control, could increase their vulnerability: a woman in their care dies and they are blamed, chronic illness makes work difficult, an important family 'contact' in the government loses their job, their husband marries a second wife. Staff with power today could lose that power and influence tomorrow and become more vulnerable. As the resident doctor explained, they were "stressed every day" (see 7.3), and felt anxious that a woman in their care might develop a serious complication.

I contend that this constant tension between power and vulnerability, between hospital hierarchy and social connections explains many of the healthcare providers' behaviours within this Kabul hospital: the need to hold onto power and to avoid shame and vulnerability in a precarious, hostile work environment.

### 8.1.2 Maintaining power

In their analysis of reasons for the abuse of power, Bargh and Alvarez (2001, p.50) claim that power is associated with goals, “because having power means having the ability to attain desired goals”. Eggerman et al. (2010) argue that poverty, or more generally the broken economy was the root of social suffering, creating complex tensions and violence within Afghan families and communities. For some healthcare providers economic survival was undoubtedly the goal of the bribes that they took to supplement their salary. For others the goals were less clear. There was evidence, however, of senior medical and midwifery staff working against change. Recently qualified midwives were strongly discouraged or prevented from exercising the extended role that they had been trained for, new enthusiastic staff were threatened and ‘subjugated’ on their first day, and advanced skills and clinical expertise was not readily shared. In addition the selection of participants for workshops and training courses was not based on need or individual merits but *wāsita*. I also noted that punishments were not meted out for staff that were negligent in caring for perinatal women but rather, they punished staff members who did not conform to the institutional culture, who threatened the status quo.

This behaviour cannot be motivated by a desire to benefit perinatal women, or the midwifery or medical professions: as it stifled progress and innovation, the emergence of new role models and a broad base of highly skilled midwives and resident doctors. In sum, it prevented improvements to the quality of care and maintained the status quo. My interpretation is that powerful people were benefiting from the existing system: change threatened to jeopardise that advantage. Oppression does not just affect those who are oppressed Freire (1972) contends, but it dehumanises both the oppressed and the oppressors.

“Dehumanization, marks not only those whose humanity has been stolen, but also (though in a different way) those who have stolen it” (Freire 1972, p.20).

Within the hospital there were those who acted without regard for the lives or wellbeing of other human beings, who dehumanised vulnerable women, who appeared to have lost their own humanity.

Vulnerable residents, midwives and *khālas* could not risk doing anything that would challenge the authority of powerful figures or their prescribed way of doing things. Compliance was necessary to avoid punishment, humiliation or job loss, for example, the resident doctor who was threatened and warned that if she reported a senior midwife she would be blamed for a serious clinical error (see 7.5). Horizontal violence characterised staff relationships and reinforced fear and vulnerability.

Freire (1972) observed that the oppressed come to value the values of the oppressors. Whether or not the vulnerable healthcare providers valued the values of the powerful staff, I suggest that it was to their advantage to imitate and adopt their behaviour. Goffman (1968, p.20), reported that ultimately the interest of the total institution “comes to mean the interests...of the staff”. Goffman explained that new inmates in ‘the asylum’ were anxious not to break the rules, fearing the consequences if they did. They therefore, made a persistent, conscious effort to stay out of trouble by complying with the rules.

It is unlikely that the majority of staff sought power for its own sake but rather that power was a survival strategy, to protect them against loss of status, loss of job, and the subsequent implications for their families. The goal behind attempts to maintain power and avoid vulnerability, I suggest, was predominantly the need to survive socially and economically, to fulfil family obligations and ultimately to maintain their status in the home.

The impact of this tension between power and vulnerability did not only affect the levels of healthcare providers’ skills and knowledge. My research findings indicated that certain powerful doctors and midwives in this hospital had set the

behavioural agenda. Kindness and compassion clashed with this agenda. Healthcare providers were verbally abused if they “started treating the women nicely” a midwife explained. Another interviewee concluded, that compassion did not pay, but that to have a career you had to act in another way. Being kind and caring increased healthcare providers’ vulnerability. To survive and maintain the power that they had, vulnerable staff members had to comply with the rules and behave like those who had power. In this hostile environment, the most vulnerable of course, were the women who had come to give birth to their babies.

### **8.1.3 Perinatal women and power**

Originally I considered including perinatal women on the continuum between power and vulnerability, because they also had degrees of power. Labouring women who knew someone in the hospital, came from an influential family or were able to pay bribes had some power and were better positioned to receive care. During observation I saw that educated women were more able to challenge and question the healthcare providers; and more likely to complain to management if they received poor care, and conversely, poor women from the rural areas were more likely to be neglected. Women who did not speak *Darī*, the main Afghan language used in most Kabul institutions, were also more vulnerable as not all healthcare providers spoke *Pushtu*. I concluded that perinatal women were also living between power and vulnerability. I finally decided not to include perinatal women on the same continuum as healthcare providers. My rationale was that every labouring woman was dependent on the healthcare providers to help her give birth to her baby safely and the risk of developing complications from inadequately trained resident doctors or absent midwives made each woman extremely vulnerable.

### **8.1.4 Power and the family influence**

Despite the hostile work environment and the pressure to conform, I argue that this remains an inadequate explanation for the abuse of power, level of neglect and apparent lack of concern for the perinatal women’s suffering by healthcare



providers. My analysis is that it is only as healthcare providers are viewed in the wider context of their lives as women within Afghan society that their behaviour in the hospital can be understood.

The findings of this study, background interviews and recent history reveal that Afghan women have limited autonomy or control in society or in their homes, especially until they become a mother-in-law. The important decisions of their lives are family decisions: if they will be educated, whom they will marry, where they will live, whether they will work and what work they will take. Even decisions regarding how conservatively they dress in public will, for most, be a family decision. I suggest that for many healthcare providers the hospital was the only domain where they had significant power and control.

Family and family connections or '*wāsita*' were the primary sources of power. Drawing together the opinions and experiences of many participants, I suggest that family background also affected how healthcare providers used their power at work. Lee-Chai et al. (2001) examined individual differences in the way power is used. They described power as the ultimate test of personal values and beliefs, as some people will see power as an opportunity to improve the lives of others or society, while some will use it for selfish goals. Values, according to Hofstede et al. (2010) are developed in early childhood. The motivation to help others has also been linked to childhood (Frieze and Boneva 2001). Hyder et al. (2007) examined intimate partner violence among Afghan refugee women and they noted that children compete for the attention or affection of their mothers, while wives and daughters-in-law compete for status and power in the home. Dupree (1997) also found competitive relationships between women in their homes. The sense of other women as competitors, probably contributed to the hostile environment where colleagues were quick to blame each other. From interviews and my previous personal experience the healthcare providers who stood out as 'working with their heart' invariably talked of a father, mother or grandmother who had encouraged them to study and supported them, even when other family members opposed their studies or career. They had role models of people who used power with kindness.

Conversely, violence at home, one interviewee (a trauma councillor) explained, was likely to affect behaviour at work. Another interviewee said that many healthcare providers had “gone through difficult times with no-one caring for them”. Another contended that it was the family that healthcare providers grew up in that made the difference in their behaviours.

### **8.1.5 Types of power**

Many studies examine power dynamics in hospital settings (Jewkes et al. 1998; d'Oliveira et al. 2002; Miller et al. 2003; Hagbaghery et al. 2004; Matthews and Scott 2008). The majority of these studies focus on one particular aspect of power, such as the unequal power of healthcare providers and women in childbirth, or the dominance of the medical profession over midwifery/nursing profession. There is a lack of studies that examine the complex interplay of professional status and hierarchy with traditional or social power in hospital settings. In this hospital there were many types of power, some obvious, some hidden. Although I am a health researcher, not a sociologist, I could not overlook the fact that authority and power within the hospital were more complex than the official hospital management structure and professional hierarchies. To adequately explain the challenges of care and the fear of the healthcare providers it was important to reflect on the nature of power and balance of power in the hospital.

In seeking to understand some of the power dynamics in this hospital and in Afghan society I find myself caught between several models and approaches to power. There was an obvious link to the writings of Max Weber [1864-1920] (1947) because his analysis of the various forms or types of authority: traditional authority; charismatic authority; and legal authority, immediately resonated with my understanding of Afghanistan today. Weber (1947, p.341) defined traditional authority as an authority that is seen as legitimate, “based on the traditions of how things have always existed”. Patriarchalism, meaning the authority of the father, husband over the household, the patron or lord over the subjects, was according to Weber (1946, p.296) by far the most important of

traditional forms of domination. Afghanistan today, for the most part, still functions as a traditional patriarchal society where men hold authority, and adherence to these cultural norms remains strong (Moghadam 2002; Eggerman and Panter-Brick 2010; Afghanistan Research and Evaluation Unit 2013). In addition there is the traditional client-patron system with the moral, social and sometimes financial bonds and obligations to individuals of higher status (see 6.6.6). Weber (1946, p.296) referred to sacred “inviolable norms” within traditional authority systems. Recent research has demonstrated that whilst attitudes are changing, for example, towards violence against women and children, or marriage practices, the process of change is slow and not without resistance (Afghanistan Research and Evaluation Unit 2007; Smith 2008). Eggerman et al. (2010) examined resilience amongst Afghan school children and their carers and concluded that the bedrock of hope, in a war-affected setting, is the maintenance of long-lived cultural values. Findings show that for healthcare providers ‘inviolable norms’ were the fulfilment of family obligations. Employment was perceived as an opportunity and obligation to benefit the family though caring for relatives, supporting the family economically, teaching relatives clinical skills, or ensuring they were selected for jobs or training courses.

In the official hospital management structure and MoPH there could be seen what Weber (1946) termed the ‘bureaucratic rule’ or ‘legal authority’, which develops from either charismatic or patriarchal beginnings. Legal authority, systems and bureaucracy within Afghanistan are well developed; which is, in part, a legacy from the Soviet occupation. Enterzar (2007, p.43) explained, that rules are not rules to be abided by per se, but obeyed only if the individual in charge is powerful and uses force. Legal authority in Afghanistan is, therefore, caught in a struggle between the official ways of proceeding and the unofficial ways. My findings show that within the health system there is also duplicity, as demonstrated by the midwife who initially explained that jobs were awarded on exam results but who then admitted that “you had to know someone” to get a job (see 6.2.2).

The power of some individuals in the hospital fell outside of these classifications. To take the senior midwives as an example, their seniority and role gave them the official 'legal' authority and power to oversee the more junior staff. They oversaw daily reports and work, gave orders and organised warning letters. I suggest that they employed other strategies too which went beyond legal/bureaucratic authority. For instance, the senior midwives must have had political support to maintain their positions; support from a *wāsita* in the MoPH or government. This additional authority linked to the traditional client-patron system. Entezar (2007) concluded, that in a collectivist society, in the absence of the rule of law, Afghans depended on their family, networks, and ethnic group for protection and advancement. The senior staff also used coercive power to achieve compliance, such as sending midwives who did not comply to work in the laundry, demeaning work for these professional women. In Afghanistan force and intimidation rather than persuasion, Entezar (2007) explained, is normally used to establish one's power and dominance.

To clarify the nature of these midwives' power it is helpful to consider the work and concepts of Foucault on relations of power and discipline. In '*Discipline and Punish*' Foucault (1977) illuminated the historical transition of law enforcement and punishment in Western Europe. He detailed the move from the gruesome public displays of torture and execution, common in the seventeenth and eighteenth centuries, to the more subtle form of control through the discipline and surveillance of the prison system. The spectacle of public executions, Foucault explained, was a deliberate display of "the strength of the all-powerful sovereign" (p.49). The prison system, although acclaimed to be more humane, had total power over prisoners. Repression, punishment and a despotic discipline ensured that they would become 'docile bodies' for the state. It is Foucault's consideration of the surveillance of prisoners and the 'panopticon' that is particularly relevant for issues of power in this hospital and Afghan society. The panopticon was a circular building that was designed to enable the surveillance of prisoners by a single guard. Although it was not possible to observe all prisoners at the same time it was designed so that prisoners were unable to tell if they were being observed. The intention was "to induce a state of conscious and permanent visibility" in the inmates so that they regulated their

own behaviour, it was the power of the gaze (Foucault 1977, p.201). There are parallels with the social pressures in Afghan society, the fear about what people will think (Loewen 2010c). The potential for shame and loss of family honour results in a similar self-regulating gaze or consciousness. My finding showed that the fear of humiliation and blame was acute for healthcare providers as they gave the morning report. They spoke of their hearts beating fast as their work and performance were subjected to public scrutiny (see 7.2). The senior midwives used the threat of public humiliation to prevent the doctor from reporting them (see 7.5) and to undermine a new midwife's confidence in her skills (see 6.3). It is hard to overemphasise how important it is for Afghans to avoid bringing shame on their family but the mother who performed a caesarean section on her daughter who had been raped (see 7.8.2) gives some indication. The threat of blame and humiliation, was less overt than being sent to the laundry; Foucault (1977) argued, however, that hidden power is potentially more effective in producing 'docile bodies'.

The findings from this study suggest that power struggles between staff dominated the environment, and that many types of power and authority were used to control. Power was both overt and hidden, ranging from official legal censure in the form of warning letters, coercion, intimidation and punishment to underlying social control – the fear of being blamed, of being shamed, the fear of what people will think (Loewen 2010c). These struggles directly affected the care of women in childbirth.

There was another powerful but hidden influence that, I suggest, affected life in this hospital. Underlying Afghan society is what Foucault might refer to as a dominant discourse (Danaher et al. 2000). This discourse portrays women as the property of men, it connects their value to their ability to 'produce children - especially sons,' and it justifies replacing them if they fail to do so. Mahmoud Fathalla<sup>29</sup> contended, "Mothers are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their

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<sup>29</sup> Professor Mahmoud Fathalla is the former president of FIGO and has been an international campaigner for Safe Motherhood and a founder of the Safer Motherhood Initiative.

lives are worth saving” (2012). An insidious discourse about the value of women’s lives in this society, I suggest, further undermined the motivation of staff to care.

## **8.2 Implications for care**

At the heart of this study has been care, the care that women wanted sharply contrasted with the care that they received. There has been the desire of healthcare providers to be valued, trained, and supported by management, in contrast to the demanding, punitive and stressful working environment dominated by the social system of *wāsita*. There has also been the detrimental effect of power struggles on staff relationships and the care of women in childbirth. In this section I discuss the implications of these findings for improving the standards of care.

### **8.2.1 Care defined**

There have been many attempts to define care (Morse et al. 1990; Kyle 1995) and the quality of care (Bruce 1990; Campbell et al. 2000). Pittrof and colleagues (2002) argued that it was critical to understand what good quality of care is and how to evaluate it. The lack of clarity surrounding this concept or a single universally accepted definition, they argued, was a barrier to progress in maternal health. Raven and colleagues (2012) reviewed the literature to define quality in maternal and neonatal health. They concluded that there was no universally accepted definition of quality of care. Hunter (2006, p.132) argues that the difficulties in defining care should not be disconcerting but that it is

“congruent with a science that emphasises the uniqueness of each midwife/nurse-client encounter”.

Defining and measuring quality of care originally tended to focus on biomedical outcomes (Raven et al. 2012) but recently definitions have become more inclusive and addressed user and provider satisfaction, emotional and social

outcomes (Pittrof et al. 2002). Bruce (1990), for example, argued that there was a quantitative bias in measuring quality that neglected the interpersonal aspects of care. Her simple framework brought together the clinical dimensions of quality and also the subjective interpersonal aspects. Campbell and colleagues (2000) drew together multiple frameworks of quality under the structure or organisational features of care (the physical characteristics and staff characteristics), the process of care (clinical and interpersonal care) and the outcomes (both health outcomes and the user evaluation). The two principle dimensions of care were access and effectiveness, or, do users get the care that they need and is the care effective?

Pittrof and colleagues (2002) highlighted that quality in maternity care has different requirements: the need to avoid over-medicalising pregnancy and childbirth; being alert and responding to unpredictable life threatening complications; balancing the needs of mother and baby, and being attentive to the cultural and emotional needs of women, which are particularly important in childbirth. Hence in practice the maternity care offered is somewhere on a spectrum between a medical and a social model of pregnancy and childbirth (van Teijlingen 2005).

Increasing attention has been given to improving the quality of care globally, as it has become apparent that coverage and uptake of services alone are not sufficient to prevent maternal mortality (Pitchforth et al. 2006; Hussein et al. 2010; Renfrew et al. 2014). Hulton and colleagues (2007, p.2093) highlighted the dangers of policies that endeavour to increase hospital births “without a commensurate concern for quality”. As van den Broek and Graham (2009) argued, there is an urgent need to address quality in maternal and newborn health but a dearth of evidence as to which interventions are effective.

### **8.2.2 Approaches to improve the quality of care**

Globally many strategies have been and are being employed to improve the quality of care. These strategies include education and training, behaviour

change strategies, criterion audits, near miss and maternal death reviews, the humanisation of healthcare and more recently a human rights approach (Fonn and Xaba 2001; Misago et al. 2001; Moore et al. 2002; Bell et al. 2003; Weeks et al. 2005; Kayongo et al. 2006; Boama and Arulkumaran 2009; Graham 2009; Hussein et al. 2009; AbuAlRub and Abu Alhijaa 2014). The findings from this study strongly suggest that before designing and applying such strategies, there needs to be an in-depth analysis of the root causes of suboptimal care. Without this analysis strategies may focus on the wrong issues and fail to produce the intended results.

The midwives in this hospital, for example, do not need more training programmes or protocols but they need authority and support to use their skills in the clinical areas. The newly qualified midwives do not need behavioural change training on why they should treat women with respect and kindness; they need role models in the wards and the removal of those who intimidate them against such behaviour. The resident doctors do not need theoretical lectures; they need a robust system for skill acquisition that is equitable and closely monitored with trainers, who are obligated to teach all residents with penalties for non-compliance. In the current climate of fear and blame maternal and perinatal death or near miss, audits are unlikely to produce results. Minimum standards need to be set, unacceptable behaviour requires consequences; those who are working 'well' need to be acknowledged and rewarded.

The human rights approach is being advocated internationally as a strategy to reduce disrespect and abuse in facility-based childbirth. From my study findings and analysis, I suggest that this strategy is unsuitable for the Afghan healthcare setting. The rights approach has an underlying confrontational tone. It advocates the rights of one group of human beings, (childbearing women) but says nothing of others' rights (healthcare providers). This type of 'human rights' approach has had unintended consequences in initiatives to reduce violence and improve women's situation in Afghanistan. The promotion of women's rights during the last decade has elicited resistance and resentment from



groups of Afghan men (United Nations Assistance Mission Afghanistan and Office of the United Nations High Commissioner for Human Rights 2010). This resentment has not only come from conservative elements in society, but also from professional, less conservative men, some of my former colleagues among them. Despite the sizable differences in power and privilege, because the rights of women have been advocated so strongly, men have felt threatened and concluded that they have lost rights. This has contributed to a backlash against women (Afghanistan Research and Evaluation Unit 2013). In the hospital setting where there are already power struggles and where staff members do not feel appreciated or valued, the promotion of the rights of women in childbirth with no concurrent emphasis on the rights of healthcare providers could produce unintended consequences, such as resentment and increasingly demotivated staff. Strategies that advocate the value of each human being, including the healthcare providers, I suggest, are more likely to engender respect and kindness.

The international community has led the Afghan maternal health interventions (Dalil et al. 2014). International research-based policies, strategies and tools have been utilised such as the *Integrated Management of Pregnancy and Childbirth* (IMPAC) books (World Health Organization et al. 2007). The appalling Afghan maternal mortality figures required urgent large-scale action and finances. Numerous non-Afghan and Afghan health professionals have led this process with a long-term commitment. The investment of large sums of money from international donors, however, required results. The pressure to achieve fast results, the application of generic systems and solutions without analysing the unique features and constraints of this context, I contend, has achieved numbers of, for example, female healthcare providers, but not the intended quality.

### **8.2.3 The quality chasm**

Care is more than a set of caring behaviours and activities, as some argue, there is an ethical component of respect for persons (Kyle 1995). Hunter and

colleagues (2008) contend that relationships are the hidden threads that hold everything together. The authors claims that the quality of relationships both between caregivers and women in childbirth, and between the caregivers themselves, affect women's birth experiences, effective team working, safe practice, effective communication and carers' job satisfaction. Chokwe and Wright (2011) examined student midwives' experiences of care as exhibited by qualified midwives. They identified two different aspects of caring; one was perceived as caring for the physical needs of women, the second was caring for the more emotional aspects, by respecting individuality, staying close to women when they had a need and not leaving them alone when they were in labour. Many Afghan women, I suggest, experienced a lack of care on the same two levels. First, they lacked high quality clinical care and interpersonal communication. Secondly, women in childbirth were not attended to with respect, but left alone and ignored; they were treated as unfeeling objects or bodies. The cumulative result was the dehumanisation of women in childbirth.

Examining the definitions and discussions surrounding concepts of care and quality, illustrates the chasm between notions of quality in different settings. The recent framework for quality maternal and newborn care by Renfrew and colleagues (2014) in particular, while representing a comprehensive synthesis of effective, research-based practice, cannot be equated with a setting where women frequently give birth alone on the corridor floor, where resident doctors practise clinical skills unsupervised on women in childbirth, and where shortly after birth women are sent home without postnatal observations. Perhaps what I observed bore little resemblance to any definition of quality care or care.

Strategies for improving care in environments such as Afghanistan require a radical rethink. For example, this study has shown that healthcare providers may not be 'in the job' for altruistic reasons or primarily motivated by desires to improve care or reduce maternal mortality. Assumptions such as these may bear little relation to the reality of their lives. For the sake of quality, I suggest that there is a need to examine each context and to engage with the actual

healthcare providers, to listen to them and work with what is, rather than stereotypical characters.

A key finding of this study is that powerful people in the health system are working against change and endeavouring to maintain the status quo. In two interviews, staff of programmes working to improve standards of care explained their programme's achievements. But then both interviewees added, "We fear the results may be on paper only". Precisely because of their roles and power, senior staff can prevent change but achieve impressions of change - on paper. Unless hidden constraints such as senior people working against change are dealt with, it is doubtful that care can be improved.

#### **8.2.4 Change and the quality of care**

Improvements to care will invariably involve change. In this environment of power, vulnerability and fear, change, is unlikely to be welcomed. For the powerful figures change is a direct threat against the status quo. For those who are more vulnerable change may be impossible. For the majority of staff, change is likely to entail more paperwork, procedures, and higher expectations that will add to their workload and stress.

In addition, findings from this study indicate that people had developed their own survival strategies. From the senior staff to the *khālas*, they were using their job and position to survive the hostile work environment and to help their families survive economically and socially. The *shīrnī* - gifts or bribes, the benefits to family members such as training in clinical skills, the compliance with powerful people to keep the job, the caring for important people to strengthen the family connections, and blaming others to avoid blame and shame on the family, all represent survival strategies. Change would threaten these strategies.

The power struggles, vulnerability, fear and horizontal violence in this hospital form an immense barrier to positive change. If standards of care are to improve the extremes of power and vulnerability must be addressed. The people who are obstructing change and a culture of kindness and care need to be dealt with or they will constantly undermine change. In addition those who are particularly vulnerable need protection, support, and encouragement. There needs to be a cultural institutional change. This will require vast political will and strength; it will also need wisdom and humanity.

### 8.2.5 Humanisation

One of the central findings of my study is that approaches must be found that humanise the healthcare providers; approaches that respect and nurture their humanity, that do not treat them as unfeeling objects that can don uniforms and work in mechanistic ways. For 'real' caring to occur, healthcare providers have to experience care themselves. Approaches must be found that respect their limitations in terms of workload, acknowledges their personal and family struggles for survival and their need for rest and healthcare.

In one of my background interviews a doctor who has been working in women's healthcare for many years shared her experience. They work in the community predominantly amongst poor families.

“When I joined this organisation there were some poor quality midwives. In the past they had worked at the hospital and to begin with they had the same (bad) behaviour here. Slowly, slowly, in very good way and manner I trained them, I explained *'this is **not** the hospital, we are an organisation working for the poor, we should improve this and this'*...Finally they changed - if you saw their behaviour today – completely different. They are working with poor people in a very dirty environment and they even help with changing nappies”.

In addition she talked about staff whose family situation affected their behaviour:

“Some of our staff, they are very traumatised because of their husband’s behaviour, but at least during the day they are busy with their work, and they have **very** nice behaviour around them, from the beneficiaries and from the management. Slowly, slowly they will change”.

She explained that she had created a friendly, caring, appreciative environment in the organisation and had enforced high standards of behaviour. Gradually the behaviour of her staff had changed. This doctor was able to change behaviour in part because she had the authority and power to compel staff members to comply with standards of care. Changing behaviour in large public hospital would be more challenging but not impossible.

An initiative to humanise care for women in a Benin hospital significantly increased women’s satisfaction with care. Fujita and colleagues (2012) decided to examine the effect of humanised care on those who had implemented the programme, midwives, obstetricians and other providers. In-depth interviews were conducted with staff two years after the commencement of the programme. Despite initial hesitation and difficulties the staff revealed that humanised care had affected them, not only women in childbirth. Improved communication by staff with women and their families resulted in closer relationships between staff and labouring women. The midwives reported increased self-esteem, awareness of their professional value and a resulting increase in job or ‘moral’ satisfaction. Fujita and colleagues describe the “highly positive cycle for those practicing humanised care” (p.485). The humanising care initiative they concluded, not only benefited women in childbirth, their families and the staff involved in the humanising care initiative, it also affected the wider hospital culture as other staff reflected on their manner of communication with women.

The women of this Kabul hospital are all affected by a lack of respect and human kindness, oppression and dehumanisation. This includes not only the women who come to give birth to their babies there but also the women who work there. The degrees of dehumanisation are different, the need for a

fundamental cultural change, however, is crucial for all of them. For a brief time, the lives of these women are interconnected. For the staff, the noxious mix of workload, a hostile environment and social obligations combined with histories of violence, upheaval and loss sometimes results in them treating perinatal women in a cruel and inhuman manner. But this is not only about individuals; there are gross failures of management and the MoPH to protect women in childbirth and protect the healthcare providers. Although they are aware of the challenges in care, in skill acquisition, workload and the detrimental effects of *wāsiṭa* these have not been addressed. Finally, there is the powerful social narrative that devalues women and, I suggest, compounds the inhumanity of women towards other women. As Erdman (2015, p.46) contends “analysis focused on the ... single act (of abuse), the victim and the perpetrator risks obscuring the structural injustices that breed disrespect and abuse in healthcare, thereby hiding their social, political and economic origins”

## **8.3 Discussion of research process**

### **8.3.1 Strengths and limitations**

#### ***Strengths***

This study is one of the first of its kind to examine the experiences, perspectives and social realities of Afghan healthcare providers. It has generated new insights into the underlying constraints to quality care for perinatal Afghan women. This is evidenced by a paper, based on the research presented in this thesis, published in a leading medical journal in the field of obstetrics and gynaecology (Arnold et al. 2014)(see Appendix I BJOG Article).

Sub-optimal care within facility-based childbirth and disrespectful behaviour of staff towards perinatal women is an issue of concern not only in Afghanistan but globally. Each cultural setting is unique and specific findings from this study cannot be generalised. The ethnographic approach that was used, however, which encompassed the social context as well as biomedical and clinical elements is applicable in any setting. This study has demonstrated the potential

of inductive qualitative studies in understanding the obstacles to achieving high quality care. Qualitative studies are especially appropriate in cross-cultural research where, as outsiders, even defining questions to ask is impeded by cultural assumptions (see 4.2.2).

Although the neglect, abuse and sub-optimal care of women in facility-based childbirth are currently receiving significant attention, it is predominantly focused on the perspective of perinatal women or interventions to educate healthcare providers. This study presents a more unusual perspective demonstrating the many complex issues that affect the ability of healthcare providers to care. These findings have relevance for similar settings in other low-income countries, furthermore, this study indicates that each setting is likely to have its own 'context specific' factors. Analysing the root causes of sub-optimal care from the perspective of the healthcare providers may contribute unique insights, which will be helpful in designing effective interventions.

### ***Limitations***

A limitation of my research is that only one hospital was studied. The study design originally included two hospitals (see 4.3.1) to increase the generalisability of the findings (Holloway and Wheeler 2010). The timeframe for PhD data collection, however, did not allow sufficient time for delays in recruiting an interpreter, in obtaining the necessary permissions, and for security issues. In addition the volume of data generated precluded moving to a second hospital. Nevertheless, based on my experience in other settings, I would suggest that the ideas uncovered in this research are transferable to other situations.

Another limitation was the use of an interpreter. Whilst every effort was taken to reduce the negative impact of translation during each phase of the study (see 4.3.14), some clarity, cultural nuances and richness was bound to have been lost in translation. Major findings have not been based on one statement or

interview but on the congruence of multiple sources, usually including interviews conducted in English and observation.

The inclusion of only two community focus groups resulted in limited data compared to those from the healthcare providers. Although this could be considered a limitation, the study's primary focus was the healthcare perspective and secondly background interviewees supplemented and concurred with the experiences and perspectives of women in the community. Thirdly, my observations of care were similar to these women's accounts of care.

As an outsider, a non-Afghan, it is easy to be critical of, misunderstand and falsely represent a system of which I have only limited understanding. I have been aware of this limitation and endeavoured to check and crosscheck information with both Afghan colleagues and/or non-Afghans who have a deeper understanding of the country and culture. The outsider stance also has the advantage of being able to see things that insiders who are so familiar with the setting cannot see (Corbin Dwyer and Buckle 2009).

### **8.3.2 Ethics**

Over the course of this research my awareness of ethical challenges inherent in the study has increased. As Murphy and Dingwall (2007) point out, the process of ethnographic data collection can be relatively straight forward compared to the dilemmas of 'writing up,' and the myriad of decisions regarding how to represent those studied in the public arena. During the writing of my first published article this became intensely troubling to me: what to say and what to leave unsaid, how to write with integrity, without shaming or betraying trust. I realised that whilst ethical approval frameworks are created to protect and guide, they are impotent against the 'pen' of the researcher. I realised how cautious the researcher must be as words can be easily committed to paper but they cannot be undone.



The hopes and expectations of participants are another part of the ethical responsibility I feel; the wish to make a difference and to honour the confidences that some, in particular, shared. This is especially difficult, because with the present political instability in Afghanistan I am not sure when I will be able to return to share my findings with key stakeholders who could make a difference. Both of these issues are ones I continue to grapple with.

### **8.3.3 Researcher reflections and issues**

#### ***8.3.3.1 The power of the researcher***

In discussing power I have to acknowledge the power of the researcher and acknowledge the choices that I have made, including the reasons behind them. The findings presented in this study represent a multitude of choices: what to study, whom to interview, which quotes to use, what data to include and which to disregard. The most difficult choice for me has been which perspective to present. From its early inception until today I have grappled with an inner drive to understand if the healthcare providers were the oppressed, the oppressors or both. Each piece of data, new information, different perspective on the culture and behaviour of the healthcare providers tipped the scales a little more in one direction or another. One day I felt sympathy for healthcare providers, another day outrage, but overriding all of this was a deep sense of responsibility for the choices I was making.

I have tried to present a broad overview of the culture of care, the neglect, disrespect, abuse and exploitation suffered by the women who came to give birth in the hospital as well as the disrespect, humiliation and exploitation that doctors, midwives and care assistants themselves suffer. The predominant focus of this study was the healthcare providers perspectives and behaviours. It must be stressed, that these individuals are not a homogenous group; there are differences in perceptions, values and aspects of power. I decided to focus on the effect of power on care and the vulnerabilities of the healthcare providers, rather than the abuses. This story needed telling and I decided that it had more potential to bring about positive change. To focus on the abuse would achieve

little at this moment as international troops withdraw, international funding in women's health has declined and the influence of foreigners is greatly reduced. To highlight the more shocking aspects of abuse and exploitation within the hospital would shame a health system that has survived against the odds. It would feel like a betrayal of trust and be unlikely to achieve anything other than alienation. To focus on the more vulnerable side of the healthcare providers is to share my journey of discovery. First and foremost it has been me who has been challenged and changed by this PhD journey. I realised that I have lived and worked alongside Afghans for many years without comprehending many aspects of their lives. I have worked to improve women's healthcare but been blind to my underlying assumptions about the motivations of doctors and midwives. I have seen some results, but was convinced that there was much beneath the surface that was being missed by the international community, myself included.

The focus on power, vulnerability, social and cultural challenges which the midwives, doctors and *khālas* face, is to bring new knowledge that will not allow non-Afghans to judge Afghan healthcare providers, but rather, will hopefully challenge assumptions, it suggests that we need to listen and change, rather than come with the answers.

This is one side of the story; it is also the easiest to tell because it was probably the more vulnerable staff who talked with me. Powerful staff did not need to talk to me, or to show the normal Afghan politeness to 'a guest' in their country. As one doctor, who I approached and greeted said in *Darī* (not knowing that I understood her), "I don't have the patience for this!" (i.e. for me).

### **8.3.3.2 Broadening the remit of the study**

In the beginning my study focused on the behaviour of healthcare providers particularly interpersonal communication, kindness and compassion: clinical care was not included. My initial rationale was that I thought that the gaps in knowledge were issues of staff/perinatal women interactions, behaviour and the

values driving behaviour, not issues of technical 'know how'. Secondly, I considered that clinical care had been comprehensively addressed over the last decade. In practice, however, it was not easy to compartmentalise 'care' and only look at interpersonal communication and attitudes. As a midwife I could not ignore clinical care and as a qualitative researcher I could not disregard the concerns and priorities of study participants and only hear 'what I was interested in'. After submitting the first article from my PhD research the clinical reviewers asked me to explain the clinical relevance of my findings. Having been forced to revisit my analysis and re-examine the clinical aspects I realised that clinical care was an aspect that had to be included. Care, and 'quality of care' in this study therefore includes: behaviour, attitudes, clinical expertise and skills, interpersonal communication, and Afghan women's definitions of 'good care'.

#### **8.3.4 Social context**

This study was not an attempt to define 'Afghan womanhood' per se as any representation of Afghan women will be limited, incomplete and influenced by my background, values and prejudices. At times it will probably be incorrect. This was, however, an attempt to look beyond the surface, to explore and listen to the perspectives of a particular group of Afghan women – the midwives, doctors and *khālas* of a Kabul maternity hospital and the women for whom they cared.

It is necessary to note that many influences on the behaviour of individual healthcare providers, including their personal histories, family dynamics and culture, cannot be changed. Although these pressures, influences and expectations cannot be changed they can be acknowledged, analysed and explored further. They can also be used to strengthen interventions. One background interviewee explained that a relief organisation, who understood the power of social opinion and the fear of shame, gave district governors a budget to use for the benefit of the district. They then gave them monthly scores for the way that this money was spent; everything was published online. This

public transparency ensured that public money was spent with thought and care as each governor competed with the others to be top of the list. I argue, therefore, that understanding culture, history, social constraints is not about changing those things, or conversely writing them off as irrelevant; rather, it is about understanding them and engaging with them in intelligent, creative ways. It is about learning new ways to achieve goals by employing locally appropriate and effective strategies.

There were several aspects of the social context that were not included in the remit of my study. The reasons were primarily because of the time constraints inherent in a PhD, not because I was unaware that they were important elements. Islam is central to life within Afghanistan and some healthcare providers talked of faith during interviews. Originally I had hoped to investigate the role of Islam in work and in motivation. However, I decided not to include this in the study protocol partly because of time constraints, but also because I realised that it would be a more appropriate focus for a Muslim researcher.

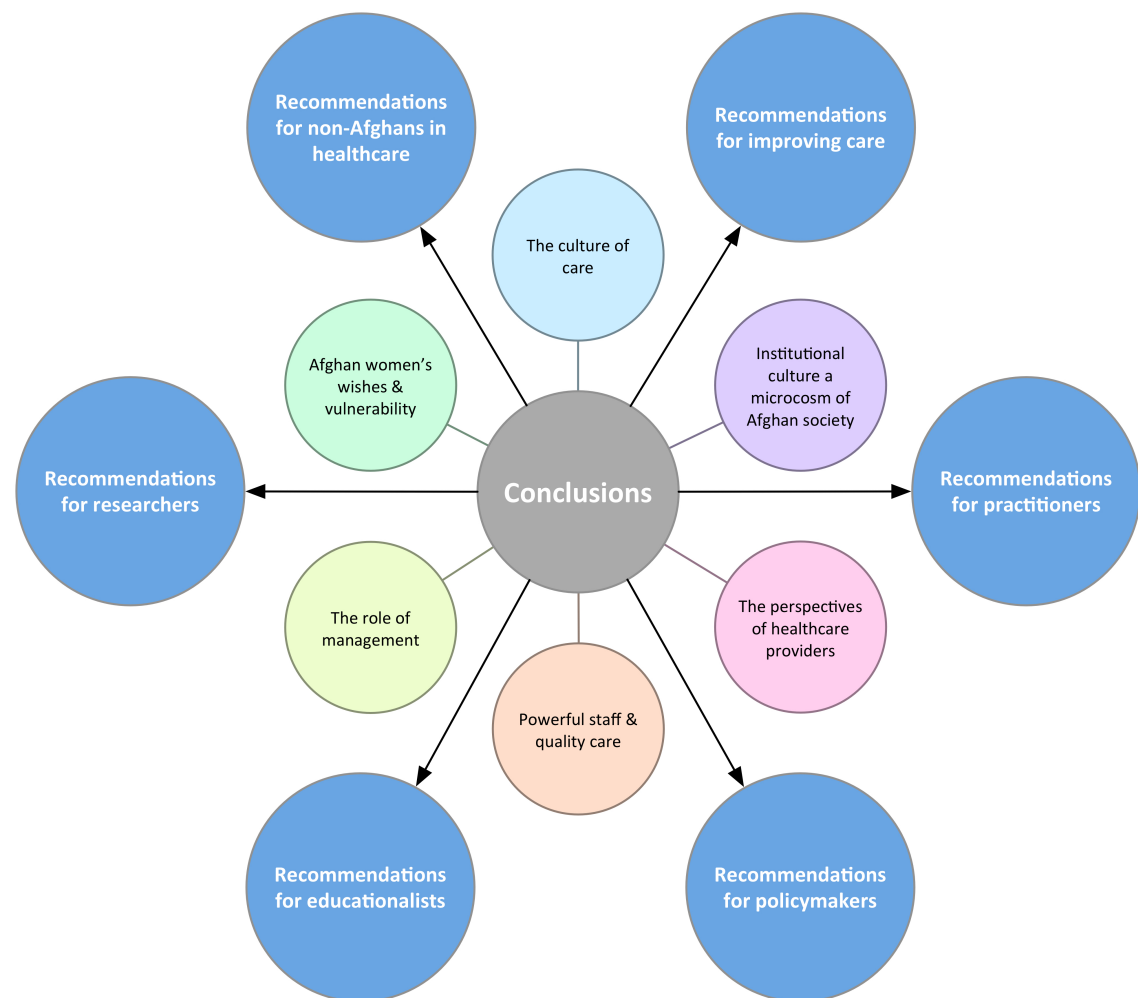
One of my first questions regarding healthcare providers was whether more than 30 years of conflict, loss and trauma adversely affected their behaviour. Several studies (van de Put 2002; Lopes Cardozo et al. 2004) had indicated that there were high levels of post-traumatic stress disorder and mental health problems amongst Afghans (see 2.3.7). A further study, however, and several conversations with counsellors during data collection indicated that despite high levels of trauma, people were more affected by their 'concerns about today' than what had happened in the past (Omidian and Miller 2006). Originally I was interested in the link between post-traumatic stress and empathy. I realised, however, that as an exploratory study it was important to keep the study broad rather than limiting possible outcomes.

Another social dynamic that I have not included is whether ethnicity affects care, healthcare provider relationships and opportunities. Once again there was neither the time to investigate this issue nor the space in this thesis to discuss

conversations related to ethnicity. I was also not comfortable to ask direct questions regarding ethnicity; I felt this was a sensitive area and did not want to raise issues of difference and risk bringing questions of difference into the workplace: if they were not there already.

## Chapter 9 - Conclusions and recommendations

In this chapter I draw together the conclusions from this research and offer recommendations for practice, education and research around improving care and working conditions in this Kabul hospital.



**Figure 7: Chapter 9 overview**

The aim of this study was to explore the culture of care in a Kabul hospital, to understand the perspectives of healthcare providers on care, their roles, and the barriers and facilitators to providing quality care. The experiences and wishes of Afghan women who had given birth to babies in Kabul maternity

hospitals were sought as a lens through which to view and interpret the service on offer. In relation to this aim, the main findings of my study were:

## 9.1 The culture of care

A maternity service is provided in this hospital but it often lacks basic clinical inputs, it is inequitable with little consideration for the psychosocial aspect of care. Women in the community, background interviewees and my observations confirmed that caring and kindness were the exceptions. Women and their unborn babies were vulnerable. They were at high risk of complications through neglect and inexperienced resident doctors who lacked vital clinical skills (see 6.2.1). The lack of monitoring of women and their unborn babies during labour and immediately after birth was also a concern (see 5.1.4 & 5.1.9). While this can in part be attributed to workload it was notable that midwives, who were all trained in the use of the partograph, were rarely seen checking women and completing it.

Interpersonal support was particularly missing as women were not permitted to have family members with them and healthcare providers appeared impervious to their distress and cries for reassurance and help (see 5.1.5 & 5.1.6). Women were frightened of the healthcare providers and did not trust them (see 5.3). Some women reported giving birth alone in the corridors of the hospital, being asked for money, ridiculed and humiliated by midwives, *khālas* and doctors (see 5.1.3, 5.1.8 & 5.2). Two factors increased the level of attention and care women received, first they had to know someone or have *wāsita*. Second, they had to give money to the midwives, *khālas* or doctors, but it had to be 'enough' money (see 5.2). In common with women in many other countries, poor, illiterate women who did not know anyone in the hospital were especially at risk of neglect (see 5.6.2). Many women in childbirth were depersonalised as they were separated from family, stripped of their agency and dignity, denied human kindness and information about their condition: they were treated more like objects than persons (Haslam 2006) (see 5.6.3). Identifying the underlying

causes for this depersonalising hospital culture has been the quest of this study.

## **9.2 Institutional culture: a microcosm of Afghan society**

The values and discourses of Afghan society also defined this institution. The traditional patriarchal society with the sacred “inviolable norms” (see 8.1.5) ensured that fulfilling family obligations dominated hospital life. Employment was not only valued for the income, it was also considered an opportunity to benefit family members and strengthen the family social network. Hospital staff were expected to care for important contacts and relatives when they had their babies, help family members secure jobs, training courses and learn new skills (see 6.4, & 6.6.3). In this client-patron society having important connections or *wāsita* was the key to advancement, vital for securing jobs, keeping jobs and acquiring clinical skills. The hospital management complained they had little power, especially over staff with powerful connections. In this ‘shame and honour’ society (see 7.8.2) the fear of being humiliated in public or blamed for mistakes was used to control staff behaviour and achieve compliance by powerful senior figures (see 8.1.2 & 8.1.5). The dominance of traditional values in guiding staff priorities and behaviour resulted in inequity of care for poor women with no connections, and an inequity of opportunity for doctors, midwives and *khālas*. There was also inequity of risk as resident doctors who did not have *wāsita* in the hospital had a higher chance of clinical errors as they practised on the perinatal women. The effects of this social system had far-reaching effects as some doctors qualified as obstetricians without essential clinical skills, such as the ability to performing caesarean sections alone (see 6.2.1).

The recent history of conflict and experiences of violence in society and homes may have influenced the behaviours of healthcare providers (see 7.6.3, 7.7 & 7.8.4). Furthermore, the women who came to give birth to their babies and the women who worked in this hospital were all connected by an insidious



discourse, one that questioned the value of women's lives in Afghan society (see 8.1.5).

### **9.3 The perspectives of healthcare providers**

The heavy workload, high number of women with complications and the absence of a shift system contributed to staff stress and suboptimal care. Staff knew that they were not working according to the standards or as they had been taught but they said it was impossible. A shift system would have utilised staff more effectively and helped them to manage the workload. Although many staff spoke of the need for such a system there appeared to be an impasse between the MoPH, hospital management and some senior hospital staff who opposed the system (see 6.1). Each cadre of healthcare providers had distinct perspectives and frustrations but the desire to be appreciated, respected and supported was important to all. The lack of appreciation, respect and value that they experienced from their managers disappointed and demotivated them (see 7.1 & 7.8.1).

Resident doctors struggled to acquire the vital clinical skills and decision-making abilities unless they knew a senior doctor in the hospital, as many trainers were reluctant to pass on their skills. Residents without *wāsīta* were generally left alone managing women giving birth and women with complications from their first night duty. They had no option but to learn by trial and error (see 6.2.1). They worried about making a clinical error and being taken to court (see 7.3). Midwives were in the position of having skills but being forbidden or intimidated against using them by senior midwives and doctors (see 6.3 & 6.6.4). Their disappointment at not using their skills was compounded by the demand that they perform, what was considered degrading work for educated women, bed-making (see 6.3). The *wāsīta* system also affected the selection process for training courses and workshops, job security, and protection against blame or legal action. Those without powerful connections were vulnerable. For the *khālas* work in the hospital was usually precipitated by the loss of their husband and the need to survive economically

(see 6.4.2). They performed menial, physically demanding work with frequent night duties. Although the *khālas* felt neither appreciated nor cared for and suspected they were being cheated out of money, they were frightened of complaining, as the job was all that stood between them and destitution (see 7.4 & 8.1).

#### **9.4 Powerful staff and quality care**

All staff in this hospital had a degree of power (see 8.1.1). Even the *khālas* had power. *Khālas* had power over women in childbirth and their families as they controlled access to the hospital and relayed medicines, vital supplies and food. All staff members were on a continuum between power and vulnerability. The struggle to maintain power contributed to the climate of fear and the lack of trust between staff (see 8.1.2). Staff relationships were marked by horizontal violence. There was a culture of blame, fear of warning letters and subsequent job loss (see 7.3 & 7.4). Despite some exceptions, doctors, midwives and *khālas* were quick to accuse each other of making mistakes; senior staff publically humiliated junior staff. There was a lack of respect, kindness and compassion, even for staff members who were seriously sick (see 7.5 & 7.7). The roots of oppression that precipitated these destructive behaviours may have originated in the hospital, alternatively they may have originated from violence and oppression during Afghanistan's recent conflicts, from society, or from within families (see 7.8.4).

For many doctors, midwives and *khālas* the hospital setting was possibly the only place where they could exercise significant power. Survival entailed avoiding shame through, for example, blaming others, humiliating other staff members in the morning report, or extorting money from the families of labouring women (see 7.2, 7.3 & 5.2). The primary focus of staff in this hospital was more on personal and family survival than the care of labouring women (see 6.4.3 & 6.4.4).

One of the most important findings of this study was that there were powerful, influential people who were working against change and setting the behavioural agenda. Kindness towards women in childbirth was discouraged (see 7.5). Staff members who were motivated to care for women found themselves working in opposition to senior staff who were endeavouring to maintain the status quo. These healthcare providers not only influenced the behavioural agenda towards women in childbirth but also influenced staff relationships. The use of intimidation, humiliation, blame and punishment to exert their authority and control undermined trust and created fear in the working environment (see 8.1.5). Driven by the need to survive, staff complied. The powerful senior healthcare providers were also role models for staff who acquired their habits and wanted to behave like them (see 7.5).

## **9.5 The role of management**

The hospital staff complained that their leadership was weak and that they did not check or enforce. They asserted that management could achieve more even with its limited authority. The hospital management placed the responsibility for care and the blame for poor care on healthcare providers but showed no openness to listen and work on problems (see 7.7). Staff complained that the hospital management focused on unimportant things (see 6.5.3), not on how women were being cared for. The MoPH has an abundance of policies advocating respectful, high quality equitable care (see 3.3.1), but these have not been implemented in the hospital, they do not reflect the experiences of women, or my observations. Interviews with MoPH staff revealed that they are aware of problems (see 5.2 & 6.2.1). To date, these problems have not been addressed effectively.

The authority of the Ministry of Public Health is vital for structural changes, such as introducing a shift system (see 6.1) and reforming the residency training programme to ensure that all resident doctors develop their clinical skills (see 6.2.1). Furthermore, the MoPH undermines the authority of hospital management when they do not back their decisions (see 6.5.1). It is unclear

why the authority has not been used to improve standards of care for women in childbirth. In addition, the MoPH visits to the hospital appeared symbolic, rather than an attempt to monitor care. Male MoPH officials could only visit the hospital offices and could not observe care or speak to perinatal women (see 6.5.2). The Ministry of Public Health hold the ultimate responsibility for care in this Kabul maternity hospital. There are indications, however, that behind the policies and bureaucracy in the MoPH the *wāsita* system (see 6.5.1 & 8.1) is strong.

## **9.6 Afghan women’s wishes and vulnerability**

Finally, care in this hospital bore little resemblance to the sensitive, respectful and high quality care which women in the community wished for (see 5.5). Women were frustrated that they had to pay for medicines that should have been free and ‘pay’ healthcare providers to help them (see 5.2). The highest priority for the majority of women in the community, however, was respect and kindness from the healthcare providers. They considered that kindness could heal and that it was more important than professional skills. They also wanted well-trained doctors that were responsible and serious in caring for them. They did not trust the doctors, their competence or their care (see 5.3). They understood that unless they knew someone in the hospital or paid they would not receive good care. Their vulnerability was illustrated by the admission that they knew there were good doctors but did not know how to distinguish between them (see 5.5). The neglect, humiliation, extortion and dehumanisation of women in childbirth was an abuse of power, a perversion of a system that purported to serve the needs of the public but was serving the needs of the staff.

## **9.7 Recommendations for improving care**

The following recommendations are grouped into recommendations for policy, practice, education and research. Some recommended solutions require further analysis of the issues as the situation might have changed since data collection.

Most important is my advice that, regardless of whether the recommendation is aimed at hospital management, MoPH, policy makers, educationalists or researchers, the opinions and ideas of the healthcare providers are sought. They understand the barriers to care and the quality of care depends on them.

### **9.7.1 Recommendations for practitioners**

The primary responsibility for standards of care in Kabul maternity hospitals belongs with the Ministry of Public Health and senior hospital management. This study has shown that improvements in care depend on these agencies as they can authorise structural changes to facilitate caring.

Senior hospital staff members who oppose change must be addressed, or they will undermine and threaten initiatives to improve the quality of care (see 8.1.2 & 8.2.4). Although this is the responsibility of the MoPH, government support might be required to achieve this.

It is vital that the MoPH exerts strong leadership in guiding the organisation and provision of care for women in childbirth. Policies regarding standards of care could be adapted if necessary but then need implementation and enforcement by hospital management. The MoPH can ensure that this is happening by sending female, rather than male representatives of the MoPH to the hospital for supervisory visits (see 6.5.2 & 9.5). These female representatives can then visit the wards, observe what is happening and talk to women, their families and the healthcare providers. It would be beneficial for senior hospital management to visit the wards regularly, investigating and checking standards of care alongside bureaucratic issues (see 6.5.3). The MoPH and hospital management need to ensure that women are monitored regularly in labour with the aid of the partograph and that postnatal women are being checked before being discharged from the hospital. This would reduce the number of maternal and perinatal fetal deaths. Midwives as well as doctors should be required to do this task (see 5.1.4 & 5.1.9). Adverse consequences for negligence will help to make this a priority.

Fair and equitable human resource management is essential if conditions are to improve. The MoPH is able to ensure that staffing and training decisions are not influenced by relationships or *wāsita*, and that there is equity in the hospital environment. As the MoPH demonstrate leadership in equity, they will be enabled to promote and enforce this in the hospital environment also. In addition, the hospital management can ensure that the selection process for workshops and training opportunities is fair, based on need and not family connections (see 6.6.6 & 9.2).

Staff management practices in the hospital need to be more caring to ensure that staff are encouraged and supported (see 7.1 & 7.8.1). One suggestion is that the MoPH might enlist the services of an IGO or NGO to facilitate a training programme in supportive (rather than punitive) supervision for the hospital managers. Ongoing supervision and support for hospital managers would help ensure the training is implemented.

Staff members need to feel that their contribution and work is valued and appreciated (see 7.1 & 7.8.1). Together the MoPH and hospital management could develop a system for publically recognising staff members who are working well. This could be verbal or written praise and acknowledgement although safeguards would be required to ensure fairness and impartiality. Thorough investigation of complaints and incidents including discussion with staff members, women and/or their families prior to warning letters or punishments is imperative in ensuring fairness and equity (see 7.3).

### **9.7.2 Recommendations for policymakers**

Policies advocating high quality, equitable, respectful care exist (see 3.3.1), but have not been implemented. The international community guided policy development and their support is now required to help the MoPH and hospital management translate these policies into practice.

A fundamental cultural change is vital for the wellbeing of both women in childbirth and also the healthcare providers. Policymakers and all stakeholders, including ideally community representatives could examine and consider several options. The strength of a humanising childbirth approach is that it would not introduce another power dynamic but rather promote the dignity and value of all. This could commence as a small-scale pilot scheme with staff volunteers. Commitment and support from the MoPH and hospital management is important, as institutional cultural change will take time to achieve.

A robust system needs to be established by the MoPH for the residency-training programme to ensure that all residents acquire the vital clinical skills and decision-making abilities. The instigation of logbooks to record experience and competencies could be part of the solution. To ensure that changes are not 'on paper only', the MoPH and hospital management must require trainers train all residents, not only those with whom they are connected (see 6.2.1 & 6.6.5). A MoPH system of programme monitoring would be prudent as this system cuts across traditional institutional and social culture and may take time to be accepted.

It is critical that staff members are utilised more effectively over the 24-hour period, and that they are given more time to rest, study and fulfil their responsibilities at home. It is recommended that the MoPH and hospital management identify the current obstacles to implementing a shift system, commit to finding solutions as an urgent priority (see 6.1). The support of donors could potentially fund the extra transport requirements.

Health education initiatives could raise public awareness of critical factors in pregnancy and childbirth. NGOs and/or IGOs in conjunction with the MoPH and healthcare providers could have a valuable role in designing and developing culturally sensitive health education tools for TV, radio and Internet (see 6.5.2). Several healthcare providers had creative ideas for styles of presentation that would appeal to a wide audience. Healthcare providers involvement in planning

would add relevance not only in presentation styles but also in selecting key messages as they are aware of the critical gaps in knowledge for women and their families.

### **9.7.3 Recommendations for educationalists**

Interactive participatory styles of learning should be used in training programmes to enable learners to question and critically appraise (see 7.1 & 7.8.3). This will improve learning but will also provide an alternative model from the normative, didactic style of education that discouraged questions and has been incorporated into 'staff-patient' interactions where staff members do not tolerate being questioned (see 5.1.3).

Learning modules on ethical behaviour, effective communication, respect for all and equity in healthcare need to be added to the medical education curriculum. All stakeholders, including MoPH, MoHE, IGOs and NGOs could work together to design and introduce these modules.

Strong role models, including both midwives and doctors who are working in the hospital, should be identified, supported and given training/mentoring roles with newly qualified midwives or doctors. These role models would be opposing the dominant culture and status quo, however, and could experience powerful opposition. They would need support and encouragement.

### **9.7.4 Recommendations for researchers**

Many areas were identified in this exploratory study that would benefit from further research.

The pressure on staff from the workload, long hours and lack of time off was said to have caused illness and stress (see 6.1). A psychological assessment of



staff members could clarify levels of burnout. If this is found to be a significant it would strengthen the case for a shift system.

Research examining the reasons behind the high uptake of services in this Kabul maternity hospital compared to other facilities is required. Of particular importance would be recommendations for increasing the acceptability of other facilities for families and women in labour to decrease demand and reduce the workload in this hospital (see 6.1 & 6.6.1).

Action research on small-scale issues of quality would have the potential to increase the interest of healthcare providers in improving care for women. Healthcare providers from each cadre, for example, could be involved in designing interventions to address issues that they consider important.

#### **9.7.5 Recommendations for non-Afghans in healthcare**

This study has shown that social norms and culture had a far-reaching impact on staff behaviour and performance. Non-Afghans working in healthcare need to investigate and understand such norms and culture and their impact on health services. Cultural insiders can contribute new insights into implementation challenges and new ways to achieve goals by employing locally appropriate and effective strategies.

## Epilogue

At the beginning of this thesis is a Persian poem – it is, Afghan friends tell me, the favourite poem of many, if not the majority of Afghans. Traditionally this poem would be recited in homes, it would be one of the first poems that small children would hear and be taught. I came across it at the beginning of my study and immediately loved it. It linked so many themes, my Christian faith, and the Muslim faith of my Afghan colleagues and friends, and it talked of feeling compassion as an essential part of being a human being. I loved this poem, but at the same time I used it in judgement against the lack of compassion that I saw and struggled to understand or to excuse. How could a nation who espoused such beautiful sentiments behave in this way towards fellow human beings? How could women be so unfeeling and cold towards other women?

Now, at the end of my study, I revisit this poem and my harsh judgements of the doctors, midwives and *khālas* of the Afghan maternity hospitals. Now I see that the poem contains a challenge for me: ...“if one day, one of its members suffers, the rest of its members do not stay silent, if you are undisturbed by the suffering of others you should not be called a human” (Loewen 2010b).

I do not know what it will take to change the narrative regarding the value of women’s lives in Afghan society, nor if there is the power and will to challenge the structural injustices that affected care in this hospital. It is my hope, however, that those who are oppressed will one day start to speak out and regain their God-given humanity.

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## Appendices

## Appendix A Overview of background interviews<sup>30</sup>

Ref #	Professional background/ experience	Face-to-face/ Skype/ email	Interview location
1B1a	Afghan community leader, ex parliamentarian	Face-to-face	Private home Kabul
1B1b	Non-Afghan midwife – 6 years experience mother & child health programmes & midwifery training programme Afghanistan	Skype	Skype
1B2	Non-Afghan nurse with midwifery experience. 14 years experience in health programmes in Afghanistan	Face-to-face	UK
1B3	Discussion with two female non-Afghan nurses and a lawyer – each has been resident/working in Afghanistan for over 25 years	Face-to-face	Private home Kabul
1B4	Non-Afghan physiotherapist – more than 16 years in Afghanistan. Fluent in Dari	Face-to-face	Office in Kabul
1B5	Non-Afghan doctor 11 years experience working in Afghan health system & training Afghan doctors. Fluent in Dari	Face-to-face	Private home Kabul
1B6	Non-Afghan anthropologist PhD student just finished 6 months fieldwork living in Afghan home in semi remote village. Previous fieldwork in Afghanistan	Face-to-face	Private home Kabul
1B7	Non-Afghan – PhD in Afghan/Iranian culture & language	Face-to-face	Private home Kabul
1B8	Non-Afghan midwife 7 years experience in Afghan midwifery training programmes	Face-to-face	Training institute Kabul
1B9	Senior Afghan female doctor – Afghan Ministry of Public Health	Face-to-face	Ministry of Public Health, Kabul
1B11	Afghan community leader, ex parliamentarian	Face-to-face	Private home Kabul
1B12	Afghan community leader, ex parliamentarian	Face-to-face	Private home Kabul
1B13	Non-Afghan researcher gender and Afghan traditional justice	Face-to-face	UK
1B14	Non-Afghan researcher gender and Afghan traditional justice	Face-to-face	Kabul

<sup>30</sup> Some details of participants have been changed to protect their identities

<b>Ref #</b>	<b>Professional background/ experience</b>	<b>Face-to-face/ Skype/ email</b>	<b>Interview location</b>
<b>1B15</b>	Senior Afghan researcher, native Dari speaker	Face-to-face	NGO office
<b>1B16</b>	Senior Afghan researcher, native Pushtu speaker	Face-to-face	NGO office
<b>1B18</b>	Non-Afghan Afghan historian & researcher	Face-to-face	Private home Kabul
<b>1B19</b>	Afghan senior midwife with experience in midwifery training programme	Face-to-face	Kabul
<b>1B20</b>	Non-Afghan midwife	Face-to-face	Office in hospital Kabul
<b>1B21</b>	Non-Afghan researcher	Email	Email
<b>1B22</b>	Non-Afghan university dean working with Afghan universities more than 20 years	Face-to-face	Kabul
<b>1B23</b>	Non-Afghan university dean working with Afghan universities more than 20 years	Face-to-face	Kabul
<b>1B24</b>	Afghan community leader, ex parliamentarian	Face-to-face	Kabul
<b>1B26</b>	Afghan staff of Afghan NGO specialising in counselling	Face-to-face*	NGO offices Kabul
<b>1B27</b>	Non-Afghan teachers/educationalists working in Afghanistan for more than 30 years	Face-to-face	Private home Kabul
<b>1B28</b>	Non-Afghan couple – Afghan cultural expert and midwife	Face-to-face	UK
<b>1B29</b>	Non-Afghan educationalist with experience in community development	Face-to-face	Private home Kabul
<b>1B30</b>	Afghan community leader, ex parliamentarian	Face-to-face	Private home Kabul
<b>1B31</b>	Non-Afghan nurse several years experience in Afghanistan	Face-to-face	Hospital office Kabul
<b>2B1</b>	Afghan female doctor working in reproductive health with NGO	Face-to-face	NGO office Kabul
<b>2B2</b>	Senior Afghan midwife with research experience, official at the Afghan Midwives' Association	Face-to-face	Office Kabul
<b>2B3</b>	Afghan female doctor working in reproductive health	Face-to-face	NGO office Kabul

<b>Ref #</b>	<b>Professional background/ experience</b>	<b>Face-to-face/ Skype/ email</b>	<b>Interview location</b>
<b>2B4</b>	Non-Afghan educationalist working in Kabul medical university	Phone interview	Kabul
<b>2B5</b>	Senior female doctor Afghan Ministry of Public Health	Face-to-face	Afghan Ministry of Public Health Kabul
<b>2B6</b>	Afghan community leader, ex parliamentarian	Face-to-face	Private home Kabul
<b>2B7</b>	Afghan official at human resource department Afghan Ministry of Public Health	Face-to-face	Afghan Ministry of Public Health Kabul
<b>2B8</b>	Afghan female doctor overseeing midwifery training programme for international organisation	Face-to-face	NGO office Kabul
<b>2B9</b>	Director of Afghan NGO working to support women victims of violence – an Afghan female doctor trauma counsellor	Face-to-face	Office Kabul
<b>2B10</b>	Non-Afghan nurse with more than 25 years living and working in Afghanistan in health programmes	Face-to-face	Kabul
<b>2B11</b>	Non-Afghan doctor who worked in Afghanistan in 1970's and from 2004 onwards	Skype	Skype
<b>2B12</b>	Afghan senior midwife with experience in midwifery training programme & previous responsibilities in Afghan Midwives Association	Skype	Skype

\* with partial translation

## Appendix B Overview of observations/ Kabul hospital

Day	Time of day	Length of observation	Location [Comments]
1	Morning/ afternoon	7 hours	Training centre/ outpatients-admissions department [Introduction to doctors at morning report]
2	Morning/ afternoon	6 hours	Outpatients-admissions department [Introduction to midwives at morning report]
3	Afternoon/ evening	4 ½ hours	Outpatients-admissions department [Observation cut short - interpreter issues]
4	Morning/ afternoon	5 hours	Labouring rooms, high risk & intensive care area
5	Morning/ afternoon	6 hours	Labouring rooms, high risk & intensive care area [Weekend]
6	Morning/ afternoon	5 hours	Labouring rooms, high risk & intensive care area [Midwives report]
7	Morning/ afternoon	5 hours	Labouring rooms, high risk & intensive care area & post natal rooms
8	Afternoon/ evening	4 ½ hours	Labouring rooms, high risk & intensive care area
9	Afternoon/ evening	5 hours	Delivery rooms
10	Morning/ afternoon	6 ¼ hours	Delivery rooms [Weekend]
11	Morning	4 hours	Midwives training session + delivery rooms
12	Afternoon/ evening	8 hours	Delivery rooms and whole hospital
13	Afternoon/ evening	5 hours	Delivery rooms, labouring room, outpatients – admission department.
14	Morning/ afternoon	6 ½ hours	Doctors morning report, post-natal wards, nursery
15	Morning	3 hours	Post-natal wards & labouring rooms [Weekend]
16	Afternoon	4 hours	Post-natal wards & intensive care ward
17	Morning	3 ¾ hours	Midwives report + theatre recovery post op rooms
18/19	Morning, evening, night	13 ½ hours	Whole hospital [Meeting with hospital director]

Day	Time of day	Length of observation	Location [Comments]
	Additional A		Meeting with hospital director and senior midwife [Preparatory initial visits to hospital to meet with senior staff]
	Additional B		Joint morning report with doctors and midwives
	Additional C		On-going observations during one month of interviews in hospital

## Appendix C Overview of semi-structured interviews<sup>31 32</sup>

Ref #	Professional background/ experience	Face-to-face/ Skype/ email	Translation yes/ no/ partial	Interview location
1ID1	Senior OBGYN doctor – 16 years experience	Face-to-face	Partial	Hospital training centre
1ID2	Specialist doctor - 5 years in hospital	Face-to-face	Partial	Hospital training centre
1ID3	Senior OBGYN & trainer - 10 years in hospital	Face-to-face	No	Hospital training centre
1ID4	1 <sup>st</sup> year resident doctor	Face-to-face	No	Private office
1ID5	2 <sup>nd</sup> year resident doctor	Face-to-face	No	Hospital training centre
1ID6	Senior female Afghan doctor	Face-to-face	No	Private room hospital
2ID1	Midwife – 3 years experience in hospital	Face-to-face	Yes	Empty ward hospital
2ID2	4 <sup>th</sup> year resident doctor	Face-to-face	No	Ward – with women hospital
2ID3	Midwife – over 30 years experience in hospital	Face-to-face	Yes	Empty ward hospital
2ID5	Midwife – several years of experience	Face-to-face	Yes	Empty ward hospital.
2ID6	Midwife - over 30 years experience in hospital	Face-to-face	Yes	Empty ward hospital.
2ID7	Midwife - 5 years experience in hospital.	Face-to-face	Yes	Empty ward hospital
2ID8	4 <sup>th</sup> year resident doctor	Face-to-face	No	Hospital training centre
2ID9	4 <sup>th</sup> year resident doctor	Face-to-face	No	Empty ward hospital

<sup>31</sup> All interviews conducted in Kabul Afghanistan unless otherwise stated

<sup>32</sup> Some details of participants have been changed to protect their identities



<b>Ref #</b>	<b>Professional background/ experience</b>	<b>Face-to-face/ Skype/ email</b>	<b>Translation yes/ no/ partial</b>	<b>Interview location</b>
2ID10	Midwife – 3 years experience in hospital. Several years working in another country	Face-to-face	Yes	Male surgeons room, hospital
2ID11	Midwife 6 years experience in hospital	Face-to-face	Yes	Laboratory staff rest room
2ID12	Midwife graduated 1 year previously	Face-to-face	Yes	Empty ward, hospital
2ID13	Specialist doctor 6 years experience in hospital	Face-to-face	Partial	Office in hospital
2ID14	Cleaner/care assistant approximately 15 years experience in hospital	Face-to-face	Yes	Empty private room, hospital
2ID17	Midwife experienced but short time in this hospital	Face-to-face	Yes	Hospital grounds
2ID20	Specialist doctor 6 years experience in hospital	Face-to-face	No	Office in hospital
2ID21	Midwife experienced but short time in this hospital	Face-to-face	Yes	Empty ward
2ID22	1 <sup>st</sup> year resident doctor (experience in other country)	Face-to-face	Partial	Empty ward, hospital

## Appendix D Community FGD2 (Demographics)

Date 8 May 2012

Location of FGD: Kabul

#	Age	Place of origin	Duration lived in Kabul	Attended school? (if yes - # of years)	Total # of children	Number born by location/ facility				Age of youngest child	Location/ facility youngest born	Daughters in law? (if yes - number)
						At home	Kabul public hospital	clinic/ provincial hospital	private hospital			
1	35	Wardak	Since birth/ Some years of migration in Iran	4 years	5	0	2	2 in hospital in Iran	1	2.5	Private Hospital	
2	55	Dah e Sabz, Kabul	Since Birth	No schooling, a few months of literacy course	5	4 with <i>dāya</i>	1			22	Hospital	2 (4 grandchildren all born in hospital)
3	27	Wardak	Since Birth/ Some years of migration in Pakistan	No schooling	3	2 with <i>dāya</i>	1			3	Home	
4	33	Wardak	Since Birth	4 years	2	1 with <i>dāya</i>	1			2	Hospital	
5	39	Kabul	Since Birth	12 years/is employed	5	3 with <i>dāya</i>	2			3		
6	39	Wardak	Since Birth	4 years	4		3		1	16		None
7	23	Wardak		4 years	2		1		1	9 months		
8	56	Wardak		Illiterate	4	4 with <i>dāya</i>				28		2 daughters in laws (one has 6 kids, the other 3, all born at home).
9	46	Barnyan	Since Birth	Illiterate	9	7 with midwife	2			3.5 years	Hospital	
10	30	Parwana		9 years	5	2 with <i>dāya</i>	3			2 years	Hospital	

## Appendix E Risk Assessment

### General Risk Assessment Form

Before completing this form, please read the associated guidance on 'I: Health & Safety/Public/Risk Assessment/[Guidance](#).

Use this form for all risks except from hazardous substances, manual handling & Display Screen Equipment (specific forms are available for these).

If the risk is deemed to be 'trivial' there is no need to formally risk assess.

All completed forms must give details of the person completing the assessment.

Risk assess the activity with its present controls (if any) -then re-assess if action is to be taken and after further controls are put in place.

The completed form should be kept within the School/Service/Department.

<p>1. Describe the Activity being Risk Assessed:</p> <p>An ethnographic study looking at care and compassion within Afghan maternity services. The student will be living in Kabul for a period of one month for vital data collection. Her activities are based for the main in a maternity hospital in Kabul city and NGO (Non governmental organisations) offices.</p>
<p>2. Location(s): Afghanistan – Kabul city</p>
<p>3. Persons at potential Risk (e.g. Specific Staff only, General Staff, Students, Public etc.):</p> <p>Participants in the study Rachel Arnold (MPhil/PhD student) Afghan nationals who work with her (Driver/Translator)</p>
<p>4. Potential Hazards i.e. <u>What Could Happen?</u>(NB: List hazards without considering any existing controls):</p> <p><b>BACKGROUND</b></p> <p>Afghanistan is experiencing a period of instability due to Anti Government forces active throughout the country. The presence of international coalition forces – International Security Afghanistan Force (ISAF) and the US troops is resented by these anti government elements (AGE). The main targets tend to be the ISAF forces, Afghan Government, Afghan Police, Afghan National Army (ANA) as they are seen as cooperating with the foreign forces. Afghans working with foreigners can also be targets as they are seen as working with the enemy.</p> <p>Kabul has been relatively stable compared with many other areas of the country. When attacks have occurred by far the majority have targeted the international security forces, the Afghan government ministries or Afghan army or police. There are also criminal elements in the city responsible for armed robberies. Much of this activity has been focused on the outlying areas where Afghans predominantly live, however homes and offices of foreigners can be targeted.</p> <p>The Foreign and Commonwealth Office states "We strongly advise against all but essential travel to Kabul." This is the same recommendation that has been in place for some years – since at least March 2009. Essential travel is defined as the traveller's own business and that only the traveller can make an informed decision based on the risks.</p> <p><b>If the Foreign and Commonwealth Office issued advice for British Nationals to leave the country, then the student would do so.</b></p> <p>In the preparation of the original Risk Assessment, advice was been taken from colleagues at Bournemouth University, Sheffield University, Aberdeen University and the London School of Hygiene and Tropical Medicine with regard to their practices and policies involving research in risky situations. Several staff from LSHTM are currently living and working in Kabul with HPRO – one of the organisations giving logistical support to the student.</p> <p>POTENTIAL HAZARDS</p>

**Hazards to researcher include:**

Being injured/killed in a suicide attack

Being kidnapped

Being shot as a result of a random attack

Being injured/killed in a rocket attack

Injured/killed in road traffic accident

Experiencing armed robbery at home.

Being caught up and injured in general civil unrest/violent demonstrations

Medical emergency

**5. Control Measures Already In Place:**

**Prior relevant experience/training**

The student has been working in Afghanistan on and off for 15 years.

The student successfully completed a 7 day crisis situation seminar prior to working in Afghanistan. The seminar was designed to assess participant's suitability for working in unstable situations as well as to equip them with the appropriate knowledge and skills for such an environment.

She has subsequently been involved in assessing other candidates suitability to work in unstable/crisis environments and has taught on the crisis situation seminar.

She has been on a brief survival course with the British Military in Afghanistan, a mines awareness course and various orientation/training programmes with the NGO's she has worked with.

During her time in Afghanistan she has lived and worked in health programmes in Kabul city, in two other less developed cities and in very remote mountainous area of the country. She therefore has broad experience of the diversity of life and culture within the country.

In addition to 15 years experience in Afghanistan the student has worked in Pakistan, Southern Sudan and Rwanda (following the genocide) with a relief agency. In addition she has worked or taught for short periods in Malawi, Zambia, Lebanon, Egypt, China, Israel, and Thailand.

**Research Activities**

Research activities will involve meetings with: Afghan Health officials, key staff of a Kabul maternity hospital, and expatriate colleagues working within the health and research sectors.

Phone and SMS communication will be maintained throughout the day reporting arrival at meeting places and each movement to a different location/arrival home.

Regular patterns of movement and meetings will be avoided and only the student's colleague will be privy to her schedule.

Most meetings will be held within the hospital compound. Access to this compound is monitored and guards are in attendance 24 hours per day. The hospital is known by the student because she has worked in them for varying periods of time over the last 15 years,

The hospital in which she will be carrying out her interviews is a women's hospital and in Afghanistan that means a naturally protected environment. No men are granted access to the hospital apart from a few males technicians on the hospital staff. The student therefore spends the majority of her day in a very protected and private domain.

She is known by some of the staff in the hospitals some of who are her ex colleagues or ex student midwives. These relationships are of great value and increase her security as there is a great respect for teachers within the culture and an obligation to care for and offer hospitality to guests.

Security alerts/warnings/reports will be checked each day and if there are warnings pertinent to the area of travel or location of the meeting then meetings will be cancelled and rescheduled.

Passport, phone with charged battery, foreigner registration document and Afghan work permit and insurance details will be carried at all times.

The student will have regular weekly communication with her supervisory team via email on a pre specified day. If there is no communication then the supervisory team will have a list of contacts and instructions as to the course of action to take. (Attached)

The student's colleague and supporting NGO's have emergency contact information (including Bournemouth University supervisory team's contact details)

### **Information Systems**

Security information – British Embassy security information received daily  
ANSO (Afghan National Security Organisation) security information received daily  
SMS alerts received from the British Embassy Warden if there are urgent warnings of incidents, areas of the city to avoid etc.

Advice from security organisations is taken and acted upon - such as avoiding certain areas or not leaving home on certain days because of tensions within the city.

The student has an informal network of friends who share security information.

Trusted Afghan local staff are deemed important sources of information and advice regarding security.

### **Minimising risk in travel**

Times of travel will be varied so that there are no predictable routes/routines

High risk potential targets such as military convoys will be avoided and drivers are trained to keep a distance between vehicle and police/military/ISAF vehicles.

Congested areas of the city will be avoided as much as possible

Government Ministries will be avoided early in the morning as most suicide attacks have happened at this time.

A known and trusted driver will be used for travel around the city

### **Civil Unrest** (as recommended by Teafund Afghanistan Programme Director)

As soon as information regarding civil unrest is received the procedure would be 'go to ground' in the nearest safe location and stay in touch with ANSO and other NGO's by phone or satellite phone.

If it appears that the civil unrest is moving closer to the area or targeting Western civilian locations then evacuate to Kabul airport or the nearest embassy (the British and Dutch embassy are the closest to the area where the student lives. The main arterial road to the airport is close to the Tearfund Guest House and would be a high priority for protection by Afghan and international security forces)

**Security at home**

Guards are on duty 24 hours per day at the NGO Guest House where the student will be staying. The guards are trained to be discrete, not pass on information regarding who lives in the property and where they work etc. The guards speak to all callers at the gate and do not let unknown persons into the compound. The same guards have been employed by the NGO for many years and are known and trusted. Good working relationships are maintained with the guards.

Respect for the local community and neighbours is demonstrated by culturally appropriate dress and behaviour as much as possible.

Personal alarms are held by the expatriates and with the guards to warn off intruders and alert the guards of the neighbours if there is an emergency situation.

Security in the area of the Guest House has been good.

**Minimising general risks**

Being careful in telephone conversations regarding movements.

Not walking around the city

Dressing with cultural sensitivity and respect

Not using local taxis

Avoiding places where large numbers of foreigners are known to gather as much as possible

**Minimising Health Risks**

Immunisations are kept up to date

Most food consumed is home cooked or from known restaurants.

**Backup system**

Regular phone contact throughout the day between the student and her colleague

Daily contact between close friend in the UK (who has also lived in Kabul for about 14 years) and the student in Kabul.

Registration with the British Embassy is on going and on returning to the country the student will notify the warden under whose jurisdiction she falls.

A UK NGO/Charity Tearfund have been approached and have agreed to have the student as an 'associate of Tearfund' whilst in the country. The Tearfund Afghanistan Programme Director will pass on security warnings and advice as well as holding UK emergency contact details and insurance details for the student.

Afghan police, security services and British Embassy warden numbers are held on the student's mobile phone for emergency.

A satellite phone is kept in the house for emergency situation if the mobile telephone system fails.

Weekly email or skype calls to the student's supervisor in BU with general progress reports. Emergency contact information with supervisor in case of no communication for more than 2 days after the weekly deadline.

A German Diagnostic Centre set up and run to German clinic standards is only 5 mins drive from the house in case of medical problems/emergencies.

**\*General health insurance needs to be organised through Bournemouth University's providers for medical emergencies etc.**

**NB. Conditions for travel insurance usually include the proviso that if the Foreign Office requires British Nationals to leave the country this must be done or the insurance becomes null and void. If such instructions were issued from the Foreign Office the student would leave the country.**

6. Standards to be Achieved: (ACOPs, Qualifications, Regulations, Industry Guides, Suppliers instructions etc)

**General health insurance needs to be organised through BU.**

**Additional comment**

Whilst there has been some civil unrest over the last few weeks according to those on the ground in Kabul this was to some extent over exaggerated by the media. The situation is now calm and normal movement around the city has been restored for the thousands of foreigners who live and work there at present.

Despite the significant risks involved in data collection in Afghanistan this is a familiar environment to the research student who has lived there for 15 years on and off and has a basic grasp of the language. She has a close circle of friends both Afghan and expatriate who also know the environment, share information and support and care for each other. She has been managing her own security for the last 8 years and is serious about avoiding risk as much as possible.

Whilst some risks cannot be avoided, the measures above represent the best risk reduction possible in the context.

7. Are the risks adequately controlled (bearing in mind 4. & 5.)? **Write 'Yes' or 'No':**  
**YES (Once medical insurance is in place)**

The HPRO (Health Protection & Research Organisation) Director (Dr Toby Leslie, himself a former Masters and PhD student at the London School of Hygiene and Tropical Medicine who has been in Pakistan and Afghanistan for many years) has agreed that the student can be directly allied to HPRO while in the country as this fits their research mandate.

Deborah Smith, Senior Research Manager: Gender and Health, Afghanistan Research and Evaluation Unit (AREU) was helpful in advising on the project to date and introducing the student to helpful and knowledgeable contacts

Dr Suzanne Griffin (Kabul University/Washington State University) has also been extremely supportive of the student. She worked in Afghanistan in the 1970's and has many links and contacts to senior figures in the government and Ministry of Health as well as within Kabul University. She is an advisor for the study.

Dr Abdullah Fahim – advisor to the Minister of Health has agreed to be an advisor to the study.

These advisors represent a great breadth of knowledge, experience and contacts. Their advice and support will ensure that the study is designed and progresses in a safe, wise and culturally appropriate way.

If **Yes**, Step 8: Ensure that those affected are informed of the Risks and Controls:  
Confirm how you have done this (e.g. written instructions):

A copy of the original risk assessment was sent to supervisors and student. Also brought to the attention of the Dean of School (Gail Thomas), Deputy Dean Research (Jonathan Parker), Deputy Health & Safety Advisors (Philip Bowtell and Kevin McCloskey), Finance Administration Manager (Drusilla Joyce) and Human Resources Manager (Jim Andrews).

Risks to Afghan colleagues of being associated with foreigners will be discussed with them prior to work commencing.

Afghan staff working with student will be given emergency contact numbers in case of accident or major incident.

Then, complete boxes below and the assessment is finished until the review date(s):

9. Person(s) Who did Assessment:	Rachel Arnold	10. Date:	5/3/2012	11. Review Date:	
12. Checked By:		13. Date:		14. Review Date:	

If **No** (to Q7) go to next section and estimate 'Residual Risk'.



Jonathan Pawler

→ KEVIN McCLOSKEY

A copy of the original risk assessment was sent to supervisors and student. Also brought to the attention of the Dean of School (Gail Thomas), Deputy Dean Research (~~Kevin Gahra~~), Deputy Health & Safety Advisors (Philip Bowtell and ~~Michael Hordon~~), Finance Administration Manager (Drusilla Joyce) and Human Resources Manager (Michael Hordon). JIM ANDREWS

Risks to Afghan colleagues of being associated with foreigners will be discussed with them prior to work commencing.

Afghan staff working with student will be given emergency contact numbers in case of accident or major incident.

Then, complete boxes below and the assessment is finished until the review date(s):

9. Person(s) Who did Assessment:	<i>[Signature]</i>	10. Date:	6/3/2012	11. Review Date:	
12. Checked By:	<i>[Signature]</i>	13. Date:	6/3/2012	14. Review Date:	

If No (to Q7) go to next section and estimate 'Residual Risk'.

*Jonathan Pawler* 6/3/12  
DDRE

*Cheryl [Signature]* 6/3/12  
School Director of Operations

Estimating the Residual Risk:  
 15. Choose a category that best describes the degree of harm which could result from the hazard, then choose a category indicating what the likelihood is that a person(s) could be harmed. Check only **ONE** box within the table which matches both of your choices.

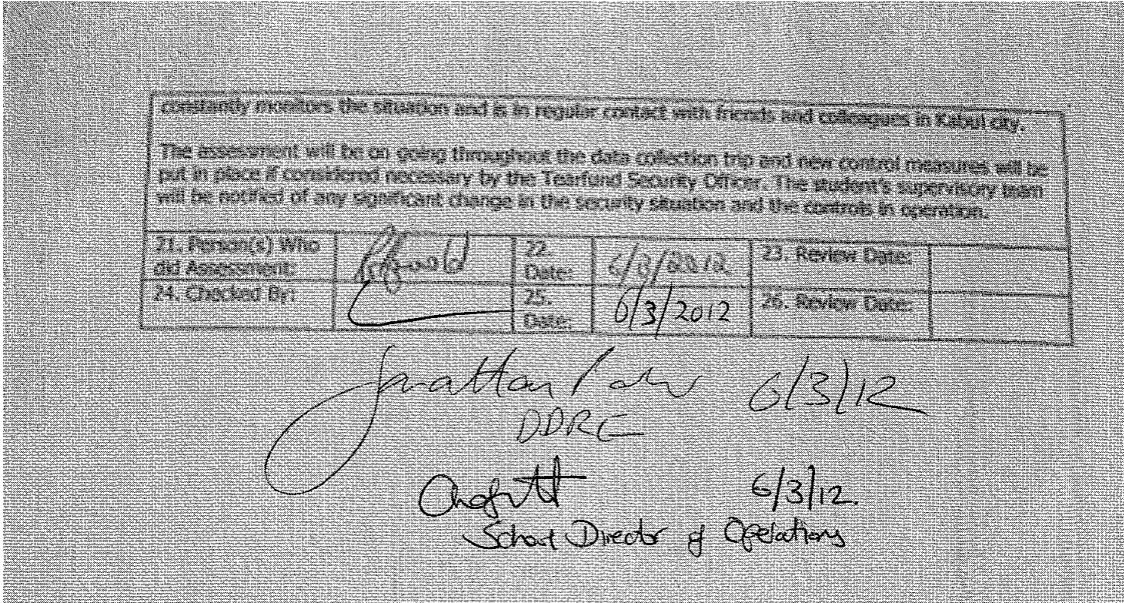
Degree of harm	<b>Slightly Harmful</b> (e.g. minor injuries such as minor cuts/bruises not always requiring first aid)	<b>Harmful</b> (e.g. serious but short-term injuries such as broken bones or curable disease)	<b>Extremely Harmful</b> (e.g. would cause fatality, major long-term injuries or incurable disease)
<b>Highly Unlikely</b>	Trivial Risk <input type="checkbox"/>	Tolerable Risk <input type="checkbox"/>	<b>Moderate Risk</b> <input checked="" type="checkbox"/>
<b>Unlikely</b>	Tolerable Risk <input type="checkbox"/>	Moderate Risk <input type="checkbox"/>	Substantial Risk <input type="checkbox"/>
<b>Likely</b>	Moderate Risk <input type="checkbox"/>	Substantial Risk <input type="checkbox"/>	Intolerable Risk <input type="checkbox"/>

16. Then note the advice below on suggested action and timescale

<b>Residual Risk Level</b>	<b>Action and Timescale</b>
Trivial Risk <input type="checkbox"/>	No action is required and no documentary records need to be kept.
Tolerable Risk <input type="checkbox"/>	No additional controls are required. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden. Monitoring is required to ensure that the controls are maintained
Moderate Risk <input type="checkbox"/>	Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and limited. Risks reduction measures should be implemented within a defined period. Where the moderate risk is associated with extremely harmful consequences, further assessment may be necessary to establish more precisely the likelihood of harm as a basis for determining the need for improved control measures.
Substantial Risk <input type="checkbox"/>	Work should not be started until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk. Where the risk involves work in progress, urgent action should be taken.
Intolerable Risk <input type="checkbox"/>	Work should not be started or continued until the risk has been reduced. If it is not possible to reduce the risk even with unlimited resources, work has to remain prohibited.

<p>17. If 'Moderate' 'Substantial' or 'Intolerable':            What New Control Measures are to be Considered to reduce risk?</p> <p>The student will now be living in the Guest House of the NGO Tearfund instead of her own home. She will meet with their security officer on arrival for an update on security and will come under their security regulations.</p> <p>The design of the study has been adapted so that travel will be kept to a minimum and travel to outlying areas and community centres within Kabul city will now not take place. The majority of the data collection will be carried out within the protected environment of a women's hospital</p> <p>Travel to and meetings in government ministries will be avoided.</p>	<p>18. Referred to:</p>	<p>19. On Date:</p> <p>5/3/2012</p> <p>5/3/2012</p> <p>5/3/2012</p>
<p>20. <u>Ensure those affected are informed of the Risks &amp; Controls</u>            Confirm how you have done this e.g. written instructions:</p> <p>The research student is aware of the risks and controls and has suggested them herself as she</p>		

constantly monitors the situation and is in regular contact with friends and colleagues in Kabul city.					
The assessment will be on going throughout the data collection trip and new control measures will be put in place if considered necessary by the Tearfund Security Officer. The student's supervisory team will be notified of any significant change in the security situation and the controls in operation.					
21. Person(s) Who did Assessment:	Rachel Arnold	22. Date:	5/3/2012	23. Review Date:	
24. Checked By:		25. Date:		26. Review Date:	



## Appendix F Ethical approval IRB Kabul

IRB Ethical approval 1, 20<sup>th</sup> September 2010



Islamic Republic of Afghanistan  
Ministry of Public Health  
Afghan Public Health Institute  
Institutional Review Board

No.: ۱۱۲۸۶۸



د افغانستان اسلامي جمهوریت  
د عامې روغتیا وزارت  
د عامې روغتیا ملي کمیټې



Date: 20/09/2010

To:  
**Dr. Rachel Arnold**  
Research Technical Advisor HPRO/PHD  
Student Bournemouth University, UK

**Subject:** Approval for proposal entitled, “Perspectives on Care Amongst Afghan Maternity Health Care Providers.”

Dear Madam,

Institutional Review Board, Ministry of Public Health has examined and reviewed your proposal entitled, “Perspectives on Care amongst Afghan Maternity Health Care Providers”

We are pleased to declare that your study is approved. However, we reserve the rights to monitor and audit your study and any violation of ethical norms during the course of study shall lead to withdrawal of given approval.

You are bound to share the result of your study with MOPH prior any dissemination plan.

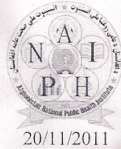
Best regards,

**Dr Bashir Noormal**  
Acting Chairman  
Institutional Review Board  
Ministry of Public Health

Telephone No.: +93 (0) 20 29 22 435  
Email Address: [moph\\_aphi@yahoo.com](mailto:moph_aphi@yahoo.com)  
Postal Address: 3<sup>rd</sup> Floor of Main Building of Ministry of Public Health,  
Masoud Square, Wazir Akbar Khan, Kabul-Afghanistan

تېلېفون: +93 (0) 20 29 22 435  
آدرس الکترونيکي: [moph\\_aphi@yahoo.com](mailto:moph_aphi@yahoo.com)  
آدرس پستی: منزل سوم تعمیر اصلی وزارت صحت عامه،  
چهارراهی مسعود وزیر اکبرخان، کابل-افغانستان

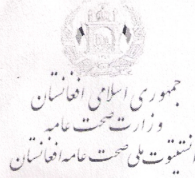
IRB Ethical approval 1, 20<sup>th</sup> November 2011



Islamic Republic of Afghanistan  
Ministry of Public Health  
Afghanistan National Public Health Institute  
Institutional Review Board

20/11/2011

تاریخ:



د افغانستان اسلامي جمهوریت  
د عامې روغتیا وزارت  
د افغانستان د عامې روغتیا ملي انستیتوت



نمبر: ۹۸۴۱۱

To:  
Dr. Rachel Arnold  
Research Technical Advisor  
HPRO

Subject: Approval for continuation of the study entitled, "Perspectives on Care Amongst Afghan Maternity Health Care Providers".

Dear Madam,

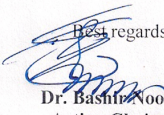
Institutional Review Board, Ministry of Public Health has examined and reviewed the key achievements and challenges of study entitled, "Perspectives on Care Amongst Afghan Maternity Health Care Providers".

We are pleased to approve your study for one further year in Kabul districts. However, we reserve to the rights to monitor and audit your study and any violation of ethical norms during the course of study shall lead to withdrawal of given approval.

The duration of approval for a study to begin the research project is valid for six months and the exact date of research project implementation (start and end) should be informed to IRB secretary.

You are bound to share the result of your study with MOPH prior any dissemination plan.

Best regards,

  
Dr. Bashir Noonmal  
Acting Chairman  
Institutional Review Board  
Ministry of Public Health

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**Appendix G Information sheets for study introduction,  
interviews, community focus groups, and consent  
forms**

## Hospital study information sheet

### PERSPECTIVES ON CARE AMONGST KABUL MATERNITY HEALTH CARE PROVIDERS

- This study has been approved by the MoPH and the Director of this hospital.
- One of the top MoPH priorities is to reduce the Maternal Mortality Ratio in this country. You are of vital importance in achieving that priority. It is therefore crucial that we learn more about your role as providers of skilled attendance and how you can be supported and assisted in that role.
- My name is Rachel Arnold and I am a British nurse/midwife who has worked in this country for some years. My translator and I will be in your hospital over the next few months, observing care, discussing your experience of caring for patients and listening to your ideas for things that would help you in your role as carers.
- This study will be looking at care in this hospital, how care is organised, your workload, the ways in which patients are cared for and the barriers and facilitators that staff face in their caring role. After I have spent time in this hospital I will also talk to some women and their husbands in the community to see what their priorities are for care.
- For the first month I will be mostly observing, giving you a hand when you need it, but I will not be directly involved in clinical care.
- During the second month I will hold some group discussions so that I can ask some of you specific questions about care in this hospital. You will be able to discuss your thoughts together and I will listen to your ideas, concerns and priorities. I will also ask a few people if they would agree to do an interview with me so that I can hear your ideas in more detail. (You can say no if you do not want to do an interview. This will not create a problem for you.)
- Everything that I see and everything that you tell me will be kept private and confidential. No one's names will appear on any report. Anything you tell me may be included in my report, however no one in the MoPH or even in this hospital will know who has said it.
- I am very interested to learn about care in this hospital and will be discussing my findings with the MoPH at the end of my study. You are the experts on care in this hospital and this is your opportunity to express your insights, concerns, and ideas.
- Participation in this study, in the discussion groups and in the interviews is entirely voluntary. If you do not want to be included in this study this will not be a problem. Please will you come and tell me, however, so that I can avoid observing in your area.
- There will be no financial benefit for taking part in any part of this study, however, this is an opportunity to have some influence on care in this hospital and to express the things which are important to you in your role as a carer.

Thank you for your support and assistance – it is much appreciated

**If you have questions or concerns regarding this study you may contact me:**

Rachel Arnold Principal Investigator 0799047474

Or Mr Atal Hewad HPRO Kabul - 0707389294

**Supervisors for this doctoral study are:**

Dr Kath Ryan Bournemouth University UK - 0044 77381 40436 kryan@bournemouth.ac.uk

Professor Immy Holloway Bournemouth University UK ihollowa@bournemouth.ac.uk

## Interview information sheet

1

### HOSPITAL - INTERVIEW INFORMATION SHEET

**Study title: Perspectives on care amongst Kabul maternity health care providers.**

#### **Introduction**

I am a British nurse/midwife. I have lived and worked in Afghanistan on and off since 1997. I am very interested in care in Kabul maternity hospitals and am therefore doing this research on care for my doctorate at Bournemouth University in the UK.

#### **What is the purpose of this study?**

The purpose of this study is to explore care in Kabul maternity hospitals. I want to understand how patient care is organised, the ways in which patients are cared for and the barriers and facilitators that staff face in looking after patients. I am interested to hear what staff members think about their job, the responsibilities that they have and how they feel about caring for patients. I will also talk to women and their husbands in the community to understand the things which are important for them when they are patients in hospital and the ways in which they would like to be cared for.

#### **Does the Ministry of Health know about this research?**

Yes – the Ministry of Health knows about this research and has given permission for me to do this study. They are happy for staff to talk to me. I am not working for the Ministry though and they are not paying for the study.

#### **Why have I been chosen to take part in this study?**

You have been chosen to take part in this study because you work in one of the Kabul maternity hospitals and I think that you have a good understanding of what it is like to work in this hospital. I am interested to hear your experiences, thoughts and views. I will be talking to other staff in this hospital and may interview about up to 14 people. After studying this hospital I plan to study one of the other Kabul maternity hospitals.

#### **Do I have to take part?**

You do not have to take part – you may say ‘yes’ or ‘no’. If you decide that you do not want to talk to me then that will not be a problem. If we start talking and then you change your mind and want to stop talking to me that is not a problem we will stop. If you do not want me to use the things which you have said then I will not use it.

#### **Who will know about the things that I say?**

Your name and the things that you say are private. I will not tell your colleagues, the hospital director or anyone at the Ministry of Health what you said. I will listen to the tape and then type it into my computer but I will not put your name with it. My translator also knows that one of the most important parts of her job is to keep everything that she hears private and that if she does not do this then she will lose her job.

#### **What will happen if I agree to talk to you?**

If you agree to talk to me then I would like you to sign a form to say that you are happy to talk to me and that I have explained what the study is about. I will then ask you a few questions regarding your experience of working in this hospital and caring for patients. There are no right answers or wrong answers. The thing which is important is your experience, your thoughts and ideas. I will record what you say on the tape recorder so that I don't forget the things you tell me. I will listen to it again and then type it into my computer. I will think about your ideas, experiences and your thoughts on the things which make your job difficult and the things which help you to care for patients. I may want to ask you more questions in the future but you can always say no.



**Are there any risks or disadvantages for me if I take part?**

The disadvantage of taking part is that it will take some of your time maybe up to one and a half hours. The hospital director and the head of nursing are both happy for me to talk to staff and for you to be released from your duties for this time.

There is a small risk that talking about some of your experiences here in the hospital could make you very sad or bring back bad memories. If that happened and you wanted to talk about it more I can direct you to an organisation that can help.

**What benefit will I receive from taking part in this study?**

You will not be given any money or gifts for talking to me. You may find it helpful though to talk about your experience and thoughts with someone who is listening and interested. It is also possible that in the future the things which you share will be used by the MoPH to facilitate you in your role of caring for patients.

**Will people know that I have taken part in the study?**

The head of nursing will know that we are talking as she needs to cover your work. No one else will be told the names of the people who have talked to me. Some of your colleagues who are on your shift may see that you are absent and may know that you are talking to me but they will not know what you have said. Unless you want to tell them yourself this will be private between us.

**What will happen to the results of this study?**

The results of the study will be presented to the MoPH and to other people who are working to support health care in Afghanistan. We hope that they will use the things discovered to help staff in their role of caring for patients. The results will also be written down as my doctoral thesis for my university in the UK. I will talk about this research at conferences and write about it in journals so that the things that you and others have helped me understand will not be lost but will be passed on to other people.

**Do you have any questions?****Contact details if you have questions or concerns regarding this study:**

Rachel Arnold Principal Investigator - 0799047474  
Or Mr Atal Hewad HPRO Kabul - 0707389294

**Supervisors for this doctoral study are:**

Dr Kath Ryan, Bournemouth University UK - 0044 77381 40436 kryan@bournemouth.ac.uk  
Professor Immy Holloway, Bournemouth University UK ihollowa@bournemouth.ac.uk

## Community focus group information sheet

1

### COMMUNITY - FOCUS GROUP INFORMATION SHEET

**Study title: Perspectives on care amongst Kabul maternity health care providers.**

#### **Introduction**

I am a nurse/midwife from England. I have lived and worked in Afghanistan on and off since 1997. I am interested in care in Kabul public maternity hospitals and am now studying this with the help of a university in England.

#### **What is the purpose of this study?**

The purpose this study is to understand care in Kabul public maternity hospitals. I have been talking to the staff in one of the hospitals about their job as carers. Now I would like to find out the things which are important to women when they go to hospital to have their babies. I am interested to know what the important things are for the men in the family and things which would encourage them to take their wives to hospital.

#### **Does the Ministry of Public Health and the hospital know about this research?**

Yes – the MoPH knows about this research and has given me permission to do this study. I am not working for the MoPH though and they are not paying for this study.

#### **If we agree to talk to you what will happen?**

I would like a small group of us to sit together and talk about the things which are important to you when you go to one of the Kabul public maternity hospitals/or think about taking your wife to one of the Kabul public maternity hospitals. There are no right or wrong answers. The thing which is important is your ideas and priorities regarding care in the hospitals – that is what I am interested in. I will start with some questions and then you are free to talk and discuss together. The discussion may last up to an hour and a half.

#### **What will happen to what we say?**

If you agree I will record what you say on the tape recorder so that I don't forget it. When I get home I will listen to it again and then type it into my computer and think carefully about the things that are important to you and to your families regarding care in Kabul public maternity hospitals.

I will write a report explaining what I have learnt in the hospitals and what you and other women and men have told me about your priorities for care in the Kabul maternity hospitals. I hope that a lot of people will read it both in Afghanistan and in other countries and that it will help the MoPH and the hospital directors and staff to care for you in ways that are important to you and to your family.

#### **Will we receive any benefits for talking to you today?**

You will not receive any money or gifts for talking to me. It is possible that the ideas which you share will be used by the Ministry of Health and hospital directors to help staff care for you in ways that would be acceptable for you and for your family.

#### **Are there any risks for each of us if we take part?**

The disadvantage of taking part is that it will take some of your time. I do not know how long we will talk for – it could be up to an hour and a half.

Normally the things that are said in this type of group discussion are kept private – we will discuss this together at the start of the discussion and see if people will agree to keep these things private. You must understand however that sometimes people do not keep their agreement and will talk about these things when they go home. You must therefore decide for yourself what you are happy

to say in the group. I will not tell anyone the names of the people who took part in the group or even in which area the group was held so you will be anonymous.

My translator also knows that one of the most important parts of their job is to keep everything that they hear private and that if they do not do this they will lose their job.

There is a small risk that talking about how you would like to be cared for in the hospital could make you sad or bring back bad memories. If that happens and you want to talk about it more I can direct you to an organisation that can help.

**Do I have to take part?**

You do not have to take part in this group. You are free to say ‘yes’ or ‘no’ and it will not be a problem if you say no. If we start talking in the group and then you change your mind and want to leave that is not a problem – you may leave. If you do not want me to use the things that you say then I will not use them

**Do you have any questions?**

**If you have questions or concerns you may contact me:**

Rachel Arnold Principal Investigator 0799047474

Or Mr Atal Hewad HPRO Kabul 0707389294

**Supervisors for this doctoral study are:**

Dr Kath Ryan, Bournemouth University UK - 0044 77381 40436 kryan@bournemouth.ac.uk

Professor Immy Holloway, Bournemouth University UK ihollowa@bournemouth.ac.uk

## Consent form

### HOSPITAL - INTERVIEW CONSENT FORM

**Study title: Perspectives on care amongst Kabul maternity health care providers.**

I confirm that the information sheet has been read and explained to me and that I have had the opportunity to ask questions about the study to clarify anything that I did not understand.

I understand that I do not have to take part in this study and that if I change my mind at any point then the interview will be stopped. I will not have to give a reason for this and this will not cause me any difficulties.

I agree for the interview to be recorded.

I understand that the things that I say and the opinions I express will be kept private.

I give my permission for the things that I say to be quoted in written reports and verbal presentations about this research.

I agree to take part in this study

Name.....

Date.....

Signature.....

**If you have questions or concerns regarding this study you may contact me:**

Rachel Arnold Principal Investigator 0799047474

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kryan@bournemouth.ac.uk

Professor Immy Holloway, Bournemouth University UK

ihollowa@bournemouth.ac.uk

## Appendix H Sample *Darī* & *Pushtu* information sheets

### *Darī* study information sheet

#### دورنماهای مراقبت درمیان فراهم کنندگان مراقبت صحتی مادری در کابل

- این مطالعه توسط وزارت صحت عامه و رئیس شفاخانه منظور شده است
  - یکی از الویت های وزارت صحت عامه این است که اندازه و فیات مادری را کاهش دهد. شما برای انجام این الویت رول حیاتی دارید. فلذا، این امر مهم است که ما در مورد رول شما منحصی فراهم کنندگان مواظبت ماهرانه و اینکه چگونه شما در آن حمایت و کمک می شوید بیاموزیم.
  - نام من ریچل ارنولد است و من یک نرس/ قابلۀ برتانوی هستم که در این مملکت (افغانستان) برای چند سال کار کرده ام. ترجمان من و من در چند ماه آینده در شفاخانه شما به منظور نظارت از مراقبت، بحث کردن در مورد تجربیۀ مراقبت مریضان توسط شما و گوش دادن به نظریات شما در مورد آن چیز هائیکه ممکن مایه کمک در رول شما به حیث مراقبت کنندگان باشد میباشیم
  - این مطالعه از مراقبت در این شفاخانه، اینکه مراقبت چگونه تنظیم میگردد، حجم کار شما، راه هائیکه مریضان تحت مراقبت قرار میگیرند و موانع و تسهیلات که کارمندان صحتی در رول مراقبتی شان مواجه میشوند نظارت خواهد کرد. بعد از گذشتاندن زمان مورد نظر در این شفاخانه من هم چنان با عده از خانمها و شوهر های شان در جامعه صحبت خواهم کرد تا ببینم که الویت های آنها برای مراقبت کدام چیز ها هستند
  - در ماه اول من اکثر نظارت میکنم، به شما کمک میکنم اگر به آن ضرورت داشته باشید، اما در مراقبت کلینیکی مستقیماً دخیل نه میباشم
  - در جریان ماه دوم من بعضی مباحثات گروهی را به راه خواهم انداخت تا بتوانم از بعضی شما سوالات اختصاصی را در مورد مراقبت در این شفاخانه بپرسم. شما قادر خواهید بود تا افکار تان را باهم مورد بحث قرار بدهید و من به نظریات، نگرانیها، و الویت های تان گوش بدهم. من از بعضی مردم خواهم کرد تا در صورت موافقه شان با من مصاحبه نمایند تا نظریات شما را با جزئیات بیشتر شنیده بتوانم. (در صورتیکه شما نه خواهید مصاحبه نه کنید نخبر گفته میتوانید. این کار برای شما کدام مشکل ایجاد نه میکند)
  - هر آنچه من می بینم و هر آنچه شما به من میگویند طور محرم و منحصی راز نگهداری میشود. نام هیچ شخص در راپور ذکر نه میشود. هر چیزی را که شما به من میگویند ممکن در راپور من شامل شود اما هیچ کس در وزارت صحت عامه و حتی درین شفاخانه نه خواهد دانست که آن نکته را کدام شخص گفته است.
  - من بسیار علاقه دارم تا در مورد مراقبت درین شفاخانه معلومات حاصل کرده و دریافت های خویش را در پایان مطالعه خویش با وزارت صحت عامه مورد بحث قرار دهم. شما ماهرین مراقبت درین شفاخانه هستید و این یک فرصت برای شماست تا برداشتها، نگرانیها، و نظریات خویش را اظهار کنید.
  - اشتراک در این مطالعه، در گروه های مباحثه و در مصاحبه ها کاملاً دعوا طلبانه است. اگر شما نه میخواهید که درین مطالعه شامل شوید این امر کدام مشکل را سبب نه میشود. لطفاً شما بیانید و به من بگویند تا من از نظارت در ساحة شما اجتناب کرده بتوانم.
  - کدام منفعت پولی در عوض اشتراک در هر یک بخش این مطالعه وجود ندارد، با آنها، این یک فرصت است تا یک مقدار تاثیر بالای مراقبت درین شفاخانه داشته و چیز هائی را که به شما در رول تان منحصی مراقبت کننده مهم است اظهار نمایند.
- از حمایت و کمک شما متشکرم. کمک شما قابل قدر است.

اگر شما سوال یا نگرانی در مورد این تحقیق و مطالعه داشته باشید، میتوانید به این آدرس تماس بگیرید:

ریچل ارنولد محقق عمومی 0799047474

یا

سوپروایزرها برای این تحقیق و مطالعه:

داکترکت ریان، پوهنتون بournemouth یوکی 0044 77381 40436 kryan@bournemouth.ac.uk

پروفیسر امی هلوی، پوهنتون بournemouth یوکی ihollowa@bournemouth.ac.uk

## Pushtu study information sheet

- د مور د درملنی په هکله، د کابل د مور د روغتیا ساتنی د کار کونکو لید لور.
- دا څیړنه د عامی روغتیا وزارت او د روغتون دمشر له خوا تاپید شوی ده
  - د عامی روغتیا وزارت په ملک کی له لمړیتوبونو څخه د میندو د مرینی د راتیته ولو کچه ده. تاسو په دغه لاسته راوړنه کی حیاتی ونډه لری. نو له دې کبله دا یو نه پتیدونکی حقیقت دی چی مونږ ستا سو په رول او مهارت وپوه شو او ستاسو د لانور ملاتړ په دې برخه کی شو.
  - زما نوم رچل ارنولد دی زه یوه برتانوی نرسه / قبله یمه چی په دغه ملک کی می څو کاله کار کړی دی. زه او زما ژباړن به څو راتلونکی میاشتی ستاسو په روغتون کی یو، ستاسو پالنه به گورو، ستاسو د تجربو په هکله د ناروغانو د درملنی په اړه به غږیږو، او ستا نظریو ته کوم چی ستا په درملنه کی مرسته کوی غوږ ونیسو.
  - دا مطالعه درملنه په دغه روغتون چی په څه ډول ده څیړی، ستاسو د کار زیاتوالی، هغه لاری چی د ناروغ درملنه پری کیږی او همداشان هغه ستونزی او اسان تیلوی چی کار کونکی ورسره د ناروغانو په درملنه کی ورسره مخ کیږی. وروسته له هغه چی ما په دغه روغتون کی وخت تیر کړ زه به له څو میړمنو او د هغوی له میړمنو سره په ټولنه کی خبری وکړم چی د هغوی لمړی ټوبونه د درملنی په هکله څه دي
  - په لمړی میاشت کی زه زیاتره څارونکی یم او له تاسو سره به مرسته کوم کله مو چی ورته ضرورت وی لکن زه به په مستقیمه د ناروغانو په درملنه کی شریکه نه یم.
  - په دویمه میاشت کی به څو گروپی مرکی شروع کړم نوله دې کبله به زه له تاسو څو کسانو نه مخصوص سوالونه د درملنی په هکله په روغتون کی وپوښتم. ته به خپلی مفکوری بیان کوی او زه به ستا مفکرو، تشویشونو او لمړیتوبونو ته غوږ ونیسم. زه به له څو کسانو وغواړم که موافقه کوی چی له ما سره مرکه وکړی نو په دې ډول زه کولای شم ستا نظریی لا نوری په غور واورم (ته کولای شی چی نه وواپی که ته نه غواړی چی مرکه وکړی. دا به تا ته کوم مشکل پیدا نه کړی)
  - هر هغه څه چی ما لیدلی او هر څه چی تارا ته ویلی هغه به پت او محرم پاتی شی. د هیچا نوم به په هیڅ راپور کی ذکر نه شی. هغه څه چی تا ویلی هغه به زما په راپور کی راشی، هیڅوک به د عامی روغتیا په وزارت او حتی په دغه روغتون کی پوه نه شی چی دا چا ویلی دي.
  - زه ډیره علاقه لرم چی د درملنی په هکله په دغه روغتون کی پوه شم او خپلی لاس ته راوړنی به د عامی روغتیا له وزارت سره د خپلی څیړنی په پای کی شریکی کړم. تاسو په دغه روغتون کی د ناروغانو د درملنی متخصص یی او دا یو ښه فرصت دی چی خپل فرصت، مشکلات او نظریی وواپی.
  - په دې څیړنه، مرکه او گروپی خبرو کی برخه اخیستل په خپله خوښه دی. که نه غواړی چی په دغی څیړنی کی برخه واخلی دا به کوم مشکل رامنځ ته نه کړی. لطفاً کولی شی راشی او ماته وواپی او همدارنگه زه به ستا د کار دخای لیدنه پریږدم.
  - دلته به د څیړنی په هیڅ کومه برخه کی په برخه اخیستو کومه مادی گټه نه وی، اگر چی دا یو ښه فرصت دی چی یو څه اغیزی به، د دغه روغتون په درملنه کی او همدا شان دهغه نظریاتو بیانول چی د درملنی په برخه کی د ستا سو د ونډی په هکله مهم دي ولری.
- ستاسو له کمک او مرستی نه مننه دا ډیر د قدر وړ دي

که پوښتنی او یا مشکل لری له ما سره اړیکه ټیگه کړه :  
رچل ارنولد څیړونکی ۰۷۹۹۰۴۷۴۷۴

د دغی د ډاکتری د درجی د څیړنی څارونکی دي  
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## Understanding Afghan healthcare providers: a qualitative study of the culture of care in a Kabul maternity hospital

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**Objective** To analyse the culture of a Kabul maternity hospital to understand the perspectives of healthcare providers on their roles, experiences, values and motivations and the impact of these determinants on the care of perinatal women and their babies.

**Design** Qualitative ethnographic study.

**Setting** A maternity hospital, Afghanistan.

**Population** Doctors, midwives and care assistants.

**Methods** Six weeks of observation followed by 22 semi-structured interviews and four informal group discussions with staff, two focus group discussions with women and 41 background interviews with Afghan and non-Afghan medical and cultural experts.

**Main outcome measures** The culture of care in an Afghan maternity hospital.

**Results** A large workload, high proportion of complicated cases and poor staff organisation affected the quality of care. Cultural

values, social and family pressures influenced the motivation and priorities of healthcare providers. Nepotism and cronyism created inequality in clinical training and support and undermined the authority of management to improve standards of care. Staff without powerful connections were vulnerable in a punitive inequitable environment—fearing humiliation, blame and the loss of employment.

**Conclusions** Suboptimal care put the lives of women and babies at risk and was, in part, the result of conflicting priorities. The underlying motivation of staff appeared to be the socio-economic survival of their own families. The hospital culture closely mirrored the culture and core values of Afghan society. In setting priorities for women's health post-2015 Millennium Development Goals, understanding the context-specific pressures on staff is key to more effective programme interventions and sustainability.

**Keywords** Ethnography, human resources, low-income countries, maternal health, vulnerability, workforce.

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### Introduction

For over a decade, improving Afghan women's health and reducing the high maternal mortality ratio<sup>1–3</sup> has been a priority of the Afghan Ministry of Public Health (MoPH) and its international partners.<sup>4–9</sup> The MoPH signed the Millennium Declaration in 2004.<sup>4</sup> The timeframe for achieving the Millennium Development Goals was extended to 2020, recognising the effect of decades of conflict on the health system.

Traditional Afghan society dictates that only women care for women, however, in 2002 following the fall of the Taliban

there was a severe shortage of female staff with only 695 doctors and 467 midwives for 4 595 000 women of reproductive age.<sup>10,11</sup> A key strategy to reduce maternal mortality, therefore, was to increase the number of midwives. A new midwifery curriculum and midwifery-training programme was introduced, midwifery schools (re)opened and an accreditation programme was established.<sup>12–14</sup> Women, excluded from university under the Taliban, were re-admitted to Kabul Medical University. Newly qualified female doctors enrolled in obstetric and gynaecological residency programmes. Skilled birth attendance increased from 14% in 2003<sup>4</sup> to 34% in 2010.<sup>5</sup> In 2014 there were 3500 Afghan midwives.<sup>15</sup>

The presence of healthcare providers does not guarantee either quality or respectful care.<sup>16–21</sup> A substantial proportion of maternal deaths occur in hospital, some of which could be prevented with timely interventions.<sup>22</sup> Post Millennium Development Goals, the challenge remains to understand the human element and context-specific motivating factors that affect the quality of care and equity.<sup>23</sup>

Despite significant improvements in Afghan women's health care, discrepancies still exist between the presence of healthcare providers and the care that women receive. Evaluations of obstetric services and perinatal outcomes indicate numerous deficits in the quality of hospital care.<sup>24–26</sup> Humiliating experiences endured by rural women in a provincial hospital appeared to discourage the uptake of services.<sup>27</sup> In an evaluation of midwifery training some women complained of poor treatment, insults, and being turned away for lack of money although care in public hospitals should be free.<sup>28</sup> Respectful care was taught in the new midwifery curriculum; however, Currie et al.<sup>12</sup> reported a lack of caring behaviours among staff.

Afghan doctors and midwives are pivotal if outcomes for women in facility-based childbirth are to improve, but little is known about their experiences, priorities and motivations. This qualitative ethnographic study examined the culture of a Kabul maternity hospital, the perspectives of staff and their effect on the care of perinatal women. The experiences and wishes of Afghan women regarding care in facility-based childbirth were also explored.

## Methods

An ethnographic study was conducted between October 2010 and April 2012, comprising observation, interviews and focus group discussions. The hospital management gave permission and helped with facilitation. The research was conducted by the first author (RA), a nurse/midwife with 30 years of experience, including eight in Afghanistan who speaks basic Dari but not sufficient for study purposes. An Afghan female interpreter who spoke Dari, Pashto and English was recruited and oriented to the study.<sup>29,30</sup> She had worked with international organisations, and whilst she had no medical background, provided insights into family life and facility-based childbirth from an Afghan mother's perspective.<sup>31</sup> She interpreted throughout observation, staff interviews and focus groups. Staff were informed about the study through information sheets in public areas and received additional written and verbal information before interviews.<sup>32</sup> If staff objected to being observed they were not included in the observation. As perinatal women were not the focus of observation consent was not requested; however, verbal explanations were given to women who enquired.

## Observation

Six weeks of observation in each area of the hospital provided insight into the organisation of care, workload, basic clinical management and caring behaviours. The researcher participated in the everyday life of staff—helping, watching, listening and enquiring about their lives and work.<sup>33</sup> Her role fluctuated between observation and participant observation,<sup>34</sup> not working clinically but supporting women in labour, being a 'pair of hands' when required, or sometimes simply observing. Key incidents were cross-checked with the interpreter to avoid misunderstandings.<sup>35</sup> Field notes made during observation were expanded and transcribed as soon as possible.<sup>36</sup> Informal group discussions occurred spontaneously during observation.

## Interviews

Twenty-five semi-structured interviews<sup>37</sup> (lasting 20–80 minutes) explored the thoughts and experiences of a cross-section of staff from different areas of the hospital including resident doctors, senior obstetricians, senior/newly qualified midwives and a care assistant. Purposive sampling ensured that each occupation and different levels of seniority were represented (Table 1). Self-selection and opportunistic sampling were also employed. An interview guide included questions about work and hospital care, satisfaction, difficulties and ideas regarding improvements to care. As an exploratory study the guide was purposely flexible to allow participants to focus on issues of importance to them.<sup>37</sup> Some interviews were directed by the experiences of the interviewees, such as a midwife describing changes in standards of care over 30 years, or a new midwife struggling with the hospital culture. Interviews were conducted within the hospital but away from interviewees' work areas. All participants were female.

Background interviews were conducted with 41 key informants from the MoPH, midwifery and medical education, Afghan and non-Afghan health professionals and researchers, a community leader and a historian. The purpose was to gain insights into the public health system and also the wider social, cultural and historical context of care.

**Table 1.** Occupational group and experience of interviewees

Obstetricians	Resident doctors	Midwives	Care assistants
Just qualified (1)	1st year (2)	6 months (3)	15 years (1)
5 years (1)	2nd year (1)	2–3 years (3)	
6 years (2)	4th year (3)	4–6 years (2)	
10–16 years (3)		Over 25 years (3)	
Total n = 7	Total n = 6	Total n = 11	Total n = 1

Values in parentheses are n.



Informed consent was obtained for all interviews<sup>32</sup> and, with permission, interviews were digitally recorded or handwritten notes were taken and transcribed as soon as possible. Interviews were conducted in Dari, Pashto or English.

### Focus groups

Two focus group discussions<sup>36</sup> were conducted with women in the community to obtain basic feedback on their experiences and wishes regarding care in Afghan maternity hospitals. A focus group discussion was held in the home of a community leader with six female members of his extended family. It was conducted in Dari and translated by the Afghan interpreter. The second was held in a poor area of Kabul with 12 women from a pre-existing self-help group. It was conducted by an Afghan researcher and facilitated by an international organisation.

### Analysis

Data were analysed using thematic analysis.<sup>38</sup> Digital recordings of interviews and focus group discussions were transcribed and translated by an Afghan midwife/researcher as a quality control measure. RA transcribed field notes and interviews conducted in English, then read and re-read all the transcripts to increase familiarity.<sup>39</sup> Data were coded section-by-section. Selected interviews were read and coded by two co-authors (EvT, KR). Similar codes such as 'no-one appreciated us', and 'we can easily be replaced' were grouped into a category such as 'not valued'. Transcripts were re-read as patterns and relationships were discerned and categories developed. 'Not valued' was linked with the category of 'no powerful connections' and became the more conceptual category of 'vulnerability'. Categories were checked against the data and redefined where a more accurate concept was identified.<sup>32</sup> The initial category 'powerlessness' was renamed 'vulnerability' after realising that all staff had some power over patients because they had insider knowledge but some were also vulnerable within the hospital hierarchy. On-going reflection, discussions with key informants and reading of the literature led to the merging of similar categories into major themes.<sup>39</sup> Five key themes were identified, we report here on two: (a) surviving and (b) family pressures.

## Results

Women in the community described the lack of care experienced in various Kabul maternity hospitals. They said that staff were 'careless' in attending to their needs, that it was 'difficult to find a doctor who would help' and that even bribes did not guarantee good care. Several women delivered alone in hospital corridors, others reported being slapped and verbally abused. Women desired a good standard of care from well-qualified and

well-motivated doctors, free medicines and supplies. Kindness and good behaviour were thought to 'heal the pain of patients' and were more important than professional knowledge. Some women said that they would not go to hospital for another baby because of the way they had been treated.

Initial observations showed a very busy, crowded tertiary hospital with care providers struggling to manage the workload. Some worked hard and spoke of their satisfaction in seeing critically ill women recover. Distressed women, however, laboured alone in overcrowded small rooms with up to four women sharing a bed. They received little monitoring of progress and fetal condition, support or information between admission and delivery. A few hours following delivery, women and their babies went home, many without postnatal check-ups. Some women were verbally abused about the number of children they had and some were sent home with life-threatening conditions such as an antepartum haemorrhage. Our analysis revealed underlying issues, dynamics and values within the hospital environment that are a part of wider Afghan society and culture. These contextual factors help to explain the behaviour of staff and the complexity of the challenges they face.

### Surviving: power and vulnerability

The experience of healthcare providers can be summed up as 'surviving' in a hospital culture where power depended on 'who you know'. Power meant having a relative or important contact in the hospital or the government who would help you get a job, ensure that you were sent on training courses and ensure that you would keep your job, whatever happened. 'Having connections' was of major importance. Vulnerability was the absence of a powerful relative or 'connection' who could be called upon to help in case of trouble and also knowing that you could be easily replaced. A resident doctor frustrated at how connections affected clinical rotations explained:

...just some doctors who have a relative in this hospital are helped. . .because I don't know anybody they didn't send me to get experience in the operating theatre for 2 years.

Clinical training and the supervision of resident doctors was also largely dependent on connections, on knowing senior staff who would share their clinical skills. Residents without relatives or contacts in the hospital generally had to develop their clinical skills by trial and error on patients and hope that nothing would go wrong.

No one showed me how to do an episiotomy or how to suture. . .the trainers just say 'you're a doctor you can do it'. First year resident doctor

One resident spoke of three major errors she had made when left alone during her first night duty. According to resident doctors, while some trainers gave support and training, the majority were reluctant to pass on their skills. When called to an emergency, most trainers performed procedures such as cervical suturing themselves rather than teach others. Resident doctors experienced high levels of stress as they worried about making clinical mistakes and consequently being 'brought before the judge'. Many were angry, frightened, tired and talked of 'counting the hours' until they completed their residency and left the hospital. They felt let down by a system that had promised a comprehensive residency training programme but had, largely, left them on their own to develop clinical skills. A doctor at the MoPH confirmed that some doctors graduate from the 4-year residency programme without being able to do a caesarean section alone, if they were not connected to a senior person.

A senior hospital doctor explained the difficulties of enforcing standards of care and behaviour within the hospital if staff had relatives in government. This doctor had dismissed a care assistant because of her 'bad behaviour' with patients. A few weeks later the care assistant came with a letter from the MoPH ordering her reinstatement.

Relationship is very very important, relationship is over the law...who they are is everything, which family they are from, relationship is everything. Senior doctor

Healthcare providers spoke of the need for a fair system where opportunity, support and training did not depend on connections, but, as in wider Afghan society, having connections made all the difference within the hospital.<sup>40,41</sup> An MoPH interviewee explained that giving more authority to hospital management was also open to abuse and no guarantee of fairness.

#### Surviving: a culture of fear and blaming

There was fear in this hospital, fear of: (a) being humiliated in public; (b) losing one's job and the consequences for one's family; and (c) being blamed for a professional error. Many staff mentioned their desire to be appreciated, to receive appreciation letters rather than warning letters. It was a punitive system, however, devoid of encouragement or praise.

...after our night duties, the next morning we are insulted by management. Why didn't you do this, or do that, they yell at us. They make trouble for us, but nobody hears our voice. At night we go without sleep but in the morning they don't encourage us—they discourage us. Midwife

Surviving meant blame someone else before you are blamed. A mother whose baby nearly asphyxiated was blamed, the family of a woman who died were blamed for not bringing her sooner, staff blamed each other, or report-

edly patient records were changed or went missing—anything to avoid being blamed. In one area of the hospital midwives were blamed for a woman's death because a doctor had not seen her—as a consequence, they refused to work on their own initiative. With no professional liability insurance in Afghanistan there is a great fear of litigation and of having to pay large fines or bribes to avoid prison.

Last year there was a big case and two doctors were involved. (I think a patient had died.) It was only because they had relatives or contacts that they were able to get off—but now everyone is very anxious about it. Resident doctor

#### Surviving: the workload

High patient numbers and long hours were mentioned by most interviewees. This hospital has up to 100 deliveries in 24 hours with a high proportion of complicated cases, as it is one of the national referral hospitals.

Every night we have 14, 16, 18 caesarean sections. They come from outside, from far away, rupture, ectopic rupture, total placenta praevia, active bleeding, concealed abruption, two or three previous caesareans, breech presentation, fetal distress, abruption. Sometimes it's so difficult. Resident doctor

Staff numbers appeared adequate overall but the lack of a shift system meant that the hospital was crowded with staff in the mornings, and for the rest of the day and night the work was conducted by small groups of doctors, midwives and care assistants. They work from 8 am until after morning report the following day, spend the rest of the day at home taking care of their household responsibilities, but are back on duty the next morning. Field notes highlighted on several occasions that staff were visibly tired.

Midwives, doctors and care assistants are so tired they are nearly unconscious! Senior midwife

Care assistants endured long hours, frequent night duties and thankless toil but did not complain for fear of losing their job. Many staff spoke of the need for a shift system to share the workload more efficiently and give them more time at home for their family duties. There were, however, constraints to the introduction of shifts including the cost of additional transport for staff in the evenings, the compliance of senior medical staff, who would sometimes have to be on duty instead of at their private clinics and, importantly, the agreement of the MoPH.

#### Family pressures: decisions, obligations and expectations

The family is the most important institution in Afghan society.<sup>42</sup> Afghanistan is a collectivist society where most

decisions are made by the family for the benefit of the family as a whole.<sup>40,43</sup> This has a direct impact on healthcare providers. For most, their career would have been a family decision often made for economic or status reasons. One obstetrician explained that some families force their children into medicine because of the status of doctors in Afghanistan.

So most students and even more families want to be the best, to get into medicine and be proud of it. Even some students who don't like this subject are forced by their families to select medicine as their career. Recently qualified obstetrician

Healthcare providers were obliged to care for family members who came into the hospital or important people connected to their family regardless of whether they were looking after other women. Doctors and midwives were often seen caring for a relative even though they were off duty and on occasions obviously unwell themselves. Some were the only wage earners in an extended family. Most care assistants were widows with children, who, after losing their husbands during the war, were forced for the first time to find work outside the home.

If I didn't have obligations do you think I would work in this place? Care assistant/widow

Families expect members to be successful, to keep their jobs regardless of working conditions and maintain the family honour. Failure in studies or occupation would shame the whole family and could lead to punishment. Staff were also expected to fulfil their responsibilities at home—as mother, wife, daughter-in-law and entertainer of guests. In a society without a social security system the only security, or insurance policy, is the family,<sup>40,42</sup> even for those who suffer violence or a lack of respect at home.<sup>44,45</sup> As highlighted in a background interview:

Generally men in Afghanistan don't value women at all. This affects how the midwife behaves with others because she doesn't receive respect in her own family, especially from her husband. There is also too much pressure from the family, as well as too much work during the day. It really affects their behaviour. Senior doctor

In summary, the culture of care in this hospital meant childbearing women were at risk through inadequate clinical training and supervision of resident doctors. Doctors without powerful connections were vulnerable and anxious about making clinical mistakes and being taken to court. Healthcare providers, devoid of encouragement, were exhausted from working long hours with high patient numbers and a large proportion of complicated cases. Women experienced minimal professional attention unless

they had relatives working in the hospital or had a high social status. Poor, illiterate, pregnant women were low priority and particularly at risk of poor care as they had little to contribute to the economic and social survival of staff. Our data indicated that many of these findings are not unique to this hospital but are widespread within Afghanistan.

## Discussion

### Main findings

This study found that the ability and motivation of Afghan staff to provide quality care is influenced by multiple factors, both within and outside the hospital. Staff were under physical and mental pressure from long hours and unrelenting workloads in the hospital and at home. Some doctors graduated as specialists unable to perform key life-saving procedures as a result of nepotism and cronyism. The acquisition of skills, workshop attendance and employment were more dependent on connections than need, motivation, or ability. Well-connected staff were 'above the law' and hospital authorities were powerless to enforce standards. Staff without powerful connections feared humiliation in a precarious, hostile environment. Neglect and sub-optimal care were unlikely to be deliberate but were the result of conflicting priorities, the workload, poor clinical skills and the struggle for survival. Community focus group discussions pointed to poor experiences in facility-based childbirth and the potential impact on the future uptake of services by women.

### Strengths and limitations

This is the first study of its kind into Afghan maternity care providers, highlighting their priorities and social realities. The combination of interviews and observation helped to provide a deeper in-sight into the culture of care in this Kabul hospital.

Those willing to talk to the researcher were possibly the more vulnerable staff, which could have skewed our findings, but background interviews suggest that this was not the case.

A limitation is that this study was conducted with the assistance of a translator. While every effort was made to reduce the negative impact of translation and ensure quality, some of the depth, richness and cultural nuances were bound to have been lost. Some questions were simplified and some sensitive questions were not asked to avoid misunderstanding.

Holding interviews in hospital was not ideal as some interviews were disturbed by the demands of the hospital. It was not possible to conduct interviews at a different location or time, due to the busy lives and family restrictions on the movements of many participants.

### Interpretation

One reason why many intercultural solutions do not work, Hofstede et al.<sup>46</sup> claim, is that differences in how people think are ignored. At the core of a culture are its learnt values, which cannot be easily changed and are revealed by actions and behaviour.<sup>46</sup> The results of this study concur with previous ethnographies in hospital culture<sup>47,48</sup> and the ideas of van der Geest and Finkler (p.1995)<sup>49</sup> that the hospital is a domain where core values and beliefs of a culture are revealed. Andersen<sup>48</sup> linked the differential treatment of patients by staff within a Ghanaian hospital to social status and the importance of the right connections within society. As Zaman<sup>47</sup> showed in Bangladesh, the hospital is often a microcosm of the larger society. Hospitals the world over are 'deceptively familiar' (p.1995)<sup>49</sup> but the familiarity belies the 'underlying social and cultural processes that are being played out in hospital settings' (p.1996).<sup>49</sup> Many elements within this Kabul hospital resonated with wider Afghan culture and society: the centrality of the family, the importance of connections and of a good reputation,<sup>50</sup> and the power of nepotism and cronyism.<sup>41</sup> In particular, doctors, midwives and care assistants were working according to the core values of Afghan society rather than to standardised global biomedical strategies and regulations.

### Implications

Many factors affected the ability and motivation of staff to provide quality care and offer possible explanations to findings from previous studies on deficits in the quality of emergency and newborn care (EmONC) services.<sup>24, 26, 51</sup> Although based in one hospital, background interviews and RA's experience suggest that these factors are present in most Afghan health facilities. In rural settings there can be more accountability to the local community; however, in remote provinces there is less oversight and control by the MoPH.

The major implication for policy makers and health professionals in Afghanistan is that it is easy to make incorrect assumptions about why people work in health care, what is important to them and what will help them do a better job, therefore, asking them is vital. Many issues from the study are rooted in wider Afghan society and cannot be easily changed; however, understanding the impact of culture on health workers presents a starting point for discussing the challenges and for more effective programme design.<sup>52</sup> As public recognition of good work was very important to staff, this would be a relatively easy change to make; it would show individuals that they were appreciated and bring honour to their families. A shift system would use staff better, give additional time for family duties and reduce tiredness. More research is needed to clarify the factors that currently prevent a shift system being implemented. Improving equity in clinical training requires an

in-depth investigation that includes all stakeholders. Cultural insights are vital to provide innovative local solutions as generic solutions alone are unlikely to solve the issues.

The importance of 'good behaviour' over professional knowledge and skills for Afghan women in the community confirms previous findings.<sup>53</sup> However, treating perinatal women with respect is difficult for health providers who do not experience respect themselves. Fundamental changes to the punitive hospital culture are therefore necessary to enable staff to think further than their own survival.

The international community brings a wealth of technical expertise, resources and passion to improve global women's health post-2015. It is the healthcare providers, however, who understand the reasons why women might not be receiving quality care in their particular workplace and what would help them provide a better service. Of course, the voices of women must be part of the post-2015 agenda;<sup>54,55</sup> however, to improve women's health post-2015 it is vital to listen to healthcare providers and examine the impact of cultural values and social pressures on their motivation, behaviour, ability to care, and consequently on the quality of care.

### Conclusion

This study has shown that training courses, evidence-based protocols and increasing staff numbers are not the whole answer to addressing deficits in the quality of care, clinical skills and decision-making. It is imperative to understand the context of care and the complex challenges that even highly motivated healthcare providers face in their work environment and lives. Generic solutions are no answer to many of these issues. No amount of international funding and strategies are likely to bring sustainable change to the quality of care for women globally unless programmes are adapted and embedded within the local context. This needs to include understanding the healthcare providers and the cultural and social determinants of their motivation and behaviour.

### Disclosure of interests

The authors have no conflicts of interest to declare.

### Contribution to authorship

RA, KR and IH designed the study; RA wrote the first draft; RA, EvT, KR and IH commented on various drafts and agreed the final manuscript.

### Details of ethics approval

Ethics approval was obtained from the Afghan Ministry of Public Health Institutional Review Board 20/09/2010 No.112868 20/11/2011 No. 984111, and Bournemouth University Research Governance Review Group 28/10/2010.

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