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Hidden Relationships: Perspectives on Leadership and Management in Afghan Maternity Services - An Ethnographic Exploration

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Hidden Relationships: Perspectives on Leadership and Management in Afghan Maternity Services - An Ethnographic Exploration

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Abstract

***Introduction**:* Health system leaders have a vital role to play in ensuring the delivery of high-quality care. Improving the quality of healthcare, particularly in low-income countries often focuses on the performance of healthcare providers and the availability, acceptability, and uptake of services. The role that health service leaders play in facilitating effective care has received less attention in the literature. This study explored the perspectives of Afghan maternity care providers, managers and other stakeholders on leadership and the provision of quality maternity care.

***Methods**:* This ethnographic study used semi-structured interviews, participant observation, and background interviews for data collection. The research setting was a Kabul tertiary maternity hospital. Participants included doctors, midwives and care assistants who were employed in the hospital (n=23). Stakeholders from the health system, government, community and non-governmental organizations provided background interviews (n=41). A thematic framework analysis was conducted across all the data sets and different participants to maintain the context and perspectives of individual groups and identify themes.

Results: The results of this study involves 1. Healthcare providers who described their managers as both autocratic and weak. They explained that their managers failed to enforce standards or listen to their concerns. 2. Managers who felt powerless to improve care because the government did not support their initiatives to reform the working environment or discipline staff members who were flouting the rules.

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3. Background interviewees who concurred that hidden relationships influenced and undermined the health system at all levels.

Conclusion: An unofficial system of connections with powerful people gave some staff privileges and power beyond their roles and undermined the power of managers who were responsible for standards of care. Strong, unwavering political will and tenacious leadership will be needed to address this. We suggest that initiatives to improve the quality of care in other low- and middle income countries (LMICs) look beyond individual staff and official systems to determine who holds the power and how that power is used.

Key words: *Leadership, management; political elites; corruption; quality care; maternity services; Afghanistan.*

Introduction

Leadership and governance have been described as "the most complex but critical building blocks of any health system".[1, p23] A lack of leadership, governance and management capacity constrains health systems in many low-income countries.[2] It contributes to poor working environments, low morale among staff and poor quality care.[3] The roles of health system leaders and managers overlap but they are theoretically distinct and require different competencies.[4] Leaders need to be able to motivate, inspire, set a direction and get people to collaborate towards the goal, while managers need to translate visions into tasks, plan, organize, manage, control and problem solve.[5,6] In complex organizations, such as health systems, both leaders and managers are necessary to provide high quality and sustainable services[7].

Global health initiatives predominantly focus on the provision of services, however, even the best designed systems fail without competent leadership.[3,8] Health system leadership literature have traditionally come from high-income settings but more recent research explored leadership in low- and middle- income countries (LMICs)[9,10]. Strong leadership is particularly needed in resource poor settings and in post-conflict fragile states because, in addition to the normal demands of managing a health system there are challenges of extreme poverty, instability, lack of infrastructure and capacity as well as the challenge of legitimacy and effectiveness for new governments.[11]

The Afghan health system was all but destroyed in the conflicts of the latter half of the 20th century, and many of the most capable senior managers, leaders and doctors emigrated to the West[12]. Following the fall of the Taliban in 2001 a period of relative stability, political

impetus and international funding provided a rare opportunity to reconstruct the health system and strengthen the capacity of leaders in the Ministry of Public Health[13]. A basic package of Essential Health Services (EHS) was developed to ensure that: (a) programs focused on the most urgent health needs; and (b) were cost effective[14, pS7.]. One such priority was to reduce the maternal mortality ratio which in 2005 was the highest ever recorded globally meaning that out of 100,000 live births an estimated 1600 Afghan women died from pregnancy related causes[15].

The way that the Afghan health system has been reconstructed, despite the challenge of ongoing insecurity in the country, has been held up as a model for other countries[13]. In a conservative country where women can only receive healthcare from women, access to healthcare has been dramatically improved by a national midwifery training programme that increased the number of Afghan midwives from 467 in 2002 to over 4,600 in 2014[16,17] There was, however, a mixed picture of improvement and some health indicators such as the maternal mortality ratio remained unacceptably high at approximately 661 per 100,000 live births in 2015[18,19]. Furthermore assessments of care in several large Afghan maternity hospitals reported a precarious situation where the quality of care was suspect with a perinatal mortality rate of 43.5 per 1000 births and stillbirth rate of 38[20]. This suggested that there could be systemic challenges in the health system not simply inadequate care by individual staff. Our study, therefore, aimed to look beyond individual staff behavior to gain broader and deeper insights into the contribution of leaders and managers in providing an enabling environment, supporting staff and ensuring standards of care in a large Afghan maternity hospital.

Methods

Ethnography[21,22] was chosen for this study to facilitate an in-depth exploration of Afghan healthcare providers, the culture of maternity services and the meanings and values that underpinned behavior. Prolonged engagement in the setting was a continual "search for meaning" [23, p5.] for the multiple realities and power differences beneath the surface[24]. Reflexivity was a vital part of this cross-cultural study to recognize the inherent cultural lens and bias of the researcher conducting the fieldwork[21].

Research Setting

This study was based in a tertiary maternity hospital in Kabul between 2010 and 2012. The first author, a British nurse/midwife with eight years' experience in Afghan health programs, conducted the fieldwork.

Data collection

Information sheets were displayed in the staff areas of the hospital. The researcher was introduced by senior managers at staff meetings, given the opportunity to explain the research to staff and answer questions.

Participant observation of over 100 hours was conducted in the hospital and included informal discussions with staff and insights into care and day-to-day challenges. The researcher helped staff with tasks such as bed-making, and also spent time with women in childbirth assuming a role that fluctuated between observation and participant observation to develop an 'emic' perspective of 'insider' views[25]. Observations, conversations, and reflections were recorded briefly during observation, then expanded into field notes as soon as possible afterwards.

Participant observation was followed by 23 semi-structured (occasionally unstructured) interviews[22] with midwives, doctors, healthcare assistants, and managers working at the hospital. Opportunistic, self-selected and purposive sampling were used to collect a wide range of perspectives[25]. Interviews were conducted in any available private space in the busy hospital, they were digitally recorded with permission; notes were taken by the researcher and cross-checked with the interpreter.

Staff interviews were complemented by background interviews (n=41) with Afghans and non-Afghans who had experience in health, education, government, research, recent history, anthropology. Background interviewees were selected because of their expertise, broad contextual insights and the perspectives that they represented[21]. Potential interviewees were contacted because of their positions; others were already known to the researcher. This helped to provide a multifaceted understanding of the social and cultural context as well as minimizing bias from individual participants or from the researcher conducting the study[22].

Ethics and risk

Informed consent[25] was obtained from all participants – the majority in writing but verbal for non-literate participants. Special care was taken to ensure that participants understood the information prior to giving consent, including their right to terminate interviews at any point[25].

The attitudes of participants during participant observation suggested that they had very different agency and social standing that did not depend on their roles. Some participants were hesitant to speak openly - others, even in lowly positions appeared bold. It was impossible to

know the unseen power or vulnerability of any participant. It was imperative that the researcher took great care to protect the identities and safety of every participant through emphasizing this to the translator and ensuring that any details which could reveal the identity of participants were changed or omitted from written accounts. Ethical approval was granted by the Institutional Review Board of the MoPH in Afghanistan and XXX University. [name removed for anonymous reviewing]

Translation

As the researcher only had basic Afghan language skills an Afghan woman had been recruited as an interpreter. Because the quality of the research depended on translation it was vital to ensure that key research terms and concepts were translated correctly. These concepts were, therefore, discussed with Afghan social scientists prior to the study commencement to ensure "conceptual equivalence rather than equivalence of word from".[26, p26] Afghan researchers translated the participant information into Dari and Pashto using accessible language and these were then back translated into English.

The first author transcribed the English interpretation of the interviews and informal conversations. In addition, an Afghan midwife researcher transcribed the digital recording of Dari interviews and then and re-translated to English to ensure accuracy.

Data analysis

Thematic analysis was used to analyses the data[27]. Each transcript was coded using 'in vivo' codes, codes were then grouped into categories, checked and refined. A framework analysis was developed to maintain and compare the perspectives of individual groups, context and method[28]. All data (field notes, informal conversations and interviews) were coded and analyzed individually, before being brought together to explore relationships and themes across the whole corpus[28]. The main themes from the ongoing qualitative analysis were checked with some background interviewees to ensure they resonated with the interviewee's understandings of the institutional culture of the health system and societal norms. We report on the range of perspectives on management and leadership in Afghan maternity services from across the dataset.

Results

Hospital staff, managers, senior MoPH staff and background interviewees from the wider health services and community agreed that the maternity system was not functioning effectively. Multiple explanations were given for care that often failed to live up to official policies or standards. The hospital staff frequently blamed the hospital management, MoPH or government.

a) Perspectives of healthcare providers

Healthcare providers spoke about the difficult working environment, the lack of essential supplies and poor support for staff.

i. **Working environment and essential supplies.** Throughout observation the hospital was busy, noisy and overcrowded. There were large groups of people outside the doors trying to gain access, and small rooms generally full of women in labor - often with two or three sharing beds. The night duty was particularly grueling for staff as the workload was high, there were few staff, and they worked from 8am to 8am the following day and then reported for work the next morning. Midwives said this was exhausting and had been asking for a shift system to give them more time to rest but this had not happened. Instead, staff claimed that management and the Ministry were passive and disinterested.

"*The Ministry are not doing their job, one midwife asserted, they are sleeping*". (Field notes 26/3/2012)

One young midwife described starting her job 'really eager' to help women and put what she had learnt into practice. A year later she was frustrated and regretted becoming a midwife. Her primary complaint was with the management and MoPH:

"*Our main difficulty is with the Ministry and Director of the Hospital. They have expectations of us, they want us to have good behavior with patients and we accept it, but we also have expectations of them*". (Newly qualified midwife).

The midwife acknowledged her responsibility to provide good maternity care. To achieve this, however, she needed her managers and the Ministry of Public Health to fulfil their responsibilities. High quality care was impossible, she explained, unless she had ongoing training and essential supplies such as gloves and medicines.

"*Because of a lack of gloves we wear only one disposable glove for vaginal examinations, sterilize and reuse them*". (Newly qualified midwife)

During fieldwork relatives were often sent to the local pharmacy to purchase gloves, medicines and intravenous canulae. "It's hard", one resident doctor explained, "there are not enough supplies and then some seem to disappear". The implication was that they were taken for use in private clinics. Staff were keen to go on learning and attend training workshops but as one midwife said, "*it is the special people who get sent every time*". No

one explained who the special people were but many midwives complained about the unfair system. Doctors, midwives and care assistants alike were frustrated that the hospital director and MoPH failed to provide them with the necessary resources, skills and working environment conducive to high standards of care. In addition, they wanted to see their management enforce standards.

ii. **Checking and enforcing standards.** Several doctors and a midwife highlighted the need for senior managers to visit the wards regularly to talk with staff and women in childbirth. They suggested everyone would be motivated if senior managers praised or rewarded those who were working well and 'punished' those who were not or were using the hospital to generate 'clients' for private clinics. A fourth-year resident doctor expressed her frustration stating that:"Nobody bothers; nobody checks or enforces – we have a weak leadership". (Young female resident doctor)

The resident doctor was frustrated with the dirty wards and lack of standards or discipline. When it was suggested that the hospital management had limited power the doctor angrily contended that:

> *With one pen she [a senior manager] could write an appreciation letter… or she could write a warning letter. If you punish one or two people when they are doing wrong, then everyone would 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*… (Young female resident doctor)

It did not take much to encourage or discipline staff, the doctor claimed. A lack of power did not excuse inaction. Representatives from the MoPH visited the hospital most evenings during observation.

> *The MoPH are coming' someone shouted and there was a flurry of activity as staff tried to find white coats to put on, clear away other clothes and tidy the head midwife's office. The two men from the Ministry stayed less than 10 minutes, they signed a big book in the office and then left (Field notes 28/12/2010)*

The irony was pointed out by the interpreter: 'Why do they send men to a female hospital when plenty of women work in the Ministry?' she asked. These visits may have fulfilled an administrative purpose, but cultural propriety precluded men from the clinical areas and from talking to women in childbirth, meaning they could not check or enforce standards of care. Some of the staff wanted to improve standards but faced difficulties in getting support from management.

iii. Staff Support. A midwife explained that no one seemed interested in staff's difficulties:

"*The hospital head and Ministry should think about their staff. They don't consider our problems at all, they tell us, 'These are simple and tiny problems and this is Afghanistan - you have to accept this situation*". (Young female midwife)

During observation, in the morning report, a midwife explained how difficult it was to complete a partograph on every woman because they often had so many women and few staff. The senior midwife responded at length in a loud voice emphasizing that completing pantographs was their responsibility.

"*It's your fault, you take everything on your shoulders, you tell the doctors 'I will do this' [like breech deliveries] and now you are complaining that you cannot manage*". (Field notes 28/12/2010)

This was an opportunity to improve care through discussing midwives' challenges. The manager, however, blamed them for wanting to use their extended skills and increasing their workload. She appeared unwilling to listen or work with her midwives to find solutions. This was not an isolated incident. Several staff explained that when they tried to discuss their difficulties the standard response from management was: 'this hospital is like a military hospital', followed by the suggestion that they resign if they 'weren't up to the job'. Some doctors used another military analogy by calling themselves 'soldiers'. When asked why they used this word, one replied: "*We are like soldiers ready at any time… you have to, you have to agree [she emphasized], even if they say the milk is black you say 'yes sir'*!" (Field notes 4/4/2012)

Staff described managers who oscillated between extremes: from inaction and passivity to intimidation, threats and punishment. Many staff appeared fearful and powerless in a system

that did not appear to care about them or the standards of care that women received. "*I am counting the hours until it is over*" one resident doctor confessed. Relationships were said to be the determining factor. Staff who were connected to powerful families had job security and could act with impunity, whereas those without such connections were vulnerable, could be punished or lose their jobs. This 'two-tiered system' also affected management.

b) Perspectives of Senior Managers in Hospital

During an interview a senior manager, explained that there was a central management system which meant she had no control over money or authority to dismiss or hire staff. She had tried to introduce a shift system to ensure better 24-hour coverage and give staff more time off. Some staff refused to comply, however, and challenged her authority as the roster clashed with the schedules of their private clinics: "We started a shift system here about six months ago. It was very good for staff because they could stay at home for two days after their night duty. Some people [other hospital staff] didn't like the system - they came to me and said, '*Where is your authority to do this pilot system, do you have a letter [of permission] from the MoPH'* (A senior hospital manager)

This manager explained that the MoPH failed to confirm its verbal permission in writing and, although those who challenged the shift system were less senior than her they succeeded in getting it stopped. During the interview another doctor interrupted to give the manager a sick note. After she left the manager held up the note - 'Viral Hepatitis' was written in English.

"*This is not true', the manager explained, 'she is not sick, but what can I do? Because of this she has one month off sick. I am very disappointed*" (A senior hospital manager)

The manager explained that rules and systems could be ignored and authority flouted if staff [like this doctor] were connected to powerful families. She accused the MoPH of having 'old minds', stuck in the old system where relationships are everything. 'Think about my job' she said: A female Afghan doctor working in the community confirmed that all hospital jobs were secured through connections with someone in the government and that, consequently, it was impossible for the director to dismiss staff. Another doctor pointed out, that these powerful connections undermine the authority of hospital managers:

> *Staff will say 'I know somebody [powerful] - so who can fire me for doing wrong things'? It is hard for the directors; the Ministry is asking them for high quality but if they do not have the authority how can they achieve it*? (Female Afghan doctor working for NGO)

c) Perspective of MoPH manager

A senior manager in the MoPH listed many challenges in maternity hospitals. Resident doctors graduated as obstetricians but were unable to perform a caesarean section on their own. There was poor care and relatives complained to the MoPH about maternal deaths but no hospital records could be found for the deceased. The doctor stated: "*There are rules and regulations but they are not followed… we [her MOPH department] have the technical responsibility but not the power to improve standards*". (Female Doctor Head of Department MoPH)

The senior manager gave an example of the powerlessness of the MoPH citing a remote hospital in Afghanistan where several members of the same family worked. They have 'bad behavior' and are 'cruel to patients', she said but because they have a relative in the government the MoPH cannot do anything.

d) Perspectives of other stakeholders

An ex-parliamentarian confirmed that from the government down, power was equated with having powerful connections or a '*wasita'.*

> *People with good intentions are trying to improve things for those who are suffering - but it's difficult because there is no power to really change the system. For example, the head of a maternity hospital cannot decide, there are lots of hidden relationships that influence*. (Ex-parliamentarian)

These 'hidden relationships' (or nepotism) he explained influenced public services and decision-making from government down. Holding a public office did not necessarily include the authority to make decisions. In addition, a female doctor working for an NGO explained that senior appointments such as heads of directorates in the MoPH were political – based on connections rather than ability.

> *Everybody here… [in senior positions] is there because of relationships, political allies. We have very eligible, knowledgeable people but they are jobless… I see also some people, they know nothing [she emphasized] but*

they belong to that warlord and therefore they are in this position. (Afghan doctor working in the community)

Afghan health professionals in our study expressed deep frustration and anger with a health system largely controlled by those with little interest in providing care. At every level there were people working towards high quality care but their efforts were constantly undermined. "Politics, bloody politics"! was the assertion of one Afghan who had left his healthcare profession feeling that his hard work was useless, adding: "This should not be, politics should not come into healthcare". For him and for several background interviewees politics and health services were inextricably linked.

These networks bypassed the official ways of doing things, they elevated the status of individuals and were the route to employment in the hospital and opportunities to attend training courses. It was particularly concerning that these relationships created a power structure where senior managers were unable to discipline or fire junior staff and that it conferred relative impunity on those with connections (or *wāsita)* at every level of the hierarchy.

Discussion

From the perspective of staff in this maternity hospital those responsible for managing the hospital were passive, weak and appeared unconcerned about standards or the wellbeing of their staff. Furthermore, their managers were autocratic - they demanded compliance from staff but appeared unwilling to discuss staff difficulties. This picture was complicated, however, by the perspectives of the hospital managers, leaders in the MoPH and those familiar with the health system and government. They explained that although hospital managers and the MoPH were responsible for the day to day running of maternity services they did not necessarily have the power to intervene, make changes or enforce standards of care.

Managers in our study have similarities with managers in other LMICs who have limited authority, must comply with administrative directives and procedures, respond to requests from the health system hierarchy and ensure well-functioning public health facilities.[6] Often managers in LMIC's also lack the authority (and budget) to initiate change, hire staff or make even minor repairs.[4]

The inability of senior managers to affect change such as introduce a shift system affected the functioning of the hospital, the care of women in childbirth and staff wellbeing. It also undermined their status, credibility, and inevitably staff compliance with their directives. Recent analyzes of the Afghanistan maternal and newborn quality of care assessment demonstrates that low quality of intrapartum care persists, healthcare providers still work in difficult, stressful and unsupported environments and ensuring respectful care remains challenging. [29-31]

Aberese-Ako and colleagues[32] described the frustration of hospital managers in Ghana who knew what needed doing but had limited powers. Similarly, senior managers and leaders in the Kabul hospital and the MoPH argued that they lacked the power to enforce standards or discipline staff. Our findings, however, highlight that it is possible to praise good practice even with limited authority thus challenging the notion that managers who lack power can be absolved from using the influence that they have. The Ghanaian managers, for example, networked and lobbied for assistance, interpreted rules with flexibility to fund essential work, abandoned unsuccessful strategies and tried alternative approaches.[32]

The failure to enforce standards was interpreted by staff in our study as managers who did not care. Aberese-Ako and colleagues[32] suggested that a sense of powerlessness could explain a laissez-faire leadership style where leaders neither guide, apply the rules, nor inspire staff but allow them to do as they please. Similarly, we suggest, the frustration of senior managers over their limited power might have discouraged them from trying to improve standards. Whatever the reasons, the lack of leadership affected morale and gave staff no incentive to work conscientiously.

Leadership, support and supervision of staff are key components of effective clinical care[33]. Major differences in organizational culture and leadership styles were linked to a striking variation in maternal outcomes between two similar resource-limited South African hospitals.[33] The authors found that strong, committed and consultative leadership motivated staff and resulted in good performance even with limited resources. An authoritarian leadership style, and blame for adverse incidents, however, created an atmosphere of fear, mistrust and a lack of commitment among staff.[33] There were many examples of authoritarian leadership in our study. Doctors or midwives who raised problems were shouted at, blamed or told they could leave if unable to cope. Managers asserted their authority by using military analogies and demanding compliance.

Effective leadership and management styles are not generic but reflect sociocultural norms.[34] The strategies that create motivated and well-functioning teams vary in different contexts. Traditionally Afghans respect powerful authoritarian leaders.[35] This explains the frustration of staff who considered that their managers and leaders were weak and ineffective - when there were no consequences for those flouting the rules, they lost respect. Although management and leadership styles, supervision and support affect the functioning of health systems[33], our study revealed that they are only part of the picture.

The influence of political elites and former warlords on the health system and other public institutions concurs with the findings of Afghanistan Research and Evaluation Unit[36]. The staff and those who knew the health system claimed that these connections or hidden relationships were the main reason for poor standards of care[37]. In LMICs public institutions often function very differently from what their rules state.[38] *Wāsita* is an integral cultural value in Afghan society and part of the wider client-patron system[39] and using connections is a normal survival strategy, especially as there is little state protection. Egan[40] compared similar systems - *blat* (Soviet Union) and *wasta* (Lebanon), but made the distinction between their use by individuals (such as kinship groups) and organized crime. Our study suggests the use of wāsita was seriously undermining maternity services through the appointment of unsuitable people to senior positions, preventing the MoPH and hospital managers from enforcing high standards or stopping the abuse of patients. This concurs with the findings of a recent study that concluded the capacity of the MoPH was undermined by socio-political influences[41].

Using your position to secure jobs for family and close associates, as our participants asserted, is an integral part of the culture. 'Afghan culture is based on relationships'[35, p98] and identity is based on the immediate kinship group as well as ethnicity, sect, region and ideology. These traditional groupings and rivalries affect appointments to public institutions but recent history has reinforced them[42].

Political settlements and corruption affecting Afghan public institutions have been well documented.[36,43] The Afghan MoPH under the leadership of the previous minister was the first public ministry to investigate corruption and take a zero tolerance approach.[44] The former minister acknowledged, however, that 'corruption remains one of the major challenges facing the health system - threatening to derail the health gains that have been made'.[45]

Our findings concur with Gilson and Agyepong[7] that strengthening leadership and governance requires recognition of the complexity of the context and the challenge of change. Addressing issues that affect quality in public health systems is politically complex, especially in fragile states where the actual holders of power may be unclear[46]. It is, however, likely to be

a more effective approach than solely focusing on the skills and behavior of individual providers.

Study Limitations

One study limitation is that it was conducted some time ago (2010 – 2012), however, recent studies that we have cited suggest that the situation has stayed much the same. Although there will be changes with the takeover of the Taliban in August 2021 many of the findings from our study will resonate with other LMIC settings where there are contextual similarities. Although our findings cannot be generalised they provide insights on the complexity of health systems and the need to look beyond the official holders of power to the social and political networks that may be influencing decisions and consequently standards of care. Furthermore, they suggest important considerations in supporting leaders and managers of maternity systems.

This cross-cultural study is based on translation which brought an inherent potential for bias, misunderstanding, and misrepresentation. Although great care was taken to ensure the accuracy of translation it is inevitable that some details and nuances will have been missed. Daily debriefs with the interpreter provided rich cultural insights and on occasion corrected false assumptions. Afghan colleagues were asked for guidance during the fieldwork and findings were frequently discussed with those who had a deeper understanding of the culture.

The wide range of perspectives elicited through interviews and informal conversations helped to create a broad understanding of the complexity of healthcare provision in this Kabul hospital. This was, a self-selected sample, therefore, those who did not take part may have had different perspectives which are not represented. Additional interviews with MoPH and government representatives would have also been valuable.

Conclusion

This study revealed the complexity of management and leadership roles in an Afghan maternity hospital and MoPH. Doctors, midwives and care assistants were frustrated that their managers did not enforce standards, listen to their concerns, or create a working environment conducive to high quality care. The managers, however, were constrained by their lack of power and a parallel system of hidden relationships with political elites and former warlords that gave some employees privileges and power beyond their roles. Staff connected to political elites could act with relative impunity and were unlikely to lose their job even if they flouted the rules. Conversely, staff who were not connected to political elites struggled to be sent on training courses, had to comply with powerful staff and were vulnerable to losing their job. It is

testament to the commitment and courage of individuals, both Afghans and foreigners, that so much has been achieved in women's reproductive health care. Further sustainable improvements to the quality of care, however, will need to address corruption and political interference in Afghan maternity services. This will require robust political will, tenacious leadership and commitment. Furthermore, this study suggests that to strengthen health systems and improve the quality of care in LMICs it is important to look beyond individual healthcare providers and official health systems and policies to explore who holds the power and how that power is used.

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