

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

Article

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

## 2    **Abstract**

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

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

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

## Research highlights

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

## Keywords

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

## INTRODUCTION

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

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

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

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

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

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

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

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

## **Methods**

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

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

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

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

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

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

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

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



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

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

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

## 176 Findings

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

### 185 1. The control of knowledge

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

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

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

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

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

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

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

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

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

## 220 **2. Equity or patronage**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

## 381 **Discussion**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

### 553 **Strengths & limitations of the study**

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

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

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

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

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

## 585 **CONCLUSION**

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

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

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

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

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

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

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