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

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Abstract

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

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

Under the surface of this maternity hospital, social norms were in conflict with the principles of biomedicine. Contested areas included the control of knowledge, equity and the primary goal of work. The institutional culture was further complicated by pressure from powerful elites. These unseen values and pressures explain much of the disconnection between policy and implementation, education and the everyday behaviours of healthcare providers. Improving the quality of care and equity in Afghan public maternity hospitals will require political will from all stakeholders to acknowledge these issues and find culturally attuned ways to address them. Furthermore, the notion of competing world-views on healthcare has relevance 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 21st century healthcare (Panter-Brick & Eggerman, 2018; Pitchforth et al., 2010).

In Kabul, state sponsored public health provision did not commence until the early 20th 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 20th 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

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

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

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

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

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

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

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

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

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

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

Findings

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

1. The control of knowledge

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

> 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 blood pressure of patients'.

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

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

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

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

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

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

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

2. Equity or patronage

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

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

> 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, and if something happens to her no action is taken.

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

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

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

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

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

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

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

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

> The attitude of staff is generally that the patient who 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.

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

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

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

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

> Researcher /first author: So does it help if you know someone in the Ministry?
>
> Midwife: Maybe… (lot of laughing from her and the interpreter) yes, it's a custom in Afghanistan!

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

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

> 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.

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

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

3. The purpose of hospital work

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

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

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

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

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

> 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.

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

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

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

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

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

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

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

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

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

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

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

> This issue is 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.

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

Discussion

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

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

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

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

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

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

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

It is impossible to make generalisations on the primary focus or purpose of work for the heterogeneous healthcare providers in this study. The strong connection to family 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’

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

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

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

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

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

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

Strengths & limitations of the study

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

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

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

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

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

CONCLUSION

At the heart of biomedical principles is the woman in childbirth and what is best for her according to scientific research (van Teijlingen, 2005). Survival strategies in a still volatile insecure setting like Afghanistan depend on allegiance to family and 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 though 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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