

DOI: 10.1111/1471-0528.13179
www.bjog.org

Understanding Afghan healthcare providers: a qualitative study of the culture of care in a Kabul maternity hospital

R Arnold,^a E van Teijlingen,^a K Ryan,^b I Holloway^c

^a Centre for Midwifery, Maternal & Perinatal Health, Bournemouth University, Bournemouth, UK ^b School of Nursing & Midwifery, Faculty of Health Sciences, La Trobe University, Melbourne, Vic., Australia ^c Centre for Qualitative Research, Bournemouth University, Bournemouth, UK

Correspondence: R Arnold, Centre for Midwifery, Maternal & Perinatal Health, Bournemouth University, Bournemouth House, Bournemouth BU1 3LH, UK. Email rea.afg.uk@gmail.com

Accepted 29 September 2014. Published Online 14 November 2014.

Objective To analyse the culture of a Kabul maternity hospital to understand the perspectives of healthcare providers on their roles, experiences, values and motivations and the impact of these determinants on the care of perinatal women and their babies.

Design Qualitative ethnographic study.

Setting A maternity hospital, Afghanistan.

Population Doctors, midwives and care assistants.

Methods Six weeks of observation followed by 22 semi-structured interviews and four informal group discussions with staff, two focus group discussions with women and 41 background interviews with Afghan and non-Afghan medical and cultural experts.

Main outcome measures The culture of care in an Afghan maternity hospital.

Results A large workload, high proportion of complicated cases and poor staff organisation affected the quality of care. Cultural

values, social and family pressures influenced the motivation and priorities of healthcare providers. Nepotism and cronyism created inequality in clinical training and support and undermined the authority of management to improve standards of care. Staff without powerful connections were vulnerable in a punitive inequitable environment—fearing humiliation, blame and the loss of employment.

Conclusions Suboptimal care put the lives of women and babies at risk and was, in part, the result of conflicting priorities. The underlying motivation of staff appeared to be the socio-economic survival of their own families. The hospital culture closely mirrored the culture and core values of Afghan society. In setting priorities for women's health post-2015 Millennium Development Goals, understanding the context-specific pressures on staff is key to more effective programme interventions and sustainability.

Keywords Ethnography, human resources, low-income countries, maternal health, vulnerability, workforce.

Please cite this paper as: Arnold R, van Teijlingen E, Ryan K, Holloway I. Understanding Afghan healthcare providers: a qualitative study of the culture of care in a Kabul maternity hospital. BJOG 2014; DOI: 10.1111/1471-0528.13179.

Introduction

For over a decade, improving Afghan women's health and reducing the high maternal mortality ratio^{1–3} has been a priority of the Afghan Ministry of Public Health (MoPH) and its international partners.^{4–9} The MoPH signed the Millennium Declaration in 2004.⁴ The timeframe for achieving the Millennium Development Goals was extended to 2020, recognising the effect of decades of conflict on the health system.

Traditional Afghan society dictates that only women care for women, however, in 2002 following the fall of the Taliban

there was a severe shortage of female staff with only 695 doctors and 467 midwives for 4 595 000 women of reproductive age.^{10,11} A key strategy to reduce maternal mortality, therefore, was to increase the number of midwives. A new midwifery curriculum and midwifery-training programme was introduced, midwifery schools (re)opened and an accreditation programme was established.^{12–14} Women, excluded from university under the Taliban, were re-admitted to Kabul Medical University. Newly qualified female doctors enrolled in obstetric and gynaecological residency programmes. Skilled birth attendance increased from 14% in 2003⁴ to 34% in 2010.³ In 2014 there were 3500 Afghan midwives.¹⁵

The presence of healthcare providers does not guarantee either quality or respectful care.^{16–21} A substantial proportion of maternal deaths occur in hospital, some of which could be prevented with timely interventions.²² Post Millennium Development Goals, the challenge remains to understand the human element and context-specific motivating factors that affect the quality of care and equity.²³

Despite significant improvements in Afghan women's health care, discrepancies still exist between the presence of healthcare providers and the care that women receive. Evaluations of obstetric services and perinatal outcomes indicate numerous deficits in the quality of hospital care.^{24–26} Humiliating experiences endured by rural women in a provincial hospital appeared to discourage the uptake of services.²⁷ In an evaluation of midwifery training some women complained of poor treatment, insults, and being turned away for lack of money although care in public hospitals should be free.²⁸ Respectful care was taught in the new midwifery curriculum; however, Currie et al.¹² reported a lack of caring behaviours among staff.

Afghan doctors and midwives are pivotal if outcomes for women in facility-based childbirth are to improve, but little is known about their experiences, priorities and motivations. This qualitative ethnographic study examined the culture of a Kabul maternity hospital, the perspectives of staff and their effect on the care of perinatal women. The experiences and wishes of Afghan women regarding care in facility-based childbirth were also explored.

Methods

An ethnographic study was conducted between October 2010 and April 2012, comprising observation, interviews and focus group discussions. The hospital management gave permission and helped with facilitation. The research was conducted by the first author (RA), a nurse/midwife with 30 years of experience, including eight in Afghanistan who speaks basic Dari but not sufficient for study purposes. An Afghan female interpreter who spoke Dari, Pashto and English was recruited and oriented to the study.^{29,30} She had worked with international organisations, and whilst she had no medical background, provided insights into family life and facility-based childbirth from an Afghan mother's perspective.³¹ She interpreted throughout observation, staff interviews and focus groups. Staff were informed about the study through information sheets in public areas and received additional written and verbal information before interviews.³² If staff objected to being observed they were not included in the observation. As perinatal women were not the focus of observation consent was not requested; however, verbal explanations were given to women who enquired.

Observation

Six weeks of observation in each area of the hospital provided insight into the organisation of care, workload, basic clinical management and caring behaviours. The researcher participated in the everyday life of staff—helping, watching, listening and enquiring about their lives and work.³³ Her role fluctuated between observation and participant observation,³⁴ not working clinically but supporting women in labour, being a 'pair of hands' when required, or sometimes simply observing. Key incidents were cross-checked with the interpreter to avoid misunderstandings.³⁵ Field notes made during observation were expanded and transcribed as soon as possible.³⁶ Informal group discussions occurred spontaneously during observation.

Interviews

Twenty-five semi-structured interviews³⁷ (lasting 20–80 minutes) explored the thoughts and experiences of a cross-section of staff from different areas of the hospital including resident doctors, senior obstetricians, senior/newly qualified midwives and a care assistant. Purposive sampling ensured that each occupation and different levels of seniority were represented (Table 1). Self-selection and opportunistic sampling were also employed. An interview guide included questions about work and hospital care, satisfaction, difficulties and ideas regarding improvements to care. As an exploratory study the guide was purposely flexible to allow participants to focus on issues of importance to them.³⁷ Some interviews were directed by the experiences of the interviewees, such as a midwife describing changes in standards of care over 30 years, or a new midwife struggling with the hospital culture. Interviews were conducted within the hospital but away from interviewees' work areas. All participants were female.

Background interviews were conducted with 41 key informants from the MoPH, midwifery and medical education, Afghan and non-Afghan health professionals and researchers, a community leader and a historian. The purpose was to gain insights into the public health system and also the wider social, cultural and historical context of care.

Table 1. Occupational group and experience of interviewees

Obstetricians	Resident doctors	Midwives	Care assistants
Just qualified (1)	1st year (2)	6 months (3)	15 years (1)
5 years (1)	2nd year (1)	2–3 years (3)	
6 years (2)	4th year (3)	4–6 years (2)	
10–16 years (3)		Over 25 years (3)	
Total <i>n</i> = 7	Total <i>n</i> = 6	Total <i>n</i> = 11	Total <i>n</i> = 1

Values in parentheses are *n*.

Informed consent was obtained for all interviews³² and, with permission, interviews were digitally recorded or hand-written notes were taken and transcribed as soon as possible. Interviews were conducted in Dari, Pashto or English.

Focus groups

Two focus group discussions³⁶ were conducted with women in the community to obtain basic feedback on their experiences and wishes regarding care in Afghan maternity hospitals. A focus group discussion was held in the home of a community leader with six female members of his extended family. It was conducted in Dari and translated by the Afghan interpreter. The second was held in a poor area of Kabul with 12 women from a pre-existing self-help group. It was conducted by an Afghan researcher and facilitated by an international organisation.

Analysis

Data were analysed using thematic analysis.³⁸ Digital recordings of interviews and focus group discussions were transcribed and translated by an Afghan midwife/researcher as a quality control measure. RA transcribed field notes and interviews conducted in English, then read and re-read all the transcripts to increase familiarity.³⁹ Data were coded section-by-section. Selected interviews were read and coded by two co-authors (EvT, KR). Similar codes such as 'no-one appreciated us', and 'we can easily be replaced' were grouped into a category such as 'not valued'. Transcripts were re-read as patterns and relationships were discerned and categories developed. 'Not valued' was linked with the category of 'no powerful connections' and became the more conceptual category of 'vulnerability'. Categories were checked against the data and redefined where a more accurate concept was identified.³² The initial category 'powerlessness' was renamed 'vulnerability' after realising that all staff had some power over patients because they had insider knowledge but some were also vulnerable within the hospital hierarchy. On-going reflection, discussions with key informants and reading of the literature led to the merging of similar categories into major themes.³⁹ Five key themes were identified, we report here on two: (a) surviving and (b) family pressures.

Results

Women in the community described the lack of care experienced in various Kabul maternity hospitals. They said that staff were 'careless' in attending to their needs, that it was 'difficult to find a doctor who would help' and that even bribes did not guarantee good care. Several women delivered alone in hospital corridors, others reported being slapped and verbally abused. Women desired a good standard of care from well-qualified and

well-motivated doctors, free medicines and supplies. Kindness and good behaviour were thought to 'heal the pain of patients' and were more important than professional knowledge. Some women said that they would not go to hospital for another baby because of the way they had been treated.

Initial observations showed a very busy, crowded tertiary hospital with care providers struggling to manage the workload. Some worked hard and spoke of their satisfaction in seeing critically ill women recover. Distressed women, however, laboured alone in overcrowded small rooms with up to four women sharing a bed. They received little monitoring of progress and fetal condition, support or information between admission and delivery. A few hours following delivery, women and their babies went home, many without postnatal check-ups. Some women were verbally abused about the number of children they had and some were sent home with life-threatening conditions such as an antepartum haemorrhage. Our analysis revealed underlying issues, dynamics and values within the hospital environment that are a part of wider Afghan society and culture. These contextual factors help to explain the behaviour of staff and the complexity of the challenges they face.

Surviving: power and vulnerability

The experience of healthcare providers can be summed up as 'surviving' in a hospital culture where power depended on 'who you know'. Power meant having a relative or important contact in the hospital or the government who would help you get a job, ensure that you were sent on training courses and ensure that you would keep your job, whatever happened. 'Having connections' was of major importance. Vulnerability was the absence of a powerful relative or 'connection' who could be called upon to help in case of trouble and also knowing that you could be easily replaced. A resident doctor frustrated at how connections affected clinical rotations explained:

...just some doctors who have a relative in this hospital are helped...because I don't know anybody they didn't send me to get experience in the operating theatre for 2 years.

Clinical training and the supervision of resident doctors was also largely dependent on connections, on knowing senior staff who would share their clinical skills. Residents without relatives or contacts in the hospital generally had to develop their clinical skills by trial and error on patients and hope that nothing would go wrong.

No one showed me how to do an episiotomy or how to suture...the trainers just say 'you're a doctor you can do it'. First year resident doctor

One resident spoke of three major errors she had made when left alone during her first night duty. According to resident doctors, while some trainers gave support and training, the majority were reluctant to pass on their skills. When called to an emergency, most trainers performed procedures such as cervical suturing themselves rather than teach others. Resident doctors experienced high levels of stress as they worried about making clinical mistakes and consequently being 'brought before the judge'. Many were angry, frightened, tired and talked of 'counting the hours' until they completed their residency and left the hospital. They felt let down by a system that had promised a comprehensive residency training programme but had, largely, left them on their own to develop clinical skills. A doctor at the MoPH confirmed that some doctors graduate from the 4-year residency programme without being able to do a caesarean section alone, if they were not connected to a senior person.

A senior hospital doctor explained the difficulties of enforcing standards of care and behaviour within the hospital if staff had relatives in government. This doctor had dismissed a care assistant because of her 'bad behaviour' with patients. A few weeks later the care assistant came with a letter from the MoPH ordering her reinstatement.

Relationship is very very important, relationship is over the law...who they are is everything, which family they are from, relationship is everything. Senior doctor

Healthcare providers spoke of the need for a fair system where opportunity, support and training did not depend on connections, but, as in wider Afghan society, having connections made all the difference within the hospital.^{40,41} An MoPH interviewee explained that giving more authority to hospital management was also open to abuse and no guarantee of fairness.

Surviving: a culture of fear and blaming

There was fear in this hospital, fear of: (a) being humiliated in public; (b) losing one's job and the consequences for one's family; and (c) being blamed for a professional error. Many staff mentioned their desire to be appreciated, to receive appreciation letters rather than warning letters. It was a punitive system, however, devoid of encouragement or praise.

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

Surviving meant blame someone else before you are blamed. A mother whose baby nearly asphyxiated was blamed, the family of a woman who died were blamed for not bringing her sooner, staff blamed each other, or report-

edly patient records were changed or went missing—anything to avoid being blamed. In one area of the hospital midwives were blamed for a woman's death because a doctor had not seen her—as a consequence, they refused to work on their own initiative. With no professional liability insurance in Afghanistan there is a great fear of litigation and of having to pay large fines or bribes to avoid prison.

Last year there was a big case and two doctors were involved. (I think a patient had died.) It was only because they had relatives or contacts that they were able to get off—but now everyone is very anxious about it. Resident doctor

Surviving: the workload

High patient numbers and long hours were mentioned by most interviewees. This hospital has up to 100 deliveries in 24 hours with a high proportion of complicated cases, as it is one of the national referral hospitals.

Every night we have 14, 16, 18 caesarean sections. They come from outside, from far away, rupture, ectopic rupture, total placenta praevia, active bleeding, concealed abruption, two or three previous caesareans, breech presentation, fetal distress, abruption. Sometimes it's so difficult. Resident doctor

Staff numbers appeared adequate overall but the lack of a shift system meant that the hospital was crowded with staff in the mornings, and for the rest of the day and night the work was conducted by small groups of doctors, midwives and care assistants. They work from 8 am until after morning report the following day, spend the rest of the day at home taking care of their household responsibilities, but are back on duty the next morning. Field notes highlighted on several occasions that staff were visibly tired.

Midwives, doctors and care assistants are so tired they are nearly unconscious! Senior midwife

Care assistants endured long hours, frequent night duties and thankless toil but did not complain for fear of losing their job. Many staff spoke of the need for a shift system to share the workload more efficiently and give them more time at home for their family duties. There were, however, constraints to the introduction of shifts including the cost of additional transport for staff in the evenings, the compliance of senior medical staff, who would sometimes have to be on duty instead of at their private clinics and, importantly, the agreement of the MoPH.

Family pressures: decisions, obligations and expectations

The family is the most important institution in Afghan society.⁴² Afghanistan is a collectivist society where most

decisions are made by the family for the benefit of the family as a whole.^{40,43} This has a direct impact on healthcare providers. For most, their career would have been a family decision often made for economic or status reasons. One obstetrician explained that some families force their children into medicine because of the status of doctors in Afghanistan.

So most students and even more families want to be the best, to get into medicine and be proud of it. Even some students who don't like this subject are forced by their families to select medicine as their career. Recently qualified obstetrician

Healthcare providers were obliged to care for family members who came into the hospital or important people connected to their family regardless of whether they were looking after other women. Doctors and midwives were often seen caring for a relative even though they were off duty and on occasions obviously unwell themselves. Some were the only wage earners in an extended family. Most care assistants were widows with children, who, after losing their husbands during the war, were forced for the first time to find work outside the home.

If I didn't have obligations do you think I would work in this place? Care assistant/widow

Families expect members to be successful, to keep their jobs regardless of working conditions and maintain the family honour. Failure in studies or occupation would shame the whole family and could lead to punishment. Staff were also expected to fulfil their responsibilities at home—as mother, wife, daughter-in-law and entertainer of guests. In a society without a social security system the only security, or insurance policy, is the family,^{40,42} even for those who suffer violence or a lack of respect at home.^{44,45} As highlighted in a background interview:

Generally men in Afghanistan don't value women at all. This affects how the midwife behaves with others because she doesn't receive respect in her own family, especially from her husband. There is also too much pressure from the family, as well as too much work during the day. It really affects their behaviour. Senior doctor

In summary, the culture of care in this hospital meant childbearing women were at risk through inadequate clinical training and supervision of resident doctors. Doctors without powerful connections were vulnerable and anxious about making clinical mistakes and being taken to court. Healthcare providers, devoid of encouragement, were exhausted from working long hours with high patient numbers and a large proportion of complicated cases. Women experienced minimal professional attention unless

they had relatives working in the hospital or had a high social status. Poor, illiterate, pregnant women were low priority and particularly at risk of poor care as they had little to contribute to the economic and social survival of staff. Our data indicated that many of these findings are not unique to this hospital but are widespread within Afghanistan.

Discussion

Main findings

This study found that the ability and motivation of Afghan staff to provide quality care is influenced by multiple factors, both within and outside the hospital. Staff were under physical and mental pressure from long hours and unrelenting workloads in the hospital and at home. Some doctors graduated as specialists unable to perform key life-saving procedures as a result of nepotism and cronyism. The acquisition of skills, workshop attendance and employment were more dependent on connections than need, motivation, or ability. Well-connected staff were 'above the law' and hospital authorities were powerless to enforce standards. Staff without powerful connections feared humiliation in a precarious, hostile environment. Neglect and sub-optimal care were unlikely to be deliberate but were the result of conflicting priorities, the workload, poor clinical skills and the struggle for survival. Community focus group discussions pointed to poor experiences in facility-based childbirth and the potential impact on the future uptake of services by women.

Strengths and limitations

This is the first study of its kind into Afghan maternity care providers, highlighting their priorities and social realities. The combination of interviews and observation helped to provide a deeper in-sight into the culture of care in this Kabul hospital.

Those willing to talk to the researcher were possibly the more vulnerable staff, which could have skewed our findings, but background interviews suggest that this was not the case.

A limitation is that this study was conducted with the assistance of a translator. While every effort was made to reduce the negative impact of translation and ensure quality, some of the depth, richness and cultural nuances were bound to have been lost. Some questions were simplified and some sensitive questions were not asked to avoid misunderstanding.

Holding interviews in hospital was not ideal as some interviews were disturbed by the demands of the hospital. It was not possible to conduct interviews at a different location or time, due to the busy lives and family restrictions on the movements of many participants.

Interpretation

One reason why many intercultural solutions do not work, Hofstede et al.⁴⁶ claim, is that differences in how people think are ignored. At the core of a culture are its learnt values, which cannot be easily changed and are revealed by actions and behaviour.⁴⁶ The results of this study concur with previous ethnographies in hospital culture^{47,48} and the ideas of van der Geest and Finkler (p.1995)⁴⁹ that the hospital is a domain where core values and beliefs of a culture are revealed. Andersen⁴⁸ linked the differential treatment of patients by staff within a Ghanaian hospital to social status and the importance of the right connections within society. As Zaman⁴⁷ showed in Bangladesh, the hospital is often a microcosm of the larger society. Hospitals the world over are 'deceptively familiar' (p.1995)⁴⁹ but the familiarity belies the 'underlying social and cultural processes that are being played out in hospital settings' (p.1996).⁴⁹ Many elements within this Kabul hospital resonated with wider Afghan culture and society: the centrality of the family, the importance of connections and of a good reputation,⁵⁰ and the power of nepotism and cronyism.⁴¹ In particular, doctors, midwives and care assistants were working according to the core values of Afghan society rather than to standardised global biomedical strategies and regulations.

Implications

Many factors affected the ability and motivation of staff to provide quality care and offer possible explanations to findings from previous studies on deficits in the quality of emergency and newborn care (EmONC) services.^{24–26,51} Although based in one hospital, background interviews and RA's experience suggest that these factors are present in most Afghan health facilities. In rural settings there can be more accountability to the local community; however, in remote provinces there is less oversight and control by the MoPH.

The major implication for policy makers and health professionals in Afghanistan is that it is easy to make incorrect assumptions about why people work in health care, what is important to them and what will help them do a better job, therefore, asking them is vital. Many issues from the study are rooted in wider Afghan society and cannot be easily changed; however, understanding the impact of culture on health workers presents a starting point for discussing the challenges and for more effective programme design.⁵² As public recognition of good work was very important to staff, this would be a relatively easy change to make; it would show individuals that they were appreciated and bring honour to their families. A shift system would use staff better, give additional time for family duties and reduce tiredness. More research is needed to clarify the factors that currently prevent a shift system being implemented. Improving equity in clinical training requires an

in-depth investigation that includes all stakeholders. Cultural insights are vital to provide innovative local solutions as generic solutions alone are unlikely to solve the issues.

The importance of 'good behaviour' over professional knowledge and skills for Afghan women in the community confirms previous findings.⁵³ However, treating perinatal women with respect is difficult for health providers who do not experience respect themselves. Fundamental changes to the punitive hospital culture are therefore necessary to enable staff to think further than their own survival.

The international community brings a wealth of technical expertise, resources and passion to improve global women's health post-2015. It is the healthcare providers, however, who understand the reasons why women might not be receiving quality care in their particular workplace and what would help them provide a better service. Of course, the voices of women must be part of the post-2015 agenda,^{54,55} however, to improve women's health post-2015 it is vital to listen to healthcare providers and examine the impact of cultural values and social pressures on their motivation, behaviour, ability to care, and consequently on the quality of care.

Conclusion

This study has shown that training courses, evidence-based protocols and increasing staff numbers are not the whole answer to addressing deficits in the quality of care, clinical skills and decision-making. It is imperative to understand the context of care and the complex challenges that even highly motivated healthcare providers face in their work environment and lives. Generic solutions are no answer to many of these issues. No amount of international funding and strategies are likely to bring sustainable change to the quality of care for women globally unless programmes are adapted and embedded within the local context. This needs to include understanding the healthcare providers and the cultural and social determinants of their motivation and behaviour.

Disclosure of interests

The authors have no conflicts of interest to declare.

Contribution to authorship

RA, KR and IH designed the study; RA wrote the first draft; RA, EvT, KR and IH commented on various drafts and agreed the final manuscript.

Details of ethics approval

Ethics approval was obtained from the Afghan Ministry of Public Health Institutional Review Board 20/09/2010 No.112868 20/11/2011 No. 984111, and Bournemouth University Research Governance Review Group 28/10/2010.

Funding

Bournemouth University Post Graduate Researcher Development Fund funded one data collection field trip.

Acknowledgements

A particular thank you to the women of Afghanistan, doctors, midwives, care assistants and mothers, for sharing their stories, frustrations, hopes and fears. Further thanks to Bournemouth University, the Afghan Ministry of Public Health and our advisors, colleagues, interpreters and the reviewers of *BJOG*. ■

References

- Bartlett LA, Mawji S, Whitehead S, Crouse C, Dalil S, Ionete D, et al. Where giving birth is a forecast of death: maternal mortality in four districts of Afghanistan, 1999–2002. *Lancet* 2005;365:864–70.
- Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, et al. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 2010;375:1609–23.
- Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], ICF Macro [India], Central Statistics Organization [Afghanistan], Indian Institute of Health Management Research Jaipur [India], World Health Organization. Regional Office for the Eastern Mediterranean [Egypt]. *Afghanistan Mortality Survey 2010*. Kabul: APHI/MoPH, CSO, ICF Macro, IHMR and WHO/EMRO, 2011.
- Islamic Republic of Afghanistan Ministry of Public Health. *National Health Policy 2005–2009 and National Health Strategy 2005–2006*. Kabul: Ministry of Public Health, 2005.
- Islamic Republic of Afghanistan Ministry of Public Health. *National Reproductive Health Policy 2012–2016*. Kabul: Ministry of Public Health, 2012.
- Save the Children. *Saving the Lives of Mothers and Newborns in Afghanistan*. Westport, CT: Save the Children, 2008.
- Ministry of Public Health Afghanistan. Action plans launched to improve reproductive, maternal, neonatal and child health. [<http://moph.gov.af/en/news/action-plans-launched-to-improve-reproductive-maternal-neonatal-child-health>]. Accessed 25 April 2014.
- Jhpiego. Jhpiego in Afghanistan. [[www.jhpiego.org/files/Afghanistan Country Profile.pdf](http://www.jhpiego.org/files/Afghanistan%20Country%20Profile.pdf)]. Accessed 25 April 2014.
- United States Agency for International Development. Afghanistan, health. 2014 [www.usaid.gov/afghanistan/health]. Accessed 25 April 2014.
- Ministry of Health Transitional Islamic Government of Afghanistan, Management Sciences for Health (MSH), Health and Development Services (HANDS). *Afghanistan National Health Resources Assessment 2002*. Kabul: Ministry of Health, 2003.
- United Nations, Department of Economic and Social Affairs, Population Division. World population prospects: the 2012 revision, DVD Edition.2013 [<http://esa.un.org/unpd/wpp/Excel-Data/population.htm>]. Accessed 23 August 2014
- Currie S, Azfar P, Fowler RC. A bold new beginning for midwifery in Afghanistan. *Midwifery* 2007;23:226–34.
- Smith JM, Currie S, Azfar P, Rahmanzai AJ. Establishment of an accreditation system for midwifery education in Afghanistan: maintaining quality during national expansion. *Public Health* 2008;122:558–67.
- Turkmani S, Currie S, Mungia J, Assefi N, Rahmanzai AJ, Azfar P, et al. 'Midwives are the backbone of our health system': lessons from Afghanistan to guide expansion of midwifery in challenging settings. *Midwifery* 2013;29:1166–72.
- United Nations Population Fund. *The State of the World's Midwifery 2014. A Universal Pathway. A Woman's Right to Health*. New York: UNFPA, 2014.
- Koblinsky M, Matthews Z, Hussein J, Mavalankar D, Mridha M, Anwar I, et al. Going to scale with professional skilled care. *Lancet* 2006;368:1377–86.
- Miller S, Cordero M, Coleman AL, Figueroa J, Brito-Anderson S, Dabagh R, et al. Quality of care in institutionalized deliveries: the paradox of the Dominican Republic. *Int J Gynaecol Obstet* 2003;82:89–103.
- Bowser D, Hill K. *Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth: Report of a Landscape Analysis*. USAID-TRAction Project. Harvard, MA: Harvard School of Public Health, University Research Co., LLC, 2010.
- Human Rights Watch. *"Stop Making Excuses" Accountability for Maternal Health Care in South Africa*. New York: Human Rights Watch, 2011.
- Amnesty International. *Deadly Delivery: The Maternal Health Care Crisis in the USA*. London: Amnesty International, 2010.
- Weeks A, Lavender T, Nazziwa E, Mirembe F. Personal accounts of 'near-miss' maternal mortalities in Kampala, Uganda. *BJOG* 2005;112:1302–7.
- Ronsmans C, Graham WJ. Maternal mortality: who, when, where, and why. *Lancet* 2006;368:1189–200.
- Freedman LP, Graham WJ, Brazier E, Smith JM, Ensor T, Fauveau V, et al. Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. *Lancet* 2007;370:1383–91.
- Kim YM, Zainullah P, Mungia J, Tappis H, Bartlett L, Zaka N. Availability and quality of emergency obstetric and neonatal services in Afghanistan. *Int J Gynaecol Obstet* 2012;116:192–6.
- Guidotti R, Kandasamy T, Betrán AP, Merialdi M, Hakimi F, van Look P, et al. Monitoring perinatal outcomes in hospitals in Kabul, Afghanistan: the first step of a quality assurance process. *J Matern Fetal Neonatal Med* 2009;22:285–92.
- Kim YM, Tappis H, Zainullah P, Ansari N, Evans C, Bartlett L, et al. Quality of caesarean delivery services and documentation in first-line referral facilities in Afghanistan: a chart review. *BMC Pregnancy Childbirth* 2012;12:14.
- Akbar S. Maternal health and the midwife training programme in Afghanistan: perceptions, deceptions and the politics of birth. MPhil Thesis, Oxford University, UK, 2011.
- Health Services Support Project, USAID. Program evaluation of the pre-service midwifery education program in Afghanistan: final phase one report. New York: United Nations Population Fund, 2009.
- Pitchforth E, van Teijlingen E. International public health research involving interpreters: a case study from Bangladesh. *BMC Public Health* 2005;5:71.
- Kirkpatrick P, van Teijlingen E. Lost in translation: reflecting on a model to reduce translation and interpretation bias. *Open Nurs J* 2009;3:25–32.
- Temple B, Young A. Qualitative research and translation dilemmas. *Qual Res* 2004;4:161–78.
- Holloway I, Wheeler S. *Qualitative Research in Nursing and Healthcare*, 3rd edn. Oxford: Wiley-Blackwell, 2010.
- Brewer JD. *Ethnography. Understanding Social Research*. Buckingham: Open University Press, 2000.
- Gold RL. Roles in sociological field observations. *Soc Forces* 1958;36:217–23.

- 35 Li J, Karakowsky L. Do we see eye-to-eye? Implications of cultural differences for cross-cultural management research and practice. *J Psychol* 2001;135:501–17.
- 36 Hammersley M, Atkinson P. *Ethnography: Principles in Practice*, 3rd edn. London; New York: Routledge, 2007.
- 37 Minichello V, Aroni R, Hays T. *In-depth Interviewing: Principles, Techniques and Analysis*, 3rd edn. Sydney: Pearson Education, 2008.
- 38 Forrest Keenan K, van Teijlingen ER, Pitchforth E. The analysis of qualitative research data in family planning and reproductive health care. *J Fam Plann Reprod Health Care* 2005;31:40–3.
- 39 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- 40 Dupree L. *Afghanistan*, 2nd edn. Karachi: Oxford Pakistan Paperbacks by arrangement with Princetown University Press, 1997.
- 41 Eggerman M, Panter-Brick C. Suffering, hope, and entrapment: resilience and cultural values in Afghanistan. *Soc Sci Med* 2010;71:71–83.
- 42 Dupree NH. Cultural heritage and national identity in Afghanistan. *Third World Q* 2002;23:977–89.
- 43 Entezar EE. *Afghanistan 101: Understanding Afghan Culture*. Bloomington: Xlibris Corporation, 2007.
- 44 Saramad MH, Sultani L. Violence against women in Afghanistan (The first six months of the year – 1392). Afghanistan Independent Human Rights Commission (AIHRC); 25 November 2013.
- 45 Zubaide M, Haniewicz Y. Two tales of brutality to women in Afghanistan. BBC News. 2013 [www.bbc.co.uk/news/world-asia-25398935]. Accessed 25 April 2014.
- 46 Hofstede G, Hofstede GJ, Minkov M. *Cultures and Organisations: Software of the Mind: Intercultural Cooperation and its Importance for Survival*, 3rd edn. New York: McGraw-Hill, 2010.
- 47 Zaman S. Poverty and violence, frustration and inventiveness: hospital ward life in Bangladesh. *Soc Sci Med* 2004;59:2025–36.
- 48 Andersen HM. "Villagers": differential treatment in a Ghanaian hospital. *Soc Sci Med* 2004;59:2003–12.
- 49 van der Geest S, Finkler K. Hospital ethnography: introduction. *Soc Sci Med* 2004;59:1995–2001.
- 50 Loewen A. What will people say?: reputation in Persio-Afghan society. In: Loewen A, McMichael J, editors. *Images of Afghanistan: Exploring Afghan Culture through Art and Literature*. Oxford: Oxford University Press, 2010.
- 51 Partamin, Kim YM, Mungia J, Faqir M, Ansari N, Evans C. Patterns in training, knowledge, and performance of skilled birth attendants providing emergency obstetric and newborn care in Afghanistan. *Int J Gynaecol Obstet* 2012;119:125–9.
- 52 de Kok BC. 'Automatically you become a polygamist': 'culture and 'norms' as resources for normalization and managing accountability in talk about responses to infertility. *Health* 2009;13:197–217.
- 53 Hansen PM, Peters DH, Viswanathan K, Rao KD, Mashkoo A, Burnham G. Client perceptions of the quality of primary care services in Afghanistan. *Int J Qual Health Care* 2008;20:384–91.
- 54 Langer A, Horton R, Chalamilla G. A manifesto for maternal health post 2015. *Lancet* 2013;308:601–2.
- 55 UN Working Group on Sustainable Development Goals. *Outcome Document—Open Working Group on Sustainable Development Goals*. New York: UN Development Policy and Analysis Division, 2013. [http://sustainabledevelopment.un.org/owg.html]. Accessed 25 August 2014.