

# Experiences and Expectations of Childbirth at Health Facilities in Afghanistan

## Report of a qualitative study



February 2019

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# Acknowledgments

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## Abbreviations

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AMC	Afghan Medical Council
AMNC	Afghanistan Midwifery and Nursing Council
BPHS	Basic Package of Health Services
FGD	Focus group discussion
IRB	institutional review board
MNH	maternal and newborn health
MoPH	Ministry of Public Health
NGO	non-governmental organization
RMNCAHD	Reproductive, maternal, newborn, child, and adolescent health department
RMC	respectful maternity care
SBA	Skilled birth attendant
VCAT	values clarification and attitude transformation

## Executive Summary

Mistreatment in childbirth exists everywhere, including in Afghanistan, and experiences or perceptions of mistreatment can affect care-seeking for facility birth. Therefore, reducing mistreatment and improving respectful maternity care (RMC) is a critical contributor to ending preventable maternal and newborn morbidity and death. RMC is a fundamental issue related to human rights, quality of care, service utilization, equity and dignity. Ensuring women have access to quality, respectful care is a priority of the Government of Afghanistan.

The purpose of this qualitative study on *Experiences and Expectations of Childbirth at Health Facilities in Afghanistan* is to generate information to inform the Ministry of Public Health (MoPH) and development partners' efforts to eliminate mistreatment and ensure quality respectful care in maternal and newborn health (MNH) care services. The study objectives were to understand:

- Women's perception of MNH services
- Healthcare providers' perception of women's right, drivers for mistreatment and elements of RMC
- Key informants' perception of women's right, drivers for mistreatment and elements of RMC

Following MoPH approval, focus group discussions were conducted with women and healthcare providers (skilled birth attendants) in Balkh, Kandahar, Herat and Nangarhar, key informant interviews were conducted with selected MoPH and NGO staff responsible for implementation of the Basic Package of Health Services (BPHS). Key findings included descriptions of what women's wishes for clean, safe and secure delivery rooms, privacy, drugs, companionship and the presence of kind and supportive midwives and doctors. Women are deterred from giving birth in health facilities by female relatives, feeling shamed, unpleasant past experiences of mistreatment, discrimination and nepotism. These findings were validated by the providers who noted other barriers to facility birth including family restrictions and traditions, insecurity, economic barriers and lack of awareness. Providers are aware of mothers' rights to respectful care but are typically working with various health system constraints such as small delivery rooms, shortage of drugs, excessive workload, lack of competence in certain areas, lack of inter-professional collaboration and teamwork when required. None of the key informants were fully aware of clients rights related to RMC such as freedom from harm and ill treatment, right to information and informed decisions, equality and equity. They made suggestions on how to improve RMC emphasizing compliance with standards, reward and recognition systems, improved monitoring services and ensuring the Afghan Medical Council (AMC) and Afghanistan Midwifery and Nursing Council (AMNC) as regulatory bodies improve provider accountability.

Underpinning the key findings were socio-cultural factors related to gender and a fragile health system affecting both providers and the women. Although the providers do wish to support the women and provide respectful care there was evidence that mistreatment during childbirth is normalized and may not be considered a problem. This along with other barriers needs to be addressed in comprehensive quality improvement efforts as well as ensuring women and providers are aware of rights based care. The report concludes with a few recommendations to address these issues.

## Introduction

This report provides an overview of research methods, key findings, discussion and programmatic recommendations for the HEMAYAT-led qualitative study on experiences and expectations of childbirth at health facilities in Afghanistan.

## Background

*Every woman, every newborn, everywhere has the right to good quality care* - was the key message of the Lancet Maternal Series 2016 (1). This focus on quality care underpinned by equity and dignity has been advanced by the World Health Organization's (WHO) *Quality of Maternal and Child care Network* (2). Ten years ago, even five years ago these concepts were not given much attention. However, in recent years, an expanding body of research has shown that mistreatment during childbirth is pervasive and a significant deterrent to the uptake of facility-based childbirth - and thus to reductions in maternal and newborn mortality (2).

Respectful Maternity Care (RMC) is a universal human right and its promotion in facility births is of high importance at international level as well as in Afghanistan (3). The WHO *Framework for the Quality of Maternal and Newborn Health Care* lists the provision of respectful, dignified care as a key aspect of quality and equal to more traditional quality domains such as provider competence and health system supplies (4). A woman's "experience of care" (effective communication, respect and dignity, and emotional support) are essential during childbirth. This means that services should be delivered in a supportive setting that takes into account the preferences of individual women. Every woman has the right to this dignified, respectful care—it is not a luxury, it is a right.

Mistreatment is prevalent in many countries including Afghanistan, where mistreatment is perceived as normal behavior (5). Women's experiences with care providers can empower and comfort them, or may cause lasting damage, emotional trauma and affect their future utilization of health services (6). In 2015, the *Afghanistan Demographic and Health Survey* was conducted with the major findings of a maternal mortality ratio of 1,291 pregnancy-related deaths per 100,000 live births and 48% births at health facilities (7). Ending preventable maternal mortality is the priority of the MoPH and acceptability of services is a guiding principle of the *Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy, 2017-2021* (8). The MoPH is committed to preventing mistreatment and improving quality of care to better meet women's socio-cultural, emotional and psychological needs but pathways for doing this or investments needed to see measurable results are uncertain. *The Patients Charter of Rights* highlights the commitment to adopting the *Universal Rights of Childbearing Women* (9).

WHO's 2016 systematic review identified seven types of mistreatment of women in facility-based childbirth, with many sub-types, including: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints (10). It is critical for both public and private healthcare providers to treat women with respect and to consider their emotional and psychological needs as part of broader efforts to ensure quality care (11). The *2016 National Maternal and Newborn Health Quality of Care Assessment* conducted by Jhpiego provided some disturbing findings related to mistreatment in health facilities (12). For example, one indicator for measuring respectful MNH care is 'the percent of women whose care provider explained procedures and asked if she had questions'. The study found this percentage to be 56% during antenatal care, 26% during labor and 30% during postpartum care before discharge. In addition, 46% of women were subjected to unindicated or potentially harmful practices during labor and birth, including fundal pressure to hasten birth of baby or placenta (7%); unindicated episiotomy (5%) and manual exploration of uterus after birth (11%). This

study did not include client's perspectives, hence the need to understand client's experiences and expectations.

Since mistreatment at health facilities is complex with significant contextual differences, approaches for addressing mistreatment and promoting RMC that may be successful in one country may not be successful in another (3). To date, few studies have touched on mistreatment in maternity care in Afghanistan, and no assessment has assessed the factors contributing to mistreatment in MNH service provision. The provision of RMC is dependent on enabling supportive environments for the providers; in conflict settings and in fragile health systems, these are particularly challenging. This formative assessment identifies factors that should be considered in design of programs/approaches to promote more acceptable and respectful care.

## **Aim and objectives**

The aim of this study was to generate information to inform MoPH and development partners' efforts to eliminate mistreatment and improve quality, dignified respectful care in MNH services in Afghanistan, as part of efforts to increase facility births and reduce preventable maternal and newborn morbidity and mortality.

The assessment's objectives were to:

- Understand women's perceptions of acceptability of maternal and newborn care at health facilities
- Understand healthcare providers' perceptions of childbearing women's rights, drivers of mistreatment during pregnancy and childbirth and elements of quality respectful maternity care
- Understand health sector stakeholders' perceptions of childbearing women's rights, drivers of mistreatment during pregnancy and childbirth and elements of quality respectful maternity care



## Methods

This study is a systematic investigation using qualitative approaches, including focus group discussions and key informant interviews, to gather rich and meaningful data specific to the issues of mistreatment in childbirth.

### *Study sites and participants*

To get a snapshot of women's experiences during facility births in different regions of the country, one district was selected for data collection in each of the four provinces considered regional population hubs: Balkh, Kandahar, Herat and Nangarhar. Using 2017 data from the National Health Management Information System, a list of public district hospitals outside of the provincial capital city was generated and one hospital per province randomly selected.

At each facility, one focus group discussion was held with women who had institutional deliveries at the identified facilities in the past 12 months and who reside in the selected facility catchment area (average 11 participants), and one focus group discussion held with healthcare providers (average number of 5 participants) delivering maternal and newborn health services. Clients from the catchment area of the clinic were selected using the clinic register book for convenience. In-depth interviews were conducted with 20 policy makers and central and provincial officers from MoPH and other relevant stakeholders to understand the respectfulness of maternal care and to reflect on the findings from the clients' and providers' perspectives identified by the FGDs.

### *Study instruments*

All instruments were semi-structured discussion guides, based on tools used in a similar WHO study in Nigeria and adapted for use in Afghanistan (13, 14). English versions of tools are presented in *Annex A*. The local team pilot tested the tools prior to implementation of the study in the field. Due to security restrictions, a 'mock' FGD was set up with office based female staff for practice of using tools with women who had 'birthed in the facility'. The importance of setting a safe environment was emphasized as well as facilitating a discussion using probing questions when indicated as well as taping and note taking. No changes were made to the tools.

### *Data collection*

The study team comprised of an international principal investigator (PI), a local (Afghanistan based) PI, and four co-investigators who are proficient researchers with substantial experience in qualitative methods. In February 2018 a group of four local female data collectors (professionals) with experience in conducting focus group discussions and qualitative interviews, and fluent in Dari and Pashto language were recruited and trained in the research methods using the tools in Dari and Pashto. One data collector assigned to groups with Uzbek speaking women was fluent in Uzbek language.

The field researchers were formally introduced by letters from the MoPH to the facility managers and through their facilitation to the participants. Verbal individual and/or group consents were obtained from the participants prior to implementation of the study.

Each FGD was facilitated in health facilities by a team of two trained researchers using the pretested and approved FGD guides. The responses were noted down and recorded simultaneously where the participants consented to use of a voice recorder. Notes taken included key issues arising in discussions as well as aspects of observations that would not be apparent from recordings such as emotions, behaviors etc.

Data collection was completed during March 2018. Field notes and audio recordings were transcribed in full in the language of data collection after completion of the FGDs as soon as the researchers were back at their work stations. The responses to the interviews were also recorded and transcribed similarly.

The same team of data collectors conducted the in-depth interviews with the key informants. The interviews were recorded and notes were taken simultaneously. The recordings were transcribed at the office. All the interviews were in Dari. Some of the items of the interview guide used for the interviews referred to the findings of the FGDs and the respondents were prompted to reflect on the viewpoints of the clients' groups.

Focus group discussions with women and providers were conducted in Balkh, Herat, Kandahar and Nangarhar provinces. Additionally, in-depth interviews were conducted with key informants from the same provinces as well as from the central MoPH. *Table 1* shows an overview of data collection.

***Table 1: Details Data Collection***

<b>Data collection methods</b>	<b>Number of sessions</b>	<b>Participants</b>
A. Focus group discussions with groups of clients	4*	43 (9 - 12, average 11)
B. Focus group discussions with groups of healthcare providers (all female)	4	21 (5 – 6, average 5)
C. In-depth interviews with key informants	20	12 from MoPH, 7 from NGOs contracted to manage primary health care facilities implementing the BPHS, 1 from another Ministry

\* Pashto-2, Dari-1, Mixed Dari and Uzbek-1

## **Analysis**

The study team used a thematic analysis approach. An analytical codebook was initially developed with deductive codes based on the study objectives and types of mistreatment as well as tools from similar studies and global literature (10; 14), shown in *Table 2*.

**Table 2: Main themes**

FGD with clients	FGD with providers	In-depth interviews with key informants
<p>1. The motivators and deterrents for use of the health facility for childbirth services</p> <ul style="list-style-type: none"> <li>○ The motivators to use health facility services</li> <li>○ The deterrents from use health facility services</li> <li>○ Participants reasons for preferring facility childbirth</li> </ul> <p>2. Women’s experience during their last birth at the health facility</p> <ul style="list-style-type: none"> <li>○ Experience of provider behavior</li> <li>○ Expected provider behavior</li> <li>○ Out of pocket payment for the services</li> <li>○ Suggestions for improving childbirth services</li> </ul> <p>3. Experience of mistreatment</p> <p>4. Awareness of rights based services for labor and birth</p>	<p>1. The motivators and deterrents for use of the health facility for childbirth services</p> <ul style="list-style-type: none"> <li>○ The motivators to use health facility services</li> <li>○ The deterrents from use health facility services</li> </ul> <p>2. The impressions and experience of the providers about childbirth services in the health facilities</p> <ul style="list-style-type: none"> <li>○ Providers’ narrative of childbirth services</li> <li>○ Providers’ experience of childbirth services</li> <li>○ Providers’ expectations for quality improvement</li> <li>○ Providers’ experience of out of pocket payment for the services</li> </ul> <p>3. Providers’ experience or recounted mistreatment</p> <p>4. Awareness of rights based services for labor and birth</p> <p>5. The providers experience and expectations for respectful workplace environment</p>	<p>1. Perspectives on respectful maternity care</p> <ul style="list-style-type: none"> <li>○ Understanding of respectful maternity care</li> <li>○ Compliance with the elements of respectful care</li> </ul> <p>2. Determinants of ensuring respectful maternity care</p> <p>3. Providers’ experience or recounted mistreatments</p> <p>4. The key informants’ experience and expectations for respectful workplace environment</p>

The local PI and the local co-investigators familiar with the local languages read all transcriptions separately and in groups to ensure adequate immersion in the data. The team (including both males and females to ensure gender perspectives were captured), jointly expanded the codebook with inductive codes based on data collector field notes and study team familiarity with the study context. (See Annex B for the final codebook). Codes were recorded manually in Microsoft Word. Excerpts in English were produced periodically and discussed with the PI and other international co-investigators. Coded text was then sorted and analyzed using latent content analysis methods to answer research questions, with a focus on similarities and differences across study sites and client, health worker and stakeholder perspectives. During the analysis process, in country and remote support meetings were held with co-investigators to consider issues of reflexivity including examples of mistreatment which can be normalized in Afghanistan and possibly missed in analysis, as well as cultural and gender norms. For example, the transcripts were reviewed again by a female only group and additional examples of gender related issues were added which were not considered by male colleagues.

## **Limitations:**

Most of the facilities included are located in urban or semi-urban communities. There may have been response bias, and the true situation might be more extreme than shown in this report. The participants were clients who gave birth in facilities therefore, their expressions may not fully represent the viewpoints of those who typically do not access facility based care. The clients might have refrained from presenting too many negative reflections in front of the group. The providers were doctors and midwives while nurses and support staff also contribute to service provision and therefore quality of care. Key informants from outside MoPH were under-represented in this study.

## **Ethical considerations**

The study was approved by the institutional review boards of the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland, USA (IRB 8117) and the Afghanistan MoPH (IRB 43984). Verbal consents were taken from the FGD participants with the clarification that any member of the group could leave the discussion at any stage. Written consents were taken from the key informants. De-identified transcripts were stored on a password protected computer server, accessible only to co-investigators.

# Results

## A. Focus group discussions with clients

### I) Motivators for and deterrents from the use of health facility childbirth services

#### I.1 Motivators for childbirth at a health facility

Participants indicated that availability of their “desired services” in the health facilities is a reason for preference of facility birth over home birth. The services cited included availability of drugs such as injections and serum, care for complications such as bleeding, low or high blood pressure, malpresentations / malpositions and post-abortion services. The risk of complications at night was specifically mentioned as motivation to go to facilities early during daylight hours.

*“Well, God forbid, if the baby is in wrong position, or bleeding happens, or [baby] is weak, there are midwives in the clinic and they will give you injections, or pills, or they will send you to another hospital for treatment.”*

*“Everyone treats us nicely, they check my blood pressure, give me serum, talk to me nicely”.*

The comfort of having knowledgeable, caring and respectful healthcare providers trusted by the clients were consistently indicated.

*“The doctors know (what to do), the Dais<sup>1</sup> and old women know nothing, I will not let them touch me”.*

Other reasons indicated included the cleanliness of the facility as compared to their homes, availability of free services at public hospitals, and the stereotype of illiterate women giving birth at home.

*“Illiterate women deliver at home...Hospital was a comfort”.*

When asked who makes decisions about where women give birth, most participants explained that decisions are made by their husbands and mother-in-laws. Other in-laws were also mentioned by a few participants. A mother-in-law may have insisted on taking the woman to the facility when the husband has been hesitant.

*“My husband was telling me to deliver at home as he could not afford the hospital, but my mother-in-law quarreled with him and reprimanded him.”*

#### I.2 Deterrents from childbirth at a health facility

The participants enumerated the reasons why “other women” prefer home birth over facility birth, emphasizing that they themselves prefer hospitals. The stigma associated with using the facility for birth, the insistence of “elders” [women] who always gave birth at home, not affording the travel costs to the facility, shame of delivering outside of home in the presence of midwives and lack of the decision making power by women were mentioned. However, dissatisfaction of the clients in their previous encounters with the facility was also indicated by some participants.

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<sup>1</sup> Local term for traditional birth attendants

*“Old people [women] told us we always delivered at home, you youngsters are weak and afraid of delivery. ... [therefore in past] I was ashamed on the midwives... but when I came, it was a big comfort to deliver in health facility.”*

*“Some [people] have no money to come to clinic; they have to come from a large distance”*

*“Women want to come to hospital [for delivery] but husbands think it is a shame”*

*“The patient should not be offended [by neglect of the providers] in the facility, because no one pays attention to them they will not come to hospital and will deliver at home”*

*“Some families are not open [conservative y], so even I remember one of my neighbors had contractions for 4 or 5 nights but she always said that I am ashamed to go to the clinic. My family told me that “you are going to facility, you aren’t shamed to go there?”*

The participants mentioned a number of reasons that prevented ‘other’ women from using health facilities for childbirth. Traditions and stigma against using facilities for birth, gender related barriers including resistance of husbands and other male decision makers, financial barriers such as not being able to afford travel costs, prescribed medicines or bribes, and poor quality of services including mistreatment and lack of the expected attention to clients.

*“Some people think that home birth is honorable. Some women think that in old times all women delivered at home, and nothing happened [to them], you [women] should also deliver at home”.*

Some suggested that decision-makers may be influenced by advice from *dais*, who may have a personal interest in discouraging facility births since they receive fees for their services at home births.

Limited access to facilities or remoteness of facilities and security barriers especially during the night was also mentioned in some study sites.

### **1.3 Participants reasons for preferring facility childbirth**

The majority of the participants in all groups emphasized they preferred the facility for their birth due to the presence of midwives and doctors, injections, serum, assurance for treatment of bleeding, high or low blood pressure, rescue of the newborn if “anything” happens and good environment.

*“In the clinic they look [examine] carefully, give drugs and serum in case you have bleeding or high blood pressure, take the baby [deliver] cleanly and wrap the baby properly, there are midwives and doctor”.*

*“They [healthcare providers] treat us nicely and take care of us”.*

## **2) Women’s experience during their last birth at the health facility**

### **2.1 Experience of provider behavior**

When asked about the experience of their last birth in the health facilities, the participants reported predominantly positive behaviors from providers and acceptable services. The positive attributes of their experience of birth included clean, safe and secure birth room, clean towels and clothes.

*“The hospital was clean, the aunty [cleaner] was also very clean. I felt safe inside.”*

Privacy and the presence of healthcare provider at all times was generally reported. A few respondents confirmed that a female companion was allowed during the labor and that they had the freedom to walk around.

The participants asserted that the health workers provided the services they “expected” including giving serum, injection, checking blood pressure, and writing prescriptions.

*“They [healthcare provider] stay with me, gave me serum and injections, checked my blood pressure. They looked at their watch and when the time was up they told me to push...finally the baby came, they put the baby on my belly... they watched me and my baby for six hours...then they took my phone number and said she will call me sometimes...if anything happens call me or come back”.*

In response to probing queries on the behavior of the health workers, the participants indicated that the providers have been “caring” and “supportive” but also indicated some reluctance in providers attending to expressed needs.

*“They [provider] treated me nicely. When I came she gave me serum and injection and told me to wait. She was watching a serial drama in the TV, my mother-in-law went to her and told her that I am in pain, she came and checked me and said with smile that I still have time”*

*“We came [to hospital] at one o’clock of night [I am], [she] helped me and gave me prescription, told me there is still time and go back home...when I came home I delivered at home with my mother-in-law. She did not give me any medicine and I went back home.”*

Instances of misbehavior, discrimination in favor of the wealthy and those who knew someone in the facility, shouting, scolding, denial of services, dirty floors and lack of heating during the winter were frequently reported.

*“Of course they treated me badly, if they didn’t why they didn’t help me [ignored me]? They discriminate between wealthy and poor. They accuse us that we linger in the facility unnecessarily and we try to find excuses to stay in hospital”.*

*“The aunty [cleaner] helped me more. The doctor does not see [examine] me properly. When I have trouble I got to aunty [cleaner]”*

*“I went to the hospital and midwife examined me (vaginal) and said still you have time so I went to washroom then my child was born there. Even I had the same experience with my second child. Midwife said ‘do not say to anybody that you went outside the delivery room’.”*

*“All roads were closed so with walking through streets we came to the hospital. The long walk increased my bleeding. When I arrived at the clinic they said we do not have any space for you because we have many patients right now. They didn’t accept me and I walked back home ...”*

*“Midwife said to client’s companion that our official working time is till 4 so if there were no real contractions or any progress, I will send you back home. The client’s companion begged for the client to stay longer in the hospital. As he said - I only have 1000 Afghani to go back home [it is not enough to return back to the hospital again] ...”*

## 2.2 Expected provider behavior

When asked what they expected the providers to do, the participants emphasized that they trusted the providers and confirmed that they received the care they expected.

*“They [providers] help, when you have pain they help, you feel reassured that here you have midwife she will help if anything happens”*

However, the participants insisted that the providers could be “more helpful.” The participants stated that they think that the providers should support women immediately after they arrive in the facility. They expected the doctors, midwives and nurses to talk to them kindly and in a reassuring tone without raising their voices [shouting].

*“A doctor should have good behavior, should give us good morale during delivery, should not reprimand us for anything.”*

On the details about the circumstances of their birth, most of the respondents said that they were in a room that they characterized as clean, with acceptable level of privacy measures, safe for the women, with at least one person always present beside them. However, some of them complained that the midwife would disappear and they were left alone or with the cleaners.

*“The midwife would not come to my bed unless we insisted repeatedly, and finally she came when I was about to deliver.”*

The communication of the provider with the clients was described as respectful but no direct response implied that the providers actively provided information to the women during their labor and birth. While some respondents indicated that they were allowed to have a companion throughout the birth, some also indicated that the companion had to leave the room when it was time to give birth.

*“When I came in the night, my mother and mother-in-law were with me. In the morning it was more crowded and the doctor told us that only one person can stay with me.”*

*“No, they told my companion not to come in”*

The participants reported that during their labor they had freedom to move around before their birth. The clients group did not mention whether they have been able to influence the providers’ decision related to the clients’ wishes during care in labor. All of the groups emphasized that they will encourage their relatives to attend the facility for childbirth care.

## 2.3 Out of pocket payment for childbirth services

While no instances of denial of services was reported due to lack of payment, ‘gifts’ (Shirini)<sup>2</sup> of 50 to 500 Afghanis were reportedly given to the cleaners, midwives and doctors, especially when the baby was a boy. Women and their families give gifts to secure good care the next time they use the services and paying ‘Shirini’ appears to be normalized.

*“This time, the doctors told me that I will need Cesarean [section], and when I delivered normally they told me I should give them “treat” [gift in cash] so I give them five hundred Afghani as gift.”*

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<sup>2</sup> Local practice of informal gifts money, sweets or similar



*“My husband’s sister gave birth here, he was a boy, the doctor asked for 500 Afghani, we gave her money. Everybody asks for presents; the cleaner asks for presents as well”*

*“Last time when I went to the hospital midwife and doctor said without our help you might have CS so we do not know [for this help] you will pay Shirini or not. I said why not, I paid 500 Afghani as shirini/gift.*

*“We thought if we pay shirini then we will receive much better care.”*

*“Sometimes Dai are not happy, they tell us for money, they say don’t go to clinic .... If you deliver here [with dai] it will be 500 or 600 [Afghani] but if you go to facility, [although] they say it is free but you will have to spend 2000 or 3000 [Afghani]. Stay here, spend only 500”*

High costs of private facilities and the burden of buying medicine prescribed outside of the facility were reported as financial constraints.

## **2.4 Suggestions for improving childbirth services**

To improve the services, suggestions included: more labor/birth rooms and beds, allowing companions consistently, availability of ultrasound imaging, and avoiding harsh language with the women.

### **2) Experiences of mistreatment**

The respondents were asked to recount the experience of their last birth specifically any mistreatment. They reported having seen or heard of “others” being subjected to a variety of disrespectful behavior from the healthcare providers such as shouting, slapping and reprimanding. Shortage of equipment and supplies, and constraints due to infrastructure were not considered by the respondents as contributing factors to such behaviors. However, the providers’ characters, exhaustion due to too much work, lack of skills and experience, overcrowding of some facilities, and the unrest due to insecurity were mentioned as possible reasons for harsh conduct of the health workers.

*“One woman came from very far away, and she had her delivery in the car. But her placenta was not delivered at the time of her arrival to the hospital. Hospital midwives helped us to deliver our babies but none of them helped that woman because they were angry - why did the woman deliver in the car? She lives in a very far village so she delivered in the car on the way to hospital.”*

*“Midwife does not understand the pain that we have in the delivery. She used her hand to pick up the newborn and hit and shouted at me to make your leg far.”*

All the respondents did not consider any misbehavior acceptable in any circumstances. A few instances of approving of the health workers’ holding down the client to the bed for “better delivery” and “preventing harm to the baby” were noted.

### **3) Awareness of rights-based care in labor and birth**

While the majority of the respondents were not literate and were not aware of the *Patients Charter of Rights* (MoPH 2014) by name, they reported being aware of their rights to respectful free services in the public facilities by good doctors and midwives, ambulance services, and good medicine.

## B. Focus group discussions with providers

### I) Motivators for and deterrents from the use of the health facility childbirth services

#### I.1 Perceived motivators for childbirth at a health facility

Participants reiterated perceptions that clients choose to deliver in health facilities for availability of care in managing complications, immunization, blood transfusion, and counselling services. The complications noted included retained placenta, pre-eclampsia and eclampsia, shock and bleeding. Other reasons cited were cleanliness and safety of the facility environment, availability of Rhogam injection, good equipment and support of providers.

*“The death and life is in the hand of Allah, however, every woman wants to give birth in a clean and safe place where skilled birth attendant is available to provide all of the services”*

It was also mentioned that those who attended antenatal care are expected to use the facility for care in labor and childbirth.

*“A woman who attends the facility for four antenatal visits, gets medicine for anemia and receives health education and counselling on vaccination, birth planning, checking blood group and checking anemia. Therefore, such women come to clinic for delivery”*

#### I.2 Perceived deterrents from childbirth at a health facility

The reasons for home birth mentioned by the participants included family restrictions, traditions, preference of Dai, insecurity during night, unavailability of service providers at the time of the delivery, fear of disrespect from the providers, economic barriers, lack of transportation, and lack of awareness of some families about the services.

*“Just because of this poverty they can't come to facility. Some [of them] come from a distant [place] and if they want to come they don't have the money for transportation. In the middle of the night, a car will ask at least two thousand Afghanis. Also the people's level of knowledge is low, and there is insecurity too.”*

*“One of the reasons is the [bad] behavior of the midwives because of too much work. The woman says I will not go there [to the clinic] unless I have a problem after my birth at home. Then if she [the patient] comes to hospital and for example has retained placenta, if the midwife can't help her [immediately] in the birth room, she will need to stay in hospital for two three days, she should get antibiotics, misoprostol, get her uterus emptied, therefore when we say come to clinic she [patient] says she will prefer to die at home but not come to hospital.”*

*“One patient came when she was at risk of uterus rupture. When asked why you came late, she said my sister in law said that 'she is showing off .... I had between 10-15 deliveries but till my 5<sup>th</sup> delivery I never seen any doctor or midwife. Why you are going to clinic?”*

The SBAs also indicated that the decision to take the mother to the facility is with husband, mother-in-law and father-in-law or other elder person in the family.

*“We also have this idea, that most [women] have complaints that their mother-in-law does not allow their husbands to take them to clinic. They [husbands] bring the women only when she has complications and her condition is worsening.”*

*“Most of the women who have pre-eclampsia or eclampsia, their mother-in-law will not allow them [husband] to take them to clinic and will force them [husband] to take them [woman] to mulla<sup>3</sup>.”*

## **2) Provider experiences and perceptions of childbirth services in the health facilities**

### **2.1 Providers’ narrative of labor and birth services**

The SBAs reported that the clients in the labor room normally receive all necessary services including registration, regular checks on vital signs and blood pressure, administration of serum, provision of vaccination to the newborn, use of partograph during labor, preventing and managing post-partum hemorrhage and determining whether the client needs a Cesarean section. All groups described the birth room as clean and safe with privacy and confidentiality maintained. The laboring women were allowed to walk around while waiting for birth and were delivered in sitting position if they wanted. The women were not left alone during the process. Companions were allowed but it was consistently reported that the clients did not want their companion from their in-laws’ family to stay during their birth and preferred to deliver in their absence. The participants stated that they provided moral support to their clients, facilitated skin to skin contact between the mother and the baby, helped in vaccination of the child, counselled on vaccinations, nutrition and hygiene to the mother, and provided the required information about progress of labor and birth.

The birth positions reported were predominantly the ‘traditional lithotomy position’, but it was mentioned that women were also allowed to deliver in standing position, on the floor, and in sitting position. However, all groups stated that alternative positions are ‘not clean’ and may result in complications.

*“Our room [birth room] is clean, and we have a separate postpartum room with two beds. The door has a curtain, we change the bedsheets and allow the patient to deliver the way she likes. Some patients even don’t allow their mother, but if she likes we allow companions to stay with her during her delivery. Some husbands bring their wives on a bike, so we have to deliver her alone without someone from her family. The woman can walk, eat, drink as she likes until her cervix is dilated enough. We insist that the women should give birth on the birth table because it is clean, but if the woman cries and makes noise [insists very much], we spread a plastic sheet on the floor and allow her to deliver on the ground.”*

*“Some patients request to not allow their mother in law to accompany her. She said please tell her we only allow one person or we are not allowing any companion. If any complication happened, we will inform you. Women said then they [mother in law] will scoff at us -which position you delivered, who saw your body...”*

### **2.2 Providers’ experience on the quality of birth services**

The groups preferred to relate the incidents of deviation from respectful care to their past experience or as events elsewhere. They reported that women often complain of delays in receiving serum and injection and think if they get injections they will deliver ‘faster’. The participants related incidents of bad behavior towards the women.

*“I have seen with my own eye, not here, in another clinic that the doctors beat patients, they [patients] are in pain but they [doctors] give them [patients] no medicine”.*

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<sup>3</sup> Local imam /religious leader

*“We have seen that the elders have complained [to the hospital manager] that their patients are not treated well, they are not given serum, pills, injections, and their blood pressure is not checked.*

*Many of our clients are Kuchi [nomads] and they are a little weak in their hygiene. With such patients, [providers] behave extremely disrespectfully, and tell them: you smell bad, I don't want to check you, get out of this room, go and wash your body first then come back.*

### **2.3 Providers' expectation for quality improvement**

The participants insisted that the women must receive respectful care which they described as moral support, maintaining privacy and confidentiality, sharing the sex of the baby immediately after birth, calling the clients by name, and speaking to them in their language. Provision of all components of the necessary services for normal labor/birth and for complications was also mentioned as determinants of respectful care.

*“First of all we introduce ourselves, we don't address the patients as “aunty”, or the sort, but call them by name. We speak in medical terms between ourselves but then explain to the patient in easy language so they will not be worried. We listen to mothers. If one patient goes out of the hospital with no satisfaction, more patients will not come.”*

On the clients' expectations, the SBAs emphasized that the services could be more effective if the women attended their scheduled ANC visits, prepare for the birth by securing a blood donor, transportation means and having enough money. They expected the women and the families to be honest in their clinical history, trust the SBAs when providing the services, be supportive to the delivering mother during her labor, and listen to health education.

On the role of their coworkers, the SBAs unanimously emphasized team work between the providers in the birth room to provide all services such as administration of serum, injections, checking the newborn, maintaining privacy, addressing bleeding and anemia, checking vital signs, and allowing uninterrupted services to the clients.

On the significance of management support, they expected the health facility management, the supporting organization (NGO) and the local and central Ministry of Public Health officials to recognize and reward the best performers regularly and consistently. They expected to be recognized and encouraged for their good performance. They also expected the system should provide sufficient drugs and equipment to all clients. Availability of electricity, laboratory services, blood transfusion facilities, ultrasonography, and surgeons and senior doctors were also indicated to improve the birth services. They wanted to be invited for trainings and be regularly visited and supported in their health facilities.

### **2.4 Providers' experience of out of pocket payment for childbirth services**

All of the participants denied any instances of taking money from the clients but admitted that they sometimes receive gifts from the families but have never denied any services to the clients if they did not pay.

*“The other day, a woman had a boy after four daughters. Next day she sent me some dried spinach and insisted that I should take it. If I did not take it she would be offended.”*

### **3) Providers' experienced or recounted mistreatments**

The mistreatment mentioned in these discussions included beating, slapping, insulting, shouting, reprimanding and scolding for bad hygiene, denying checking of blood pressure or other timely services, but were mainly attributed to either the health worker's character or the stress due to too much work.

However, the groups reported equally prevalent mistreatment of the SBAs by the clients and their family members including beating, using abusive language, and being threatened. The contributing factors to such instances cited by the groups included small birth rooms, shortage of drugs, harsh nature of some providers, excessive workload, lack of competence in certain areas, lack of supporting staff and other coworkers when required. They suggested by addressing these system issues the behavior of the providers will be improved. Specifically recruiting additional midwives in lower level facilities, less frequent night duties, and allocating larger birth rooms were mentioned.

The SBAs did not approve of any of the mistreatment mentioned. However, it was stated that if the clinical condition of the mother or the baby require, the mother could be held to the bed.

#### **4) Providers' awareness of right based birth services**

The groups reported that the SBAs are normally aware of the rights of the patients to respectful care. Some members of the groups were familiar with the *Patients' Charter of Rights* distributed throughout the country.

#### **5) The providers' experience and expectations for respectful workplace environment**

The workplace environments and working experiences of the SBAs were also assessed. The SBAs considered it "rewarding" when the clients are served to their expectations and leave the facility 'happy'. They consider it discouraging when their supervisors ignore the hard work of the SBAs or fail to recognize and appreciate successful performance. They also noted it is stressful when clients insist the provider stay with the patient continuously which is not normally possible when one provider has to take care of multiple women in various stages of labor. Overall the SBAs considered their profession as "valuable".

The workplace stressors mentioned included exhaustion due to many clients, too many and lengthy night duties which usually happen as continuation of the day shift, lack of transport to commute to their homes, low salaries, gaps in their skills and confidence in certain tasks, and lack of proper certification of community midwives.

### **C. Key informant interviews**

Twelve MoPH staff of varying levels, seven BPHS representatives and a focal point from another sectoral ministry working on gender issues were interviewed using open-ended iterative question. The MoPH representatives had experience ranging from 2 - 28 years in various roles, and included doctors and midwives, as well as clinicians and managers.

#### **1) Perspectives on respectful maternity care (RMC)**

##### **1.1 Understanding of respectful maternity care**

The White Ribbon Alliance have laid out the seven key elements of RMC in the Universal Rights of Childbearing Women (3) and these are incorporated in the *National Patients Charter* (freedom from harm and ill treatment; right to information and informed decisions; confidentiality; dignity and respect; equality and equity; right to timely and quality care; and all aspects of autonomy). These were not however mentioned by any of the respondents. Most of the definitions given for RMC were limited to kindness, lack of verbal or physical abuse, good behavior, privacy and respectful communication. A few respondents also indicated there should be no discrimination, as well as ensuring provision of the full package of services in a timely manner.

*“For me, at least the provider should treat the patient kindly, listen to her, allow her to have a companion, and maintain confidentiality”*

*“Respectful care is receiving all the health services that all humans should receive, and the human rights of women should be observed.”*

## **1.2 Compliance with elements of RMC**

The respectfulness of maternity services was rated variously by the key informants and ranged from satisfactory to abusive. The mistreatment referred to in the interviews included verbal disrespect such as reprimanding women for having too many children, insulting; physical abuse mentioned included slapping, beating, and limiting the mobility of the patient unnecessarily. Contributing factors included the character of the individual health workers, work environment stress due to exhaustion, lack of religious dedication, and capacity.

*“Well, the care is respectful, definitively respectful, however maybe not a hundred percent of times... for example when we see that a doctor or midwife examines a woman in an inappropriate location, where the privacy is not maintained, and ask why she does not take her to a place where her privacy could be maintained... they say we have no place, all the rooms and beds are occupied, it was the only place that I had.”*

## **2) Determinants of ensuring respectful maternity care**

The respondents reflected on the roles of clients and families to ensure respectful care. They emphasized that the client should be helpful in providing accurate and detailed information about their medical history, and comply with any health advice including hygiene. The clients and the families should trust the medical advice as opposed to conflicting cultural and traditional views. They should actively participate in health education and behavior change initiatives, and attend health facilities for antenatal and other health services. The family should ensure all the necessary preparation for the birth, be aware of the dangers to the health of the woman and the baby, ensure an empowered and trusted companion for the woman during her trip to the facility and her birth experience be cooperative in provision of anything that might be needed including some medicine and equipment in case of shortage at the facility.

*“The provider expects that the patient should be truthful and should not hide anything from the provider.”*

*“The woman should come for ANC. In many places the mother-in-law says we had 10, 12 children at home, why do you go to doctors so often? But they should come. If anything goes wrong, we can identify and help.”*

*“Sometimes the providers cannot be blamed. The patients have no hygiene and that upsets the provider. We expect that patients also take care of their hygiene.”*

The respondents emphasized that the healthcare providers should form and maintain effective and strong teams to serve the women. They also said that mutual support, peer learning, respect for each other, respect for the clients and their family members, and delegation of tasks to different persons should be strictly observed.

*“I have worked in a clinic; if you want to be effective as a clinician you have to work as a whole team.”*

*“The health [team] is teamwork in general. Having only a doctor, or only a midwife is not effective. When a patient comes [to hospital] she sees white gowns she does not differentiate who is doctor, who*

*is midwife, who is nurse. She expects to be treated and taken care of by all. So the supervisor should make sure that all workers play their role. Someone should take the patient to the respective ward, someone should give her health education, even the guard and cleaner should guide her. Otherwise the women will be discouraged and will not come again.”*

The supervisors and facility managers should be sensitive to the needs of the providers, listen to clients and complaints, ensure availability of the required equipment and supplies, and continuously build the capacity of the healthcare providers.

*“The supervisor should be kind and mind [her] language with the providers. If the supervisor is angry the provider will be angry with the client.”*

The implementing organization (NGO) and MoPH should implement behavior change sessions with healthcare providers in support of RMC and clients’ rights. One suggestion was establishing a psychological support unit in each facility to provide counselling services to healthcare providers to mitigate abusive trends in their behavior due to workplace and other stresses. Merit based appointments and remuneration, implementing reward and recognition activities, provision of the required equipment and supplies, providing opportunities for capacity building, increasing number of staff, supportive supervision, and continued education for midwives were mentioned as means to enhance respectful care for the women. The respondents also emphasized the need to develop and implement specific formal guidelines for respectful care. One of the concerns raised was safety and security of the providers and the respondents emphasized that there should be a guarantee that the clients and their family will not beat or harm the provider.

*“There are issues that the leaders should know. The workers that do their jobs correctly should be recognized and rewarded. This enhance the capacity of the providers. They should praise those who perform better.”*

*“MoPH should treat all health workers [equally]. It is not correct that one provider working in a remote area is forgotten and no one knocks on her door, so if the visitors visit her she will be very motivated.”*

### **3) Key informants’ experienced or recounted mistreatments**

The key informants confirmed various types of mistreatment such as slapping, reprimanding for too many children, beating, pinching, insulting, not listening to the patient, discrimination against the poor and those with poor hygiene, and one reference to ethnic discrimination. However, all of the respondents rated such incidents as being rare to not very common.

*“I have heard many stories but have not seen it. When a woman has many children, sometimes with low voice, sometimes louder, the provider advises her to stop and bring no more children.”*

*“I heard that a doctor had beaten a client. And another one pushed a patient [disrespectfully].”*

*“I don’t want to specify, but long ago a person with white gown next to the patient slapped the patient hard and used inappropriate words that I can’t repeat here. I could not defend her because I was not a doctor [yet], but if there was a system and any health worker who abuses a patient is disciplined, such events will not be repeated.”*

The factors contributing to mistreatment pinpointed by the key informants included: the inherent character of the provider, shortage of supplies, small birth rooms overcrowded with patients, excessive patient load, shortage of staff especially at night, lack of an official mechanism to reward and recognize

best performers, low salary, and in one instance the lack of explicit reference to respectful care in the job description of the health worker.

*“There are many reasons. The situation in the country [unrest and insecurity] causes all people to be tense and irritable. And when the health worker puts on a white gown she thinks she is superior to others and she is tempted to be harsh and abusive to the patients as they are in need of her services.”*

Policy level advice generated in these interviews included enforcement of health service standards, establishing a reward and recognition system, explicit monitoring of RMC in service provision, increasing the number of staff in facilities, regular sessions on health workers’ behavior change, recruitment of female managers who are expected to understand the situation of women better than men. To improve the people’s awareness, regular frequent media events, health education, awareness through mullahs and shuras, and use of IEC material were suggested.

*“We should inform all families and people about their right to health services. All health workers from the guards to cleaners to providers should be educated about the patient rights; there should be a monitoring system that everyone complies with the requirements. If there is any flaw in the way they [providers] treat the patient, they should be trained and encouraged to be respectful.”*

#### **4) The key informants’ experience and expectations for respectful workplace environment**

Elements of the SBAs working environment was explored with the key informants and it was again reconfirmed that official recognition of the best performers and rewarding them according to a specific policy is desired. Disrespect to midwives by the doctors was mentioned. Too much work, shortage of staff, low salary, and lack of facilities to health workers were also mentioned as stressors for the providers. While addressing these factors was recommended a few respondents suggested to develop a policy for hiring the husband of the SBAs in or near the remote facilities and recognizing midwives as the main provider of maternity services. The respondents emphasized the importance of establishing the Afghan Midwifery and Nursing Council (AMNC) as soon as possible<sup>4</sup> and indicated that several stagnant issues in midwifery such as quality of education, continuing education, recognition, accreditation, and protection of clients and midwives against mistreatment will be addressed by AMNC.

## **Discussion**

Ensuring access to health services that are safe, timely, respectful, and culturally appropriate is not only a right for all women, but is essential for reducing maternal and newborn mortality. *The Global Strategy for Women’s, Children’s and Adolescent’s Health* highlights the rights of women, children and adolescents to the highest attainable standard of health (15). The Afghan Government has committed to the ambitious goals outlined in the *Global Strategy* in which women and children can survive and thrive including improving the quality of respectful, gender sensitive MNH care. The key findings of this study reflect areas requiring significant attention in these quality improvement efforts, and will be discussed.

### **Perceptions of giving birth in a health facility**

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<sup>4</sup> AMNC was established in December 2018



Giving birth in a health facility remains the main recommendation for reduction of maternal and newborn deaths however, the quality of MNH care in Afghan health facilities remains mixed and as in other settings is frequently poor (16).

In a systematic review of ‘what matters to women’ during childbirth, most women want to give birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions, and competent, reassuring, kind clinical staff (17). This was noted by the women and in Afghanistan extends to facility cleanliness and security which can be both personal security given the insecurity as well as feeling safe in accordance with gender norms. However, some participants explain that going to the facility is only when complications arise and it is traditional to birth at home, especially in Pashtun communities. Going to a facility regardless of reason was also stigmatized in some areas by female relatives and stigmatization was identified as a form of mistreatment by Bohren in her systematic review (10). In the same review women reported feeling shamed by health workers who made inappropriate comments to them regarding their sexual activity. In Afghanistan this was hinted at in the interviews but was closely linked to feeling ‘shamed’ which is linked to women’s low status, lack of information, and strong socio-cultural norms. In many societies, there are expectations, even during labor, for women to be quiet and modest, and being loud or making noise is considered unacceptable (18). These gender related perceptions are strong and in Afghanistan the lack of visual privacy /curtains mean other relatives may see women in labor. This is often what husbands fear and is linked to the need for preserving men’s and families honor. Even the providers who are all female, can impose their morals and beliefs on the women, resulting in judgment, blame, and subsequent mistreatment.

Another gender related factor is the decision maker which varied among close family members but a woman in Afghanistan rarely has the opportunity to make decisions regarding her own health, even in emergencies. There were examples where gender roles were reversed and mother’s in law are often the family head holding power as the decision maker on all aspects of family life. Inevitably poverty was raised by both women and providers as a barrier to accessing facility care such as transportation costs and informal charges. The view that ‘illiterate women give birth at home’ is another example of stigmatization and there is recognition of the role of socioeconomic inequalities underpinning women’s experiences of obstetric care (17). National data shows the inequity related to facility birth in 2015, with 22% of women from lowest wealth quintile and 82% women from highest giving birth in a health facility (7).

### **Acceptability of services/the experience of care:**

With reference to women’s, providers and selected stakeholders’ perceptions of the acceptability of maternal and newborn care at health facilities there was a range of experiences during labor and birth, good and bad.

It is interesting how much ‘medical interventions /technology’ are valued by the women and their families for example ‘getting serum & drugs’ even in routine uncomplicated labors there was an expectation of augmentation of labor. This likely reflects the medicalization of childbirth care a global phenomenon and may be deliberate on providers’ parts to limit the involvement of women in their own health care so providers ‘authority’ and ability to attract respect can be maintained (1). Providers appeared to focus on addressing physical needs and performing tasks. Although technical competence is essential for quality care it is by itself insufficient to address health outcomes. Services that ignore the relationships, culture and context central to care provision are fundamentally flawed (19, 20). The issues related to respect in Afghan society including the client –provider relationship are complex and discussed at length by Arnold who analyses the related historical, social and political contexts in which maternity care is typically provided (19). However, influencing the care provision by addressing the complexities of provider – client relationships can be challenging to influence especially in Afghanistan

and merit consideration of the conflicting discourses and political pressures on staff at all levels in Afghan public health and government (19).

Companionship in labor and birth has been a standard of care for over 10 years as it is shown to improve birth outcomes (21). Yet providers frequently deny this right and do not support women's choices as noted. Due to strong cultural norms the choice of who the companion is in some regions of Afghanistan is nonnegotiable and mothers in law may force their presence. Similar to findings in a Kenya study some women do not wish companions to be present for reasons including embarrassment and fear of gossip (22). Therefore, WHO emphasizes that all women have the right to decide freely whether to have a childbirth companion and whom to choose, and they should be provided with the information, education and means to make and implement these choices.

### **Experience of mistreatment**

The types of mistreatment noted in the study reflect those noted in a comprehensive typology (10). There was clear evidence of some women being left to birth alone and this concept of 'neglect and abandonment' is a well-known manifestation of mistreatment (13, 23). Indeed, it is one of the most serious as facility birth is promoted as the right choice for women to access skilled care during childbirth. The women also experienced discrimination linked to various factors including poverty as well as family connections and nepotism which is a feature of health facility culture in Afghanistan (5).

There was evidence of both having trust in providers as well as lack of trust on both sides. Providers wish women to share all relevant health related information but women may have fear of disclosure and withholding reproductive, obstetric and social history information can be a coping strategy to reduce the risk of provider abuse (23).

There was also evidence from all respondents of limited understanding of what RMC is as well as women's rights and their autonomy. There were positive examples of efforts to meet women's wishes for example laboring or giving birth in an alternative position. However, there were also expectations of compliance from the SBA such as women will 'do as they are told' and there are limited opportunities for women exercise their rights. Many of the findings across all groups are gender related and rooted in power dynamics. The finding shared by both women and providers that '*its ok to be restrained*' was noted in a similar study in Guinea where both women and service providers were accepting of mistreatment during childbirth under certain conditions (24). As Betron found mistreatment of women inside and outside of the health facility is normalized and accepted, including by women themselves (17). Many forms of mistreatment during childbirth are normalized so they are not considered a problem; as a result, women have low expectations of care and women generally accept this abuse because they have never experienced any other type of care (17, 25). This is applicable in Afghanistan where gender inequality and to a certain degree gender based violence (GBV) are also normalized. GBV is ubiquitous in Afghanistan. While data on GBV is scarce, according to a Global Rights study conducted in 2008, around 87% of Afghan women experience at least one form of GBV in their lifetime (26). A more recent study found 14% of women experienced mother-in-law physical violence. This type of violence is linked to poverty and along with GBV /IPV it has a major impact on women's health (27). GBV stems from complex inequalities and cultural practices which, when aligned with poverty and lack of awareness, subordinate women to men and prevent them from acting on or receiving support.

While it is recognized anecdotally that the clients have to pay "bribes" to receive an acceptable level of services, earlier, this study provides evidence to that effect. These payments are often referred to as "presents" or "sweets" in this study. The amounts indicated have not been very high to be considered as a large financial barrier for most of the clients. These payments are normalized by many of the clients which may reflect lack of their awareness on one hand and fear of disrespect and mistreatment on the

other. It is necessary for the MoPH and the local partners to clarify the payments required during the services if any. Private facilities should also include all of the payments in the receipt they provide to the clients for transparency and accountability.

### **The carers (providers)**

It is imperative to understand the complex challenges that even highly motivated health workers face in their work environment and lives. Many midwives and providers of MNH care work in situations of adversity, with negative effects on wellbeing, morale and retention. It is understood that it is too simplistic to attribute poor quality of care, including mistreatment and lack of respectful care, solely to the healthcare provider (10, 28). The health system in Afghanistan is especially fragile, and providers face worsening security and armed conflict with more and more people now living in areas that are affected by high levels of insecurity (29). Health system constraints noted by the providers included staff shortages, inadequate supplies, weak support structures, safety concerns and limited infrastructure (all drivers of mistreatment) and this affects their ability to provide quality care. They especially value recognition and reward which appears to be strongly cultural but weak within the existing health system. It is accepted that health provider performance and resilience is ultimately determined by a combination of factors contributing to a positive practice environment and motivation (30).

The social, economic and health system barriers healthcare providers experience in their daily working lives can be significant and there were examples of these in the study (17). As in other countries but more so in Afghanistan where providers of MNH care are all female these are frequently embedded in gender inequality (31). Fulfilling women's rights to quality maternal health care remains a challenge in many settings with health system issues affecting both the women and the providers (32). Special consideration needs to be given to health worker needs in fragile overburdened health systems and /or in conflict settings such as Afghanistan where mistreatment triggers are greater and women and their providers are especially vulnerable.

Preventing and eliminating mistreatment during childbirth requires a "systems approach" to address underlying drivers of mistreatment, including gender inequalities, shortages of staff, and disempowerment of female midwives and other providers.

## **Conclusion**

Preventable maternal and perinatal mortality remain unacceptably high in Afghanistan and access to quality respectful care continues to hinder the health and human rights of women and their families. This study includes multidimensional evidence that mistreatment exists in maternity care in Afghanistan and it is normalized. What women wish of the health services is understandable in terms of rights based 'patient centered care' provided with compassion and kindness and this can be achieved especially in terms of provider behavior. Yet sub-optimal care remains the norm in many settings despite decades of substantial investment, the introduction of evidence-based policies, procedures and training programs. Improving the experience of facility-based care for childbearing women in Afghanistan is an example. There is little doubt that the context of pervasive gender inequality affects both women and providers. This along with worsening insecurity and a fragile health system are significant contextual barriers however this study suggests that providers do wish to support the women and provide respectful care.

## Recommendations

**Respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth – is recommended (WHO 2018).**

The need to promote respectful, dignified care is widely viewed as an essential component of quality maternal and newborn health care to improve care seeking yet questions remain in terms of how to best address this complex, context-sensitive issue. Several publications demonstrate promising results for improving respectful maternity care and reducing mistreatment in childbirth (33-35). Importantly the absence or lessening of mistreatment or disrespect does not guarantee the provision of respectful maternity care and approaches to preventing and eliminating mistreatment during childbirth must consider contextual and social norms and develop a comprehensive intervention that addresses the root causes /drivers (36).

**There is no one-size-fits-all approach when it comes to ensuring respectful childbirth care. Identifying and testing solutions for preventing mistreatment and promoting RMC need to be tailored to each country's context.**

Source: MCSP 2018 Moving RMC into Practice in Comprehensive MCSP Maternal and Newborn Programs Operational Guidance

The following recommendations are in line with evidence informed solutions for reducing mistreatment and improving the provision of respectful maternity care.

1. **Engaging and empowering clients and families:** promote rights based care by applying a human rights framework to ensure that high-quality reproductive, maternal and newborn health care is available, accessible and acceptable to all who need it. This is a guiding principle of *Ending Preventable Maternal Mortality* (37).
  - Invest in rights awareness and education at all levels, including among policy makers, parliamentarians, program managers, service providers, and the public
  - Increase community awareness of the right to respectful dignified care for example through female shuras
  - Conduct a media campaign to ensure women are aware of their health rights
  - Expand social accountability mechanisms which are considered promising in improving women's agency and driving demand for quality care
  - Test client feedback mechanisms to ensure all sides of determining and measuring quality of care are met
  - Ensure RMC is framed as a gender and equity issue
  - Advance women's empowerment for example harness the positive role of mothers-in-law in encouraging women to access facility-based birth
2. **Foster caring and accountable service providers:**
  - An immediate action is ensuring all facility and community based health care providers are orientated to the *Patients Charter* and it is upheld at facility and community levels
  - Reinforce medical ethics and their application in health service delivery beginning with pre-service education for all cadres of health care providers. Medical ethics are the foundation of professional behaviors and codes of conduct and should be reflected explicitly in scopes of practice. Developing and monitoring professional Codes of Conduct must be given priority by AMC and AMNC. Contrary to some beliefs these will help providers provide higher standards of care and to a certain extent protect them as well as the public.
  - Ensure any RMC 'training' activities include values clarification and attitude transformation (VCAT) components which support health care providers to reflect on how they work and

- cope with working in under-resourced and often stressful facilities. This should be complemented by behavior change and communication (BCC) to reinforce caring and respectful behaviors
- Support AMNC and AMC to prioritize quality of care within broader efforts to ensure accountable health care providers by strengthening public trust through accreditation, regulation and licensing mechanisms as well as addressing professional misconduct
3. **Cultivate caring systems:** the human right to health is meaningless without good quality care because health systems cannot improve health without it (38). The system must be valued and trusted by all peoples in Afghanistan
- Apply and measure WHO standards for ‘experience of care’ in maternal and newborn health. In WHO’s *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities* (2016) three of the eight standards directly relate to how a woman experiences care and the extent to which she feels she has been treated in a dignified, respectful and supportive manner. These standards need to be prominent and valued in national quality improvement (QI) approaches.
  - Embed gender and RMC in health system strengthening efforts as a cross cutting issue
  - Integrate measurement of RMC into routine M&E – for example HEMAYAT has measured the *% of women with a birth companion at the time of delivery*
  - At a minimum all health facilities must be clean, warm and have water (refer WASH standards<sup>5</sup>)
  - Utilize data to drive decision making including measurement of client experiences
  - Consider further research to refine the optimum approach to provide and achieve RMC in Afghanistan
  - Building on recommendations in I, consider a participatory community-health system intervention that articulates new norms, standards, and practices for mutual respect between patients and providers and supports their implementation through facility-based management and health provider reflection
  - Support providers: caring for the carers
    - Fully equipped and safe enabling environments
    - Mediation provided to process challenging situations
    - Recognition of providers and their services
    - Facility-sponsored tea /snacks for providers working overnight and on weekends
    - Supportive mentoring and opportunities for professional advancement
    - Build resilience for example by building health worker communication networks; expanding clinical mentorship and peer-support networks
    - Address gender inequities for female providers as part of HR management

#### 4. Reinvigorate an enabling policy environment

Multi-component RMC policies appear to reduce women’s overall experiences of mistreatment and some components of this experience. However, sustainability of the demonstrated effect over time is unclear, and the elements of the programs that have most effect have not been examined (39).

- Ensure existing policies and strategies recognize the right to health and quality dignified health care
- Share information on health system performance with the public and promote transparency of quality measurements
- Ensure anti-corruption policies are implemented

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<sup>5</sup> <https://www.washinhcf.org/wp-content/uploads/2019/04/9789241515504-eng.pdf>

## REFERENCES

1. The Lancet 2016. Maternal Health: An Executive Summary for *The Lancet's* Series.
2. <http://www.qualityofcarenetwork.org/home> Accessed 16 April 2019.
3. White Ribbon Alliance. 2015 *Policy Brief: Pulling Back the Curtain on D&A*. WRA Washington DC.
4. World Health Organization 2016 *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities*. Geneva.
5. Arnold R, van Teijlingen E, Ryan K, Holloway I 2015 *Understanding Afghan healthcare providers: a qualitative study of the culture of care in a Kabul maternity hospital*. *BJOG* 122:260–7.
6. Ganle J et al. 2014 *A qualitative study of health system barriers to accessibility and utilization of maternal and newborn healthcare services in Ghana after user-fee abolition*. *BMC Pregnancy and Childbirth* 14:425
7. MoPH 2015 *Afghanistan Demographic Household Survey*. CSO, MoPH and ICF Kabul
8. MoPH 2017 *National Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy 2017–2021*, Ministry of Public Health, Kabul, Afghanistan
9. MOPH 2013 *Patients Charter of Rights* Kabul, Afghanistan
10. Bohren M et al 2015 *The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*. *PLoS Med* 12(6)
11. MoPH 2016 *Position Paper: promoting respectful maternity care (RMC) and reducing disrespect and abuse (D&A) of women during facility-based childbirth*. Ministry of Public Health, Kabul, Afghanistan
12. <https://www.unicef.org/afghanistan/sites/unicef.org.afghanistan/files/2018-02/afg-report-MNH-QoC2016.pdf>
13. Vogel J et al 2015 *How women are treated during facility-based childbirth: development and validation of measurement tools in four countries – phase I formative research study protocol*. *Reproductive Health*, 12:60
14. Bohren M et al 2016 “By slapping their laps, the patient will know that you truly care for her”: *A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria*. *SSM –Population Health* 2 640–655
15. Every Woman Every Child 2015 *The Global Strategy for Women’s, Children’s and Adolescent’s Health*
16. <https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality>
17. Downe S et al 2018 *What matters to women during childbirth: A systematic qualitative review*. *PLoS ONE* 13(4)
18. Betron M et al 2018 *Expanding the agenda for addressing mistreatment in maternity care: a mapping review and gender analysis*. *Reproductive Health* 15:143
19. Arnold R et al 2018 *Parallel worlds: An ethnography of care in an Afghan maternity hospital*. *Social Science & Medicine* 216 33–40
20. Lambert J et al 2018 ‘I thought they were going to handle me like a queen but they didn’t’: *A qualitative study exploring the Quality of Care provided to women at the time of birth* *Midwifery* 62, 256–263
21. World Health Organization 2016 *Companion of choice during labor and childbirth for improved quality of care. Evidence-to-action brief*. Geneva.
22. Afulani et al 2018. *Companionship during facility-based childbirth: results from a mixed-methods study with recently delivered women and providers in Kenya*. *BMC Pregnancy and Childbirth* 18:150
23. Yevoo et al 2018 *Mothers’ reproductive and medical history misinformation practices as strategies against healthcare providers’ domination and humiliation in maternal care decision making interactions: an ethnographic study in Southern Ghana*. *BMC Pregnancy and Childbirth* 18:274
24. Balde et al 2017 *A qualitative study of women’s and health providers’ attitudes and acceptability of mistreatment during childbirth in health facilities in Guinea*. *Reproductive Health* 14:4

25. Freedman L et al 2018 *Eye of the beholder? Observation versus selfreport in the measurement of disrespect and abuse during facility-based childbirth*. Reproductive Health Matters, DOI: 10.1080/09688080.2018.1502024
26. <http://www.emro.who.int/afg/afghanistan-news/who-trains-2800-healthcare-providers-to-respond-to-gender-based-violence.html>
27. Jewkes R et al 2019 *Violence against Afghan women by husbands, mothers-in-law and siblings-in-law/siblings: Risk markers and health consequences in an analysis of the baseline of a randomized controlled trial*. PLoS ONE 14(2): e0211361
28. Bowser D and Hill K 2010 *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth*. USAID-TRAction Project Harvard School of Public Health University Research Co., LLC
29. Chopra M, Arur A. 2018 *Progress in the face of insecurity: improving health outcomes in Afghanistan*. Washington DC: World Bank Group.
30. World Health Organization 2015 *HEALTH WORKFORCE 2030 Towards a global strategy on human resources for health.*, Geneva
31. Filby et al 2016 *What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective* PLoS ONE 11(5): e0153391
32. John T et al 2018 *An account for barriers and strategies in fulfilling women's right to quality maternal health care: a qualitative study from rural Tanzania* BMC Pregnancy and Childbirth 18:352
33. Abuya T et al. 2015 *The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya*. BMC Pregnancy and Childbirth, 15:224
34. Ratcliffe H et al. 2016 *Applying a participatory approach to the promotion of a culture of respect during childbirth*. Reproductive Health, 13:80
35. Kujawaski S et al. 2017 *Association between Disrespect and Abuse during Childbirth and Women's Confidence in Health Facilities in Tanzania*. Matern Child Health J DOI 10.1007/s10995-015-1743-9
36. Sen G et al 2018 *Beyond measurement: the drivers of disrespect and abuse in obstetric care*. Reproductive Health Matters, DOI: 10.1080/09688080.2018.1508173
37. World Health Organization 2015 *Strategies toward ending preventable maternal mortality.*, Geneva
38. Kruk M et al 2018 *High-quality health systems in the Sustainable Development Goals era: time for a revolution*. Lancet Global Health.
39. Downe S et al. 2018 *Effectiveness of respectful care policies for women using routine intrapartum services: a systematic review*. Reproductive Health, 15:23

## ANNEXES

### Annex I: Data collection tools

#### Tool A: Focus Group Discussion Guide - Women Who Have Delivered in a Health Facility in the last year<sup>6</sup>

Province: \_\_\_\_\_

Date of Discussion: \_\_\_\_\_

Number of Participants: \_\_\_\_\_

Time Started: \_\_\_\_\_

Time Completed: \_\_\_\_\_

Facilitator Name: \_\_\_\_\_

Note Taker: \_\_\_\_\_

Recorded: Yes / No

**Step 1:** Introduce yourself to the participants. Describe the purpose of the discussion and how information will be used. Obtain oral consent.

**Step 2:** Conduct the discussion. Please remember to audio record the discussion.

**Step 3:** Explain this will be a discussion – there are no right and wrong answers. Encourage the group to agree that what is discussed remains within the group and they should respect each other's information.

#### Explain the following by way of an introduction to the study:

The aim of this study is to generate information for the MoPH to improve respectful care in maternal and newborn health (MNH) care services in Afghanistan. To date, we have little information on this topic but we know that mistreatment in maternity care happens in Afghanistan as it does in other countries, and no assessment has assessed the factors contributing to mistreatment during childbirth. The proposed assessment will include discussions with women and health care providers to assess their experiences and expectations during facility births as well as their awareness of women's rights including factors contributing to mistreatment and to explore how care could be more acceptable to the women. We are also gathering perspectives of selected key informants.

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<sup>6</sup> Questions for this guide are adapted from the WHO Multi-Country Qualitative Field Guides (2015)



## Focus group discussion guide

### Childbirth narrative

1. Please take a moment to think about how women give birth in your community.
  - a. Can you tell me about how women give birth in your community? Where do women usually give birth?
  - b. Why do women give birth in health facilities?
  - c. Why do women give birth at home?
  - d. Where did you give birth? Why did you choose to give birth (*at home or in the health facility*)?
  
2. Who was involved in making this decision about where to give birth? How are they involved?

*Perceptions and experiences of care provided at the most recent facility-based childbirth, focusing on treatment by health workers and the facility environment.*

3. Now I would like to talk to you about your perceptions and experiences of care during your last birth. *Ask a few women to share their experiences of their most recent childbirth.* I would like to know the most memorable parts – both good and bad. **[Interviewer: allow the women to describe the childbirth in their own words. Please probe using the prompts below if needed. As they share the information other women may also speak.]**
  - a. How do you think you were treated by health workers in the health facility when you came in for childbirth?
  - b. Did you feel supported by the staff during your childbirth? Please explain.
  - c. In your opinion, what would you have needed from MIDWIFE, NURSE or DOCTOR in the hospital in order to feel supported during childbirth?
  - d. From the time you arrived until you started delivering the baby, what do you remember about your surroundings? Who was there?  
*Interviewer: use probes below as needed. As they share the information other women may also speak.*
    - i. Where were you?
    - ii. What was the room like? Was it clean? Did you have privacy?
    - iii. Did you feel safe in the hospital from a security perspective?
    - iv. Was the health worker(s) present? Did she/they provide respectful care for you?
    - v. Were you told what was happening during the labor and what to expect? Did you have an opportunity to ask questions?
    - vi. While you were in labor [during contractions but before pushing], were you given the choice to have a companion who was present? Was someone with you besides a health worker? For example, a family member or friend
    - vii. Did you feel like you had control over decisions around the childbirth?
    - viii. Would you recommend that a friend/family member deliver in this hospital? Why or why not?
    - ix. Did anyone ask you for money to provide care? (Probe: if yes who asked for money? Do women and families pay this money?)
    - x. At any point during your stay for this delivery were you or your baby prevented from leaving the hospital because you could not pay?

- xi. Is there anything that you would change about this place to make the care more acceptable to you? Please explain

*Elements and experiences of mistreatment of women during childbirth*

4. Do you and women in your community experience anything during childbirth in health facilities that makes them feel unhappy or upset? Ask a few women to explain.

*Interviewer: allow the women to describe the experiences that made them feel unhappy in their own words. As they share the information other women may also speak*

*After the women/group explain(s) the scenario, ask her/them if there were any other times or ways that she/others was mistreated.*

*Perceived factors that influence how women are treated during childbirth*

5. You mentioned these types of mistreatment: (Interviewer: restate what type of mistreatment the woman experienced. For example, some of you mentioned that you were shouted at by the health worker]. In your opinion, what factors influenced how you were mistreated? Please explain.
- Probe: Related to supplies (availability of medication, equipment)
  - Probe: Related to facility (infrastructure/ set up)
  - Probe: Related to health workers (number of staff, heavy workload, lack of training, attitude and biases towards patients based on economic and educational status, tribal affiliation, number of children, etc.)
  - Probe: Related to the insecurity in the area (who is in control, fighting)
  - Probe: Related to patient load (number of patients, overcrowding, patient's or companion's expectation/ attitude)
6. In your opinion, what could be done to address these factors so that women are treated better during labor and childbirth?

*Acceptability of how women are treated during childbirth*

7. Now I would like to ask your opinions on how you feel about the way that women are treated during childbirth. If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable?

Probe – if YES when would it be acceptable?

8. If a woman was yelled or shouted at or ignored by a health worker during her childbirth, would this be acceptable?

Probe – if YES when would it be acceptable?

9. If a health worker was mean and refused to help a woman during her delivery, would this be acceptable?

Probe – if YES when would it be acceptable?

10. If a health worker physically held a woman down during her childbirth, would this be acceptable?

Probe – if YES when would it be acceptable?

How would you feel if this happened to you? What would you do?

11. All women are entitled to care which respects their basic dignity, privacy and autonomy. Are you aware of this right? (For example the right to make an informed choice? The right to respectful, safe and competent care).

12. Have you seen or heard of the Patients' Charter of Rights from the MOPH which outlines these rights?

13. What would you most like to see change in the facility to make the care more acceptable?

*Wrapping up*

14. Is there anything else that you would like to tell me about childbirth in your community?

*Thank the participants for their time. Remind them that the information they shared will be kept confidential.*

## Tool B: Focus Group Discussion Guide - Skilled Birth Attendants (SBAs)

Province: \_\_\_\_\_

Date of Discussion: \_\_\_\_\_

Number of Participants: \_\_\_\_\_

Time Started: \_\_\_\_\_

Time Completed: \_\_\_\_\_

Facilitator Name: \_\_\_\_\_

Note Taker: \_\_\_\_\_

Recorded: Yes /No

**Step 1:** Introduce yourself to the participants. Describe the purpose of the interview and how information will be used. Obtain oral consent. Assure participants of confidentiality; that information obtained will be anonymous.

**Step 2:** Ask the participants to identify themselves. Interviewer: fill out the information below FOR EACH HEALTH CARE PROVIDER prior to starting recording and beginning the discussion. Include current work positions and the number of years each SBA has been in the position.

**Step 3:** Conduct the interview. Please remember to audio record the interview.

**Step 4:** Explain this will be a discussion – there are no right and wrong answers. Encourage the group to agree that what is discussed remains within the group and they should respect each other's information.

### Explain the following by way of an introduction to the study:

The aim of this study is to generate information for the MoPH to improve respectful care in maternal and newborn health (MNH) care services in Afghanistan. To date, we have little information on this topic but we know that mistreatment in maternity care happens in Afghanistan as it does in other countries, and no assessment has assessed the factors contributing to mistreatment during childbirth. The proposed assessment will include discussions with women and health care providers to assess their experiences and expectations during facility births as well as their awareness of women's rights including factors contributing to mistreatment and to explore how care could be more acceptable to the women. We are also gathering perspectives of selected key informants.

**Participants information – can be expanded as needed (NOT RECORDED)**

Health worker category	Number of years working in this facility	Number of years of experience overall
Midwife/ community midwife		
A.		
B.		
C.		
General physician/clinician		
Obstetrician		
Other		

## Focus group discussion guide

### Introduction

We'd like to begin this discussion by asking you all a few questions about childbirth in this community:

1. In your opinion, why do women seek care at health facilities during childbirth?
2. In your opinion, how is the decision made for women to seek care at facilities during childbirth? Who is involved in this decision-making?
3. What do you think are the main reasons that women do not come to the facility to give birth?

### Childbirth narrative

4. Now I would like you to describe what it is like for a woman to deliver in this hospital, from when she first comes in labor until she is discharged. Could you tell me about the place where women are when they are in labor?

#### Probes:

- a. What does this place look like? Do you think it is clean and secure? Is there privacy?
- b. What do women do while they are in this room (probe: Are they allowed to move/walk around)?
- c. Who else is in this room? [Probe: Are they sometimes left unattended?]
- d. Do women have anyone there with them besides health workers? Are they given the choice to have the companion who is present? For example, family members?
  - i. If not, do you think that women want a non-medical person to be with them during this time?
- e. As health workers, what are your roles and responsibilities during this time? Are you able to provide this?
- f. In your hospital, what position do women deliver in? [Probe: lying on your back, kneeling, squatting or other?]
  - i. Are women allowed to make the decision and to deliver in a different position? Please explain.
- g. With reference to the picture you have described is this always what it is like for women in labor here? Are there times where women's experience might be different?

*Perceptions and experiences of care provided in facility-based childbirth, focusing on treatment by health workers and the facility environment.*

5. Now I would like to talk to you about your perceptions and experiences of care during childbirth. In your opinion, how are women treated by health workers at this facility during childbirth? Please explain.

#### Probes:

- a. Is the type of care you described the way you would like to provide care?
- b. In your opinion, what is supportive care during childbirth? Please explain.
  - i. Do you think this kind of supportive care that you have described is consistently provided to women during childbirth?
- c. In your opinion, what would you need from a WOMAN in order to provide this type of supportive care?
- d. In your opinion, what would you need from the WOMAN'S FAMILY AND HER COMMUNITY in order to provide this type of supportive care?

- e. In your opinion, what would you need from your COLLEAGUES in order to provide this type of supportive care?
- f. In your opinion, what would you need from your SUPERVISOR in order to provide this type of supportive care?
- g. In your opinion, what would you need from your HOSPITAL/SEHAT implementer in order to provide this type of supportive care?
- h. In your opinion, what would you need from your MINISTRY OF PUBLIC HEALTH in national and provincial levels in order to provide this type of supportive care?
- i. Have you seen a woman being asked to pay for a service and you know she and her family have no money?
- j. Have you ever seen a woman who do not pay money being detained in the hospital?  
PROBE – is there anything else you wish to share about patients and their families being asked for money?

*Elements and experiences of mistreatment of women during childbirth*

- 6. Sometimes women are mistreated or poorly treated during childbirth. Have you ever seen or heard of any type of mistreatment happening in your work? Listen to a few examples and probe for details as follows:
  - a. Could you explain the situation?
  - b. Who was involved in the situation?
  - c. How was the woman mistreated? [probe: verbal, physical, emotional?]
  - d. When did it happen? [Probe: time of day, during labor, during childbirth or postpartum].
  - e. Why do you think this happened?
  - f. In your opinion, how common is the situation that you described? [Probe: do situations like this happen every day?]
  - g. Did you or anyone intervene to correct the situation? How?

*Interviewer: after the health worker explains the scenario, ask if there were any other times or ways that mistreated happens. If they describe another scenario, follow-up with questions 6a-6g.*

*Perceived factors that influence how women are treated during childbirth*

- 7. You mentioned these types of mistreatment: *(Interviewer: restate what type of mistreatment the woman experienced. For example, you mentioned that the woman was hit or yelled at by the health provider).* In your opinion, what factors influenced how the woman was mistreated? Please explain.
  - a. Related to supplies (Probe: availability of medication, equipment)
  - b. Related to health workers (Probe: number of staff, heavy workload, lack of training, attitude and biases towards patients based on economic and educational status, tribal affiliation, number of children, etc.)
  - c. Related to patient load (Probe: number of patients, patient or companion's expectation/attitude)
  - d. Related to your health facility (Probe: management practices, policies, infrastructure/setup, services)
  - e. Other reasons such as stress, insecurity  
Probe: Has the insecurity (who is in control in the community, fighting) affected how you do your job?  
Probe: How does stress affect your work?

- f. In your opinion, what could be done to address these factors so that women are treated better during labor and childbirth? Go through each items (a to e) above as needed.

*Acceptability of how women are treated during childbirth*

8. Now I would like to ask your opinions on how you feel and act about the way that women are treated during childbirth. If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable? PROBE - If more than one SBA says YES:
  - a. When would it be acceptable?
  - b. How would you feel if you witness it happen? What would you do?
9. If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable? PROBE - If more than one say YES:
  - a. When would it be acceptable?
  - b. How would you feel if you witness it happen? What would you do?
10. If a health worker was mean and refused to help a woman during her delivery, would this be acceptable? PROBE - If more than one say YES:
  - a. When would it be acceptable?
  - b. How would you feel if you witness it happen? What would you do?
11. If a health worker physically held a woman down during her childbirth, would this be acceptable? PROBE - If more than one say YES:
  - a. When would it be acceptable?
  - b. How would you feel if you witness it happen? What would you do?
12. All women are entitled to care which respects their basic dignity, privacy and autonomy. Are you aware of this right? For example the right to make an informed choice about having a birth companion?
13. Have you seen or heard of the Patients Charter of Rights from the Ministry of Public Health which outlines these rights?

*How staff are treated*

14. What is the most rewarding part of your work? Why?
15. What is the most challenging part of your work? Why?
16. Do you feel valued or appreciated in your work? Why or why not?
17. Have you ever experienced mistreatment or harassment by clients, colleagues, or supervisor? Please explain.
18. Have you ever witnessed mistreatment or harassment of your colleagues/peers by clients, colleagues, or supervisor? Please explain.

What did you do?

19. Could you please describe what the relationship that you have with your colleagues (i.e.: other health workers of your cadre)? PROBE:
- a. Do you feel you support one another?

*OPTIONAL – if there are no supervisors within the group.*

20. Could you please describe what the relationship that you have with your supervisor is like?  
Probe: Do you feel supported by your supervisor? Why or why not?
21. Please describe how the health facility (set up, availability of supply of medication, and equipment) allows or limits you in providing supportive/ respectful care to women who give birth.  
What improvements in the health facility do you need most to help you better provide supportive care to women who give birth?
22. Overall, do you feel that your work environment is supportive? What could be done to help you feel more respected?
23. Do you feel safe and secure as a female health care worker in this facility?  
Please explain.

*Wrapping up*

24. Is there anything else that you would like to tell me about your work with women who are giving birth?

*Thank the participants for their time. Remind them that the information they shared will be kept confidential.*



## Tool C: Key Informant Interview Guide

**Type of Key Informant:**  MoPH Official  Donor  Technical Stakeholder  Other

\_\_\_\_\_

**Province:** \_\_\_\_\_ **Date of Interview:** \_\_\_\_\_

**Time Interview Started:** \_\_\_\_\_ **Time Interview Completed:**

\_\_\_\_\_

**Interviewer:** \_\_\_\_\_ **Note Taker:**

\_\_\_\_\_

**Interview taped: Yes/No**

**Step 1:** Introduce yourself to the informant. Describe the purpose of the interview and how information will be used. Obtain oral consent.

**Step 2:** Fill out the information below prior to beginning the interview.

**Step 3:** Please remember to audio record the interview.

### **Brief overview of the study:**

The aim of this study is to generate information to inform MoPH and development partners' efforts to eliminate mistreatment and ensure quality respectful care in maternal and newborn health (MNH) care services in Afghanistan. To date, few studies have touched on mistreatment in maternity care in Afghanistan, and no assessment has assessed the factors contributing to mistreatment in MNH service provision. The proposed assessment will include discussions with women and health care providers to assess their experiences and expectations during facility births as well as their awareness of women's rights including factors contributing to mistreatment and to explore how care could be more acceptable to the women.

### **Key Informant information**

**Title/position:**

**Professional Qualifications:**

**Number of years in current position:**

**Most recent position before this:**

**Responsibilities in relation to maternal and newborn health:**

## Key informant interview guide

*Perceptions and experiences of care during childbirth, focusing on treatment by health workers and the facility environment.*

1. In your opinion, how are women in general treated by health workers in the health facilities when they come to deliver?
2. Could you describe for me what supportive/respectful care during childbirth means to you?
  - a. In your opinion, is respectful care provided to women during childbirth in hospitals/health facilities? Please explain.
  - b. In your opinion, what would health workers need from a WOMAN in order to provide supportive/respectful care?
  - c. In your opinion, what would health workers need from a WOMAN'S FAMILY AND COMMUNITY in order to provide supportive/respectful care?
  - d. In your opinion, what would health workers need from their COLLEAGUES in order to provide supportive/respectful care?
  - e. In your opinion, what would health workers need from their SUPERVISORS in order to provide supportive/respectful care?
  - f. In your opinion, what would health workers need from their HOSPITAL/SEHAT implementers in order to provide supportive/respectful care?
  - g. In your opinion, what would health workers need from Ministry of Public Health at national and provincial levels in order to provide supportive/respectful care?
3. Sometimes women are mistreated or poorly treated during childbirth. Have you ever seen or heard any type of mistreatment happening? [Probe: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints?]  
Could you explain the situation?
  - a. In your opinion, how common is the situation that you described? [Probe: do situations like this happen often?]

**If the informant is not aware of any cases of mistreatment - share examples provided by participants in FGD with recently delivered women.**

*Interviewer: After the key informant explains the scenario, ask if there were any other times or ways that mistreated happens. If they describe another scenario, follow-up with questions 3a-3b.*

*Perceived factors that influence how women are treated during childbirth*

4. You mentioned these types of mistreatment: (*Interviewer: restate what type of mistreatment the woman experienced. For example, you mentioned that you/friend/family/clients were hit or yelled at by the health care provider*). In your opinion, what factors influenced how you/friend/family/clients were mistreated? Please explain.
  - a. Related to supplies (availability of medication and equipment)
  - b. Related to health workers (number of staff, heavy workload, lack of training, attitude and biases towards patients based on economic and educational status, tribal affiliation, number of children, etc.)
  - c. Related to patient load (number of patients, patient's or companion's expectation/ attitude)

- d. Related to health facility (management practices, policies, infrastructure/setup and services)
  - e. Related to the insecurity – who controls the local community, fighting
  - f. Related to health system (MoPH at central or provincial level and SEHAT implementers)
  - g. Other factors
5. In your opinion, what policies could be issued or revised to address these factors so that women are treated better during labor and childbirth from a policy maker perspective?
  6. In your opinion, what improvements in the HEALTH SYSTEM could be done, involving health facility managers, SEHAT implementers or MoPH at the central and provincial levels, to address these factors so that women are treated better during labor and childbirth?
  7. All women are entitled to care which respects their basic dignity, privacy and autonomy. How can we ensure women and communities are aware of these rights?

*How staff are treated*

8. In your opinion, what is the most rewarding /motivating part of health workers' work? Why?
9. In your opinion, what is the most challenging part of health workers' work? Why? [Probe: what mistreatment or harassment by clients, colleagues or supervisor do you think they experience?]
10. In your opinion, do they feel valued or appreciated in their work? Why or why not?
11. Overall, do you think that health workers' work environment is supportive? Please explain.
  - a. What do you think could be done to make health workers' work environment more supportive?
12. Do you think the proposed Midwives and Nurses Council and the established Medical Council can improve the provision of quality respectful maternity care? If so HOW?

*Wrapping up*

13. Is there anything else that you would like to tell me about your work that may be helpful for understanding women's and health care providers' experiences during facility births?
14. What are you most interested in learning from our assessment of women's experiences during facility births?
15. Do you have any question for me?

Thank so much for your time and assistance. The information you shared will be kept confidential and is anonymous. We look forward to sharing the results of the study with you in the coming months.

## Annex 2: Codebook

Theme	Sub-theme	Tags/prompts	Illustrative example (quotes)
<b>Motivators for and deterrents from childbirth at health facilities</b>	<ul style="list-style-type: none"> <li>• The motivators to use health facility delivery services</li> <li>• The deterrents from use health facility delivery services</li> <li>• Participants reasons for preference of clinic for delivery</li> </ul>	<p><i>FGDs with women</i> – location of birth, reason for location, who made decision</p>	<p><b>Positive:</b> Well, Dear Midwife, sometime, God forbid, one’s baby is inverted [local term for malpresentation], one has bleeding, or is weak, or something [else] happens, then if [she] comes here, the midwives will give her medicine, injection or if she is worse will refer her to Mazar, you see? Midwives and doctor help us so much.</p> <p><b>Negative:</b> No, we knew about hospital, but the old people said [criticized] we delivered all the time at home and were fine, you are spoiled and are weak, now that we know we come to hospital.</p>
		<p><i>FGDs with providers</i> – location of birth, reason for location, who makes decision</p>	<p><b>Positive:</b> When a woman comes [to clinic] for her ANC visit, we register her, advise her to allocate/save money for her delivery, talk to someone with a car and driver in case you need transport, prepare clean cloths for yourself and your baby, find someone [donor] for blood transfusion, and seek help from mother, mother-in-law or husband [so they come to facility for delivery]</p> <p><b>Negative:</b> For poverty, some of them [women] that come from far away, they can’t find the money for transport, if they find a car at night they [car owners] will ask at least 2000 Afghanis, but the woman may not have that much. Some deliver because of the level of their awareness which is low, or maybe because of insecurity on the way</p>
<b>Experience of the women during their last delivery</b>	<ul style="list-style-type: none"> <li>• Experienced behavior of the providers</li> </ul>	<p><i>FGDs with women</i> – best experience you remember, worst experience you remember, behavior of health</p>	<p>“[I delivered] in the clinic, [they] look at me [take care of me] properly, treat me, give me serum and injection, take care of bleeding, issues in blood</p>

<p><b>at the health facility</b></p>	<ul style="list-style-type: none"> <li>• Expected behavior of the providers</li> <li>• Out of pocket payment for the delivery services</li> <li>• Suggestion for improvement of delivery services</li> </ul>	<p>worker, feeling supported, services needed to feel supported, memories of facility (cleanliness, confidentiality, safety, presence of health workers, explanation of procedures, being allowed to ask questions, feeling in control over decisions made, companion allowed), would recommend facility to others, payment, not able to leave without payment, what would want to be different</p> <p><i>FGDs with providers</i> – cleanliness, confidentiality, safety, companion allowed, woman left alone, freedoms, could walk/move about, skilled birth attendant role, birth position, woman allowed to choose birth position, treating client with respect, outlier/deviation, expectation</p>	<p>pressure, high or low, take the baby clean and in orderly manner and clothe the baby [properly]”</p> <p>“They [clients] come to hospital for cleanliness, knowledgeable people and midwives, their privacy is respected, only one companion like mother of mother-in-law or sister is allowed. Some women that are illiterate say “we don’t go to hospital, our privacy is not maintained” but the women who know say “we go to hospital because if something is wrong like bleeding, it is better to be in hospital...”</p>
<p><b>Mistreatment</b></p>	<ul style="list-style-type: none"> <li>• Examples of mistreatment</li> <li>• Normalization / acceptability of providers disrespectful behavior</li> <li>• Prevalence of disrespect and abuse</li> </ul>	<p><i>FGDs with women</i> – painful/unpleasant experiences, your own experience vs others’ experiences, discrimination, insecurity, overcrowding, how to improve, shouting, neglecting, denying help, holding on the bed, acceptance of physical abuse, what would do in such cases</p> <p><i>FGDs with providers</i> – shouting, neglecting, denying help, holding on the bed, acceptance of physical abuse, what would do in such cases, how often this happens, reasons for</p>	<p>That night three women delivered and one midwife was there for each. One midwife was standing near to me I was afraid, I was trembling, only one midwife was there, I was worried what if something goes wrong with me, but had no problem. ... Midwife conducted a little harsh but it must be difficult for them too, I have no complaints. We were in one room, only a thin curtain was between us, the cleaner and my mother were present, but I understand, I have no complaint.</p> <p>No I personally try to be nice with my patients because I am also a mother I never do anything to hurt a woman during her pains. And I try to help her treat her nicely encourage, but there are mothers who kicked me when I tried to examine and later she apologized. Sometimes when the</p>

		<p>mistreatment, character, low capacity, shortage of staff / overcrowding, building/room arrangements, equipment, drugs, insecurity, discrimination, how to improve</p> <p><i>Key informant interviews – Observed disrespect and abuse, descriptions, prevalence</i></p>	<p>patient or the companion demands too much interferes with treatment, insist on injection and serum, a midwife who has delivered ten - eleven women at night duty may react and be harsh naturally.</p> <p>I have heard such complaints from families that the provider had bad behavior with the clients. In my 15 years' experience I can't say I have not seen such cases</p>
<b>Respectful workplace environment</b>	<ul style="list-style-type: none"> <li>• Provider expectations</li> <li>• Provider experiences</li> </ul>	<p><i>FGDs with providers - rewarding attributes of work, challenging attributes of work, feel valued (yes, no, why), subjected to abuse (by clients, peers, supervisor), witnessed abuse (by clients peers, supervisor), how to support, feeling supported</i></p> <p><i>Key informant interviews - rewarding attributes of work, challenging attributes of work, feel valued (yes, no, why), enabling environment for RMC, how to improve work environment, Afghan Nursing and Midwifery Council, other</i></p>	<p>It is rewarding to see a woman receive good care and leave the clinic healthy and happy. They pray for us and thank us which make us very happy.</p> <p>When I first encountered a laceration - I only had experience with the model - and I was worried but I managed the case and was happy</p> <p>I can say in past one and a half years I had no complaints against midwives, the society is more involved and even we share our budget with people</p> <p>I have heard of a case that the client slapped the doctor, we talked to the community and the man apologized</p>

<p><b>Determinants</b></p>	<ul style="list-style-type: none"> <li>• Factors influencing behavior of health workers with clients</li> </ul>	<p><i>FGDs with providers</i> - supplies, human resources, congestion, management of health facility, insecurity, health system / MoPH, other reasons</p> <p><i>Key informant interview</i> - supplies, human resources, congestion, management of health facility, insecurity, health system / MoPH, other reason</p>	<p>If there are no gloves, no suction, no equipment and clean item, it is not possible to work</p> <p>Well, different reasons may contribute [to disrespect], for example a midwife deliver five cases during the night duty and in the morning many patients are waiting, the midwife might be harsh because she is exhausted.</p>
<p><b>Awareness of right based delivery services</b></p>	<ul style="list-style-type: none"> <li>• Understanding of respectful maternity care</li> <li>• Compliance with elements of respectful maternity care</li> </ul>	<p><i>FGD with clients</i> - Aware of patients' charter of rights, how to improve</p> <p><i>FGD with providers</i> - behavior of health workers with clients, what is RMC, observations/examples of RMC, need from clients, need from family/community, need from health workers, need from supervisors, need from health facility/NGO, need from MoPH</p> <p><i>Key informant interviews</i> - behavior of health workers with clients, what is RMC, observations/examples of RMC, need from clients, need from family/community, need from health workers, need from supervisors, need from health facility/NGO, need from MoPH</p>	<p>Yes, this is some chapter hanging outside on the wall and shows what are the rights of the clients, that the services are free and similar things</p> <p>When a woman attends the clinic we take her history, give her blood tests, respect her and keep her privacy and during delivery we tell her about each step of care, if we inject her without telling this may be shocking to her</p> <p>I think we need to improve our capacity, [RMC] should be made part of curriculum and medical ethics should be taught in institutes and school.</p>