Author’s response to reviews

Title: Villains or victims? An ethnography of Afghan maternity staff and the challenge of high quality respectful care

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Author’s response to reviews:

Reply to reviewers questions BMC Pregnancy & Childbirth “Villains or Victims”?

Dear Dr Mohammed Ali,

Thank you for the opportunity to improve this manuscript. Please find attached our revised manuscript “Villains or victims? An ethnography of Afghan maternity staff and the challenge of high quality respectful care”.

We have addressed each of the points raised by the two reviewers, made changes, copied the amended text and provided additional information as required. We think that we have fully addressed their points but please do not hesitate to contact us if further amendments or clarification is required.

Yours sincerely

The authors
Background interviews were conducted with experts (key informants) who provided background to the Afghan health system, culture, language and recent history. We used ‘background interviews’ because of the recent history of (negative) ‘informing’ in Afghanistan. This knowledge could not have been gained from hospital interviews alone. More explanation has been added to the text. (Page 7 line 26 onwards.) The text now reads:

“Forty-one background or key informant interviews were undertaken with Afghans (n=19) and non-Afghans (n=22). Informants were selected for their expert knowledge and were either already known to the first author, were met during the course of the study or introduced as someone who could provide an important perspective. These interviewees had in-depth knowledge of pertinent issues including conducting research in Afghanistan, the health system, the MoPH, midwifery and medical education, the culture, linguistics, education, and the impact of recent history on society and mental health. Background interviews were conducted at the commencement of the study and throughout. They were a safeguard against forming premature judgements and provided broad perspectives on the Afghan health system and the society that defines the healthcare providers”.

2. We have added more detail regarding interviews, focus group discussions and participants. (Page 6 line 8 onwards) The text now reads:

“Semi-structured interviews (38) were then conducted with 23 hospital staff members who were asked about care in the hospital, their roles, and ideas. A broad range of staff was interviewed including senior and junior midwives, obstetricians and gynaecologists, resident doctors and care assistants… The selection of participants was a mixture of purposive sampling, opportunistic and self-selection to ensure that wide variations of views were represented. Staff who appeared particularly informative or knowledgeable were asked if they would give us an interview. In addition, we announced at staff meetings that anyone was welcome to talk to us - four resident doctors and one senior midwife volunteered for an interview. Ongoing informed consent was obtained from all participants. An aide memoire was used as an interview guide but after the initial questions the interview was adapted to the participant and explored issues that they considered important. Some participants needed few questions or prompting, others more. Interview questions evolved during data collection as new understandings and perspectives of
what was important to healthcare providers developed. This flexibility gave the opportunity to hear unexpected perspectives and not be limited by initial assumptions. Interviews lasted 20-90 minutes and were digitally recorded with permission then transcribed by the first author. Alternatively, handwritten notes were taken during the interview then later checked with the interpreter to ensure important information had been recorded”.

(Page 7 top) “Focus group discussions (FGDs) were conducted during this time with two groups of women from different Kabul communities to understand their experiences and priorities regarding care (39). One FGD was held in the home of a community leader with six female members of his extended family. The second FGD was held in a poor area of Kabul with ten women who were members of a pre-existing self-help group. The main purpose of the FGDs was to understand what was important to Afghan women when they were in childbirth and to interpret maternity care from their perspective rather than from Western notions of care. For this reason it was decided that any women were eligible for the FGD regardless of where they had delivered their baby. Verbal consent was given by both groups for their discussions to be digitally recorded. The first FGD lasted 93 minutes and the second 45 minutes”.

3. We have now added details regarding the source of each quote.

4. Although some specifics will be different we think there will be many similarities with other settings and that this qualitative study has elements that are transferable. (Page 25 line 56 onwards). The text now reads:

“A limitation of this research is that only one hospital was studied. Women in the FGDs, however, had given birth in various Kabul maternity hospitals and there were no detectable differences. Background interviewees also confirmed that institutional cultures are similar across Afghan public maternity hospitals. We would therefore suggest that the findings are transferable to other Afghan maternity hospitals.

Although findings from this research are unique to Afghanistan, the drivers of suboptimal care and mistreatment of women in other LMICs are likely to involve similar complicated groups of healthcare providers and imperfect health systems (12, 49, 50). It is probable that aspects of the context and findings will resonate with other settings and thus be transferable beyond Afghanistan”.
Reviewer 2. Thank you for your encouraging comments and for helping us to improve this manuscript.

We apologise about the two sets of numbers – we didn’t spot it until after submission.

Afghan colleagues/researchers were pivotal to the whole research process. As this is a PhD registered in the UK, there were no Afghan academics involved in the analysis and writing.

We took great care to ensure the quality of translation throughout although acknowledge that some fine detail was inevitably lost. We have, however, included more details on the quality control measures that we took throughout. (Page 8 line 19) The text now reads:

“As a cross-cultural study that depended on translation, we took care to ensure the quality of translation throughout. Prior to the study commencement two Afghan researchers advised on the correct translation of key terms and words… An Afghan midwife researcher later transcribed and translated digitally recorded interviews as a quality control measure”.

Also (page 26 line 17)

“As an outsider, a non-Afghan working through an interpreter, RA (who had limited understanding of the language), could have unintentionally misunderstood and therefore misrepresented the health system and staff. With this in mind, throughout data collection and analysis the findings were checked with Afghan and foreign colleagues”.

Specific comments – ABSTRACT

Sorry it was error copying and pasting. This has now been rectified.
Background

2. Thank you this is an ethnographic study, more than a case study, so ethnographic case study is a good term. Heterogeneous has been removed. Questions have been rephrased as statements. (Page 2 line 4 onward). The text now reads:

“Explanations for suboptimal care often include poor working conditions for staff, a lack of essential supplies, respect and support. Other explanations suggest that doctors, midwives and care assistants may be unaware of or unconcerned about the rights of the women for whom they care”.

Methods

2. That’s a good point thank you. (Page 2 line 14 onward). The text now reads: “This ethnography examined the everyday lives of a group of maternal healthcare providers working in a tertiary maternity hospital in Kabul, Afghanistan between 2010 and 2012”.

3. The women were interviewed in the community not in the hospital - this has been clarified. (Page 2 line 30). The text now reads:

“Focus groups were held with two diverse groups of women in community settings”.

We have also added more details about the FGD women in the methods section that is under methods below. (The primary aim was to understand the wishes of Afghan women around care in childbirth - we therefore included any women as this was not dependant on where they delivered or how long ago.)

Conclusion

4. We have re-written and restructured this for clarity with more emphasis on the implications for the provision of quality care. It is difficult to provide detailed prescriptive recommendations, however, because each issue or staff behaviour had many contributing factors and will therefore require multifaceted solutions. (Page 3 top). The text now reads:
“Providing respectful quality maternity care for women in Afghanistan requires multifaceted initiatives because the factors leading to suboptimal care or mistreatment are complex and interrelated. Standards need enforcing and abusive practices confronting to provide a supportive, facilitating environment for both staff and childbearing women. Polarized perspectives such as ‘villain’ or ‘victim’ are unhelpful as they exclude the complex realities of human behaviour and consequently limit the scope of problem solving”.

Key Words
5. We have removed the obscure words and added MeSH terms.

“Afghanistan; ethnography; midwifery, facility-based childbirth; mistreatment; respectful care; quality of healthcare; health personnel; Low and middle-income countries”.

MAIN MANUSCRIPT

Background
6. (Page 3 line 28). This has been changed to: “More often than not, debates on the quality of maternity care primarily focus on healthcare providers”.

7. (Page 5 line 31 onward) We rewrote but then removed this phrase as it seemed to add unnecessary detail.

8. (Page 5 line 37) We have changed ‘babies’ to ‘newborns’

9. (Page 4 top) This has been rephrased to …”The paradox is that despite professional training many healthcare providers do not provide good quality care (9)” and supporting references added to this and the following sentence.

10. We have combined two sentences as supporting references were at the end of the following sentence. (Page 4 line 13 onward) The text now reads:
“Yet another explanation centres on healthcare provider ignorance or disregard for the rights of childbearing women and suggests the need for training, behaviour change strategies and accountability mechanisms (15-17)”

Methods

11. We have added some further detail on methodology and methods – see below.

We also added context and history, however we have situated this under introduction where there was already some background to the context. (Page 4 line 29 onward) The text now reads:

“For more than four decades Afghans have suffered political upheaval, violence, migration and conflict (19). The hoped for peace following the fall of the Taliban regime (2001) has not materialised. Even in Kabul city, despite a semblance of normality, there is the constant threat of unpredictable violent attacks for all - including healthcare providers travelling to work. The health system and infrastructure were all but destroyed during the height of the conflict and many professionals fled the country (20, 21). Despite the immense national and international efforts to rebuild the health system (22, 23), difficulties in assessing care due to insecurity, poverty or terrain, as well as suboptimal care and political interference continue to undermine its effectiveness (24, 25).

We have added more details/maternal and perinatal mortality estimates to the section in the background (Page 5 line 6 onward) The text now reads: “The proportion of births attended by skilled providers has risen from less than 10% in 2003 to 51% in 2015 (27, 30)”

Also, (Page 5 line 20 onward) the text now reads: “Recent surveys estimate that the maternal mortality ratio remains one of the highest globally at 1,291 deaths per 100,000 live births (30, 35). Perinatal mortality rates (which are comprised of stillbirths and neonatal deaths within the first seven days of life) are estimated at 36 deaths per 1,000 pregnancies although the report noted that neonatal deaths appeared to be under-reported (30)”

Details regarding the selection of participants are now included. (Page 6 line 23 onward) The text now reads:
“The selection of participants was a mixture of purposive sampling, opportunistic and self-selection to ensure that wide variations of views were represented. Staff who appeared particularly informative or knowledgeable were asked if they would give us an interview. In addition, we announced at staff meetings that anyone was welcome to talk to us - four resident doctors and one senior midwife volunteered for an interview”.

Inclusion criteria for FGD women is now included. (Page 7 line 8 onward) The text now reads:

“The main purpose of the FGD was to understand what was important to Afghan women when they were in childbirth and to interpret maternity care from their perspective rather than from Western notions of care. For this reason it was decided that any women were eligible for the FGD regardless of where they had delivered their baby”.

We have added an explanation about the care assistants. (Page 6 line 15 onward) The text now reads:

“The care assistants, or khālas, were untrained female workers who transferred women between wards, washed and dressed newborns, ran errands for staff and women in childbirth, conveyed messages to relatives, cleaned and controlled entry to the obstetric wards.”

12. (Page 5 line 61) We have changed this to ‘a tertiary maternity hospital in the capital Kabul’.

13. We have removed ‘typed up the same day”. We have also tried to make the various data collections and the order in which they were done clearer. We have also summarised the different data collection methods and participants in a table (see pages 7&8)

14. We deliberately did not ask about ethnicity but know that at least two different ethnic groups were represented in the FGDs. We have added detail about the FGD including numbers of women, locations

(Page 7 line 3 onward) This now reads:
“One FGD was held in the home of a community leader with six female members of his extended family. The second FGD was held in a poor area of Kabul with ten women who were members of a pre-existing self-help group”.

15. You are correct - there are no quotes from the community leader, anthropologist or historian in this manuscript as their expertise was the wider culture/context not the behaviours of healthcare providers. We have added more detail regarding the various key informants and how they were identified and recruited. (Page 7 line 26 onward) The text now reads:

“Forty-one background or key informant interviews were undertaken with Afghans (n=19) and non-Afghans (n=22). Informants were selected for their expert knowledge and were either already known to the first author, were met during the course of the study or introduced as someone who could provide an important perspective. These interviewees had in-depth knowledge of pertinent issues including conducting research in Afghanistan, the health system, the MoPH, midwifery and medical education, the culture, linguistics, education, and the impact of recent history on society and mental health. Background interviews were conducted at the commencement of the study and throughout”.

16. We have now included information regarding the interview guide. (Page 6 line 37 onward) The text now reads: “An aide memoire was used as an interview guide but after the initial questions the interview was adapted to the participant and explored issues that they considered important. Some participants needed few questions or prompting, others more. Interview questions evolved during data collection as new understandings and perspectives of what was important to healthcare providers developed. This flexibility gave the opportunity to hear unexpected perspectives and not be limited by initial assumptions”.

17. Yes, the interpreter was Afghan and recruited locally. She accompanied the lead researcher for the entire period of observation and interviews, translating everything from informal conversations to morning reports and interviews. (Page 8 line 31 onward) The text now reads: “A female Afghan interpreter was recruited locally and trained specifically for this research. She accompanied the first author and interpreted informal conversations throughout participant observation, staff meetings and semi-structured interviews”.

18. (Page 6 line 54). Typed up has now been replaced with transcribed.
19. (Page 8 line 46). UK has been added after Bournemouth University.

20. We have added much more detail to this section. (Pages 8 line 49 onwards – page 9) The text now reads:

“Thematic analysis was used to analyse the data manually (14). Data was coded section-by-section often using ‘in vivo’ codes or labels that came from the words or phrases of the participants. Similar codes were grouped together into categories and then combined into more conceptual themes (15). Initially FGDs, field notes from observation and background interviews were analysed individually. Semi-structured interviews were also analysed separately by professional grouping and level of seniority such as junior and senior midwives, resident doctors and senior doctors. Finally, a broad framework was developed to combine, compare and refine categories from all the different types of data. The first author did the majority of the analysis and ET & KR analysed some interviews. The developing and final themes were discussed and agreed with all authors”.

Results


This paper focuses on the themes ‘culture of care’ and ‘fear, power & vulnerability’ but includes links to the other three themes as they are intertwined.

22. We have ensured that there is an ID for each quote and have included the table showing the professional categories and numbers of participants. (We have deliberately not given many identifiers to protect the anonymity of participants in Kabul maternity services - a very small and interconnected professional setting.)
The women in the FGDs were not given individual IDs as when the recordings were listened to it was impossible in places to distinguish between the different speakers. Where appropriate details have been added.

23. Thank you – we have clarified these or rephrased them as general statements.

Specific comments:

24. (Page 9 bottom and throughout) We have changed this punctuation and introduced the quote/identified the speaker more clearly.

25. Thank you – this was linking to our earlier paper but we have removed it for clarity.

26. (Page 10 line 43 onward). On re-reading we feel this is important information as it shows that politeness, kindness and respect are priorities for Afghan women regardless of status, education or ethnicity. We have therefore left it in.

27. Good point - we have removed the first sentence and shortened the second one and removed ‘small sample’. (Page 12 line 2 onward) The text now reads:

“Interviews and informal conversations with healthcare providers revealed a challenging, punitive and stressful working environment. Many interrelated issues affected the ability and motivation of staff to provide respectful high quality care”.

28. (Page 14 line 24 onward). The source of this quote has been identified more clearly. “A newly qualified midwife concurred:
Senior managers say ‘if you have the ability stay, if you cannot tolerate it [the workload and conditions implied], then leave. There are many jobless midwives and doctors, I can fill your place’. (Newly qualified midwife)”

Discussion

29. We have added some recommendations/mentioned promising approaches and references.

The text now reads:

(Pages 21 line 49). “More promising approaches are multicomponent interventions that include analysis of the broader health system, supportive rather than punitive supervision for staff that listens to their voices, and respects their rights alongside those of the women for whom they care (16, 17)”.

Also (page 22 line 41) “While the need to enforce standards appears an obvious statement, in the current cultural and political context of Afghanistan this is challenging to accomplish. The establishment of the Afghanistan Nurses and Midwives Council (18) is clear progress towards professional regulation”.

Also (page 25 line 6). “For outsiders there is the need to examine their own assumptions regarding staff behaviours and the root causes of sub-optimal care, as well as working towards a more reflective practice”.

30. This section has been re-written as it demonstrates the importance of gaining first hand information on the behaviours and perspectives of healthcare providers. (Page 20 line 3 onward) The text now reads:

“Bradley and colleagues (19), pointed out that midwives’ voices have been largely missing from the discourse. They based their conceptual framework of healthcare provider behaviours, however, on the assumptions of women they had cared for (19). We would dispute the premise that a “robust analysis of the factors driving disrespectful care” can be developed from conjecture (46, p166). Our findings demonstrate the complexity of institutional cultures and the
dangers of making judgements without gaining first-hand insights from healthcare providers themselves”.

31. We have re-written this paragraph as it was not clear and taken out this phrase. (We meant standard solutions as a generic approach- not something that had been implemented in this hospital). (Page 26 line 4 onward)

“Although findings from this research are unique to Afghanistan, the drivers of suboptimal care and mistreatment of women in other LMICs are likely to involve similar complicated groups of healthcare providers and imperfect health systems (12, 49, 50). It is probable that aspects of the context and findings will resonate with other settings and thus be transferable beyond Afghanistan”.

Other Minor Comments

32. This has been changed

33. Thank you – this has been corrected.

34. Thank you for spotting this – we have changed it to the correct one - MoPH.

35. Thank you we have done this.