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Case Series

Exploring the perception of Afghan childbearing women about respectful maternity care: a qualitative study in Afghanistan

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ABSTRACT

Pregnancy and childbirth are critical periods for women, yet thousands of women and newborns die annually due to preventable factors. Despite global efforts, progress in reducing maternal mortality has been slow, especially in low-income and conflict-affected countries like Afghanistan. Respectful Maternity Care (RMC) is essential to improving maternal health outcomes, but mistreatment during childbirth in Afghan healthcare facilities deters women from seeking necessary care. This qualitative study explores the perceptions of Afghan childbearing women regarding RMC during childbirth. Through thematic analysis of interviews with nine women who recently gave birth in a major maternity hospital in Kabul, significant barriers and challenges were identified. The findings reveal that Afghan women frequently endure verbal and physical abuse, discrimination based on financial status and connections, lack of informed consent, and non-dignified care. These factors contribute to a lack of trust in facility-based childbirth, perpetuating high maternal mortality rates. The study underscores the urgent need to implement RMC practices that ensure fairness, compassion, and dignity to improve the maternal healthcare experience and outcomes in Afghanistan.

Keywords: Afghanistan, Child bearing women, Healthcare providers, Maternal mortality, Respectful maternity care

INTRODUCTION

Pregnancy and childbirth are significant personal and social moments in the lives of women, families, and communities. That is why the health of both mother and child needs to be highly supported throughout this process.[1] However, every year more than 303,000 women and 2.7 million newborns die during childbirth due to many preventable factors all over the world.[2] Reducing maternal mortality rates has been on the international agenda ever since the creation of the Millennium Development Goals (MDGs) in 1990. Although a global decline of 44% occurred between 1990 and 2015, this is still considered a slow decrease.[3] Most of these maternal deaths could have been prevented if there had been proper implementation of the global standards of quality of maternal and childbirth care. Therefore, the international community has joined efforts to further reduce these mortality rates through the creation of a new target under the Sustainable Development Goals (SDGs) to improve the quality of care in middle to low-income countries.[3] The Sustainable Development Goals (SDG) prioritize maternal reduction to 70 per 100,000 live births.[2] World Healthcare Organization (WHO) has highlighted quality of care as one of the priority factors in addressing the preventable factors resulting in child and maternal mortality rate, and states a vision 'Every woman, child and adolescent should receive quality care throughout the continuum of their life course and care'.[2] The WHO framework for quality of maternity and new-

born care highlights that experience of care should receive equal attention and consideration as the provision of care. Experience of care included effective communication, respect, dignity, and provision of emotional support.[4] To only focus on preventing maternal and newborn mortality and morbidity is not enough, care should be done considering basic human rights including the right to respect, dignity, confidentiality, information and informed consent, and freedom from discrimination.[1] Women's negative experience with the health system is connected with not being able to get care, receiving improper, neglected, and careless care, facing verbal and physical abuse, and dealing with discriminative care particularly if they are poor. All these factors make it very difficult for women to decide whether they need to go for maternal healthcare services or not.[4] Evidence around the globe women are repeatedly receiving poor quality care, they are being abused verbally and physically, humiliated, and discriminated against.[5] Respectful Maternity Care (RMC) is the right of all women giving birth in every health system all around the world.[3] To stress the importance of this universal right, the White Ribbon Alliance has developed a document called "The Respectful Maternity Care Charter: The Universal Rights of Childbearing Women".[1] This document has set the foundation for RMC as a universal human right for all childbearing women everywhere.[6] This document stresses the importance of women's experiences during childbirth while respecting and preserving their autonomy, dignity, choices, and feelings. In 2015 systematic review of disrespect identified physical, verbal, and sexual abuse, discrimination, stigma, substandard care, poor provider-recipient rapport, and healthcare system conditions and constraints.[4] This led to updated charter by the White Ribbon Alliance (WRA) on the Universal Rights of women and newborns including 1) freedom from harm and ill-treatment; 2) right to information, informed consent, respect to choices and preferences; 3) privacy and confidentiality; 4) (newborn's) dignity and respect; 5) equality and equity; 6) healthcare and health; 7) liberty, autonomy, self-determination and freedom; 8) (children's) being with their parents or guardians; 9) (children's) identity and nationality from birth; and 10) adequate nutrition and clean water.[4] Every woman all around the world has the right to receive high-quality care that also includes the right to respectful care but unfortunately, many women experience disrespect and abuse during childbirth at healthcare facilities. This behavior does not only violate women's right to respectful care but also their right to life, health, and freedom from discrimination.

Respectful Maternity Care (RMC) in Afghanistan

Maternal Mortality (MM) remains a huge Public Health concern in low and middle-income countries to meet Sustainable Development Goals. Afghanistan is one of the developing countries where maternal mortality was among the highest worldwide during the conflict and now.[7] A study has shown that in 2000, Afghanistan counts as a country with the highest proportions of maternal mortality rate in the world (1,800 deaths per 100,000 live births). Between 2001 to 2015, Afghanistan made good progress in the extension of primary health care services using the Basic Package of Health Services (BPHS). Delivery at health facilities and birth through skilled birth assistance in recent years increased from less than 15 % to 32 % for birth at health facilities and 48 % for birth by skilled birth assistance in 2010. In 2015, these figures increased to 48% of births happening at health facilities and 51% of births by skilled birth assistance.[8] However, the materiality rate is still alarming in Afghanistan compared to other developing countries around the world. Evidence proved that improved access to maternal health has not resulted in proportional reductions in maternal mortality in numerous low-income countries. Conflict-affected countries are more likely to face the access and financial challenges of healthcare. Even in this situation focus needs to be given to quality of care since it will highly contribute to the population's health. Despite this significant turn by focusing on quality care besides access to facility-based care, this shift remains slower in the areas where access to services is limited.[9] Considering this, the World Health Organization calls for a focus on quality of care in conflicted affected, and poor areas to assess the gaps in quality of care and develop strategies to address those. In Afghanistan, although RMC is a key element of The National Strategy for Reproductive, Maternal Newborn, and Adolescent Health (RMNCAH), less attention is being paid to it. There is less data available on this critical aspect of maternal health.[4] In Afghanistan, studies show that mistreatment during childbirth is considered normal, which is also one of the underlying factors preventing women from seeking maternity care and delivering babies at healthcare facilities. The result from the 2016 National Maternal and Newborn Health Quality of Care Assessment by Jhpiego in Afghanistan show that women's experience of care which includes effective communication, respect and dignity, and emotional support is considered highly important and women in Afghanistan receive mixed quality care, that usually meets some international standards for RMC and not others.[10]

Lack of Respectful Maternity Care promotes home-based delivery without the support of skilled birth attendants since women will stop trusting facility-based birth caused of an increased rate of maternal childbirth. The national 2016 assessment of the quality of maternal and child health care in Afghanistan shows that only % 40.1 of women receives information about care during admission in labor, % 34.3 receive an explanation about what will happen during giving birth, and less than % 37.1 were encouraged to walk. A study by 4 shows that significant deterrents to using maternal healthcare facilities are stigma and shame of being exposed to a stranger, transportation issues and financial difficulties, and negative experiences during previous childbirth due to disrespect and mistreatment.[4]

Rational

Understanding disrespect and abuse during childbirth has great implications for reducing maternal deaths around the globe. Usually, the problem of maternal mortality is tackled through the lens of the inability of women to access and pay for healthcare facilities, however, it has been shown that the issue of maternal morbidity lies behind the mistreatment and violence committed by health workers during childbirth.[11] Most of the interventions are designed and implemented to improve access to skilled birth attendance; however, studies show that, in countries with high maternal mortality rates, the fear of disrespect and abuse is an influential determinant of using skilled birth attendance.[12] In low and middle-income countries, it is believed that childbearing mothers need to experience respectful maternity care to improve their attendance at a skilled birth facility.[13] Disrespect and abuse in a skilled birth facility have been seen to lower a woman's confidence in seeking service at such a facility for her subsequent births; therefore, she would seek fewer safe alternatives in giving birth increasing her risk of maternal mortality.[14] Among the other factors, the attitude and behavior of health care providers, the fear of being insulted by a physician, and the threat of stigmatization have a significant role in the dissatisfaction of women with the health system, therefore diminishing the likelihood of seeking antenatal care (ANC), childbirth and postnatal services. Most women prefer to birth at home.[15] In Afghanistan, there is limited literature on the experience of women within the maternal care field, although there is an increased use of such services across the countries.[8] This step will let us understand how women perceive, analyze, and evaluate the numerous aspects that affect their health-care-seeking experience.[16] To my knowledge, limited studies have been done on this topic among pregnant women giving childbirth in health facilities in Afghanistan. It would be useful to explore the perception of Afghan childbearing women giving birth in Afghanistan to understand how they define RMC which plays a role in explaining access and use of health care services during childbirth and help decision-makers identify, plan, and implement interventions that reduce or eliminate this burden. This study aims to explore the perception of Afghan childbearing women about respectful materiality care during childbirth.

CASE SERIES

To identify, understand, and analyze the challenges and barriers that women face accessing healthcare services, a qualitative methodology was used. This approach was selected since it allows for rich information and provides the opportunity to listen to those who were rarely heard.[17] It helped in obtaining an insight into the lived experiences of women while seeking maternal health care. This study was conducted in one of the biggest maternity hospitals in Kabul, Afghanistan between June 2023 September 2023. This a national maternity hospital located in the capital of Afghanistan was selected because it is one of the most crowded hospitals with more than thousands of deliveries per week.[18]Participants are women of their reproductive ages (between 18 and 49) who have used maternal healthcare services in the selected hospital and have given birth during the last month before the interview. In Afghanistan, 9 women were recruited to be part of the study. Among them, 2 were from Ghazni Province who came to Kabul to give birth and 7 were from Kabul. Most of these women give birth for the second or third time. Two women gave for the first time and one woman with 13 births. These women were recruited from one of the national and most crowded gynecology hospitals in Kabul province. In Lebanon, we have recruited 10 participants who have given birth recently.

Before the study, approval was obtained from the Ministry of Public Health, followed by approval from the hospital management. Then selected gynaecologists were contacted through appointments to obtain their consent to approach their patients. After approval from hospital management and physicians, I approached women in the postpartum ward, gave a brief description of the study, and asked about their interest in being part of the study. Phone numbers and home addresses of the women interested in the study were noted in a private diary so that later on, I could contact the women one by one to know about the most convenient time and place to conduct the interview. No sensitive questions were asked in the postpartum ward, I only asked whether they were interested in being part of the study or not. Later I chose women using purposeful sampling for the interview. The purposeful sampling method means choosing your study participants intentionally since their experience, knowledge, and characteristics meet the study needs.[19] I called potential participants by phone to set an appointment for an interview at a time and place that was suitable for the woman. I obtained informed consent before conducting interviews. The interview took approximately 30 to 45 minutes. To ensure privacy, I asked for a private room and asked those present in the room to leave during the duration of the interview. The women were also the ones to set a suitable time for the interview. The interviews were set in the participants' homes as they had just given birth. In total, nine women were recruited to be part of the study. Thematic analysis was used considering its steps: familiarization with data, code generation, searching for themes, reviewing potential themes, defining and naming the themes, and producing the report.[20] Data collection has stopped after reaching saturation. The recordings obtained from each interview were transcribed. I read the interview many times and assigned codes to categorize the information. Themes were generated from these categories.

Outcomes

Nine women were selected to participate in the research, with two originating from Ghazni province who traveled

to Kabul for childbirth, and seven from Kabul itself. The majority of these women were experiencing their second or third childbirth. Additionally, two women were giving birth for the first time, while one woman had experienced childbirth 13 times. The results that have been generated from the data collected in Afghanistan are divided based on the classifications of disrespect and abuse in maternity care, informed by the literature.

Table 1: Study participants.

No	Participants	Province	Number of birth
1	Participant 1	Kabul	2
2	Participant 2	Kabul	3
3	Participant 3	Kabul	3
4	Participant 4	Kabul	2
5	Participant 5	Kabul	2
6	Participant 6	Kabul	3
7	Participant 7	Kabul	1
8	Participant 8	Ghazni	13
9	Participant 9	Ghazni	1

Theme one: Abuse (physical, verbal, and sexual/rapport between woman and medical staff)

Although accounts of sexual abuse were not reported, instances of verbal and physical abuse were found. Verbal abuse has mostly been linked to the rapport between the woman and the physician/the medical team. The experiences with communication were all negative. Verbal abuse is more pronounced in the form of insulting women like using bad language, screaming at her, making her feel down among other women, and not allowing her to ask questions. In some cases, there was no communication with the patient at all. Most of the women said they are also not talking with health care providers and asking them questions because of the fear of stigmatizing them as bad women in the hospital. "It was my first birth and I had very severe pain and bleeding.

I could not tolerate the pain which is why I started crying. The doctor came and laughed at me and told me you people are very shameless I know you will come next year again" a woman from Kabul. "I didn't know what was wrong with that doctor she suddenly came to me and started telling me is this the only hospital in the country? Why you people are not stopping giving birth, it's enough that you fill the country with addicts and Taliban. At that time, I had no idea what I did even though I did not even ask her any questions" A woman from Kabul. Instances of physical abuse were also reported. A woman coming from the south-eastern part of the country experienced physical abuse by hospital staff. She was harmed by a worker in the hospital before giving birth. She was pushed to the wall and as a result, she fell and started bleeding. "When I came to the hospital it was almost midnight and I had very severe pain I went to the doctor and asked for help. She even did not look at me and told me go you still have time. I could not sleep until morning because of the pain. In the morning, I went to another one and asked her to help me. When she looked at me, she told me your case is very serious we have to do a C-section. I went outside of the hospital to inform my mom and talk with her because I didn't have a mobile but one of the workers in the hospital who was next to the hospital door pushed me to the wall and screamed at me 'You are not allowed to bring your family member inside the hospital'. I fell and started bleeding and there was no one around me to help me or at least take my hand" a woman from Ghazni.

Theme two: Discrimination based on specific attributes/abandonment of care

The main factors that led to discrimination were the financial status and networks (who you know in the hospital). This was shown through giving money on the side, in an informal way. Discrimination based on ethnicity was not the main attribute that led to discrimination: money (or the lack of it) determined how well the women were treated. The common term for money in the hospital, which was paid to the physician or hospital team informally is called (SHERNEE) and the common term for personal networks is (WASETA). "SHERNEE" is the most common term used for money in hospitals which starts from 50 AFs to thousands of AFs. The care, services, attitude, and behavior of physicians and hospital staff, provider within the hospital are highly dependent on money or "SHERNEE". "Money makes childbirth very easy in the hospital" a woman from Kabul. "When you have money, the doctor becomes your family" a woman from Kabul. There was also a story of a woman who was asked directly for money through the hospital staff to bring her mother inside the hospital and provide her with special treatment. "I am from Kandahar province and my in-laws are living here; my husband went to Iran to find a job. My mom is a widow. Hardly we can afford two times meals. The doctor does not know my language and I do not know her language. I cannot explain my problem or my pain to her and it is almost 2 days that I did not eat proper food did not talk with anyone and did not change my diaper. I asked one of the hospital staff to call my mom, and she directly asked me for money. She told me to give me 500 AF then I will call your mom" a woman from Kandahar.

Discrimination based on the personal network (WASETA) was also addressed by the women in the hospital, and they emphasized the importance and role of (WASETA) in timely and respectful care and services. "You will be treated differently when you know someone in the hospital, they ask about your health several times, you will have your mom beside you, you will receive food timely, everyone respects you" a woman from Kabul. "My turn was given to another woman because she knows the doctor" a woman from Kabul.

Theme three: Non-consented care

Regarding non-consented care, the issue of decision-making and giving choices to the patients has been highlighted. Almost all of the received experiences towards consent care were negative. Women were not provided choices and they were not given the right to talk or were not involved in any kind of decision-making related to herself or her birth. In some cases, women were unfamiliar with the term of consent care and were unaware of having decision-making authority. "We are just like symbols (things), we don't have the right to talk" a woman from Kabul. "We are not allowed to talk, they usually make you feel like you don't know anything, when we ask questions they say (stay calm you know or Dr. knows)" a woman from Kabul.

Theme four: Non-dignified care

Dignified care has been perceived or defined by women as the care that treats women as human beings, rather than objects or things. Equity in services, kindness & compassion, emotional support, and carefulness (rather than carelessness) were perceived as dignified care. Women highlighted the significance of equity in the type of services between those who have money and WASETA and those who do not. "No money no respectful care, by money the hospital is yours" a woman from Kabul "If I was rich and had money I never come to this hospital, it was the worst experience of my life" a woman from Ghazni.

DISCUSSION

One aspect that should be highlighted about this study is that it was certainly difficult to generate experiences or stories from the women who had just given birth. It is quite difficult for women to speak out about their birth experiences either because of fear or because of the fact that they have normalized their experiences, as found in the literature. In Afghanistan where the women sometimes were reluctant to answer the team members' questions, especially because of all their bad experiences and the fear of being stigmatized and opinionated as bad women within the hospital. One woman even refused to give out any personal information about herself and her baby. As mentioned, and highlighted in the literature, women have been facing instances of disrespect and abuse while giving birth.[21] The results that have been generated by the interviews have been found to be consistent with the literature, as instances of disrespect and abuse have been identified. We have identified concepts of what constitutes of respectful maternity care, in their own way. These will be discussed in the framework of classifications of disrespect and abuse, as in the literature. When comparing with the literature, we can find that certain forms of abuse are consistent while others are inconsistent. Sexual abuse, for example, has not been highlighted as a major issue in the women's birth experiences. No instances of sexual abuse have been recorded. Therefore, one can conclude that sexual abuse is not applicable in Afghani contexts, or it has not been reported for specific reasons. However, when looking into verbal abuse, it was found that it is an occurring problem. One can notice, as mentioned in the literature, that verbal abuse is one of the most common forms of disrespect and abuse.[22] It has been shown that verbal abuse is highly interlinked with a poor rapport between the women giving birth and the medical staff, based on the data collected. Therefore, we can conclude that communication style is one of the main factors determining whether verbal abuse occurs or not. Therefore, these two classifications of disrespect and abuse cannot be separated from one another. However, the fact that determines whether verbal abuse occurs or not, based on the data collected in both countries, is the financial status of the patient. Simply put, it has been found that verbal abuse would not occur if the woman is of a high socioeconomic status i.e., she is fully covered, if she can give a little bit of money on the side. This can be interpreted through the fact that money can give the woman the privilege in being talked to in a respectful manner. Women have highlighted the importance of being talked to in a non-rude manner i.e. not being scolded, insulted, talked to as if they don't understand, not screaming at her, having eye contact with her while talking… and have stressed the importance of having the procedures explained in details. Leaving the woman clueless with no idea of what will happen to her body or her child can be seen as a form of verbal abuse.

When looking at the literature, abandonment or neglect of care has been seen to be consistent with the data that has been collected. Women have expressed that they constantly need the physician or medical staff to be available and responsive for their needs. In Afghanistan, it does not matter if she is Tajik, Pashto, or Hazara as long as she can pay an informal amount of money on the side "SHEERNE" or know someone in the hospital (Waseta) will be treated in a very respectful manner and received all the needed services. This discrimination based on personal networks (or "WASETA") has not been found in the literature but has been highlighted as an important concept for women when it comes to disrespect and abuse during childbirth in Afghanistan.

As highlighted in the literature, there are instances of physical abuse while giving birth.[22] From the collected information, physical abuse was reported. Again, it was highlighted that there was a direct link between the financial status of women and the attitude and behavior of physicians and hospital staff. The women who were able to pay money (SHERNEE) did not face any kind of abuse particularly physical ones; however, the case was different for those who were not able to pay.

This has been found to be of utmost importance to the women giving birth. This has been found to be consistent with the literature as giving choices and autonomy for the women is an important part of childbirth.[6,23] Mostly

women were unfamiliar with the terms of consent care since not having the right to talk and accepting what physicians and hospital staff decide on behalf of the woman and her baby was perceived as a normal process of childbirth. Women were never given choices and the authority of decision-making about their bodies and babies. Some women were aware of consent care but never asked for their right of decision-making and were able to make their own choices in fear that that doctor or medical team would perceive them as troublemakers and therefore would deny them care.

The concept of "dignity" and "dignified care" is vital which is consistent in the literature.[13] However, in the specific context of these two countries, (non-) dignified care has been seen to have a lot more dimensions. Equity in service was highlighted as one of the aspects of dignified care. They asked for equity in the type of services for those who are able to pay "SHERNEE" and have "Waseta" or those who cannot pay and do not have a personal network. Humane behavior and kindness were other main aspects of dignified care which was highly emphasized by women in Afghanistan. They want physicians and hospital staff to treat them like humans, not animals, and understand that women who are coming to this hospital and give birth are also human beings like them, they also have self-respect and most importantly, they also have feelings. Social support and having a companion were another issue, which was highlighted through women. Having someone with her in the hospital to take care of her and her baby and provide her emotional support was perceived as very important by women. Given that the data was collected from selected hospitals, the results cannot be generalizable to the entire country. For example, the data was collected from a public hospital and not a private hospital. Another limitation that the researcher has faced was the issue of time constraint. This might have affected the quality of our researcher. Issue of privacy in recruitment and interview of patients within the hospital, which could have affected the quality of obtained information. Issues of recording the interview was another limitation in the recruitment of women in Afghani context since most of the women thought it will be broadcast on any radio or TV.

CONCLUSION

In conclusion, in Afghanistan mothers and pregnant women suffer from various types of disrespect and abuse, which directly and negatively affect their decision to seek care in the future. Childbearing women mostly suffer from verbal and physical abuse, non-dignified, and consent care. Additionally, women are not given privacy during birth and they are being decimated based on their wealth and networking in the hospital. To decrease the maternal mortality rate in Afghanistan and promote facility-based childbirth more attention is needed to be paid to quality of care and patient experience. Some recommendations are, Provide regular training to health workers on proper communication with patients and person-centered approaches (compassion, respect, and protection of confidentiality and privacy). Place rewarding mechanisms for health workers who are reported by patients are being nice, delivering person-centered care, being respectful, etc. Establish feedback mechanisms in the hospitals for patients. More research and evidence from both patients and healthcare providers on RMC. Introduce person-centered care in academic institutions where health workers can familiarize themselves with its significance early on.

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