ANTHROPOLOGY Vienna Evaluation Unit MEDECINS SANS FRONTIERES

"TELL IT TO MY MOTHER-IN-LAW"

WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH, THEIR PERCEPTION OF AND ACCESS TO MATERNAL HEALTH CARE SERVICES IN KHOST PROVINCE, AFGHANISTAN

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Carrying out this study on women's sexual and reproductive health in Khost province, Afghanistan was an enormous experience for me. I was able to learn from the respondents in their social environment, which helped me to better understand women and their daily realities in relation to their health, pregnancy and childbirth.

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A researcher cannot give immediate assistance but I hope that the information I gathered and the conclusions I have drawn will enable us to strengthen our interventions in order to create a successful dialogue with the patients, caregivers, families and health staff to improve knowledge about and access to safe maternal health care services and to decrease maternal mortality.

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To all those who may continue to work in Afghanistan.

Cover picture: Family planning message painted on the wall of the male waiting area at Khost maternity. ©Doris Burtscher/MSF

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Executive summary

This report provides an analysis of women's sexual and reproductive health, their perception of and access to maternal health care services in Khost province, Afghanistan. MSF-OCB is focusing on women with direct obstetric complications to achieve a reduction in sexual and reproductive health related mortality and morbidity among the population of Khost province. The main objective of this study is to assess if there are additional factors that need to be included or changed in the Medical Strategy for 2016 and the Health Promotion Strategy for 2016 in order to reach the project objectives for 2016.

Specific objectives

The study set out to analyse patients' and caretakers' perceptions of MSF Khost maternity and the community's perception of the maternal health care services provided by Khost provincial hospital, comprehensive health centres, basic health centres, private clinics, MSF and other informal "services" by:

- Assessing the point of view of the communities of Matoon, Mando Zay and Gurbuz of the proposed referral system through participatory tools
- Exploring the different formal and informal communication channels, such as community health workers, volunteers of the Afghan Red Crescent Society, information agents from MSF, information agents from the community, TV and radio to sensitise the communities for danger signs during pregnancy and delivery
- Elaborating how women with danger signs during delivery can be referred timely to the MSF health structure
- Developing possibilities for the set-up of a data collection for a prospective maternal mortality study

Outcome

By achieving the specific objectives, the study assists the project team in adapting the **Medical Strategy for the Khost Maternity Project** in 2016 to implement its two key pillars:

1. Reducing the number of normal deliveries carried out in the hospital
2. Increasing the number of direct obstetric complications treated in the hospital

Methods

The whole study is based on qualitative research techniques. Fifty-nine interviews were conducted in total, thereof 50 in-depth individual interviews and 9 group discussions from 4 March to 6 April 2016. A total of 75 persons were talked to. One visit to the comprehensive health centre in Gurbuz and one visit to the Khost provincial hospital with some observation additionally fed into the analysis of the research questions. Respondents were selected with the help of MSF team members. All interviews except two were recorded. Transcriptions were screened for relevant information, manually coded and analysed, inspired by a qualitative content analysis. An extended literature review prior and after the field stay, as well as discussions with the field team in Khost, the coordination and HQ in Brussels further helped to validate the findings and to give recommendations.

Findings

In Khost province, **pregnant womens' health-seeking behaviour and their perception of danger signs during pregnancy and delivery were strongly connected to the Pashtun ethical and moral code**, Pashtunwali, which controls tribal life and determines traditional life style. Apart from that, health-seeking behaviour for delivery is influenced by a large number of factors. The decision where to go for delivery is taken by the pregnant woman's mother-in-law. She is the one who informs the elder men of the family, who then give their approval.

It is very challenging to refer women with danger signs during delivery to the MSF health structure in a timely manner. If women 'realise' that they have the so-called danger signs, it might already be too late to reach a health facility that can deal with them. It seems that many women still die because of bleeding during pregnancy or after delivery. Families who do not have the financial means or women who do not get the recognition and permission from their family-in-law are not able to go to any health facility and the woman will die. Another difficulty is that women feel shame (*sharam*) to talk about their health issues; culturally a woman is not allowed to express any (health) problems to her mother-in-law. Antenatal care is also not widespread and services are not very well used, so any direct obstetric complications during pregnancy might go without being noticed.

The options for delivery include the delivery at home, the private sector, MSF Khost maternity, comprehensive health centres and Khost provincial hospital.

For most of the respondents delivering at home is an emergency solution. The reasons include contractions starting at nighttime, distance to the next health facility, financial problems to go to a private clinic, the perception of the health facility as being inappropriate or in-laws telling the woman to deliver at home.

The biggest problem with private clinics is the rapid dispense of labour-inducing medication like oxytocin and misoprostol, which can be bought everywhere, even in the smallest village, and are given to every woman before or during labour. In general, it was difficult to assess the quality of the private sector as the services and professional support differed very much in the rural and urban context.

MSF Khost maternity is *the* place to go for the majority of respondents. At MSF Khost maternity people very much appreciate the high level of quality of free care in terms of medical quality, like drugs and medical services, human resources, location, security and safety. Everyone who knows MSF and who is able to reach it will come to deliver there regardless of any complications during pregnancy.

Comprehensive health centres are not an option. They are seen as inappropriate for women to deliver for many reasons, including opening hours, services provided, quality of care, sometimes corruption issues to missing electricity and antenatal care services not being convenient. There is no maternity, which means that the delivery room is inside the health centre and in some places separated from the male area only by a curtain. It is considered a big shame if men can hear the women scream during delivery.

Khost provincial hospital is only a solution for practical reasons. Everyone who can afford the transport and knows about the MSF maternity will try to reach it. No positive comments were made in the interviews and people were complaining about everything in this hospital.

Patients do not feel comfortable with MSF's referral system from Khost maternity to Khost provincial hospital and from the comprehensive health centres to MSF in case of direct obstetric complications because the quality in those facilities is worse than in the overcrowded MSF maternity.

The most important communication channels at community level to raise awareness for danger signs during pregnancy and delivery are the male elders of every village, the Imam of the mosque, schools and teachers, radio channels and community health workers.

The possibilities for the collection of data for a maternal mortality study are limited, since women are restricted in their mobility and access to houses is restricted. However, one option could be to connect MSF health promoters with the health shura supervisors.

Note: The findings in this report represent the opinions and subjective experiences of respondents who have already reached the MSF maternity in Khost. They do not stand for the general population of Khost province, as it was not possible to reach out to all the communities because of security constraints. Nevertheless data speaks for a reality that is characteristic for most of the people living in the area. Many women have reached the MSF maternity for the first time and had several deliveries at home or in another health facility before. People do not always speak for themselves but rather recount what happens in their direct social environment.

Key recommendations

The recommendations are categorised and presented in regard to the study objectives. They are to be understood as general recommendations to achieve an appropriate, suitable and practicable way to reach the objectives of the Medical Strategy for 2016.

Choosing a simple name for Khost maternity hospital

- ➔ Use a name for the hospital that is familiar and understood by the people at community level, such as 'without borders hospital'.

Timely referral of women with direct obstetric complications to Khost maternity

- ➔ Spread more knowledge and awareness about direct obstetric complications within the communities.
- ➔ Deliver health promotion activities directly to men and women (mothers-in-law and other female members).

Health promotion activities

- ➔ Give face-to-face health promotion and community sensitisation at different levels in the communities: to men in public places like schools and mosques; to women inside the houses, mainly targeting mothers-in-law.
- ➔ Communicate health messages via radio.

Improvements to the referral system

- ➔ Provide trained midwives, guarantee supervision of these midwives at Khost provincial hospital and facilitate all the other needed support or stop referring patients.
- ➔ Communicate the conditions of the referral system to the comprehensive health centres.
- ➔ Address health promotion messages to the private clinics, mainly in remote areas, to inform about danger signs and timely referral of their patients to Khost maternity. Make clear that there is no intention to compete.

Reducing normal deliveries at MSF Khost maternity

- ➔ Consider an extra facility supported by MSF that only covers normal deliveries or extend the capacities in MSF maternity with the risk of the number of deliveries further increasing.
- ➔ Continue supporting the comprehensive health centres with an acceptable solution for the 24/7 service, since the main challenge is the nighttime.

Abbreviations

ANC	antenatal care
APHI	Afghan Public Health Institute
BHC	basic health centre
BPHS	Basic Package of Health Services
CEmONC	comprehensive emergency obstetric and neonatal care
CHC	comprehensive health centre
CHW	community health worker
CHS	community health supervisor
CPP	country policy paper
CSO	Central Statistics Organisation
CT	caretaker
DOC	direct obstetric complications
ERB	Ethics Review Board
EPI	enlarged programme of immunisation
HC	health care
HP	health promoter
IIHMR	Indian Institute of Health Management Research
IMF	International Military Forces
IPD	inpatient department
KPH	Khost provincial hospital
LAMA	leaving against medical advice
MoPH	Ministry of Public Health
MD	medical doctor
MoU	memorandum of understanding
MSF	Médecins Sans Frontières
NGO	non-governmental organisation
OCA	Operational Centre Amsterdam
OCB	Operational Centre Brussels
OCP	Operational Centre Paris
SMOWR	The State of the World's Midwifery
SRH	sexual and reproductive health
TBA	traditional birth attendant
WHO	World Health Organisation

1 Introduction

1.1 Brief description of the historical background

Afghanistan is a country at war and not one in a war-like situation. It is so today and it has been like this since late 1979 when the Russian Army invaded the country.

As a nation state Afghanistan was created by King Ahmad Shah Durrani in 1747, when he unified the Afghan tribes. Afghanistan has always been prone to war; given its strategic location the country served as a buffer between the Persian, the Russian and the British Empire, hence during the 19th and 20th century, it was a battle ground for regional ambitions of the Russian and British empires, the so called 'Great Game'. Finally, it won independence from national British control in 1919.

In 1989 a defeated Russian army left the country; Moscow continued to support the communist government of Najeebullah until 1992; then the Mujahedeen entered Kabul and took over power. The country engaged in a brutal civil war. This crisis led to the formation of the northern Alliance and the Taliban movement of Mullah Omar. The crisis ended when the Taliban took control over the city in 1996. Until 2001 the Taliban government provided a period of relative tranquillity, achieved through a repressive and conservative rule of law. Following the 9/11 attacks and the 'refusal' of Mullah Omar to extradite Osama bin Laden, the US under George W. Bush invaded Afghanistan under the concept of 'war against terror'. In less than six weeks the Taliban were defeated and massacred. In December 2004 Hamid Karzai became the first 'democratically' elected president.

The frustration about the lack of reconstruction and development and the fact that the international military forces (IMF) relied on warlords to control some areas of the country had opened the door for a re-emerging of the Taliban. With the strong support of Pakistan, with their claims of justice and anti-corruption, the Taliban gained popular support, once again mainly amongst Pashto ethnic groups, which were suffering the most from the terror and their often brutal revenge towards previous Taliban supporters by the Northern groups.[1]

Political instability and insecurity continued to impede peace in Afghanistan, showing its magnitude in the exhausting and contentious election process of the new president. Results were only declared after a long period of stonewalling tactics. Finally the new president, a US-educated anthropologist, Ashraf Ghani was sworn in on 29 September 2014. In his inauguration speech he said, "We are tired of this war" and asked the Taliban and the Hezb-i-Islami to prepare for political negotiations.

After two years of presidency not much has changed and insecurity in the country remains a major constraint of MSF being more visible at community level. The bombing of the Kunduz trauma centre in October 2015 additionally hampered MSF's operationality and presence in this area.

1.1.1 Socio-demographic data

Afghanistan, officially the Islamic Republic of Afghanistan, is a landlocked country located in Central Asia and South Asia. It has a population of approximately 32 million people, making it the 42nd most populous country in the world. It is bordered by Pakistan in the south and east; Iran in the west;

[1] This introduction part is adapted from the MSF Country Policy Paper 2015, Afghanistan.

Turkmenistan, Uzbekistan, and Tajikistan in the north; and China in the far northeast. Its territory covers 652 000 km^2 making it the 41st largest country in the world.[2]

Due to its historical status as a country at crossroads, Afghanistan is a multi-ethnic society. The two main ethnic groups are the Pashtu (42%) in the south and southeast (Sunni Muslim and Pashtu speaking), the Tajik (27%) mainly in the northeast, north and west (Sunni Muslim, Dari speaking). Other important ethnic groups are the Turkmen ethnic groups (9%) in the north (Uzbek and Turkmen, who speak Uzbek or Turkmen, and are Sunni Muslim), Hazara (9%; an ethnic group with Asian roots living in the central region of Afghanistan, speaking Dari and being Shia Muslim). Sunni Muslim account for 80%, Shia Muslim for 19% and other confessions represent 1%. Outside these main divisions, the Afghan society is further fragmented into clans and sub-clans. One of the roots of the current conflict can be found in Afghanistan's complex ethnic and linguistic fault lines, which are dividing the country between competing political and armed factions.[3]

1.1.2 Health situation in Afghanistan

The country developed a framework of health services with universal free access at a very basic level during the USSR presence. Some health structures were built, mainly in urban centres. Until 2002 health services were only provided by hospitals and a few health structures, supported by NGOs (among them MSF) and the private sector. In 2002, the WHO started developing and implementing a functioning country-wide primary health care system, the 'Basic Package of Health Services' (BPHS). The Ministry of Public Health (MoPH) set the target of a 95% coverage to be achieved by 2015. Given the lack of capacity of the MoPH to run the health system, it was decided to subcontract the health services to private actors, meaning NGOs. Currently the MoPH manages most of the secondary and tertiary hospitals, while some are supported by donors or NGOs.

The health system is under-resourced (with 2.7 MDs and 4.6 other medical staff per 10 000 people and with 2025 people per hospital bed) and underfunded. Despite indicators that show an overall increased utilisation rate of health services from 1.2 consultations per person per year in 2010 to 1.6 consultations per person per year in 2012, the access to health care remains uneven between urban and rural areas and challenged by several factors such as security, difficult geographic terrain as well as financial barriers.[4]

In 2013, the ongoing war and its consequences continued to restrict people's access to quality medical services – in particular to specialist healthcare. Private clinics are unaffordable for most Afghans and many public hospitals are understaffed and overburdened. Many rural health clinics are dysfunctional, as qualified health staff has left the insecure areas and the supply of reliable drugs and medical materials is irregular or non-existent. Insecurity can also prevent entire communities from travelling to hospitals. Afghanistan has some of the worst health indicators in the world according to the World Health Organization and is still one of the riskiest places to be a pregnant woman or a young child. MSF focuses on ensuring better access to free, quality healthcare in some of the most conflict affected areas.

1.2 Background of MSF in Afghanistan

MSF has been present in Afghanistan since the 1980ies, throughout the civil war from 1992 to 1996 and during the Taliban years from 1996 to 2001. After a temporary evacuation following 9/11, MSF

[2] https://en.wikipedia.org/wiki/Afghanistan (accessed 17 May 2016)
[3] For more details see MSF CPP 2015, Afghanistan.
[4] Source Central Statistic office of Afghanistan, Health Information System report 2012.

re-entered Afghanistan with a strong emergency response in the North (Balkh, Sar-e-Pul, Baghlan, Takhar and Kunduz) and now continues its work in Bamyan, Badakshan, Kandahar, Badghis and Herat.

Following the killing of five MSF workers in Bhadgis in June 2004, all five sections closed their missions. In 2009 MSF returned to Afghanistan after heavy internal debates on the question of resuming operations. In order to gain access, MSF negotiated to first work in two MoPH-run hospitals, the District hospital in Ahmad Shah Baba, in District 12 in Kabul, and the provincial Boost Hospital in Lashkar Gah, Helmand province. After initial difficulties in identifying MSF's role and responsibilities, the patient loads in both projects kept on growing, resulting in remarkable acceptance by the population and goodwill from the authorities. In September 2011, MSF opened the trauma hospital in Kunduz province. In March 2012 the first baby was born in the maternity ward in Khost. At the beginning of October 2012, MSF-OCA took over Helmand under the management of MSF-OCB. On the 25 November 2014, MSF-OCP started its activities in Dasht-e-Barchi hospital in Kabul – a similar assignment as Ahmad Shah Baba hospital project. After the bombing of the MSF trauma centre in Kunduz on 3 October 2015 MSF had to close all services but is currently discussing and negotiating a re-opening of the hospital.

The added value of MSF in Afghanistan is growing year by year, not only due to the size of the operations, but also due to the principled nature of the work. The 2011 CPP quote still stands firmly that "MSF financial independence, single mandate medical humanitarian nature and extensive, positively perceived history in the country gives MSF a unique position to negotiate presence in areas that are no longer assumed to receive meaningful healthcare due to the conflict." MSF is in Afghanistan to primarily address the medical needs of populations caused by the armed conflict and the consequent lack of health care.

Secondary health care is best provided in referral hospitals (at district level or above), often located in populated areas, in provincial capitals, which means that MSF is working in government-controlled areas. Today all four projects are located in government-controlled cities, while the most affected populations are mainly located in conflict/non-governmental areas.

1.2.1 MSF's history in Khost

This project is the first big MSF project in Khost Province. However, in the 1980s MSF worked in the historical and cultural Loya Paktia region comprising Paktya, Paktika and Khost. In the early 1980s, MSF did some outreach activities, ran a hospital and conducted vaccination campaigns in the winter. During this period MSF was unable to work in Khost city as it was under Russian/Afghan Army control. Much of the work was possible thanks to the support (and protection) of Jalaluddin Haqqani, who regularly intervened to resolve issues when discussions with local Mujahedeen leaders became endless. In 1982 MSF launched a vaccination campaign against Tuberculosis, which was very well accepted. In 1983 MSF stopped the programmes in Khost, amongst others, to focus more on remote areas where people did not have easy access to healthcare, while still conducting vaccination campaigns (maternal and infantile) as well as iodine distribution in Khost from 1986 to 1989.[5]

Khost province is situated in the east of Afghanistan and is surrounded by Paktia province (north west), Pakistan's Kurram Agency (north east), Paktika province (south west) and Pakistan's North Waziristan agency (south east). The capital of the Province, Khost city, is located about 150 kilometres south east of Kabul, 100 kilometres from Gardez (Paktia province) over the Kabul road, a one-hour drive from Kurram and a two-hour drive from North Waziristan Agencies in

[5] For more details see MSF Khost project document 2016, Afghanistan.

Pakistan. The province is composed of 13 districts (Bak, Gurbuz, Jaji Maydan, Matun, Mando Zayi, Musa Khel, Nadir Shah Kot, Qalandar, Sabari, Shamal, Spera, Tani, Tere Zayi).

1.2.2 Major outlines of medical activities in Khost

May 2011: MSF reached an agreement with Khost Governor and the provincial MoPH to use the former military hospital compound and started construction activities.
March 2012: The maternity ward opened, but closed after only six weeks following a security incident (bomb blast inside the compound).
December 2012: Medical activities were resumed and reached a volume close to maximum capacity during 2013.
2013: The decision was made to focus on complicated deliveries, relying on a referral system from some CHC to MSF and from MSF to the provincial hospital. This process was embedded by a Memorandum of Understanding (MoU) between the Provincial Health Directorate, the Health-Net-TPO and MSF on 3 December 2013.
2014: Training for the identified HC staff was conducted. (MSF needed to export its capacity and reduce volumes in the maternity ward, so as to concentrate on complicated cases).
2015: Focus was put on bringing the project back to its original objective: providing care to women suffering from Direct Obstetric Complications (DOC) in Khost Province. While this objective was only partially achieved, the total number of deliveries kept increasing, thus resulting in a congested hospital and in a lower quality of care than expected.

Fig. 1 Patients' and CT entrance to Khost maternity hospital

Fig. 2 Hospital entrance, Khost maternity hospital

1.2.3 Population

At the beginning of the project intervention, the population in the province was estimated at 551 245 (Department of Statistics, Khost Province 2010), of which 131 500 lived in Khost city. However, the Ministry of Economy also confirmed the updated estimated population figures, provided by the Governor's office in May 2013, at 1 002 563 inhabitants. Extensive research and information gathering by different stakeholders indicated that MSF was under-estimating the population at 1 000 000 and coordination in Khost concluded an estimated population in Khost Province at **1 679 950** in March 2016.[6] This number was not said to be approved but a more accurate population figure could help MSF understand why admissions were increasing and should help predict future trends and take appropriate measures.

[6] For more details see the population figures doc from Khost coordination.

Households consist of seven to ten members on average; the extended family can have up to 50 members. The population is mainly composed of six Pashtun tribes: Khostwal, Mangal, Gurbuz, Zadran, Sabari, Tani and sub-divided in 17 tribal/ethnic majorities. The ethnical composition of the society has a strong reference to Pashtunwali or the Pashtun customary law. The majority (99%) are Sunni Muslims who speak Pashto. Kuchi tribe (nomads) counts for around 75 000 to 150 000 inhabitants that transit in and out of Khost depending of their commercial/agricultural income, generating activities and seasonal weather changes. It is said that around 25% are settled in Khost while 75% are migratory and wintering mostly in Khost.

1.2.4 The Pashtuns

Afghans are said to be naturally conservative people and deeply religious. Their independence comes from the harshness of the country, where cultivable land is rare and the difficulties of the terrain have promoted self-reliance and inhibited the formation of strong central governments. As a result, power has devolved down to the tribe, village and – central to Afghan life – the family. The household and the mosque are the cornerstones of community.[7]

Pashtuns, the largest ethnic group in Afghanistan, are considered to be the most conservative population. *Kuchi*, an Afghan Persian word meaning 'those who go on migrations', is the term used for nomads. They are also a Pashtun tribe and have suffered greatly in recent years, losing much of their livestock to droughts, coupled with effects of land mines on traditional grazing grounds.

Pashtunwali

The Pashtun ethical and moral code, Pashtunwali, controls tribal life and determines traditional life style. It is so essential to the identity of a Pashtun that there is no distinction between practicing Pashtunwali and being a Pashtun. Its key concepts are *melmestia* (hospitality), *nang* (honour) and *sharam* (shame), *purdah* (gender boundaries) and the council of elders, the *jirga*.

Hospitality, ***melmestia***, must be offered to any visitor without expectation of reward. This can go as far as offering sanctuary to a criminal, and laying down one's life for a guest. A famous example showed the magnitude of Pashtunwali when Mullah Omar rejected requests to hand over Bin Laden.

Gender boundaries and gender segregation, the so-called ***purdah***, means physical boundary between men and women. The honour element, ***nang,*** is related to gender boundaries, "(…) if someone offends the rules of the gendered order, then there is reason to act in defence of one's honour." Men may interpret gender boundaries as ´defence of the honour of women´ and may use these boundaries as a way of controlling women. A woman's father, brother, husband and her son are responsible for her behaving according to the code of honour. If a woman earns a bad reputation, it will disgrace her entire family. A Pasthun proverb says: "The loss of women's honour cannot be compensated", meaning that dishonour caused to or by women due to rape, adultery or elopement cannot be restored. Slight sexual misconduct by a woman outside of marriage can lead to severe consequences, not only for her but also for the whole family as such an act is taken as a severe threat to the honour of the family (Sanauddin 2015:141). Spaces where men and women are mixed increase the chances of dishonour. Therefore, women have restricted freedom and are often not allowed to go outside alone. Even if parents want to send their daughters to school, it is socially unacceptable to leave the house for education. Parents are often very afraid of their daughters losing their honour if behaving inappropriately in the eyes of the community and thereby bringing

[7] Lonley Planet, 2007:41.

shame to the family. A girl can easily lose her honour due to harassment or by being exposed to 'modern views' such as non-arranged marriages and pre-marital sexual activity.

Jirga is an assembly of tribal elders called for various purposes; it plays an important and constructive role in solving tribal matters. The elders get together and hold a meeting in a *hujra*[8] near by the mosque or under the shade of a tree. The *jirga* usually deals with inter-tribal affairs; they bring both sides together asking questions and decide on the basis of available evidence.

Special attention needs to be paid to the code of honour or ***sharam*** (shame) that includes the disrespect of women, family, relation, community, ethnicity, nationality and culture. While masculinity is judged by a man's honour, femininity is judged by the concepts of *haya* (modesty) and *sharam* (shame), which summarize the ideal virtues of femininity of Pashtun culture (Sanauddin 2015). Women in the presence of men exhibit *sharam* by silence, subservience, and obedience, by asking no questions, lowering their eyes, refraining from eating until after the men are done and sitting on a lower level. Hence, men's honour lies in women's shame and modesty (Grima 1992).

Honour and shame prevail over any other ethical code; they are interrelated with all the key concepts of Pashtunwali. In the conversations with caretakers, patients, midwives and others it was observed and understood that shame lies like a mist over every individual. While its comprehension for men is symbolically, for women shame materialises its virtue in the hijab and the burqa. This concept has to be looked at as it plays a role in the recognition and communication of health problems and danger signs[9] during pregnancy. In the majority of conversations it was said that a woman cannot talk to her mother-in-law about her health problems and her health condition yet the pregnancy itself is a state of shame. She can discuss and talk about it with her husband but because of the 'shamefulness' of the subject, he is morally also not allowed to address these issues to his mother. To overcome such codes of conduct women try to convey their problems to a third person that does not have these rigid behavioural restrictions in talking to the mother-in-law. This could be another woman in the same household or another female relative of the mother-in-law. It is a way to bring up a sensitive matter without being held responsible for the statement or risking shame or embarrassment. It was often mentioned that mothers-in-law do not take the problems of their daughters-in-law seriously and consider them as weak and complaining. We will come back on this issue in the chapter on health seeking behaviour.

Family

Traditionally the clans live in a joint family system, which means that married sons live with their parents in one household. Women move to their husbands' places and live with their family-in-law. In most cases the extended family forms a social unity that not only lives together but also supports and most importantly protects each other.

Like in many other countries in the region the preference for boys is widespread among Pashtuns. Giving birth to a boy is more rewarding than bearing a girl. This can be observed during deliveries in the hospital. Also, giving birth to a girl provokes men and sometimes their mothers-in-law to beat the woman when she has only given birth to girls before. Some women abandon their baby girl to avoid disappointment in their family-in-law.

The two major reasons for preferring sons over daughters are of economic and social nature. Sons can assist in agricultural production, earn wages and entail security. Additionally, derived from the

[8] A hujra is the place where tribal elders meet for assemblies.

[9] The expression 'danger signs' is used to refer to direct obstetric complications and will be used throughout the report in alteration.

kinship and descent system, sons provide the family with social status and strength. In Khost province the preference for boys was mainly explained by giving strength and security to the family in an insecure environment. Furthermore, sons would guarantee inheritance of land and its defense, like one woman explained, "If you have more man, it means you have more power in our country."[10]

Additionally, daughters need to be taken care of when they reach adolescence, because chastity is considered crucial in terms of her marriage and to protect the honour of the family. Since girls only stay in the family for a short time, investment in them is considered a waste.

Marriage

The practice of arranged marriage affects both men and women, but women are much more likely to be married without their consent. A number of proverbs advise men when and whom to marry, but no proverb guides women when and whom to marry. This is because Pashtun women do not marry in the active sense of the term; they are ʿmarried offʻ or ʿgiven in marriageʻ (Sanauddin 2015).[11] Early and arranged marriages are still common among Pashtuns. While earlier marriages prevail within the rural population with a low education level of women, arranged marriages are widespread in the whole province. "When the girl is adult, she belongs to the son-in-law (should be married)" says a Pashtun proverb. This proverb not only illustrates the idea that a girl should be protected through marriage but also her inferior status within the matrimony. The purpose of early marriage is to channel girls' sexuality into the culturally approved marriage. Women are considered weak and uncontrolled and thereby in need of control by men (Grima 1992).

Girls become engaged when they get their menstruation. This can be at the age of 12, 13 or 14. In most of the cases they will be married when they get 16 or 17. Some respondents stressed the fact that nowadays girls are married off earlier because "time has changed", meaning that marriage will protect them from any disgrace regarding their honour. The dowry may range from 600 000 rupees (5700$) to 1 Mio (9000$).

A number of unmarried young respondents emphasized that they would prefer not to be married as they feared family life with the husband and the family-in-law. Not getting married is desirable for many women at first, because they remain with their mother in the security of their natal home, but when their parents die unmarried women endure fights and submission to their brothers' wives, who are often hostile (Grima 1992). Marriage is mainly arranged within the same clan/kin group and is often between cross cousins. Girls are given to 'unseen' men (men they have not seen before) and in their powerless situation remain silent on the day of their marriage. This is well captured in the following proverb: "A bride's silence is her consent".

A women's 'muteness' starts with her marriage. Limitations of movements and restrictions on behaviour become more severe. The moral codes of honour and shame apply more than ever.

The young women do not get any formal preparation for their wedding; mainly their fathers and mothers will advise them how to behave with their husbands and families-in-law; everything she does wrong will fall back to her family.

According to Islamic law, men can have up to four wives. Even though polygamy is not widespread and most men live with one wife. Only in cases where the first wife does not get pregnant at all or only gave birth to daughters the husband will marry another woman, often pushed by his mother.

[10] I 28: midwife, 24y

[11] For more information read http://theses.gla.ac.uk/6243/ (accessed 22 May 2016).

Many men and often their mothers as well blame the women for giving birth to daughters. These women are considered 'bad' women or wives. It was also mentioned in numerous interviews that the man is not allowed to show love for his wife and, even worse, that it is widespread and accepted to beat the wife.

Pregnancy

Pashtun women fit into the idea of emotions as learned, gender specific behaviour. Events in a woman's life are interpreted as sorrow and sadness. Usually women construct their life story as a series of sorrow. Male life begins with the shooting of guns, cries of joy, days of visiting and congratulations and gift bearing to the mother. Female life opens with a sigh or even tears. The birth of a daughter is classified as sadness and a girl may even be referred to as a shame for her family (Grima 1992).

Pregnancy is usually an event of joy and happiness but in many settings pregnancy is accompanied by depressing social dynamics and life-threatening circumstances. It could be a normal healthy state that most women aspire to at some point in their lives. Yet this normal life-affirming process carries with it serious risks of death and disability (Berg 2001).

1.2.5 MSF Khost maternity – operational strategy

After 30 years of war, health care in Khost remains affected by the conflict. MSF needs to continue addressing the specific acute needs of women and newborns, as initially identified by MoPH and the communities, since they are most excluded from the emergency health care.

Sexual and Reproductive Health (SRH) remains a priority part of operation because in this area of high density and acute needs statistically 460 women within 100 000 live births are likely to die (WHO 2008) or 327 according to UNFPA [12] and the mortality survey of 2010.[13]

Project objectives

General objective: Sexual and reproductive health related mortality and morbidity are reduced in Khost province.

Specific objective: The target population of Khost province (1 002 563 inhabitants)[14] makes use of the (qualitative and accessible) sexual and reproductive curative health services provided by the MSF maternity.

To achieve a reduction in SRH related mortality and morbidity in Khost province, the project will focus on women with direct obstetric complications. In 2014 and in 2015 an attempt to increase referrals of complicated cases from CHCs to MSF maternity was implemented through an in-house one-week training for the midwives of four CHCs, but the results were not as expected. The number of DOCs remained stable at around 9% of the total deliveries. In 2016, this strategy will be revised by increasing health promotion activities and the support of district CHCs through outreach activities thanks to the involvement of MSF national staff.[15]

[12] http://afghanistan.unfpa.org/topics/sexual-reproductive-health-3 (accessed 20 May 2016)
[13] APHI/MoPH et al 2010.
[14] Estimated population figure at project proposal.
[15] For more details see the Khost Project document 2016.

1.3 Rationale for the anthropological study

The MSF maternity hospital had an important impact on reducing morbidity and mortality providing access to CEmONC for women with severe complications. Nevertheless MSF needs to re-adapt the strategy of the project, since more deliveries without complications and less DOCs attended the maternity ward. The strategy, partly implemented in 2015, to have access to referrals of complicated pregnancies and related emergencies coming from the districts' CHC did not provide the expected results, and therefore needs to be revised in 2016.

In 2016, the medical strategy for the Khost Maternity Project, is based on two main pillars:

1. Reducing the number of normal deliveries carried out in the hospital
2. Increasing the number of direct obstetric complications treated in the hospital

In August 2015 two FGDs were organized with male caretakers (25 persons in total). It became clear that at community level people are neither aware of the referral system nor of the collaboration between MSF and KPH (and the CHCs) or danger signs during pregnancy and delivery.

Therefore, a socio-cultural assessment of the context in Khost is needed in order to ensure a successful strategy at medical level and at the level of health promotion.

Based on the results of the anthropological study, it will be assessed if there are additional factors that need to be included or changed in the Medical Strategy/HP Strategy for 2016.

2 Objectives of the study

2.1 General objective

Assess if there are additional factors that need to be included or changed in the Medical Strategy for 2016 and the Health Promotion Strategy for 2016 in order to reach the project objectives for 2016.

2.2 Specific objectives

1. Assess the perceptions of patients/caretakers inside MSF Khost maternity and of the community on maternal health care services provided by KPH/CHCs/BHCs/Private Clinics/MSF/other informal "services" (at home, Mullah, etc.)
2. Assess the communities' (Matoon, Mando Zay[16] and Gurbuz) point of view of the proposed referral system through participatory tools.
3. Assess the different formal and informal communication channels (CHWs, volunteers of the Afghan Red Crescent Society, information agents from MSF, information agents from the community, TV, radio, etc.) to raise awareness for danger signs during pregnancy and delivery.
4. Assess how women with danger signs during delivery can be referred timely to the MSF health structure.
5. Assess possibilities for the set-up of a data collection for a prospective maternal mortality study.

2.3 Outcome

To assist the project team on how the two main pillars for the medical strategy for the Khost Maternity Project in 2016 could be achieved.

1. Reducing the number of normal deliveries carried out in the hospital
2. Increasing the number of direct obstetric complications (DOCs) treated in the hospital

[16] During the field stay Mando Zayi was replaced by Nadir Shah Khot.

3 Methods

3.1 Study setting

This qualitative study was conducted in Khost province between 4 March and 7 April 2016.[17] The study population for the in-depth interviews was a subset of patients (female only), caretakers (male and female), midwives and doctors (gynaecologists) as well as health promoters, cleaners and some other individuals attending the MSF maternity in Khost. Additionally, members of the health shura[18] of three different districts and community health workers from several districts were invited to the MSF office (see Table 1: Target groups for a detailed list of respondents). One visit to the CHC in Gurbuz and one visit to the KPH were possible in spite of the tight security situation.

3.2 Study design

This study is based on in depth-interviews to understand the challenges of pregnant women in Khost province. The study followed a qualitative research design. Its aim requires an exploratory approach (Pope & Mays, 2006) to understand health-seeking behaviour of pregnant women and their families, the decision making process and influencing factors in Khost province.

A flexible participatory technique was applied, i.e. the researcher gathered data using non-participant observation, field notes as well as in-depth interviews guided by topic-led questions. The questions were based on themes relevant to the research question and the literature research appraisal. Following standard qualitative interview procedures, the order of questions was driven by the nature of each participant's answers, which means that both the wording and the order of questions were likely to be modified.

With a few participants, mainly the ones who were invited from 'outside' to the MSF office, group interviews were conducted. In almost all encounters an individual interview would have been more appropriate as Pashtun people and mainly men cannot talk about certain topics in front of others. Since these respondents came many miles we could not ask them to wait until it was their turn and had to question them together. In a few occasions the group interview happened naturally.[19]

A triangulation of findings was undertaken to enhance the interpretation of data. Triangulation enables an accurate representation of reality through use of multiple methods or perspectives for data collection (Brikci, 2007). For this study a methodological triangulation was used; in-depth individual interviews were combined with group discussions, non-participant observations and documents.

The qualitative study team consisted of the principal investigator, a medical anthropologist, a male and a female translator and a study assistant for the transcription of the interviews.

3.3 Study sampling

59 Interviews were conducted in total; 50 in-depth individual Interviews and 9 group discussions with a total of 75 persons that were talked to. A purposive sampling technique was applied. The

[17] Please refer to the anthropologists' work programme in the Annex.
[18] A shura is a process of decision-making by consultation and deliberation.
[19] Please refer to the interviewee's profile list in the Annex.

sample size of purposive sampling is determined by the notion of saturation. Based on this logic the sample size cannot be planned beforehand. Categories for the choice of participants for the study included age, sex, education level, occupation, geographical location, patient in the MSF maternity ward, working at the MSF maternity ward and participants not related to MSF. All interviewed individuals were asked beforehand if they agreed to an interview and where they preferred to be interviewed. Interviews with female patients and caretakers were organised through the translators in the different wards of the hospital and in the male and female waiting areas for caretakers. Interviews with invited respondents were done either in the MSF office or in the male waiting area.

Respondent characteristics	**Total interviewees = 75; n**
MSF hospital	
Patients female	3
Caretakers female/traditional birth attendants	14
Caretakers male	9
Gynaecologists	2
Midwives	7
Lab Tech male	1
Sterilizer male	2
MSF Ambulance driver	1
Cleaner female	3
Cleaner male	3
Health promoters female	3
Health promoter male	1
Medical translator	1
Non-MSF related	
Doctor male	1
Gynaecologist	2
Midwives KPH/CHC/BHC	6
Lab Tech private sector	1
CHW male	6
CHW female	2
Psychosocial support male	1
Psychosocial support female	1
Mullah	1
Health Shura	3
Shop keeper	1

Table 1: Target groups

Respondent characteristics	**Total interviewees = 75; n**
Age	
Younger than 35	37
Older than 35	38
Gender	
Male	31
Female	44
Education	
educated	49
uneducated	26
Geographical location of respondents	
Khost Matun	**20**
Mando Zayi	9
Nadir Shah Khot	2

Gurbuz	2
Tani	5
Spera	2
Shamal	4
Qalandar	1
Musah Khel	7
Sabari	0
Bak	6
Tere Zayi	6
Jaji Maydan	1
Other	4

Table 2: Respondent characteristics

Interview type	**Total interviews = 59; n**
Individual interview	50
Group Interview	9

Table 3: Interview characteristics

3.3.1 Interviews

In-depth individual interviews were conducted for data collection related to sexual and reproductive health care of women and their families and the choice where to go for delivery. This qualitative method provides an emic perspective of people who are confronted and deal with SRH issues, be it the families or health care providers. Specific aspects related to the research question were explored through semi-structured interviews. In this case the researcher followed a topic guide of open-ended questions. These were structured to build trust and rapport, encourage openness and honesty of respondents, with more emotive questions coming later on in the interview. This topic guide was held flexible to avoid the conversation taking on a 'vertical' nature. The researcher followed up on the answers and information the interviewees gave.

3.3.2 Participant observation

Observations were carried out as part of the data collection. Participant observation is a crucial qualitative method as it gives an account of what people say and what they actually do (Burgess 1984). It is therefore an essential method in combination with interviews.

Participant observation allows the researcher to learn about details that the participants themselves would not come up with during the interview. This is the case when interviewees do not consider information as worth speaking about or essential for the context. Thus, the strength of this method is that it gives an account of the "mundane and unremarkable features of everyday life" (Green and Thorogood 2004:148). To give an example, at the hospital the researcher could observe conversations and behaviours among patients, feelings of patients when receiving treatment, caring for the new-born baby, women feeding their new-borns in the neonatology, communication between patients and health care providers, women's behaviour during delivery, reception of women in the hospital entrance and participation during HP sessions in the admission rooms, etc. Nevertheless, in some situations it was experienced that the presence of the interview team influenced the setting in the sense that people deviated from their 'normal' practices due to the presence of an 'outsider' who was conducting the study (Burgess 1984). For example, the midwives were showing a friendly attitude towards the patients and caretakers in the hospital entrance when they saw us. This behaviour was in contrast to what caretakers sometimes described in the interviews.

3.4 Data management and analysis

The crucial first step was to fully transcribe all interviews and notes taken during the observations. Data has been stored without any information identifying the respondents and is only accessible to the principal investigator. The two translators and the research assistants who transcribed the recorded interviews signed a confidentiality agreement. At the end of the transcription process all data was deleted from the assistants' computers and was stored only on the principal investigator's computer.

The manual analysis of the interviews was inspired by the qualitative content analysis of Mayring (2010): Transcriptions were screened for relevant information, which was then organised, coded, categorised and interpreted. This implies reducing the material to only those passages essential for the work and to generalise the statements. A category (label) was attached to the statements in order to structure the data (Mayring 2010:67f). The content was analysed in two ways: descriptively (describing data without reading anything into it) and interpretively (focusing on what might be meant by the responses) (Hancock 2002:17).

The empirical data was analysed in an inductive and a deductive way. This means that categories/codes were mainly generated on the basis of collected data. However, codes were also developed based on anthropological theory known prior to the research. Anthropological theoretical concepts that may appear as a code could, for example, be decision-making process for health seeking behaviour, body concepts and health-seeking behaviour etc.[20]

Continuous reflection on data is part of the creative process of analysis and necessary for contextualising and linking findings with anthropological theory. To follow the principles of good practice, the research process is clearly described in this report; validity of data is therefore ensured by a 'thick' description[21] of the research context and also by presenting deviant cases.

3.5 Study limitations

This short-term study is designed to provide answers to current operational questions. Gathered data will not amount to long-term or multi-sited anthropological fieldwork.[22]

One limitation of this study might have been that the study team was restricted to the hospital premises and could not conduct interviews in the communities in order to better understand living conditions of patients and caregivers and to have a more neutral stance. The study team was connected to the MSF network. This bias was balanced by carefully explaining the role of the anthropologist and her neutrality and strict assurance of anonymity and confidentiality. Another limiting element of data collection was the fact that the team had to ask the MSF staff members to find key informants for the interviews.

Working with translators can also be limiting since the quality of the translation depends very much on the translators' soft and hard skills. This limitation was reduced to a minimum as both translators transcribed the interviews they had done and double-checked the translation while transcribing.

[20] See Munro et al. (2007)

[21] Originating from Geertz (1973), a 'thick' description of human behaviour is one that not only explains the behaviour but also its context, so that the behaviour becomes meaningful to an outsider.

[22] Multi-sited fieldwork takes a comparative approach and studies phenomena at different sites and time periods.

Finally, qualitative data is not a reflection of reality but always influenced by the presence of the researcher at the field site. In addition, the background of the researcher (gender, age, social status, origin etc.) will shape the research process. The researcher is well aware of this characteristic and therefore took a critical stance towards her position in the data gathering process and while analysing the findings.

4 Ethical aspects

No official ethical approval was thought for this study. Nevertheless essential and crucial ethical issues were taken into consideration.

The in-depth interviews covered quite a few sensitive topics that might have prompted negative feelings such as shame or anxiety with the participants. Therefore, the primary investigator and her team assured that interview techniques for sensitive subjects were applied and the feelings of interviewees were considered in whatever way they appeared.

It was guaranteed that participants' confidentiality would be respected and all data obtained through in-depth interviews were anonymised and stored on password-protected computers without inclusion of personal identifiers such as names.

Verbatim quotations in dissemination materials like this report are designated by the interview number, age, sex and category of participant (e.g. male caretaker, aged 45 or midwife, aged 25).

Interviews were tape-recorded when the respondent gave permission, which was obtained in all but two of the conversations. Additionally, the primary investigator took notes after the interview. Informed consent was obtained verbally. Each respondent was assured of the confidentiality and privacy of the interview and informed that s/he is free to stop the interview at any time or refuse to answer any questions.

For the group discussions, informed consent was also obtained verbally. The translator introduced the aim and objective of the study. Participants were advised that they are free to leave the group at any time and can choose their level of participation throughout the session.

5 Major findings

This report provides an analysis of women's sexual and reproductive health, their perception of and access to maternal health care services in Khost province, Afghanistan. The major findings will help to answer the following questions: What is the state of pregnancy in Pashtun society? How do women, caretakers and their families decide where to go for delivery? Which factors influence a decision and when is the decision taken? What does it mean in practical reality? What do people know about danger signs during pregnancy and how do they deal with them? How do they recognise access to health care? Why do they come to Khost maternity hospital and how do they perceive this health care facility and its services? How do patients and caretakers perceive other maternal health care services provided by KPH, CHCs, BHCs and in the private and informal sector? What are the communication channels in the communities for HP activities? What is the best way to set up a data collection tool for a maternal mortality study?

In this project MSF-OCB is focusing on women with direct obstetric complications in order to achieve a reduction in sexual and reproductive health related mortality and morbidity among the population of Khost province. The main objective of this study is to assess if there are additional factors that need to be included or changed in the Medical Strategy for 2016 and the Health Promotion Strategy for 2016 in order to reach the project objectives for 2016.

Since all the gathered information is analysed from the perspective of patients, caregivers and health care providers, the results will be presented according to these different understandings. The findings are underlined with quotations to give the voice to the people that were interviewed during the field stay.

This study will help to better adapt MSF's and MoPH's interventions to the needs of the population. The main question of how to provide best quality of care to pregnant women is to be answered and translated into appropriate actions. In this sense the study not only benefits MSF's and MoPH's operations but also encourages discussions on decision makers' level regarding maternal health services and their quality.

5.1 A pregnant woman's state

Maternal mortality accompanies the fears of pregnancy in the context of the Pashtun society. Additionally, a first pregnancy is a traumatising experience for a young woman. She has no power over her body, sex takes place when the man desires and wants it. Pregnancy is expected within the first months of the marriage and mothers-in-law have control over their daughters-in-law by counting their menstruation days and observing if they are still praying, since Muslim women do not pray during menstruation.

> "My mother in law was following me, and she followed my menstruation.
> And how did you know that you are pregnant?
> She is asking that you are praying or not.
> I was not pregnant up to the 8th months.
> But the mother-in-law was asking you?
> Yes, she is counting the days; it means the mother in law is counting the days for the menstruation.
> And what was she saying to you?
> My mother in law told me what is going on with you, you are not an old women and you also get the menstruation on time, so why you can't get pregnant."[23]

[23] I 17: patient, 22y, delivered twins

Women are only of value as mothers and wives but not as an individual. And the more boys they give birth to, the greater value they earn inside the family. In this regard women have to bear enormous pressure.

When a woman gets pregnant, she usually[24] does not tell it to anyone but her husband. Pregnancy is a state of shame because it is the result of sexual intercourse. A young woman's pregnancy can proceed unnoticed by the members of her family-in-law. If the new bride in the family is not under constant observation of her mother-in-law, the family will recognize her pregnant state only when she gets into labour. This factor greatly influences health-seeking behaviour for deliveries and access to health care in case of complications.

> "First pregnancy they are shy and cannot say it to their mothers-in-law and husbands. They will not go to doctor and ANC they will deliver at home, nobody will know that they are pregnant."[25]
>
> "Sometimes they can't say to anyone that this is my time of delivery (contractions), because they are shy. "[26]
>
> "But most of them are shy. If they have any danger signs they are not saying. When she becomes worse and worse than they say. If she becomes bleeding she will not say. If she has lots of bleeding than maybe she will say."[27]
>
> "Some of them are shying they are trying to hide the pregnancy, some of them are telling the pregnancy to the mother-in-law or to the sister-in-law. I was also shy when I was first pregnant; when I delivered then I tried to hide the children from my father, I was hiding my daughter from my father. I was feeling shame so much. Some women nowadays they show their babies to the others and say look this is my baby. The past people were feeling shy more, but nowadays the people don't feel shy more, we are Pashtun. From mother and father they are shying more because mother and father will say she slept with her husband and now she has a baby."[28]

During pregnancy sexual intercourse is not prohibited and the couple can have sexual relations until the eighth or ninth month. Also during breastfeeding no restrictions are put on the couple.

5.2 Health-seeking behaviour of pregnant women in Khost province

Health-seeking behaviour for delivery is influenced by a large number of factors apart from knowledge and awareness of danger signs. Among different populations, this behaviour, particularly in the rural communities, is a complex outcome of many factors operating on individual, family and community levels including their socio-cultural background, their past experiences with the health services, influences on community level, the availability of (alternative) health care providers including traditional birth attendants, security and the restrictions on moving freely and their perceptions regarding efficiency and the quality of services.

5.2.1 General considerations

The decision where to go for delivery is taken by the pregnant woman's mother-in-law. She is the one who informs the elder men of the family, who then give their approval. Most respondents said it is the elder men in the family, but in reality it is the mother-in-law who has the control over the daughter-in-law and makes the decisions.

[24] In some cases younger women talk to their mothers-in-law but in many cases they don't.
[25] I 25: MSF staff female, 21y
[26] I 28: midwife, 24y
[27] I 29: MD, 27y
[28] I 33: female CT, 50y

The HSB very much depends on the financial situation of the family, where the family in the mountains live) and where they are coming from (district). The main factors that influence the decision are distance, time when the contractions start (e.g. night time), recognition of problems and danger signs, transport issues and also security.

> "Transport is the biggest problem, no roads, no transport, no cars, no security, no money."[29]

Many deliveries still happen at home due to adverse circumstances, but the majority of women would like and try to deliver in an appropriate health facility (private clinic or at the MSF maternity; KPH is only an option if they live close to it) with the agreement of the family (mother-in-law and male elders).

5.2.2 Women with danger signs

If women 'realise' that they have the so-called danger signs it might already be too late to reach a health facility that can deal with them. It seems that many women still die because of bleeding during pregnancy or after delivery. Families who do not have the financial means or women who do not get the recognition and permission from their family-in-law are not able to go to any health facility and the woman will die. The following account illustrates the reality of women who live in far-away districts very well; although the security factor is not mentioned.

> "First when the women are coming from the community they have some problems. It is very difficult to bring the women straight to the maternity because first she need to go to the mother-in-law, if she allows, that she says I am not feeling very well so thinking that she is making excuses from the housework. So she say yes ok, maybe we see after 2 days if you are ok maybe you just take one paracetamol. Or maybe she is making some drugs in the home, from the plant or something. Or if she accepts that she [the pregnant woman] is really sick so she sends the sister-in-law to the father-in-law. So again she is taking a decision for the treatment. So if the father-in-law has very good behaviour or very good attitude so maybe he decides to send the women to the CHC clinic or to the private clinic to bring the mother to the city. But it is taking a long time and if some people don't have the money for the treatment so this is another problem, so they need to find first the money. Because a lot of them they are poor families and joint families and there is one man to take care of all the family and others are jobless. So they need to find some money also."[30]

As mentioned before, another difficulty is that women feel shame (*sharam*) to talk about their health issues; culturally a woman is not allowed to express any (health) problems to her mother-in-law.[31] A daughter-in-law has no problems; she has to show an obedient, respectful and hard-working behaviour; any expression of health issues is considered as a complaint. Complaining about her life and health in the family-in-law is inappropriate and disrespectful.

> "This in our culture, I was 16 when I became the first pregnancy; when I was 3 months pregnant, then I did heavy works on the kitchen and I did not know that the heavy work is dangerous for me, after that then I lost a lot of white water, then the doctor said that you should rest and you should not work, when I was in the rest then the sisters-in-law told me that you are not shy (feel ashamed), that you are the new woman in the house and you don't work, so then again I had to start my work; but my husband was nice with me, he said to me you should rest."[32]

The wife can and usually tries to speak to her husband about her problems – the restrictions among the couple are not so severe – but in most cases the husband cannot talk about these female

[29] I 24: midwife, 42y
[30] I 26: midwife, 28y
[31] Women living in urban areas and in educated families might see this differently but in the interviews it became clear that for younger women it is often a problem to express their health issues to their mothers-in-law.
[32] I 23: GD 4 midwives from CHC and BHC, 21, 37, 40, 44y

health issues with his mother. Some women have the support of their husbands, but the husband again is caught within the Pasthun behavioural codes. In some cases, husbands try to convince their wives to talk to other female family members so that they can inform the mother-in-law.

> "There are many problems, when they become pregnant, the woman cannot talk freely about their problems to their husbands. Because sometimes they feel shame and sometimes they cannot talk due to the cultural issues (…) they hide their problems inside them and they work a lot during the pregnancy, they cannot, e.g. if she is too tired she cannot say anything to her husband or the mother of her husband, because the mother of the husband is like the king of the family."[33]

Therefore it is essential that danger signs are visible, so that the mother-in-law 'sees' them, like bleeding, vomiting, anaemia, weakness, etc. If the pregnant woman has other female relatives in the family, it can be easier for her to communicate her health condition to others and ask for support. If the people are aware of and able to, they will try to reach the MSF maternity. This is the overall goal of most of the people, who know about it.

5.3 Perception of danger signs during pregnancy and delivery

Danger signs or problems during pregnancy have to be understood first, realised and communicated or just 'seen' to be taken care of. Some minor conditions can be treated at home or by the Mullah. In most cases people try their best to assist women with serious health problems. If they are far away, people will try to find transport. If they do not have the financial means, they will borrow money but when they face security problems, people are powerless.

5.3.1 Antenatal care

Antenatal care (ANC) is not widespread and services are not very well used, so any DOCs during pregnancy might go without being noticed. This is more relevant for people from the mountains and far-away areas. Because pregnancy is a state of shame, women neither want others to know that they are pregnant nor seek ANC, unless it is really needed. People from Khost Bazaar and Khost Matun as well as people who are educated or well off will rather seek ANC in private clinics or governmental clinics during pregnancy, which means that DOCs can be discovered earlier and treated timely. ANC is also a question of affordability. Going for a check-up to a private clinic during pregnancy means that expensive tests will be done. Furthermore it was mentioned that sometimes unnecessary tests are ordered, e.g. H. pylori[34] for financial reasons only.

Respondents explained that x-rays or ultrasounds are done to see if the baby is healthy and in the right position; only in rare cases to find out the sex of the baby. For these kinds of tests respondents often mentioned that they would go to Dr Ayob in Khost. These were people from Khost Matun and from far-away areas like Tani, Bak and Musa Khel. Some others explained that they never went to any ANC before delivery.

5.3.2 Causes and treatment of danger signs

Danger signs most mentioned were bleeding (*Jamee Kedal* meaning also menstruation), loosing of 'white' water, low and high blood pressure (*peshar*), weakness (*kamzuri*), anaemia (*de weenay kami*), belly pain, swollen body and diabetes. Some people from the mountains mentioned cat and cow disease.

[33] I 35: male health care provider, 48y
[34] Helicobacter pylori testing is normally ordered when someone is experiencing gastrointestinal pain.

All respondents said that these problems are caused through heavy work during pregnancy when the family does not allow the women to rest.

> "One of our daughters missed [aborted] two children in the pregnancy, she was washing the heavy carpet then she missed the child. And then she delivered one baby dead and also she had anaemia at that time."[35]

Their mothers- and sisters-in-law support pregnant women. However, as mentioned earlier, women are not allowed to be weak or to complain about any problems at all.

Minor conditions are treated with the Mullah first, if people think that the evil eye (*nazar*) or any other bad spirits or ghosts are involved. For the protection of the evil eye people burn herbs (*speelani*) in the houses; the smell will keep it away. Women wear amulets (*taweez*)[36] from the beginning of their pregnancy to protect them from abortions, in order for the baby not to die in the womb and to protect it from any other ill-health condition.

> "When they start bleeding, then the people said this is because *bala* [ghost/Jin] hit the woman.
> How can we save her from *bala*?
> Yes, also nowadays we are doing *taweez* to prevent them from *bala*.
> When the pregnant woman feels fear, then we take advice from the Mullah or the Mullah writes a *taweez* for her and they wear it."[37]

Others treat minor conditions at home with decoctions of herbs or sugar water; the latter one is mainly used to stop bleeding after delivery. Oil or sugar water is understood as thickening the blood. The woman is told to sit on a pillow and put her legs upwards.

When the placenta is staying inside the womb people try to provoke its expulsion by giving the woman hair to eat, so that she vomits, or they put a finger deep into her throat. One man said he was shooting near the house to provoke a shock and others would massage the woman's belly or try to pull it out with their hands.

These home treatments do not keep people from coming to a health facility but they delay medical consultations considerably.

5.3.3 The labour-inducing drug oxytocin

Oxytocin, a labour-inducing medication, is extremely prevalent among the population of Khost province. Unfortunately, it is often used by insufficiently trained healthcare workers. It is considered as the necessary and sometimes magic treatment that women want to get when they come for delivery. It has a huge and often negative impact on their health and their health-seeking behaviour. Women think they need oxytocin for their delivery because all kind of healthcare workers use it, be it a trained or untrained midwife, medical doctors in governmental or private institutions or traditional birth attendants (TBAs) in the rural areas. It is said that 'private doctors'[38] use oxytocin because they want to have a quick delivery procedure.

> "The private doctors want to deliver to force them by the injection in this way the private doctor want to deliver her as soon as possible for the money. They want to get the money fast."[39]

Women are disappointed when they come to the MSF maternity and do not receive an injection because for most of them it is part of the delivery procedure. In the interviews some respondents

[35] I 12: female caretaker also a TBA, 50y
[36] These amulets are mostly written Quran verses that people put in to a fabric and wear it.
[37] I 9: male caretaker, 28y
[38] Private doctors is used for any person working in a private clinic, be it a trained doctor, a trained midwife or a TBA.
[39] I 50: midwife, 30y

spoke proudly about the injections women receive. This male caretaker speaks about the information he gets from the female caretaker:

> "Yes some time she [female caretaker] is coming here [male caretaker area] and I talk with her and a little time ago she was here and she wanted some juices [for the patient] and also said that the patient is fine, the doctors gave her an injection [oxytocin]."[40]

This same caretaker recounts another story. They came to Khost maternity at an earlier stage with a woman that was told she still had seven days until delivery; they were sent away. (This family did not want to go back home with the pregnant woman, since they lived far away in Shamal district and did not have easy access to health care and also because it was a difficult area security wise. If the delivery started in the night, they would not reach Khost again.) The family decided to go to a private clinic; the woman delivered the same day and also went back home the same day. She delivered because of an oxytocin injection. The family was happy and satisfied, but was disappointed by MSF. Most of the patients who come to Khost maternity expect an oxytocin injection because they either hear it from others or are used to it themselves due to former deliveries.

> "The people complain that MSF doesn't use the injection [oxytocin] at the delivery time and the private doctors doing it. They want the injection as soon as possible but it has a time, in the specific time we can use it.
> Why they like this injection?
> When we use it then they can deliver fast."[41]

Oxytocin is called 'hot injection' because it makes the contractions 'hot' and 'hard' which means they are reinforced. The problem is that the sale of oxytocin is not regulated. It can be bought everywhere and used by any healthcare provider. One respondent affirmed:

> "Yes, many people in the families can pass the [oxytocin] injection in your vein."[42]

And a Kutchi woman who is also a TBA said:

> "Yes, I help them, I take them during the delivery time, if she can't deliver then I give them an injection.
> Where did you buy this injection?
> In the drug shop.
> How did you learn to give this injection?
> We can't do anything, we have to give the injection, what can we do if we face such problems in the night?"[43]

People can buy oxytocin and misoprostol over the counter in the villages; they buy it themselves and use it for any delivery. Midwives in Khost maternity are mainly confronted with uterus and placenta ruptures provoked through oxytocin injections in an unregulated manner, in too high dosages or without medical indication.

This short case study shows why the mother and her baby died. The family first went to a private clinic where the patient was given one injection, later she received four more; but the baby still could not be delivered; the health care provider in the private clinic diagnosed a bridge position. The woman suffered a uterus rupture and the baby couldn't be delivered. By the time the family had reached the Khost maternity, the mother and the baby had died. In the interviews with health care providers, they continuously emphasized the fact that many women die in their homes due to oxytocin and misoprostol.

[40] I 1: male caretaker, 32y
[41] I 21: midwife, 25y
[42] I 22: MSF staff, 25y
[43] I 42: female caretaker + TBA, 55y

5.4 How to deliver the baby and where?

There are different options for delivery. This chapter looks at the possibilities, challenges and their perception.

5.4.1 Delivery at home with or without a traditional birth attendant

For most of the respondents delivering at home is an emergency solution; not to forget that all the respondents knew MSF and were interviewed in the MSF premises. Almost all, male and female, underlined that the situation has changed. They said in the past many more women delivered at home. Some illustrated it with numbers; one male caretaker said 3 to 4 out of 10 would deliver in the houses, another female respondent said 50% of the women would deliver at home, 40% in private clinics and only 10% in governmental structures. An MSF employee explained that about ten years ago 70% of deliveries were in the homes, but now 70 to 80% deliver in institutions. Out of these 10% would go to private clinics and 90% to MSF. One male caretaker said that only 2% would deliver at home as in the past there was no MSF and fewer private clinics. A female caretaker from the Kuchi tribe said that they mostly deliver at home, as they are nomads.

Reasons to deliver at home include contractions starting at nighttime, distance to the next health facility, financial problems to go to a private clinic, the perception of the health facility as being inappropriate or in-laws telling the woman to deliver at home.

> "Some people don't want to show the woman to the other people like to doctors or to the Mullah so that is why they stay in their homes. And the wives whose husbands are Mullah, they don't want to go outside."[44]

Mothers-in-law argue that their daughters-in-law should deliver at home because they also delivered at home themselves. Others stated that 'stronger' women would prefer to deliver at home.

> "Those female who are strong they want to deliver in the house and those who are weak, the family tries to take this woman to the hospital. Or the mother-in-law will keep her in the house when she is strong."[45]

For most of the factors influencing HSB a solution can be found, e.g. a car can be found; money can be borrowed to pay the car. The main reason why most of the women deliver at home is insecurity. If security does not allow it, the family is stuck at home.

> "Can you always find a car to rent if you need to go somewhere?
> No, we can't, especially at the nighttime, but if your friends and cousins have a car then they can help.
> What do the people do if they can't find a car or it is nighttime?
> They stay at their homes and they are waiting to the Allah.
> Do you have many deliveries at homes?
> Yes, because they can't reach to Khost city or to MSF."[46]

TBAs who learn and inherit their profession from their mothers and grandmothers do not really exist; in most cases elder women from the same family or the mothers-in-law help the women during delivery.[47] They are referred to as 'elder', 'famous', 'experienced' or 'intelligent' women.

Many of these elder women started to help during deliveries because they were 'forced' to assist, e.g. when a delivery happened suddenly in the night. Some respondents mentioned an interesting

[44] I 22: female MSF staff, 25y
[45] I 49: male caretaker, 35y
[46] I 15: male caretaker, 30y
[47] To facilitate the reading of this report TBA will be used, when referred to these elder women.

aspect. They thought that former cleaners from health facilities would start their 'business' as TBAs in the rural areas and open private clinics.

> "When MSF close here or they [the cleaners] resign from this job, then you will see our cleaners they will open clinics in the far area. Because they don't have jobs so they will become TBAs in the far village."[48]

In earlier times deliveries at home took place in cowsheds. Nowadays women deliver in their own rooms. They put some sheets on the floor and deliver in a crouching position. The parturient sits on her haunches, one woman is in front of her and one behind.

5.4.2 Private sector

It was difficult to assess the quality provided in the private sector as the services and professional support differed very much in the rural and urban context. In villages and remote areas private clinics were partly run by TBAs without formal midwifery education. They just put on a white coat and called themselves 'doctors'. Referrals from the private sector were delayed because of lack of knowledge and recognition of DOCs including the other factors like transport, finances and insecurity.

The biggest problem with private clinics is the rapid dispense of labour-inducing medication like oxytocin and misoprostol, which can be bought everywhere, even in the smallest village, and are given to every woman before or during labour.

In cities it is the opposite. Private clinics, like the one from Dr. Wagma and Dr. Sharifa, seem to provide good care and referrals from these health facilities to MSF work very well.

The private sector in Khost is more depending on services like giving ANC and OPD instead of deliveries; only during nighttime private clinics are busy because free health care facilities cannot be reached. Therefore it is a good solution that MSF does not provide any OPD services.

In rural areas private clinics work well because most of the midwives only work until noon or 2 pm and then continue in their private facility. In these cases people are forced to go to the private clinics if they don't want to deliver at home.

Private facilities are often consulted when childbirth starts at home and results in a complicated delivery. A hospital cannot be reached anymore and so the problem is solved in the private sector. Patients who still have time until delivery and are sent back home often search for a private clinic in Khost as they refuse to go to KPH or don't want to go back home. They are afraid that later they will not be able to reach Khost again. In their initial decision they were opting for a 'safe' delivery.

In the private sector payments range from 3000 rupees (30$) in the rural areas up to 10 000 rupees (100$) in urban facilities. The payment for a baby girl is also lower than for a baby boy, e.g. for a baby girl it is 3000R and for a baby boy 5000R might have to be paid.

A worrying information was received about private institutions for midwifery like Hakim Taniwal in Khost; graduates from this institution do not have any knowledge and some never went to school but own a certificate. And they perform in private clinics.

> "They [midwives in private clinics] are not trained. Even some of them don't have any certificate from school and they just have a certificate from the midwifery. So they just open a clinic and they are practicing. Just they are destroying the life. Some of the patients come like this they come from private clinics and they are in bad condition."[49]

[48] I 50: midwife, 30y
[49] I 29: MD, 27y

5.4.3 MSF Khost maternity

Why do family members decide to come to Khost maternity? People appreciate the high level of quality of free care in terms of medical quality, like drugs and medical services, human resources, location, security and safety. MSF Khost maternity is *the* place to go for the majority of respondents. Everyone who knows MSF and who is able to reach it will come to deliver there regardless of any complications during pregnancy.

Since MSF started working in the hospital in 2012 it was understood that 'foreign' doctors are working there and that the treatment and drugs are of good quality. MSF is also highly appreciated for the special care given to babies in the neonatology and for the behaviour and attitude of its international staff, called 'foreign' people by the population and 'experts' adapted from 'expats' by their national colleagues.

- It is a 'safe' place.
- It is close to where the people live.
- The treatment and delivery is free.
- The drugs are of good quality.
- The hospital is clean.
- 'Foreign' people are working there.
- People listen to you there.

> "This hospital provides good treatment (Tadavee) as well as good medicines and the doctors are very caretaking to the patients."[50]
>
> "It [Khost maternity] is very good, the people are really happy from it especially from the foreign doctors."[51]
>
> "(…) this hospital has foreign doctors and they are intelligent."[52]
>
> "(…) someone told us that go to the MSF there are many good doctors; now the woman has delivered and she has born a baby which is already in the glass [neonatology]."[53]
>
> "Our villagers said MSF has good services and good treatment if our women born weak baby, they have best medicine for this."[54]

People also mentioned the impartiality of MSF. They treat everyone in the same way and do not favour anyone. However, in other interviews we have heard that nepotism plays a major role in getting admitted or avoiding referrals to KPH. People do not consider the Khost maternity to be crowded or having not enough beds.

Under normal circumstances women prefer to leave the maternity ward as soon as possible after the delivery; many women have other children at home and they are worried. But it was also said that sometimes they leave too early against medical advice and come back with bleedings. An SRH referent explained that the first 24 hours after delivery are crucial in terms of mother and child mortality.

MSF has a very good reputation. However, complaints about the behaviour of the female guards at the gate during nighttime and (younger) midwives inside the maternity increased steadily, like this man recounted:

[50] I 1: male caretaker, 32y
[51] I 4: male caretaker, 50y
[52] I 37: female caretaker, 20y
[53] I 6: female caretaker, 60y
[54] I 9: male caretaker 28y

> "The people are very happy from the hospital, but sometimes in the night the female guards do not open the door for the patients, so sometimes the women deliver at the door. I saw it myself; when the people have emergency patients they should open the main gate directly, but they did not do it. The female guards miss their behaviour, one time one of my sisters who was a caretaker came to the gate, she wanted a blanket then the female guard abused her, they used bad words like whore (*Rendai*) to my sister; me and my sister we were very sad."[55]

> "When we pray in the mosque then they [the patients] are talking about these issues, like in the past the hospital was good, now we see many deliveries in the toilets, they don't give blankets (…) etc. The midwives are sleeping in the night, we are calling the midwives to come to check the patients but they don't do it. At around 4 am in the night all the midwives are sleeping, the woman delivers alone. In the night it is our shift, when you see them sleeping, sitting and drinking tea and chatting and patients shouting in the corridor and in the toilets, patients will be in the tents, patients delivered in the toilets, back in the IPD toilets. Nothing will be there. We can see the women, you [MSF international staff] cannot see."[56]

When people refer to Khost maternity, in most cases they name it *Be Sarkhad* (without borders) or *Be Sakrhad Shafakhana* (without borders hospital) or *Be Sarkhad doctoraan* (doctors without borders) but many also know it by its former name *Askarey Shafakhana* (military hospital). In one interview it was mentioned that medical staff in KPH referred to MSF as the "non-Muslim".

5.4.4 Comprehensive health centres

Comprehensive health centres (CHCs), known as governmental clinics or just 'clinics', are not an option. They are seen as inappropriate for women to deliver for various reasons:

- no 24/7 service,
- no midwife available after 2 pm or sometimes not at all
- midwives not well trained, lack of experience and knowledge
- no electricity or only on request
- not a 'secure' place in terms of quality and HR
- not appropriate in terms of location of the delivery room
- no trust and
- no equipment and material
- no drugs available
- not reachable (checkpoint, river, snow)

One respondent explained the following:

> "They don't have any equipment to do the test or for examination and they are too crowded over there; you will never get your turn until 12 o'clock because they don't work after 12 o'clock."[57]

The CHCs differ according to the districts they are located in. A number of interviews were done with male caretakers of whom not all knew the clinics personally but they referred to what they heard from their female family members and what they could observe in their local community.[58]

In Shamal district, villagers have to cross a river. During wintertime snow or meltwater are problematic. Shamal also had security problems because the Taliban destroyed the clinic building.

[55] I 14: male caretaker, 24y
[56] I 44: GD MSF staff, 45+60y
[57] I 1: male caretaker, 32y
[58] This informal information would need to be confirmed and completed with medical assessments of each of the clinics.

Spera district faces the same challenges like Shamal with additional security problems and a checkpoint to pass. The trip to Khost takes three hours and the clinic has no electricity.

In Tani disctrict there are no female health care providers.

Mando Zayi CHC is said to be open until 4 pm and deliveries during nighttime are not attended. To reach the CHC people have to pass a checkpoint and many prefer to go to Nadir Shah Khot because it has a much better reputation.

The Gurbuz clinic mainly receives people from the mountains and far-away areas. These people, if it is their first time, are afraid to come to the CHC because they have never been to a public health facility. A midwife explained that they try to get rid of their fears.

> "What would be the wish of a woman where to deliver if they could decide themselves?
> First they want a place where only women will be there and no men. They want a separate place which are working there just women and also the women which come for the first time to the clinic, they have only delivered in the house, they are afraid from the clinic then we said to them don't worry we are you sisters, sure, then they will be ok."[59]

The clinic is open only until 2 pm and is close to Khost. When people come from the mountains they do not go back when they find the clinic closed but they go to Khost. During nighttime they cannot reach the clinic or the hospital at all because of insecurity.

Tere Zayi is a three-hour drive away from MSF maternity and people face security problems during nighttime like robberies etc. The CHC is not appropriate as the delivery room is near the male area. But it was said that the health staff is well trained and attended workshops with MSF and OHPM.

Concerning Jaji Maydan CHC, it was said that people go there and use the services. It is the area that is furthest away from Khost but has a good tarred road to reach Khost. Still the people who live in the mountains have first to reach the tarred road. [60]

Bak CHC seems to be acceptable but respondents also complained about the lack of good services and medicines and described it as a crowded place. There was also a bomb blast (against vaccination) and the clinic had to be rebuilt. Bak is an area with many Taliban. Respondents explained in the interviews that they could not go to the clinic in the night because of security.

> "15 days ago one of our villager's woman faced the problems in the night but we couldn't bring her to the hospital because of security. We are living next to the Bak district in the area of Chenargai, she was in a very bad situation then at the early morning time we went to the private clinic, which is close to my village, the CHC was not open. That female doctor (midwife) also works in the Bak CHC clinic, when we went to her private clinic, she just give us one injection then we came here (MSF)."[61]

This family reached the MSF maternity only late in the afternoon. Time had passed until daytime to decide where to go for delivery, then they had to find a car to get to the place and finally find someone to borrow money from.

Sabari is a 95% Taliban area and far away from Khost; hence mainly distance, transport, financial und security factors apply for this area. But one of the MSF midwives has a private clinic there and this one is appreciated by the population and works very well. The CHC is a problem. This might be because it is a Taliban area but also due to the quality proved in the governmental clinic.

Musa Khel has a female health care provider, but people say she is only one midwife and she cannot help all the people; additionally she is not always there, so people might find the CHC closed and the female area is only separated with a curtain from the male area. Most deliveries take place

[59] I 51: midwife, 19y
[60] No interviews were done with caretakers form Jaji Maydan.
[61] I 15: male caretaker, 30y

at home or in private clinics and also maternal deaths were mentioned in the interviews, because of the distance to Khost, the road condition and the price to rent a car (3000 to 3500R equals 30 to 35$). Additionally a river has to be passed to reach Khost.

Qalandar district faces similar problems mainly related to distance, mountains and security. It was also said that women do not deliver there and a midwife would only occasionally be present.

Nadir Shah Khot has several midwives but respondents said that they don't have the 'equipment and machines' like MSF. It was explained that the women in this district either come to MSF, the KPH or go to private clinics. If they have 'small problems', they will stay at home. Furthermore some respondents said that the midwives have bad behaviour and use bad words. But if someone has a relative in the clinic, then services are good.

Mando Zayi has no qualified, experienced staff, like respondents named it "no real doctor". Mando Zayi has male and female staff but the female health care provider is known for her 'bad behaviour'. Women only go to the CHC for vaccinations but not for deliveries.

> "But the problem is also that the midwives who work in the CHC they work there from 8AM until 2PM. So this is a very short time. The women who are going to a CHC, most of them they are normal patients, antenatal care or postnatal care, family planning, etc. Very few women who have problems go to the CHC. So the mothers, because they know that at the CHC the midwives are not the whole day there, she is just working until 1PM or 2PM she is strait coming to MSF. If they do night shift so maybe the people go and we receive a lot of referrals. But the referrals are low because the midwives are not complete the whole day or night there."[62]

Payments for transport to come to Khost range from 30 to 35$ (one way only) for Jaji Maidan, Qalandar, Sabari and Musa Khel; 15 to 20$ for Tere Zayi and Bak, 20$ for Spera and Shamal and 10$ for Tani and Gurbuz.

5.4.5 Khost provincial hospital

The Khost provincial hospital (KPH) is only a solution for practical reasons; for people who live in the neighbourhood, like Kuchi, who have their camps near KPH and people who have their homes close to the hospital. Everyone else who can afford the transport and knows about the MSF maternity will try to reach it. No positive comments were made in the interviews. People were complaining about everything in the KPH.[63]

> "Then they refer our patients to KPH at 9 pm when we went to the KPH, the KPH doctor said to us go out, first you went to the non-Muslim then now you come to us. They don't honour and they don't care about the patients in KPH. … The KPH doctor also stole our drugs (hygiene kit, medicines, soap), which MSF gave to us. They took the kit and wrote a new prescription for the patient. I took the prescription from the private pharmacy over there then she [the patient] took the new drugs; finally I brought her to Dr Lailoma and I paid 4000 rupees."[64]

> "People say that KPH is not a good hospital, their behaviour is not good, men are going in and out."[65]

The KPH is lacking equipment, medication and staff. The quality of care is not on the same level as MSF and people have expressed this. The midwives only earn half of the salary of an MSF midwife; they have a bigger workload, as they are responsible for several wards and not only for the maternity and they are frustrated with the additional work created through MSF. On the other side respondents recounted sleeping midwives and doctors who do not attend the patients at all.

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[62] I 26: midwife, 28y
[63] Please see also the assessment report done by the PMR.
[64] I 14: male caretaker, 24y
[65] I 17: patient, 22y

Another factor mentioned in several interviews was that the KPH is lacking guidance and supervision in general but mainly in the maternity ward. Doctors in the KPH try to bring the patients to their private clinics. They send them to do some tests and when they come back the doctors are not there anymore, so the patients are forced to go to their private clinics. "The doctors have made the KPH like their business centre."[66]

5.4.6 Visiting a Mullah

The Mullah is only consulted if people think that there are some supernatural forces involved in the condition of the woman, but it does not prevent people from seeking health care. He is important for the pregnant woman to support her before the delivery and to protect her from abortion, the evil eye or any other bad forces by giving her amulets, A Mullah is consulted when a woman has continuous abortions, does not get pregnant at all or to ask for a boy child.

> "Yes, we have Mullah, sometimes we go to Mullah whenever a woman does not get pregnant. So they go to the Mullah and the Mullah makes an amulet and is praying for them [the women] to make them pregnant in an easy way."[67]
>
> "I refuse the Mullah and the amulets but some people go to the Mullah and they want help from the Mullah to have a boy, because some don't like daughters."[68]

For the newborn baby a Mullah or any other male person in the family is performing the first prayer called *Azaan* into the right ear of the baby. They prepare amulets to protect the baby from any ill-health conditions and the evil eye. They also consult the Mullah when the child has Tetanus (*Qablai*), when the child has a rush in the mouth or when it is crying a lot, which is said to be caused by the evil eye. For the crying they put a cowry shell on the baby's neck. For these amulets people pay between 100 to 500 rupees (1 to 5$). It was also mentioned that an amulet might cost up to 10 000 rupees (100$).

5.4.7 The newborn baby

When the baby is born at home, the umbilical cord will be cut with a razor blade. The placenta has to be buried to prevent the child from vomiting. The navel is treated with hot (cow) oil or *sorma* (the black colour that is put on the eyes of the baby). The newborn baby is massaged with oil mixed with flower to rub off the 'dirty hair' on the baby's body. *Sorma* is put on the baby's eyes and forehead for beauty. Usually it is the father's family who chose the name for the baby, which is given on the eighth day after birth. The mother starts breastfeeding only after a few days as the colostrum is considered to be dirty milk. Respondents explained that in earlier times they gave green tea with sugar to the baby. Nowadays they would give 'glucose' (sugar water) until the mother can start breastfeeding.

In most cases the birth of a baby boy is celebrated differently than the birth of a girl. The festivities are bigger and more people are invited. A sheep or sometimes a cow is slaughtered and happy shootings take place. In the Khost maternity women distribute fruits and sweets when they give birth to a boy. The birth of a girl is often accompanied with sadness and tears. Men are calling the female caretakers to ask for the sex of the child and when they have to announce the birth of a girl, men usually just drop the phone. The birth of a baby girl is stressful for the parturient, the mother-in-law and all the other female caretakers.

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[66] I 35: MSF staff, 48y
[67] I 1: male caretaker 32y
[68] I 11: female caretaker, 32y

5.4.8 Neonatal or postnatal death

If the child is born dead or dies before receiving its name, the family will not prepare a funeral; the baby will be covered in a white cloth and buried without any special ceremony or prayers. If the baby already received a name and the childbirth was celebrated, it would be buried like any other person wrapped in a white cloth accompanied by a Mullah and prayers.

5.5 The role of the husband

Since the husband also has some influence on the health-seeking behaviour of his pregnant wife, it was assessed how his role in taking care of his wife and his new-born children affects access to health care.

The husband is restricted in his behaviour and expression of feelings for his wife and children especially in front of his parents and the family in general. He is not allowed to show love and affection for his wife in front of others. Additionally, the moral code of Pashtunwali forbids asking about a man's wife; hence he would never talk about her and her health condition in front of others.

Most of the men do not accompany their wives to the hospital because they are shy themselves and the community considers it a shame. It is rather the father- and brother-in-law who go with the woman.

> "Yeah, they are shy. So when they come to the hospital their husband is even not coming with them. And their father-in-law or brother-in-law comes with them and they bring them to the hospital. If the husband comes with his wife they are thinking that it is a shame. Because we had one patient and she died because of uterus rupture when they brought her she was dead. The husband took the dead body into the car and when he put her into the car the husband wanted to sit with her. But the other man was just shouting with him like what are you doing, come out it is really a shame, you should not sit with your wife."

The emotional relationship between father and newborn only starts when it is one to two years old or when the child starts to sit. The father is not supposed to carry his baby or show any feelings towards it. A male respondent said it would not be good for men to carry their babies as they could be dirty (or urinate on them) and this would hinder them from praying.

5.6 Community perception of the referral system

MSF has started a referral system from MSF Khost maternity to KPH and from the CHCs to MSF in case of DOCs to reduce the number of normal deliveries. The 2016 project document for Khost states, "Since MSF maternity target of total deliveries is set at 1200 deliveries/month, it is expected that about 300 patients/month (10 patients/day) will be referred to KPH. A standard package of drugs and consumables ("referral kit") will be provided to every patient referred to KPH."[69] Meanwhile MSF has reached 1600 up to 1800 deliveries per month.

In the following the experiences and opinions of patients and caretaker on these referrals will be explored.

[69] Please refer to Project Document 2016, Khost project.

5.6.1 Perception and challenges of referrals to Khost Provincial Hospital

MSF is referring patients to KPH to reduce normal deliveries in the MSF maternity with the objective to keep the same level of quality standards they provided up to now. Accepting more normal deliveries would go beyond MSF capacities in terms of quality of care. In this regard the question arises how MSF can refer patients to a hospital that is known of providing less quality than an overcrowded MSF maternity? Patients rather prefer to lie on the floor or to share beds than going to KPH.

> "Yes, they like this maternity, when we refer them then they don't want to go KPH, they are saying that we want to deliver in the MSF yard or in the door, outside in the sand but we don't want to go KPH."[70]

Referrals to KPH pose a big problem for the people. Most of them took a long journey to reach Khost and MSF maternity and already spent a considerable amount of money (1000 to 3500 rupees equals 10 to 35$) only to be sent somewhere else again, where they don't want to go and where they know that they have to pay again.

> "Many never reach KPH, they go to private clinics, they do not go to KPH, so many were referred and never reach KPH. Also people are frustrated if they come from far to MSF maternity and are sent away. They say we come from far and have spent a lot of money to reach here MSF maternity."[71]

The people come because they trust MSF; a referral is negatively impacting on their trust in MSF as an organisation, the MSF maternity in Khost and the people working with MSF, national and international staff. In the interviews it was also reported that most of the people who get referred to KHP are from the Mangal tribe (Musa Khel and Qalandar district) and from areas that are further away, like Sabari, Jaji Maydan and Bak.

Taking into consideration the MSF principle of impartiality we treat any individual as a patient first regardless of his or her political orientation. We can expect that among the patients there are also women whose men are being part of the AOG (armed opposition groups) who might get disappointed and astonished when their women get referred, which could result in a security concern for MSF (mentioned in the interviews).

People do not understand why we refer them, as the reasons given – that we have too many normal deliveries and have neither the space nor the capacity to provide the appropriate level of quality of care – are not perceived in the same way. They are not admitted in the MSF maternity and are being referred to a place where it is even more crowded and where the quality of care, equipment and drugs is worse.

The MSF ambulance only takes along the patient and one female caretaker. This is an additional constraint, as the male caretakers have to rent a private car to follow the ambulance. It is unacceptable for the women to go alone. If the delivery takes place on the way to the ambulance, it will bring dishonour to the woman and her family because the driver is present (since he cannot leave the car).

> "But if we are referring the patient to KPH if she is delivering in the car this will give a bad reputation to MSF. It will, because it is really a shame that the patients deliver in the car and it will be really a shame for them [family]. It will not be good for MSF."[72]

One man said he would rather prefer the death of his wife than the shame of the delivery on the road. One of the MSF ambulance drivers reported that he had seen 13 to 14 deliveries on the way to the KPH in the last 7 months. Others recounted that no one took care of them at all upon arrival

[70] I 21: midwife, 25y
[71] I 24: midwife, 42y
[72] I 29: MD, 27y

at KPH and the woman delivered at the entrance of the hospital. Others again told that drugs were taken from them and they were asked to buy medication from outside.[73]

As a result many patients try to hide inside the MSF maternity in the tents and in the IPD not to be referred until it is late afternoon or the cervix opening is more than 6 cm to match the admission criteria. Nepotism also seems to be an issue; whoever knows someone inside the MSF maternity tries to contact this person to be accepted at the MSF facility. It was also reported that the ones who are referred to KPH and who can afford it do not go to KPH but rather try to find a private clinic in Khost.

The midwife supervisor from the KPH expressed the pressure they experience at the KPH when patients from the MSF maternity are referred. The Patients expect to receive the same care they get at the MSF facility but the KPH is not able to offer it. She even said they are satisfied when patients are angry with MSF:

> "We are laughing at that time; we become happy that they are sad [angry] and sent back by MSF like this we and MSF we have some jealousy and competition."[74]

She also said that sometimes patients do not need to take the drugs of the MSF referral kit, but the patients want to take the medication and are confused when those are not administered at the KPH. This results in misunderstandings and mutual distrust and frustration.

Additionally, people mentioned that KPH is dirty, crowded, does not have enough staff, sufficient equipment or drugs and the gynaecological ward is missing supervision and management. Also, 'women and men mix' there and the behaviour of the KPH staff is not suitable. They mistreat patients physically and verbally. During the visit to the KPH with the PMR it was observed that it is no too busy (at around 2 pm) but people include all the other services provided like IPD, vaccination, dentist, X-ray etc. in their perception of crowdedness.[75]

5.6.2 Referrals from Comprehensive Health Centres

It was challenging to find out how and if referrals from CHC to Khost maternity function. Since most of the respondents in this study never went to a CHC they could not evaluate if referrals worked. Additionally, most of the deliveries take place during nighttime, CHCs are closed and people go to the private clinics. Consequently almost no referrals from CHCs are received, as people do not go there for deliveries at all. The study team tried to follow one announced referral from a CHC but it turned out that the woman and her caretakers never reached the MSF maternity.

In numerous interviews when caretakers or patients spoke about their path of reaching MSF, it turned out that only a few of them have been to the clinics before and many more to private clinics from where they were referred to MSF. All health care providers who know about Khost maternity send women with problems during delivery to MSF – with the drawback that it is often delayed or too late.

[73] There are several private pharmacies in front of the hospital.
[74] I 57: midwife, 34y
[75] Please refer also to the assessment report of the PMR.

5.7 Communication channels at community level

5.7.1 Decision makers at community level

Every village has the so-called male elders or village leaders who are the decision makers. The villagers come together and select these elders according to their age, experience, wisdom, family background, reputation and education. For example, if there are four big families in one village, every family will have their elders being part of the community elders. They are consulted in case of any problems inside the village or with other villages.

5.7.2 Current communication channels in the communities

To find out about current communication channels in the communities, respondents advised to first contact and inform the male village leaders before starting any health promotion activities. These elders will pass the information to the Imam of the mosque and from the mosque the male villagers bring the information back to their families.

This means that the male village elders and the mosque are the main channels to communicate information to the people. Male and female community members can also be approached via schools and teachers. The oldest male person of every household is responsible for all the family members. Through the village elders and head of the family it can be planned how to reach the women but everything has to start with men.

> "First they [MSF] start with the men so little by little they start to the women. But first if they make a very good plan for this, they need to start from the men. Because the decision maker all of them in this community are men."[76]

In the villages itself it was mentioned that not all women can be brought together for health promotion sessions as some families might have internal conflicts with each other. Therefore they would not be able to go to each other's houses. Women have to meet inside the houses. Men can assemble outside, in schools or in the mosque during evening prayers.

Radio channels are another possibility to pass information at community level; some households were said to have a TV but it seems that more families possess a radio and that messages through radio broadcasting would reach more people – given that all people are able to receive the respective channel and that the audio quality is adequate. In some remote areas and mountainous regions it might be a problem to receive certain radio channels.

As mentioned in the survey on radio listening patterns and behaviours (MSF 2016) most people listen either in the morning or in the evening. The survey suggests that women rather listen in the morning and men rather in the evening. This result matches the findings of the anthropological study at hand. Additionally, it informs about the fact that only a few participants aged over 50 years took part in the survey. Therefore, the listening behaviours of this age group couldn't be assessed, which would have been crucial, since this age group plays a decisive role in the decision making process of delivery.

There seem to be various organisations, which have community health workers (CHW) that should provide health information at community level. The OHPM, WHO, Red Crescent, IRC etc. were mainly mentioned. However, in almost all the interviews people replied that they have never seen a CHW. In a group discussion with CHW and their supervisors we learned that the villagers call the male CHW 'doctors' because the CHW receive drugs from the CHC and distribute these drugs in their basic health centre (BHC) in the village. Most of them have a small health post (BHC) in their

[76] I 26: midwife, 28y

home where they give the drugs to the people. A female CHW said that women send their children to pick up the medication for them. Male CHW move around freely. Female CHW face many restrictions, especially when they are young. Normally, these female CHW stay at home and only give the drugs if women asked for. Besides, it is not common to just enter any household to talk to women. The head of the family has to be informed and asked for permission first.

5.7.3 Different actors offering sensitisation on health topics

It is not clear if health information practically takes place in the communities. In theory it does. All CHW and CHW supervisors said that they communicate HP, but caretakers and patients replied that they did not understand what a community health worker was. After it was explained they confirmed that they did not receive health information. They said that the CHW mainly provide drugs in their health posts and that they have seen people going to the houses only for vaccinations. Some said that they received health information through the radio but when asked further, it was more about announcements of the opening of a new private clinic somewhere.

It is said that the OHPM, the Afghan Red Crescent and also the WHO branch in Khost perform HP in the communities. In terms of the WHO it might be a misunderstanding as they provide vaccination and information related to the vaccination.

5.7.4 Acceptability of awareness raising options for women and men

Men talk to men, women talk to women – when these communication channels were respected, there was no problem to sensitise people, they even asked for more information. It was only emphasized that MSF should not talk about any political or religious issues and keep its neutral stand.

Giving HP to men did not pose any problems; during several health promotion sessions in the male caretaker tent in the Khost maternity it was observed that the male attendants perceived the information very well, were interested, wanted to get more information and even asked about some support material to bring to their communities. Health promotion given to women was a greater challenge because women and their caretakers in the admission room were occupied with the upcoming childbirth, starting of labour and in the IPDs women were busy with breastfeeding. Nevertheless it was observed that information was welcomed and messages positively received. The parturients felt happy about their mothers-in-law being present.

At community level HP can be given to women only inside the houses. It is not acceptable to gather women in a public place. It is possible to bring women from different families together in one house, but not all women would be able to join depending on their family relations and the approval of their mother-, father-in-law and husband.

Clear communication about the health information coming from MSF and the MSF maternity encouraged people to participate. Every house has a guestroom or an extra guesthouse called *hujra* in Pashto. It is mainly reserved for men and male visits but as proposed in the interviews it could also be used for HP sessions for women of one house and their female relatives from the same clan.

An easy and acceptable way of bringing messages to the people is through the radio. Some respondents mentioned that they have heard about MSF on the radio. In the evening around 7 to 9 pm people are at home and if they have a radio they will listen to it, but this was said for men only. For women it would be more convenient to listen in the morning while they are doing their housework.

5.8 How to collect data for a maternal mortality study

Since women are restricted in their mobility and access to houses is restricted, it might pose some problems to continuously collect data from female household members directly. In the interviews it was said that every death is announced at the mosque. Therefore the Mullahs of the villages are informed about every death that happens in their community.

Since men have easier access to homes and people, they could ask the oldest male family member to report any death at the CHC. MSF could collaborate with the CHW supervisors of the CHCs to supervise the data collection at household level through the CHW. MSF's community health promoters could talk to the Mullahs who report any maternal death to the health shura of the CHC. The health shura keeps record of any reported death. The CHW are selected by the health shura and the health shura is elected from the different tribes. If we want to collect data ourselves, we could connect our health promoters with the health shura supervisors.

However, since we need maternal death to be reported, women have to be involved, as male household members might not be aware that a woman who died was pregnant. Therefore, the female members of the health shura have to be involved and could receive this special task of data collection on maternal mortality. Additionally, women in the households could be asked, in case one of their female relatives had died, to confirm the data collected through the health shura members or CHW supervisors. One of the main key informants should be the mothers-in-law as they watch over the pregnancies of all female household members.

However, it has to be assessed how much shame (*sharam)* a maternal death creates in the family itself as well as for the TBAs or elder women that have been present during the delivery and how this influences the reporting of maternal deaths.

6 Discussion and recommendations

6.1 Discussion

This study focuses on women's sexual and reproductive health and their perception of and access to maternal health care services in Khost province, Afghanistan. It is one among several other studies (van Egmond et al 2004, Bartlett et al 2005, Khorrami et al 2008, Hirosi et al 2011, Kim et al 2012, Lin & Salehi 2013, Vogel 2014, Todd et al 2015, Izquierdo et al 2016) reporting on reasons for and factors leading to maternal mortality in Afghanistan. Previous articles report on the role of delays (Pacagnella et al 2012) and health-seeking behaviour in neighbouring contexts (Khan 1999, Fikree et al 2004, Mumtaz & Salway 2005,) related to maternal morbidity and mortality. This research does not report on maternal mortality itself but analyses women's access to sexual and reproductive health care services in Khost province with a special focus on decision-making processes and factors influencing these. It adds to the previous report of MSF that discusses the ongoing struggle to access healthcare in Afghanistan (MSF 2014) and comes to the same conclusions.

Afghanistan is a country with one of the highest maternal mortality rates ever reported, with an estimated average of 396 deaths per 100 000 live births in 2015 (WHO 2015). Multiple stakeholders together with the Ministry of Public Health try to reduce maternal mortality by improving access to proper health care. Although the number of health facilities in Afghanistan has increased over the past years, respondents reported that there are still not enough functioning and affordable clinics close to them. Poorly functioning health care provision is not only due to lack of equipment and medication and absence of trained medical staff in governmental institutions (Trani et al 2010); these facilities are not accessible due to multiple factors. Distance and costs are only secondary reasons; the main barrier is that people cannot move because of the insecure environment. Safe access to health care is disguised by its inexistent feature in a volatile conflict zone like Afghanistan; insecurity covers everything.

The unstable context hinders people to access health care and impedes MSF in providing its services outside the 'bunkerised' institution of Khost maternity hospital. On the other hand this protective situation inside the walls of Khost maternity has a critical symbolic meaning for the people. In an unpredictable environment giving birth in a safe place is a question of survival and a moment of reassurance. Not only for the mother and the child but also for the whole family.

People risk their lives to receive health care (Vogel 2014). This is one of the main reasons why MSF should not refer patients to KHP, which signifies an 'unsafe' place. Many people take time and great effort and spend a lot of money and resources to reach Khost maternity. They would have gone to KPH, if they had wanted to, but they chose MSF Khost maternity. Being rejected is a humiliation and negatively impacts MSF's reputation. Families of MSF employees were called to complain about the daughter and her failure in not helping them to stay in Khost maternity. This is considered a shame for the whole family, as similarly analysed in a study on understanding Afghan health care workers (Arnold 2011).

MSF Khost maternity is confronted with an increasing number of deliveries (over 1800/month in March and April)[77], especially normal deliveries. The question arises why more women are coming to the MSF facility to deliver naturally and less women with DOCs. To analyse this feature and to answer the question we have to dig into the moral code of conduct and behaviour of Pashtun society. The analysis of the interviews suggests that it is due to the critically ill and fatal condition of

[77] Sitrep Khost May 2016.

the women with DOC, which is a shame for the people. The families of such women decided that they should deliver either at home or somewhere else and initially ignored their severe condition. When they realised the severeness of the situation, it was already too late in many cases and they could not rush to the clinic anymore. On the one hand it is considered a shame because the family took the wrong decision and on the other hand it is shameful to travel with a bleeding woman. The ones who have to carry the woman are men and the drivers of cars are men. People feel uncomfortable to travel with a woman in the middle of labour, bleeding and impossible to cover her entire bodily condition. Having said that the family will try to do everything to save her life and first try to 'fix' the problem close to where they are with TBAs and private clinics, which often worsens the situation with unregulated usage of labour-inducing medication. This was also reported from Pakistan where unauthorized staff is most frequently administering oxytocin (Shah et al 2015).

MSF is making all their efforts to step out of the 'bunker' situation to bring sexual and reproductive health care closer to the people by supporting comprehensive health centres in Gurbuz and Nadir Shah Khot district and by proposing light support to KPH. Together with the health promotion outreach to the communities it is a crucial step forward to inform and sensitise people about danger signs and the importance to travel earlier to a place near MSF Khost maternity.

The radio plays a crucial role in health promotion. It will take time to reach the families directly, but a special radio programme dedicated to MSF at a certain day and time in the week will help to reach more people in the communities. If men are convinced of the importance of these messages, they will watch over their family members to listen to it. Men will not 'allow' their family members to listen but they are the ones who 'encourage' them to listen. Men are given an important role using their power inside the family for a positive matter. The tradition among Pashtun female elder women to talk about sad events in their life – the sadder the story and the better the woman is able to talk about it, the more she is appreciated and consoled by the others – is an essential feature among others to use in the radio programme (Grima 1992). With the community health promoters MSF has women reaching out to homes, which will increase the uptake of services as reported from Pakistan (Mumtaz & Salway 2005). First and foremost targeting mothers-in-law will further encourage women to negotiate care during pregnancy and delivery. The advice of the patients who said "Tell it to my mother in law, it is not my decision" should be taken into account in the construction of the entire health promotion strategy.

As other studies showed, even in remote areas reliable data on maternal mortality are produced through key informant systems (Barnett et al 2008, Qomariyah et al 2010). The maternal mortality data collection is an additional step forward to get more information about maternal death by using key informants like the Mullah, health shura and CHW.

6.2 Recommendations

The following recommendations are drawn from the analysis of the field research, exchanges with national and international MSF staff working in Khost maternity and Kabul, discussions and debriefings with technical referents from the cell and the medical department in the HQ of OCB. Informal discussions with colleagues at project level and discussions with other medical anthropologists have also been integrated in the analysis. An extended literature review of articles and books related to access to health care for pregnant women, delays in seeking health care and the provision of health care at all in Afghanistan was carried out prior to the field research and was continued after the mission. Finally, the anthropologist's own field experience with MSF, especially from an earlier study done in Ahmad Shah Baba hospital in Kabul, enriched and facilitated data analysis and the elaboration of these recommendations.

The recommendations are categorised and presented in regard to the study objectives. They are to be understood as recommendations to provide timely and adequate treatment for women with or without direct obstetric complications, i.e. they are addressed to MSF and the MoPH in Khost.

Many of the following points were already discussed with the team in Khost, with the HP supervisor in Kabul and with SRH referents and people from the cell in Brussels. Some activities have already started and health promotion messages are defined.

6.2.1 Choosing a simple name for Khost maternity hospital

The Khost maternity hospital shall be re-named into "Emergency obstetric maternal and neonatal care" as mentioned in the medical strategy for 2016.

This name is chosen by a medical organisation and is typically referring to its provision of high-level health care. It is understandable and even more comprehensible with the challenges the project faces. MSF wants to change the name of the hospital into something that refers more to its real objectives, which are treating women with direct obstetric complications and not women with normal deliveries.

However, the chosen name is long and complicated and will only be understood and used by MSF, the MoPH and medical trained people. We need a name for the hospital that is used and understood by the people at community level because we want them to use the facility for DOCs. In the revision of the health promotion leaflet it was also highlighted that most of the people did not know what CHC means, they just called it clinic. Therefore, it is highly recommended to choose a simple name for the Khost maternity. The findings in this report suggest that people use either 'without borders hospital' or they call it by its former name 'military hospital'. Even MSF and maternity is not recognized, therefore either a simple and understandable new name can be given or MSF keeps the present appellation.

6.2.2 Timely referral of women with direct obstetric complications to Khost maternity

The same factors that influence the health-seeking behaviour of women with DOCs delay them in reaching Khost maternity. Timely referral is first influenced by the three delays developed by Thaddeus and Maine[78] more than 20 years ago:

- Delay in deciding to seek care by the woman and/or her family
- Delay in reaching an adequate health care facility
- Delay in receiving adequate care at the facility

Additionally, the delay in recognising that the woman is pregnant and the delay in realising that she has a problem need to be considered.

MSF will only be able to leverage on these delays by providing more knowledge and awareness about DOCs in the communities, through HP directly delivered to the men and women (mothers-in-law and the other female members). In addition, more people can be reached through radio messages, which will lead to them having a better understanding of DOCs, being able to recognize and talking about them and seeking healthcare earlier. It should be advised that families from remote areas come earlier to Khost with their pregnant women representing danger signs and to stay with their relatives in order to be closer to Khost maternity when labour starts.

One important aspect has to be considered in terms of the health promotion messages. We need to be careful not to provoke any feelings of shame or fear when people come late with women with

[78] Thaddeus S and Maine D 1990.

DOCs; we always need to make sure that they are welcome in whatever shape they bring the woman. A 'failed' home delivery could cause shame for the family as they might feel as having taken the wrong decision.

6.2.3 Health promotion and health promotion messages

Health promotion is successfully carried out inside the Khost maternity hospital and in the male caretaker area. Recently, MSF has extended its mobility to the communities in Nadir Shah Khot and Gurbuz. In a further step we hope that MSF will be able to reach out to more and other far-off districts, as these are the most affected ones.

Face-to-face

Face-to-face health promotion and community sensitisation should be given at different levels in the communities.

- To men in public places like CHC, schools and mosques
- To women inside the houses, mainly targeting mothers-in-law in respecting the proposed communication channels.

It has to be assessed which female members from which families can be brought together in one house to receive HP information in a bigger group. Most importantly the female elders have to take part, above all the mothers-in-law as they are the decision makers.

Radio

The radio is an excellent channel to reach out to communities with health information, specific messages and the storytelling tradition of Pashtun society. Grima explored in her book *The performance of emotion among Paxtun women* the widespread tradition of sad storytelling and the importance it has among women (Grima 1992). This tradition could be a basis for a broadcasting programme, where stories related to delay in seeking care are recounted and then analysed in terms of how these cases could have been avoided with earlier access to proper care.

The radio should go along with the health promotion messages given face to face and in the leaflet:

- ➔ information on MSF and Khost maternity
- ➔ health information on danger signs during pregnancy and delivery
- ➔ information about what delays access to care in case of DOCs (these delays can go into the stories)
- ➔ information on referrals from private clinics, CHCs and KPH
- ➔ special programme with storytelling and solutions or advise (to see if this works)
- ➔ special programme dedicated to private clinics in the rural areas

The afore-mentioned problem that the target group of the people over 50 years was not in a representative number in the survey on listening patterns can easily be tackled. The HP team could start with the village elders and the Mullah to inform them first about any radio broadcasting. Following the traditional hierarchy these elders should make sure that their elders in the family, male and female, listen to the radio. In that way the male elders will be made responsible for their (female) family members to listen to the radio – using the power they already have for a positive matter. Any programme MSF is going to have on the radio will be announced in the mosque; day and time, the channel and its importance for men and women, elder and younger ones. Special encouragement to listen will be given to the mothers- and fathers-in-law. Unknown or inexistent listening habits will become normal and part of the daily routine.

Mothers- and daughters-in-law should listen together as many patients in Khost maternity asked the health promoters to talk to their mothers-in-law first. In the same way as mentioned above mothers-in-law should be asked, whereby giving them the important role to make sure that their daughters-in-law listen to the radio together with them.

Another use of the radio could be the encouragement of families to report maternal death, either to the health shura or the CHW in the CHCs, and to explain to them why this is important.

6.2.4 Suggested improvements related to the referral strategy

Khost Provincial Hospital

Referrals to KPH are not an option to consider with the current (at the time of the anthropologist's field stay in March 2016) situation found in the hospital. The medical anthropological approach represents an emic vision of the people MSF works with and therefore suggests and highly recommends not to refer any patients anymore to KPH because of the above-mentioned reasons and perceptions; it is considered unethical.

The referral strategy to KPH is only supported under the one and only condition that patients receive the same level of quality of care in KPH that they would receive with MSF. Thus, MSF either provides trained midwives and guarantees supervision of these midwives at KPH and facilitates all the other needed support in terms of logistics, equipment, material and drugs or stops referring patients. These recommendations are based on the study findings and the assessment report of the medical director of Khost who said, "Without providing support to KPH we shouldn't consider referring any more patients, unless we are able to support them so they can respond sufficiently to the needs."[79]

Comprehensive Health Centre

The referral system needs to be clearly communicated to the CHC. This information needs to be communicated to the patients, in order for them to know that they do not have additional costs etc. It should be made clear to the CHCs under which conditions they can refer to MSF Khost maternity and what the referral criteria are.[80]

Private sector

The private clinics are staffed with unskilled and untrained midwives, which again is a main delaying factor for women needing appropriate maternal care. Therefore, MSF should consider addressing health promotion messages to the private clinics, mainly in the remote areas, to inform about danger signs and timely referral of their patients to Khost maternity. At the same time MSF should make clear that there is no intention to compete with them but to receive complicated cases, which cannot be handled in the private clinics.

6.2.5 Supporting KPH und CHC to reduce normal deliveries in Khost maternity

The light support to Gurbuz and Nadir Shah Khot CHC with midwives and other non-medical material is a great first step and an important signal to the communities in rural areas. The 24/7 service is an ambitious objective and hampered by the security situation concerning all CHCs in

[79] For further information read the assessment report of KHP.
[80] This information is already part of the HP activities and was presented by the HP team in Khost in March 2016.

Khost province. People fear to travel during the night to wherever, so why should they come to deliver at the CHC when they fear to travel to Khost MSF maternity?

The 24/7 provision of care will mainly serve people living nearby these clinics. The challenges MSF will face are that midwives might not be allowed by their families to work over night in the CHC; it is also not very realistic that the husband or another male relative would accompany the midwife to her nightshift as this male person again would have to stay outside the female area but would be on the premises of the CHC. MSF has to guarantee the security and safety of the midwife in the night in the CHC. Even if the midwife would agree to stay overnight, her family might object. MSF should supervise the midwives' presence overnight. The initiative to have two midwives at night is a constructive solution. According to the HP supervisor the message has already spread in the community that the CHCs provide overnight service.

The following HP message should be addressed to elder males: "Tell the men that our quality in MSF is also due to having the staff in the night." Maybe then the male elders can help us to let these women stay overnight to work.

Two other options were thought of in case the night shift does not work. In case the midwife lives near the CHC, she could stay at home and be on call during the night. If needed, she would come to the CHC accompanied by a male relative. However, in such a case the midwife could ask herself why she should come to the CHC, when she can do the delivery in her private clinic and get some additional income, so she might rather ask the woman to come to deliver at her place.

Another solution could be to have an ambulance on call in the CHC that would pick up the midwife at her home in case she is needed for deliveries during the night. However, she would still need to be accompanied by a male relative. This solution would need good communication and HP to be understood that women will be served during the night if they need it.

MSF maternity

A possible solution for the overall reduction of the number of normal deliveries could be an extra facility supported by MSF that only covers normal deliveries. All DOC cases would be treated in the MSF Khost maternity and the extra facility, in cooperation with the MOPH, would provide MSF level of quality of care like in Khost maternity.

Otherwise it is suggested to extend the capacities in MSF maternity with the risk of the number of deliveries further increasing.

At the same time MSF should continue to support the CHCs, not only Gurbuz and Nadir Shah Khot, but also the other CHCs in Khost province with an acceptable solution for the 24/7 service, since the main challenge is the nighttime.

7 Concluding remarks

In this project MSF-OCB is focusing at reducing mortality and morbidity among the population of Khost province by providing free quality health care services to pregnant women. To achieve a reduction in sexual and reproductive health related mortality and morbidity in Khost province the project focuses on women with direct obstetric complications. However, the MSF Khost maternity hospital receives a higher numbers of normal deliveries and women with direct obstetric complications are still decreasing.

This study was undertaken to map the perceptions and approaches concerning decision-making and access to maternal health care services in Khost province, Afghanistan. Questions like where do women with or without danger signs go for deliveries, what and who influences their decision and which factors are beyond any control were analysed and recommendations discussed.

The findings in this report clearly suggest that the majority of the general population coming to MSF Khost maternity hospital lacks knowledge, understanding and recognition of danger signs and risks of delivering at home or in private clinics with unskilled staff. Multiple powerful factors influence the Pashtun people in Khost province in terms of access to health care. Therefore, these factors need to provide the basis of awareness raising for the recognition of danger signs, seeking help in case they occur and accessing skilled health care providers in an insecure environment.

This study reveals the complex reality patients face in terms of access to health care in an insecure environment. To overcome these barriers people risk their lives to reach medical care. Manifold life threatening situations hinder families to travel and to receive appropriate care. With the light support of selected CHCs in districts, support to KHP and further mobility of the health promotion team MSF will reach the communities and will be able to impact on people's access to health care.

8 Annex

8.1 References

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8.2 Anthropologist's programme in ASB hospital, Kabul

WEEK 1

Saturday	05 March	Arrival in Kabul, briefings
Sunday	06 March	Coordination Kabul briefings
Monday	07 March	Flight to Khost cancelled, literature review
Tuesday	08 March	Flight to Khost, briefings
Wednesday	09 March	Briefings, preparation for transcriber recruitment
Thursday	10 March	Transcriber recruitment
Friday	11 March	

WEEK 2

Saturday	12 March	1 male CT, 2 female CT
Sunday	13 March	3 male CT, 4 male CT, 5 male CT, 6 female CT, 7 female CT
Monday	14 March	8 male CT, 9 male CT, 10 female CT, 11 female CT, 12 female CT + TBA
Tuesday	15 March	13 female CT+TBA, 14 male CT, 15 male CT, 16 female CT, 17 patient
Wednesday	16 March	18 female CT, 19 male CT, 20 male MSF staff
Thursday	17 March	21 midwife, 22 female cleaner, 23 FGD midwives CHC, BHC
Friday	18 March	

WEEK 3

Saturday	19 March	24 midwife, 25 translator, 26 midwife, 27 female MSF staff
Sunday	20 March	28 midwife, 29 MSF MD/GYN
Monday	21 March	30 female MSF staff, 31 female MSF staff, 32 female CT, 33 female CT+TBA
Tuesday	22 March	34 GD male cleaner, 35 GD male MSF staff
Wednesday	23 March	36 Patient Neonatology, 37 CT+Patient Neonatology, 38 Mullah, 39 MD KPH and Lab private sector
Thursday	24 March	Interview check, transcription check
Friday	25 March	

WEEK 4

Saturday	26 March	40 CT female, 41 GD health shura, 42 CT female, 43 MSF MD/GYN, 44 GD cleaner female
Sunday	27 March	45 CHW female, 46 CHW male, 47 CHW female, 48 GD CHS+CHW male
Monday	28 March	49 CT male, 50 midwife
Tuesday	29 March	51 midwife CHC Gurbuz, 52 psychosocial counsellor female, 53 psychosocial counsellor male, 54 male MSF staff
Wednesday	30 March	55 midwife, 56 GD MD/GYN private sector, 57 midwife supervisor KPH
Thursday	31 March	58 midwife
Friday	01 April	

WEEK 5

Saturday	02 April	First findings writing
Sunday	03 April	Debriefing Khost
Monday	04 April	Transcribing Interviews
Tuesday	05 April	Transcribing Interviews
Wednesday	06 April	Flight from Khost to Kabul, Debriefing Kabul
Thursday	07 April	Departure from Kabul to Vienna

8.3 Interviewees' profiles

Interview code	Date	Interviewee profile	Sex	Age	ethnicity	tribe	Province	education	# kids	# HH
01_IDI_CT_M	Sa 12/03	CT for his cousin's wife	M	32	Pastho	Sedkhel	Shamal	illitrate	8	70
02_IDI_CT_F		CT for mother's brother daughter	F	23	Pashto	Zadran	Spera	illitrate	0	0
03_IDI_CT_M	Su 13/03	CT for daughter in law	M	40	Pashto	Mangal	Musa Khel	illitrate	8	14
04_IDI_CT_M		CT for daughter in law	M	50	Pashto	Tani	Tani	educated	8	30
05_IDI_CT_M		CT for wife	M	43	Pashto	Tani	Tani	2 grades	7	20
06_IDI_CT_F		CT for daughter in law	F	60	Pashto	Pashto	Spera	illitrate	10	40
07_IDI_CT_F		CT for daughter in law	F	40	Pashto	Pashto	Gurbuz	illitrate	11	25
08_IDI_CT_M	Mo 14/03	CT for brothers's wife	M	45	Pashto	Dawar	Mando Zayi	illitrate	8	18
09_IDI_CT_M		CT for brothers's wife	M	28	Pashto	Babakar Khel	Bak	3 grade	4	27
10_IDI_CT_F		CT for daughter in law	F	40	Guji	Kuchi	Tere Zayi	illitrate	8	30
11_IDI_CT_F		CT for sister in law	F	32	Pashto	Mando Zayi	Mando Zayi	illitrate	4	9
12_IDI_CT_F		CT for her daughter+TBA	F	50	Pashto	Bak	Bak	illitrate	9	24
13_IDI_CT_F (same like 12)	Tu 15/03	CT for her daughter+TBA	F	50	Pashto	Bak	Bak	illitrate	9	24
14_IDI_shop keeper_M		shop keeper	M	24	Pastho	Khost centre	Matun	3 grade	0	23
15_IDI_CT_M		CT for brothers's wife	M	30	Pashto	Balkhel	Bak	illitrate	3	15
16_IDI_CT_F		CT for daughter in law	F	50	Kutchi	Tere Zayi	Kuchi	illitrate	7	20
17_IDI_patient_F		Patient, has twins	F	22	Pastho	Khost Matun	Tani	8 grade	4	15
18_IDI_CT_F	We 16/03	CT for husband's cousin wife	F	50	Pashto	Mangal	Musa Khel	illitrate	5	13

19_IDI_CT_M		CT for his wife	M	35	Pashto	Zadran	Nadir Shah Khot	2 grade	7	18
20_IDI_driver_M		MSF staff	M	31	Pashto	Mando Zayi	Mando Zayi	8 grade	2	46
21_IDI_midwife_F	Thu 17/03	midwife	F	25	Pashto	Mangal	Mangal	12 grade	3	16
22_IDI_cleaner_F		cleaner	F	25	Pashto	Jaji	Jaji Maydan	illitrate	2	15
23_GD_midwives_F		midwife 1 CHC	F	37	Pastho	Mando Zayi	Mando Zayi	12 grade+	7	10
		midwife 2 BHC	F	21	Pashto	Khostwal	Khost Matun	12 grade+	3	25
		midwife 3 BHC + MSF	F	44	Pashto	Pashto	Gurbuz (Kabul)	12 grade+	10	15
		midwife 4 BHC	F	40	Pashto	Tani	Tani	12 grade+	6	8
24_IDI_midwife_F	Sa 19/03	midwife	F	42	Pashto	Pashto	Khost Bazaar	12 grade +	6	8
25_IDI_translator_F		MSF staff	F	21	Pashto	Pashto	Mando Zayi	12 grade +	3	5
26_IDI_midwife_F		midwife	F	28	Pashto	Oskhail	Tere Zayi	12 grade +	4	6
27_IDI_HP_F		MSF staff	F	18	Pashto	Khostwal	Khost Matun	12 grade	0	7
28_IDI_midwife_F	Su 20/03	midwife	F	24	Pashto	Mangal	Musa Khel	12 grade +	4	6
29_IDI_MD_F		MSF MD/Gyn	F	27	Pashto	Nurgal	Kuner	University	0	12
30_IDI_HP_F	Mo 21/03	MSF staff	F	30	Pashto	Khostwal	Khost Matun	12 grade	0	18
31_IDI_HP_F		MSF staff	F	19	Pashto	Khostwal	Khost Matun	12 grade	0	7
32_IDI_CT_F		CT for sister in law	F	30	Pashto	Khostwal	Khost Matun	illitrate	1	20
33_IDI_CT_F		CT for daughter in law+TBA	F	50	Pashto	Zadran	Nadir Shah Khot	illitrate	8	15
34_GD_cleaner_M	Tu 22/03	cleaner 1	M	41	Pashto	Matunwal	Khost Matun	12 grade	9	11
		cleaner 2	M	25	Pashto	Matunwal	Khost Matun	University	2	20
		cleaner 3	M	28	Pashto	Tani	Tani	illitrate	10	18
35_GD_HC_M		MSF staff	M	48	Pashto	Ismael Khel	Mando Zayi	Lab Tech	7	7

		MSF staff	M	27	Pashto	Lander	Tere Zayi	University	3	32
		MSF staff	M	25	Pashto	Aryub Zazi	Khost Matun	nursing sch	3	25
36_IDI_patient_F	We 23/03	patient baby in neonatology	F	19	Pashto	Zadran	Qalandar	illitrate	1	14
37_GD_CT+patient_F		CT for her sister	F	20	Pashto	Khostwal	Khost Matun	6 grade	0	35
		patient baby in neonatology	F	22	Pashto	Khostwal	Khost Matun	illitrate	1	35
38_IDI_Mullah_M		Mullah from Khost	M	47	Pashto	Shamal	Khost Matun	University	8	9
39_GD_MD+Lab_M		Medical doctor from KPH	M	27	Pashto	Ismael Khel	Khost Matun	University	1	13
		Lab Tech private sector	M	30	Pashto	Ismael Khel	Khost Matun	Lab Tech	3	20
40_IDI_CT_F	Sa 26/03	CT for brothers's daughter	F	50	Pashto	Wazir	Waziristan/Tere Zayi	illitrate	4	10
41_GD_health shura_M		Health Shura 1	M	68	Pashto	Babkher Khel	Tere Zayi	12 grade	8	23
		Health Shura 2	M	37	Pashto	Mangal tribe	Musa Khel	3 grade	5	21
		Health Shura 3	M	55	Pashto	Zadran	Shamal	relig studies	11	23
42_IDI_CT_F		CT for her brothers in law's son	F	55	Pashto	Kutschi	Khost Matun	illitrate	6	25
43_IDI_MD_F		MSF MD/Gyn	F	40	Pashto	Khostwal	Khost Bazaar	University	6	8
44_GD_cleaner_F		Cleaner 1	F	45	Pastho	Khostwal	Mando Zayi	illitrate	6	15
		Cleaner 2	F	60	Pashto	Khostwal	Mando Zayi	illitrate	1	4
45_IDI_CHW_F	Su 27/03	CHW female is the mother of 46	F	55	Pashto	Mangal	Musa Khel	illitrate	8	28
46_IDI_CHW_M		CHW male is the son of 45	M	28	Pashto	Mangal	Musa Khel	illitrate	4	28
47_IDI_CHW_F		CHW female is the sister of 48/4	F	40	Pashto	Mangal	Tere Zayi	illitrate	8	31
48_GD_CHS+CHW_M		Community Health supervisor 1	M	50	Pashto	Alisher	Tere Zayi	12 grade	10	25
		Community Health supervisor 2	M	26	Pashto	Zadran	Shamal	University	3	16
		Community Health supervisor 3	M	19	Pashto	Mangal	Musa Khel	12 grade	0	20
		CHW male 4 brother of 47 CHW	M	28	Pashto	Alisher	Tere Zayi	11 grade	5	31

		CHW male 5	M	19	Pashto	Zadran	Shamal	8 grade	0	12
49_IDI_CT_M	Mo 28/03	CT for his wife	M	35	Pashto	Hasansari	Mando Zayi	3 grade	2	17
50_IDI_midwife_F		midwife	F	30	Pashto	Alisher	Tere Zayi	12 grade +	0	15
51_IDI_midwife_CHC_F	Tu 29/03	midwife CHC	F	19	Pastho	Bakakher	Bak	12 grade +	0	10
52_IDI_psy_CHC_F		psychosocial counsellor CHC	F	18	Pashto	Tutakhel	Paktya	12 grade +	0	9
53_IDI_psy_CHC_M		psychosocial counsellor CHC	M	45	Pashto	Tutakhel	Paktya	12 grade +	7	9
54_IDI_HP_M		MSF staff	M	49	Pastho	Matunwal	Khost Matun	University	10	14
55_IDI_midwife_F	We 30/03	midwife	F	37	Pashto	Lakhanwal	Khost Matun	12 grade +	6	8
56_GD_MD_priv_F		MD private sector 1	F	55	Pastho	Nabkhel	Paktya	University	0	10
		MD private sector 2	F	45	Pashto	Khostwal	Khost Matun	University	5	7
57_IDI_midwife_KPH_F		midwife supervisor KPH	F	34	Pashto	Khostwal	Khost Matun	12 grade +	4	25
58_IDI_midwife_F	Thu 31/03 midwife OT	midwife	F	52	Phillipini	Philippini	Bak	nursing sch	2	34

8.4 Map of Afghanistan and Khost province

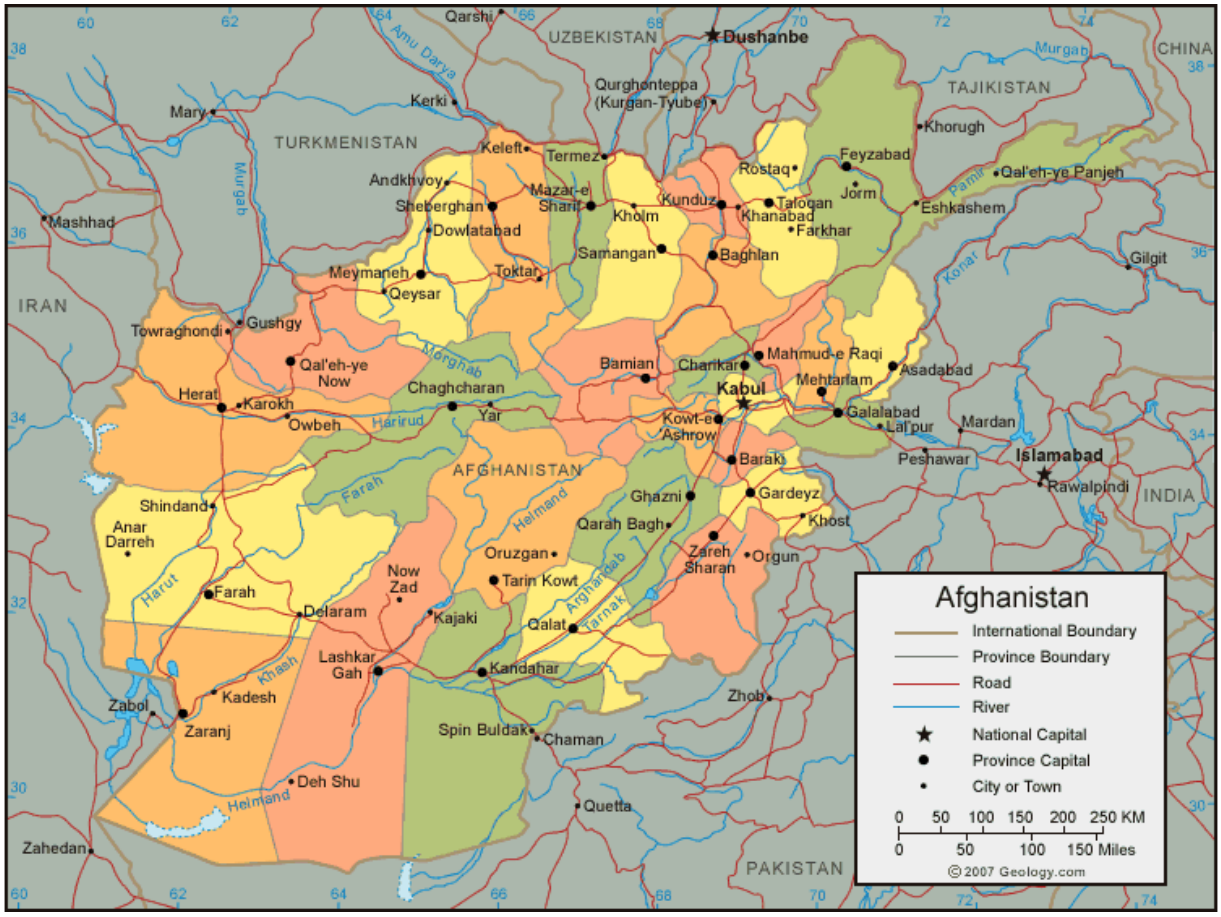
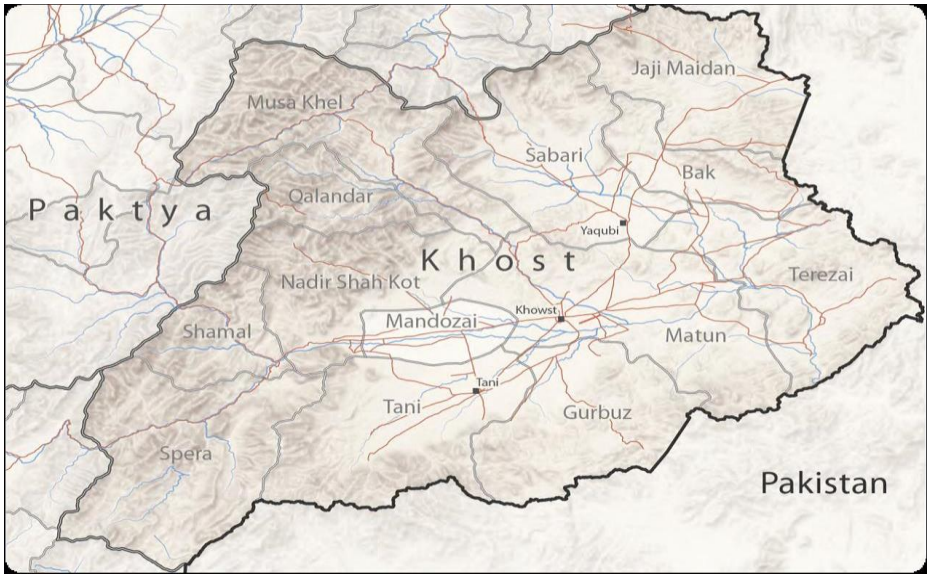


Image showing Afghanistan with provinces and province capitals.[81]



[81]Map: geology.com (accessed 28 November 2014).