NO TIME – NO DILATION

Sexual and reproductive health of Iraqi women in Najaf and reasons for the high number of Caesarean sections at Al Zahra hospital in Najaf, Iraq

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Acknowledgements

Carrying out this review with MSF in Najaf city and its neighbourhoods in Iraq was an enormous experience for me. I could learn from all the respondents in this new social context, which helps me now to better understand Arabic and Islamic cultures related to sexual and reproductive health and its local perception. I was able to add many aspects to my medical anthropological knowledge during this field research, with a special focus on childbirth and Caesarean section in relation to its significance in Al Zahra hospital and gynaecologists proposing it. I realise that every mission is obviously distinct. However it is of utmost interest to find numerous similarities, which support the understanding and validation of the results of this report.

In this sense I would like to thank all the people in Najaf who worked with me in order to make my review possible and constructive. It was an enriching and often touching experience to speak with them. I would especially like to thank them for all the openness with which they shared their personal experiences associated with female reproductive health matters. Personal life stories of young women who felt worried about their first childbirth were all overlain by their personal fears and by the social pressure they should correspond to.

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, to create a successful dialogue with the staff and to empower women and mothers to raise the awareness of Caesarean sections and health risks related to it.

I would like to thank the MSF teams in Najaf and Amman as well as at the headquarters in Barcelona and Vienna for their valuable support. I particularly want to thank my international and national MSF colleagues in the project in Najaf for their professional attitude, their in-depth knowledge of the country and its people, and our enlightening discussions. My translator for this anthropological review was great, both work-wise and personally in taking good care of me. I especially want to thank her for her affection and support and all the fruitful discussions, formal and informal. The Najafi people are the experts of their culture. I can only learn from them and bring their knowledge to paper with my analysis as a medical anthropologist. Last but not least I would like to thank my colleague Sandra Bauer for her excellent editing of this report.

My experiences with MSF, my colleagues, and the people of Najaf are precious to me; they have all my respect for their ability to cope with their difficult living conditions and their consequences. To all those who may continue to work in Iraq.

TABLE OF CONTENTS

Executive summary

The executive summary presents an overview of the most important findings of the review's topic in general. It provides answers to specific points discussed with the operational cell in Barcelona, the head of mission and medical coordinator in Amman, and the field coordinator and field team in Najaf in October 2012.

Marriage and pregnancy
At what time is a woman "allowed" to become a mother? As in other different Arabic contexts, Iraqi women are expected to be a virgin at their marriage. A young woman's wedding should take place in her early 20s. Most of the marriages are arranged between relatives or families. In general, men express their wish who they want to marry. His family then goes to the girl's family to make the proposal. Men and women celebrate the wedding separately.
After marriage, immediate pregnancy is expected from the couple by the family-in-law and these expectations have to be fulfilled. Women know about their pregnancy when they miss their period. They go to the primary health care centre for a test, buy a test at the pharmacy, or get tested at the gynaecologist in the private clinic. Tests are often repeated as people do not trust the primary health care centre. At the beginning, the pregnancy is kept a secret to protect the mother from the evil eye.
In case of infertility the husband can take a second wife or divorce his wife and take another one. Sometimes he is highly pressured by his family, mostly by his mother.

Family planning
Most women take the pill or do the "external" (withdrawal). Many women, who already had numerous children, expressed their wish to practice family planning but forget to take the pill, which results in unwanted pregnancies.
In case a sterilisation is asked for, gynaecologists tell the women to have another pregnancy, so that they can do the sterilisation while performing the Caesarean section at the same time.

Vaginal tears
Vaginal tears are stated as marital or wedding tears as they appear in the wedding night. They are injuries caused through first sexual intercourse, which is performed in a harsh and violent way. Many young, newly married women suffer from these vaginal tears, either inside or outside the vagina.
Explanations for vaginal tears from interviewees include the girl having moved (back), being afraid, tense, clenched, or both being afraid and clenched during this first intercourse, feeling ashamed, not knowing how to do it, the man having to proof that he was able to deflower the girl and showing that she was a virgin. Afterwards, the mother-in-law and the other women in the house check the "white towel" and see if the woman is ok. For the man, there is also a lot of social pressure as he has to proof to be a man. It was also reported that some young, unmarried girls come with these tears, which arouses suspicion of rape.

Antenatal Care
All women know the sex of their baby before delivery through ultrasound, go for a check-up to the private clinic of a gynaecologist, and do some tests and examinations. Some do it monthly, some two times during pregnancy.
In most cases information before delivery for a primipara is inexistent. Sometimes the mother talks to her daughter; sometimes it is a female married relative or the mother's aunt. The same seems to be true for the wedding night. There is no formal or traditional preparation for the girl.

Pregnancy
For women living in Najaf, some of the regulations are not to work too hard, not to carry heavy things, to avoid certain food, and in general not to eat too much, so that the baby is not too big for delivery.
From a religious point of view, a pregnant woman should not fast during Ramadan but has to make up these missed days after delivery. There are no special prohibitions for sexual intercourse, it is even recommended towards the end of pregnancy to provoke labour.

Abortions
Women, who have many miscarriages, go to a gynaecologist to see what is wrong but at the same time talk about bad dreams. They see a so-called "follower", the *dohsa* (seen in the dream as a woman), who makes the baby "fall down" (abortion). Women can protect themselves against the *dohsa* with Koran prayers, which are worn on the body during pregnancy. Sometimes they shall be worn on

the back as the pregnancy is hold by the back. It is also widespread that women go to the Holy Shrine of Imam Ali in Kerbala to ask for a pregnancy or for protection of the pregnancy.

Health-seeking behaviour
Health-seeking behaviour or where to go for delivery is a “women’s thing”; men do not intervene. Women inform their husbands but they do not interfere, in contrast to health-seeking behaviour for children, which is a decision taken in the family. Most of the women arrive at the hospital in time, brought by the family, a relative, a neighbour, or by taxi.

Where to go for a vaginal delivery or for a Caesarean section?
For a Caesarean section women have to go to the hospital. Some prefer or have tried the private hospital, even though they said that the care there is worse than in Al Zahra hospital. Care is related to medical care and not so much to human care. In most cases the gynaecologists tells the women in which hospitals they work and where they should go.
For a vaginal delivery women can choose between a traditional midwife with licence, going to a private clinic of a trained midwife, or going to the hospital, either governmental or private. Some primary health care centres have delivery facilities but it was never mentioned that these are an option. Advantages to deliver with a traditional midwife or at a private clinic of a trained midwife, according to the interviewed women, include that a midwife gives the women time, comforts, and talks to them, the women are not exposed like in the hospital, and they can bring a caregiver. Some women said they don’t want to go the hospital because “they cut you there”. A disadvantage is that women have to go to the hospital, if there is a complication.
The advantage to deliver in the hospital is that Al Zahra hospital offers specialised obstetric care and paediatrics. Even though the maternity ward of Al Zahra hospital has a bad reputation in terms of care, the decisive factor to go there is that women are safe, if there are complications during delivery. The bad reputation refers to the unfriendly and harsh behaviour of the midwives. Women are insulted during delivery with phrases like “for the man you open your legs, now you don’t want to open them!” or “for intercourse you did not cry, now you cry” or “who asked you to get pregnant”, etc.
The maternity ward of Al Hakim hospital seems to have a better reputation in terms of behaviour but it is not a specialised tertiary hospital.

Caesarean section
Only very few women choose by themselves to have a Caesarean section. In most cases, the gynaecologist tells the woman that she needs it. This recommendation may arise out of different reasons, such as the woman waiting for a pregnancy for a long time, having had several abortions before, being told that “the water is finished”, or having “no dilation”. In case of “no dilation”, time is the factor leading to a Caesarean section: the women are given no time for a vaginal delivery.
If women choose by themselves to have a Caesarean section, it is out of fear of the pain, so either the woman herself wants a Caesarean section or her mother says that her daughter cannot bear the pain. However, in almost all interviews women said that vaginal delivery was better.
The advantages of a Caesarean section, from the women’s point of view, are that there is no pain during delivery and that it is projectable. On the downside, it takes a long time to recover and women are in pain for a long time after the delivery. Furthermore, the mother cannot take care of her baby as she would like to, because she is not able to walk and cannot breastfeed in most cases.
After a vaginal delivery, the recovery period is short and women can breastfeed. However, the pain during delivery and the bad care in the maternity ward, especially for primiparous women who are anxious and let alone, are disadvantageous.

Anaesthesia
In terms of anaesthesia in case of a Caesarean section, the gynaecologist decides if spinal or general anaesthesia is necessary. Sometimes the doctors also ask the women. Women fear spinal anaesthesia as it is said that it causes permanent back pain.

Post-partum care
The family-in-law, meaning the woman’s mother-in-law, her sisters-in-law as well as her husband, should support the woman during the post-partum period, as she lives with her husband’s family. Some women go back to their family or mother up to 40 days after the delivery, especially if it is their first delivery. This is also to give the mother some rest from her husband after delivery. The woman will take a purifying bath on the 40th day as she is considered to be impure until then. She should not have sexual intercourse during the first 40 days after delivery and will not pray either.

Caring for the baby
Mothers suffer a lot when their baby is in the sterile neonatal unit, because they would like to be with their babies and care for them. Primiparas need support to breastfeed. The mothers, fathers, and relatives are very tender with their babies in the post delivery room.
The first words the baby should hear are the words of God. One of the relatives, in most cases a male person, like the father, grandfather, or uncle, whispers into both ears of the baby.
The mother-in-law shows a possessive behaviour towards the newborn. She is the one who holds the baby and has the power over it.
The baby is wrapped tightly into a white cloth in order to protect its shoulders when carrying it. The wrapping shall help the baby sleep, protect it from hurting itself with its fingers, make the baby strong, and strengthen its bones. The baby should be wrapped like this for at least 40 days; some do it up to four to six months.

Protection
As soon as the baby is wrapped into its cloth, the family puts some amulets on its chest, which will be taken away after 40 days. These amulets contain beads in different colours and shapes, which intend to protect against distinct dangers, a safety pin, or any other iron object and sometimes a golden ring. Some families put a small Koran under the baby's pillow. A ritual bath with special ingredients is done for the baby on the first, third, seventh, or tenth day and one on the 40th day.

Circumcision is compulsory for all boys but the time, when it is done, varies a lot. The circumcision is done at the home of the boy's family. Usually, a male nurse is called to perform the operation with either a razor blade, scissors or a circumcision machine, which respondents recently talked about. Perceptions about this circumcision machine differed. Some said they don't like it as it is harming the boy or cutting too much. In none of the interviews I was told that the circumcision was done in a hospital or private clinic.

Death of a baby
Generally, the loss of a baby is perceived less painful than the death of an adult person. Still, it is a hurtful experience for the woman and her husband. Friends and relatives will comfort the mother in saying that it is God's will, that she should not be too sad and that she will have another child. The stillborn baby will always receive a name, be washed, and buried. Its funeral will only be attended by a few people and sometimes women are excluded as they would cry too much.

Staff in the hospital
Reciprocal blaming from staff and patients was observed. The patients and their caregivers particularly assert that they do not receive sufficient information about the patients' condition and the medication to take. They report that they receive neither information nor any answers to their questions. It appeared as if the doctors felt insulted and disrespected when asked – in their opinion – irrelevant questions.
The staff on the other side blames the patients, their caregivers, and relatives to be the "troublemakers", like they call them. Not all the doctors have the same opinion, some state, "the patient is a patient" but affirm that they experience an impolite, unfriendly, and sometimes inappropriate behaviour from the caregivers' side.
Furthermore, respondents reported that the contact with the doctors and nurses is in general friendlier in the primary health care centres than in the hospital. This is also due to the fact that the staff sometimes knows the patients as they live in the same neighbourhood. On the other side, people do not prefer to go to these centres for doing tests or any other medical analysis out of lack of trust.
Nurses appear to be in the most difficult situation as they lack respect from all sides, from the patients' and caregivers' perspective as well as from the doctors' side – we may say from the public in general. It was also mentioned that MSF staff talks to doctors in a different way than they talk to nurses, the tone towards doctors being perceived more respectful. This fact represents an additional frustration for the nurses. But much worse seems to be the general notion in Iraqi communities that the nursing profession was and still is perceived to be a menial occupation.
To get better care in terms of interpersonal contact and behaviour of hospital staff, patients affirmed that they bribe – even though it was reported that it did not guarantee better care in some cases. Bribing is mostly relevant for the maternity ward and the operating theatre. Mothers pay to be allowed to stay with their daughters during delivery, when the delivery is at night, and additionally they give money to the staff to take good care of the parturient. In general, the cleaners get money from the caregivers without questioning, as they are perceived as poor people whom you have to help. When the patient has some relatives or friends in the hospital, she will receive kind attention.

Abbreviations

ANC	antenatal care
BCC	behaviour change communication
CS	Caesarean section
DOH	District of Health
ER	emergency room
ERB	Ethical Review Board
FGD	focus group discussion
FIC	field integration course
GYN	gynaecology
HP	health promotion
HSB	health-seeking behaviour
IEC	information education communication
IQD	Iraqi dinar
KMC	Kangaroo Mother Care
MCH	mother and child hospital
MoH	Ministry of Health
MSF	Médecins sans Frontières
NGD	natural group discussion
NSNU	non-sterile neonatal unit
OB	obstetrics
OCBA	Operational Centre Barcelona
OPD	out-patient department
OT	operating theatre
PAED	paediatrics
PHC	primary health care
PPD	preparation for primary departure
SNICU	sterile neonatal intensive care unit
SRH	sexual and reproductive health
TMW	traditional midwife
TOR	terms of reference
US	ultrasound
VD	vaginal delivery

Before going to Iraq I met the only Iraqi person I know in Vienna to talk about my mission and the subject I am going to elaborate on. The first thing he said when I mentioned that I wanted to find out more about the reasons for the high numbers of Caesarean sections (CS) in Iraq, "They don't give time to the women". He did not say much more about the subject, as it is "a women's thing". I was expecting a more thorough discussion but in that very moment I did not know how right he was with his short comment.[1]
Among many other reasons – medical, personal, or concerning comfort/convenience - women have CS, because they are not given enough time and attention for a natural, vaginal delivery (VD). In the following, I will elaborate on reasons and factors influencing the decision for a CS from the women's and health staff's perspective.
Apart from childbirth, I will also describe a woman's path from getting married to conception, pregnancy, delivery, and care for the newborn.

1. Introduction

This report has been carried out in order to analyse the findings based on field research comprising qualitative interviews and observations, mostly done in Al Zahra hospital and some home visits in Najaf city and Kufa, behind the Euphrates River. The field research was carried out between September 1st and October 4th, 2012. In-depth document review before during, and after the fieldwork as well as productive discussions with MSF teams in Amman, Najaf, and the MSF OCBA headquarter are included in the analysis.
Internal MSF reports and comprehensive discussions with the medical coordinator, head of mission, field co-ordinator, medical team leader, and the research team in Najaf have been taken into account for the definition of recommendations.

The report makes no claim to be exhaustive. It gives an insight into the perspective of the people we are working with and will serve to help us to better understand them. In this regard we especially focus on the voices of women I interviewed either in Al Zahra hospital or in their homes. In order to integrate as many perspectives as possible, I also talked to the medical personnel dealing with these women, including senior and resident doctors, nurses, pharmacists, trained midwives, and traditional midwives with licence. But the women, who delivered in whichever way, were in the very centre of the review. How do these women deal with their pregnancy, childbirth, and childcare? Who decides where to go and on which grounds is this decision based? What is the perception of CS and VD? Who or what influences the decision for or against a certain form of delivery?
These questions are outlined more specifically in the general and specific objectives and this report will try to give adequate answers, leading to the adaption of our operational approach and strategies to the local and cultural particularities. Finally, this qualitative research should give us a reflective understanding of the functioning of the communities and more specifically the families regarding women's perception of reproductive health and childbirth, which will enable us to become supportive stakeholders in raising awareness for CS and VD. Furthermore, the research will inform women and their families about the consequences of CS and VD for women's reproductive health.

The report is divided into three parts: part one is an introduction, which consists of background information of MSF OCBA's activities in Al Zahra hospital, the review's objectives, and the methodologies used. Part two highlights all relevant findings according to the terms of reference (TOR). And part three focuses on recommendations. A glossary of some important Iraqi Arabic terms can be consulted in the annex, as well as the detailed bibliography with a list of external and internal documents. The anthropologist's working plan with a list of the interviewees' profiles is shown in order to give a better idea of the target groups and working procedures. Additionally, some maps of the area are provided at the end.

[1] Personal communication in Vienna in August 2012

1.1. Background information

1.1.1. General context

The southern Iraq/Najaf context is of fragile stability, embedded in a politically unstable and violent country, prone to recurring conflict. MSF activities there concentrate on practicing new approaches, such as bedside training, capacity building, participatory approach, and partnership building to improve the quality of secondary and tertiary comprehensive obstetric and neonatal health care services.

Najaf is the religious and therefore in large part also the political centre of Iraq; the administrative centre being in Baghdad. Najaf is called the "black city" because all the women wear the black *abaya*.[2] On the international level, Najaf together with Kerbala and the city of Qom in Iran are the most important intellectual centres of Shi'a religion. By Shi'a beliefs, public, political, and religious life are not separated. The fact that religion is not openly intervening in politics in Iraq is related to the quietist approach adopted by the grand Ayatollah Ali al-Sistani, born in 1930.[3]

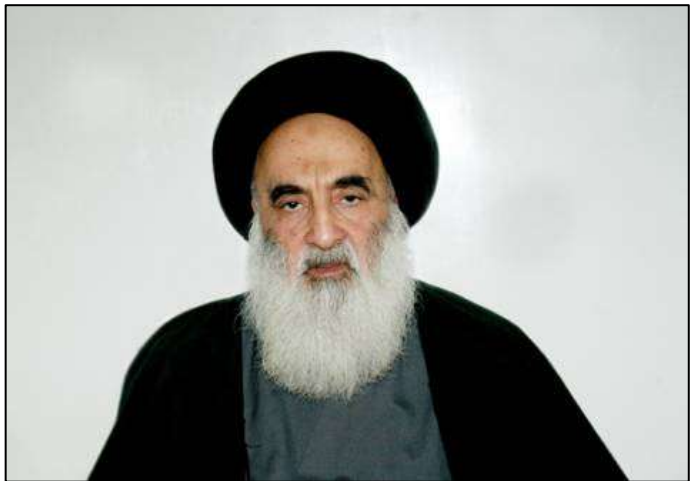


Fig. 1: Grand Ayatollah Ali al-Sistani

1.1.2. Najaf governorate[4]

An-Najaf governorate is one of the 18 governorates in Iraq. An-Najaf is located in the middle of Iraq, about 165 km southwest of Baghdad. An-Najaf is bounded by sacred Karbala and Babil governorates in the north, by Al-Qadisiyyah and Al-Muthanna governorates in the east, by Al-Anbar governorate in the west, and Saudi Arabia in the south.

Fig. 2: Najaf city

Fig. 3: Najaf city

[2] The American forces called the women "moving black objects" (personal e-mail communication).
[3] Find more information in the Najaf project proposal.
[4] Find more details in the TOR Anthropology study.

The governorate has a population of 1,193,603 (male: 600,996 / female: 592,607). An-Najaf Al-Ashraf is a historical holy city and it is an ancient place of science and religion established around the Holy Grave of Imam Ali It inherited its dignity and popularity from Al-Kufa city, while it is one of the biggest cities of Iraq today, and one of the most important centres of Shi'a Islam in the world.

The health structure in Najaf includes six hospitals. One of them is Al Zahra hospital with 473 beds, specialised in tertiary care of paediatrics, gynaecology, and obstetrics. There are also 55 primary health care centres, corresponding roughly to one health centre for 21,000 persons, and 15 specialised health centres.

1.1.3. MSF OCBA mission in Najaf

MSF Spain started working in Najaf in October 2010 and has been able to conduct medical activities with the arrival of medical staff since May 2011. Currently, there are ten people in the project team on average, of whom six to seven have a medical profile.
In Iraq, MSF is atypically working in a middle-income country with low performance of health indicators. It has been a strategic decision to work in an urban area. Within this urban setting specialised care for the neonate has been identified as the main focus, with the ambition to also tackle the root causes of the problem of quality of obstetric care.
MSF is tackling high neonatal mortality, partly by improving skills to save neonates but being very aware of the fact that a large part of the mortality is related to bad practices in obstetric care. Aside from medical decisions, these bad practices may be partly related to patient demands. MSF would like to discover how far this is the case and understand the reasons as far as possible; in order to propose ways of tackling it and in further consequence achieve the project purpose.

1.1.4. MSF operations in Al Zahra hospital

MSF operations in Al Zahra hospital (Fig. 4 and 5) focus almost exclusively on capacity building and (bedside) training in five selected departments of a tertiary mother and child hospital (MCH). The project also addresses transversal matters, such as infection control, statistics, and supply. Rehabilitation is implemented in the hospital to improve patient flow and hygiene conditions as well as a centralised sterilisation. MSF aims to provide some hospital management tools. In this 400-bed hospital in an urban setting, the workload has increased steadily, from 19,982 deliveries in 2009 to 21,827 in 2010 and 23,427 in 2011, with a constant CS rate above 37 %.

Fig. 4: Al Zahra Hospital, street view

Fig. 5: Al Zahra hospital, main entrance

As a result of the operations being focused on training and capacity building of MoH staff, the opportunities for MSF staff to have direct contact to the patients are reduced and the possibilities to get insights into the community dynamics limited. Due to these reasons, support from an anthropologist was agreed to be of an important added value.

1.2. General objective[5]

The very general objective of this review is to develop a comprehensive analytical report on the socio-cultural context of women and their reproductive health in general and women's and health professionals' perspective of delivery and their resistance to change.

1.3. Specific objectives

1.3.1. Sociocultural context and barriers

- Who are the persons making the decisions about pregnancy (and in general about reproduction) in the Najaf family/society?
- What is/are the process/es and tempo for seeking of health care regarding pregnancy, delivery, and perinatal processes?
- What factors are considered when making decisions about choices regarding pregnancy, delivery, and perinatal care?
- To what extent are religious beliefs influencing?
- What role/position does pregnancy/reproduction have in Najaf society?
- What are the perception, status, and use of preventive medicine (especially related to pregnancy) in Najaf society?
- What are the roles of private and public health care systems in Najaf society?
- What are the terms of interaction between patient and health carer in Al Zahra hospital? And in Najaf public and private health systems?

1.3.2. Resistance to change

- How is the collaboration between Al Zahra hospital and MSF perceived by the practitioners, whose bad clinical practices MSF aims to change? What are their expectations?
- What could be expected from these professionals to overcome their resistance to change in a model of partnership with a third institution ("renowned" teaching hospital, medical university, etc) to achieve MSF objectives in the hospital?
- Is there any specific institution that would be appreciated differentially / have an intrinsic added value for this purpose?

After briefing and discussion with the HoM and Medco in Amman, it was agreed that the review should focus more on the women's/patients' perspective than on the prospect of health staff. Women's reproductive health, health seeking-behaviour (HSB) and all the way until a woman reaches the place for delivery were therefore decided to be the main centre of this review.

1.4. Additional information in the TOR

1.4.1. Perception of Caesarean section

37 % of performed deliveries in Al Zahra hospital are CS. This is a high percentage compared to the WHO recommendation of 15 %. Is it because doctors push for it or is the patient asking for it? It was also observed that women prefer general anaesthesia to local anaesthesia. Is there an explanation for that?

1.4.2. Use of the health system

50 % of all deliveries in the Najaf governorate are believed to take place in Al Zahra hospital. Out of an estimated total number of 48,000 deliveries 24,000 take place in Al Zahra hospital but only 38,000 are registered. Where do the missing 10,000 take place?
Patients go straight to the tertiary health structure to deliver instead of being referred from a primary health care (PHC) or secondary health care structure, where non-complicated deliveries could take place. Also, the private sector has expanded rapidly and it seems that people prefer it to the public sector. What are the reasons behind?

[5] General objective derived from the TOR Anthropology study.

1.4.3. Perception of newborns

In the present circumstances, mothers are not involved in the care of newborns as long as they are in the sterile neonatology.[6] How do the mothers feel about this situation?

1.4.4. Religion in health-related decisions

Najaf is the most holy place for Shi'a religion worldwide. After the fall of Saddam and the repression of the Shi'a there has been a revival in the application of Shi'a religious rules in everyday life. How far does religion influence women in their decision making concerning their health in general and during pregnancy?

2. Methodology

2.1. Research Methods

The whole investigation is based on qualitative methods. The research team consisted of a driver, a female interpreter and me as co-ordinator and field researcher. Following briefings in Barcelona, Amman, and Najaf we started introducing myself and the review's objectives to the authorities at Al Zahra hospital. We managed to shortly meet the responsible gynaecologist of the gynaecology (GYN) and obstetrics (OB) ward, Dr. Zeynab and Dr. Nedal, director of the health visitor program. After this short introduction we started working in the different wards of Al Zahra hospital right away.
Purposive sampling was applied, a technique employed in qualitative investigation, which means that the number of people interviewed is less important than the criteria used to select them. The characteristics of individuals are used as the basis of selection, most often chosen to reflect the diversity and breadth of the sample population.
Ethnography, the classic qualitative method, was used as the theoretical research approach. The two main characteristics of ethnography are the emic view of phenomena and its holistic embedding of these. The emic (or insider) perspective analyses and interprets the data from the viewpoint of the population under review and the holistic one examines all aspects of the phenomenon as parts of an interrelated whole.

After discussing whom we wanted to and whom we could meet along with suggestions from the translator we decided to start in the hospital. The research team was independent in its course when working in the hospital and could organise the interviews autonomously. Identified target groups were women of reproductive age in and outside the hospital; medical staff working in Al Zahra hospital; other medical staff like trained midwifes working in private clinics outside the hospital, traditional (and "untrained"[7]) midwives with license in their private clinic, PHC practitioners as well as women and families in their homes.

Fig. 6: Traditional midwife with licence

We almost completely excluded men as target group to talk about SRH. Only occasionally men were present in the wards by chance and a few health staff I interviewed were men. Among the women we chose in the hospital we tried to select women from different economic backgrounds and from different areas in Najaf city and Najaf governorate. We spoke to younger and elder women, to women who

[6] The TOR were finalised in May 2012, at the time of the study the situation had slightly changed.
[7] "Untrained" in terms of a biomedical, western, academic education

already had many pregnancies and childbirths and to primiparas, to women from the countryside and to women from an urban context. But one of the main including criteria was if the woman had a VD or a CS. We also spoke to women in the gynaecology ward, who did not have a delivery but a complication with their pregnancy or reproductive health. Furthermore, we interviewed women in the paediatrics ward and in the ER of paediatrics and gynaecology.
Altogether 64 interviews were conducted and around 139 persons (117 female and 22 male) participated during the stay of four weeks in Najaf.[8]

One to one, in-depth semi-structured interviews, and narrative interviews were conducted in the participants' first language Iraqi Arabic. In most cases the women in the hospital were accompanied by at least one relative. Generally, this was the mother or mother-in-law. Only a few group interviews were undertaken and a few FGD with medical staff, as it is inappropriate for women to gather in one place after a CS. Women, who had a VD, stayed for two hours in the post delivery room and wanted to leave the hospital earliest possible. It was also observed that women and their caretakers from the countryside were much more open to their neighbouring women in the hospital than families from an urban context, and in consequence neighbouring patients were sometimes participating in the interviews.
Serving as an outline for the interviews, a questionnaire was compiled prior to the field stay[9]. The questionnaire was never directly used during the interviews. Flexibility is a key in qualitative research. I had to listen carefully, ask questions appropriate to the respondent's narrative and adjust to every particular interviewee. In the course of the field research, some of the questions were changed to adapt to the local characteristics and to the persons we spoke to.
A female translator was needed as most of the people did not speak English and I did not speak Arabic. Only some of the doctors and nurses spoke English and insisted on doing the interview in English.
A system of manual coding was used to identify the central concepts that emerged, making it possible to describe categories, themes, and patterns related to the research question.
Validation of data will be achieved through triangulation, seeking evidence from a wide range of different sources (interviews, observations, document review, etc), and comparing the findings (Brikci and Green 2007).

2.2. Applied medical anthropology

The review is part of the field of applied medical anthropology, which looks at the applied aspects of health care and preventive care. Questions, such as "how do people deal with health and illness", "what do people do when they feel sick", "where do they go and who takes the decision where and how a sick person has to be treated", were asked in the interviews.[10] In this particular review, I tried to find out how women choose their way of delivery, the place they go to, who is involved in the decision, and what factors influence the choice.
In practice, interviewing begins by trying to understand what health problems are common in a particular community and what causes these health problems. General questions related to women's main health problems in relation to pregnancy and childbirth were used as a starting point for the interviews to open up the discussion and gain the counterparts' trust. This particular review is focusing on sexual and reproductive health of Iraqi women in a context with a high number of Caesarean sections. In this sense, I agree with Winkelman, who said, "Pregnancy and birth are profoundly shaped by culture. Cultural responses to pregnancy may produce support, risk factors for mother and child, or conflict with providers" (Winkelman 2009:131).
Another important aspect is to question ourselves in which way we cooperate with medical staff in Al Zahra hospital and how far we try to be free of ethnocentric assumptive behaviour and vice versa.

2.3. Limitations

One limitation of this review may be the selection of the persons to be interviewed. As it was mentioned before, we intentionally did not interview male respondents as we were told that SRH is a women's issue and men do not have much say in it. Even though there were some subjects coming up towards the end of the review, where, in my opinion, men's voices would have been a great asset to the information I obtained from female interviewees.

[8] Please refer to the work schedule in the annex to see all the interviews, discussions, and observations done.
[9] The questionnaire can be asked from the author.
[10] Precisely, the questions were asked in relation to women's health problems and how they deal with these.

An additional constraint I consider of importance is that out of security precautions I only did a few interviews outside Al Zahra hospital, compared to the number of encounters I had inside the hospital. My stay in the field coincided with the publication of the American movie about prophet Mohammed followed by a French and a Spanish cartoon. Movements were limited and were only possible after a security assessment of the place I wanted to go and the permission of the HoM in Amman. With all these restrictions, I managed to visit the old city and the shrine of Imam Ali, I was able to do some home visits in Najaf and a visit to Kufa behind the Euphrates River.

Fig. 7: Small PHC centre in Kufa behind the river

Fig. 8: Euphrates River in Kufa

I always try to do the interviews in the place where people live to accomplish participant observation. It makes it possible to witness in what circumstances women reside, what their living conditions are, how the family and home is organised and what the role of these women inside the family is. Additionally to the interviews, it gives an insight into the role the context is playing in influencing people's mechanisms to cope with health hazards or medical problems. When this is not possible for a majority of interviews carried out, I see it as a limitation. In this present review, I was able to meet some women from different backgrounds in their homes. It was interesting to experience how families organise gender separation inside the houses and how they deal with (female) visitors. We all know it theoretically but to see the reality is of utmost importance to really understand the given context, where women have to be covered with the black Iraqi Abaya.
Another limiting element of data collection I consider worth mentioning is the fact that some medical doctors, who were not fluent in English, insisted on speaking English during the interviews. Out of respect towards the doctors, the translator could not intervene, as this would have been perceived as inappropriate in a hierarchical sense.

2.4. Ethical considerations

The research team explained the purpose of the review to participants prior to any interview or discussion. The team offered information about the review, its purpose, and its aim. No information was collected from the participants without prior consent. The respondents were assured that all data would be handled with confidentially. Participants enrolled in the review had the right to withdraw at any time during the discussion. Moreover, permission to take written notes during the interviews was obtained before the start of any interview, discussions, or focus group.

A written informed consent form with all information on the review content, purpose, and objectives was translated into Arabic for interview partners to sign. Finally, this form was not used as it was considered to be inappropriate in the hospital context to ask women to sign a paper. For the same reason Hopkins, who did a survey on CS in Brazil, withdrew from the initial intention to have signed informed consent, as "requesting signatures made women extremely uncomfortable" (Hopkins 2000:730). We also came to the same conclusion as Solomon in her dissertation on prenatal and postpartum health care beliefs and practices of Arab women, who said that trustworthiness is a fundamental element in Arab culture and giving ones word is thought to be culturally convenient (Salomon 1990:55).

In the preparation phase of the review it was planned to get ethical approval, which finally was not requested as it was agreed to not publish the review results.

3. Major Findings

In this chapter we will concentrate on the major findings that will help us to understand, where women go for delivery, how the decision is taken, and why women have a VD or a CS in this very special context of the holy city of Najaf in Iraq. What do women think about a natural delivery and what about a Caesarean section? The findings will be underlined by some quotations of the interviews. To protect the identity of respondents only the number of the interview and the interviewee's profile are stated.

3.1. Arab culture and women

Traditionally, the women's place is in the home, caring for the children, and managing household affairs. Most women live in the extended family of their husbands, only the wealthier ones will build their own home. Women and female relatives mainly form their emotional and social support system and are the ones they turn to. I Iraqi women are raised in a strong patriarchal system and contacts with men are limited. Women have to cover their hair with a Hijab and wear wide clothes that should not show any body shape. Especially in Najaf, women have to wear the black Abaya, which is a long wide black gown covering the woman from top to toe (Fig. 9). (Remember what we said in the introduction about Najaf being called the "black city".) If the husband requests it, women will cover their face completely (Fig. 10). As Bahar et al. states, "Islam requires that women respect men's authority […]" (Bahar 2005:558).
Men should not glance at women. If they do so, it is perceived as very offensive. Traditionally, a woman is expected to be modest in her dressing, shy in her speech, and should marry and bear children as the ultimate goal in life - even though many women have a higher educational level and review in colleges and universities. In Al Zahra tertiary MCH hospital, all the doctors and nurses in gynaecology are women. Only in paediatrics male doctors and nurses are employed. In the sterile neonatal intensive care unit (SNICU) and in the baby reception room the number of male nurses (22) is higher than the total number of female nurses (10).

Fig. 9: Women with black Abaya

Fig. 10: Women with black Abaya and face cover

I have observed that, despite higher education, women are expected to marry and bear "a lot of" children. Some women told me that they don't want to or are waiting to marry to keep their "freedom" of working as it depends on the husband if the wife is allowed to continue her job after marriage.

3.2. Arab culture and women's health

Coming back to the quotation of Winkelman in the introduction of this report, who said that culture is shaping an individual's perception of pregnancy and birth, I suggest that we as well look at the influence of Arab culture on women's health. What is important to consider during the childbearing time? What is the mother's role during her daughter's pregnancy? Which traditional rules are to be followed to ensure the baby's health and avoid the evil eye (envy of jealous persons)? And what role does the Islamic religion play in pregnancy, childbirth, and postnatal care?
For example, all the women I spoke to emphasised the importance of the first 40 days after delivery and the abstinence of sex. In general, I observed that the number 40 is often referred to be the ideal

period for any time related actions and behaviour. Another important aspect is the belief in the negative power of individuals possessing the evil eye, which is a synonym for being jealous of other people due to their good fortune or good looks. To protect the person and avert the evil eye, the use of amulets is recommended. In the different chapters that follow, we will further explore the protection of the mother during pregnancy and the child after birth. When talking about the different health related subjects, we will always refer to these underlying cultural characteristics

3.3. Women's reproductive health

As an introduction to all the interviews, we asked a question about women's health in general as a grand tour question to open up the conversation. When we were in the paediatrics ward, we asked a general opening question about the health problems of children.

3.3.1. Becoming pregnant – becoming a mother

Before going into detail about women's reproductive health, we have to highlight at what time a woman is "allowed" to become a mother. As in other different Arabic contexts, Iraqi women are expected to be a virgin at their marriage. A young woman's wedding should take place in her early 20s. A girl, who is not married at the age of 25, will be questioned, if she is not accepting any proposals or if something is wrong with her. Most of the marriages are arranged between relatives or families.

Marriage
In general, men can express their wish for a woman they would like to marry. In that sense, a young woman may get a proposal from a man, who is interested in her, through someone of his family, be it his mother or father, an uncle or any other relative. Usually, one or more of these relatives go to see the girl's family, present their interest, and ask for her hand. If the man's family is unknown to the girl's parents, they will investigate about him and his family by asking around in the area he is living, at his workplace, etc, only then, after a thorough investigation, the woman's family may accept him.
Sometimes marriages are possible between two persons, who are not relatives and did not know each other before but are in love. I was also told that cousins might be in love as, in some occasions, they live in the same house and the family agrees for them to get married.
Men and women celebrate the wedding separately, which allows women to dress in whatever way they want, to be without Hijab (headscarf), and to put on make-up. During the wedding, the bride changes her dresses several times. It depends on the family's wealth how many times she will do that. Later in the evening, the groom comes to take his wife and bring her to his home for the wedding night.

In this very first night the couple spends together, they have to approve the girl's virginity by showing the "white towel". The groom, after "finishing his duty" (to deflower his wife), has to confirm that she was a virgin. The groom's mother, sometimes also the girl's mother and female friends may wait in the house to take care of her after the wedding night.

> "For the virginity my mother had to prove and also my husband. After the first night with me, he came down and said I have finished my duty. And then the women go upstairs and check, if I am ok or if I need something, and then they check also the white bed sheet."[11]

> "The man has to finish his duty for social expectation. There are rules he must be a man."[12]

"Wedding/marital" tears
Towards the end of my stay, I came across the so-called "wedding tears" or "marital tears", which in medical terms are understood as vaginal tears. They are called wedding tears because most of them are related to the wedding night. Doctors told me to come to the hospital on Thursday night to see all the brides coming in this night. Thursday is the day for weddings.

> "[…] you should come on Thursday night. It is the night when most of the cases are coming. Thursday is the day of weddings because it is a blessed day, also Monday. Maybe the woman is moving or the man has been taking something."[13]

[11] Interview 49, home visit, young woman
[12] Interview 54, gynaecologist, resident doctor
[13] Interview 59, resident doctor

There are a lot of stories being told about these wedding tears. According to the information I gathered, they can be outside the vagina but also inside. Women and even health professionals said it is because the girl moved (back) when they had their first intercourse, because she was afraid and clenched, the girl was ashamed, the couple didn't know each other before marriage, they don't know how to do it, and also because they feel the social pressure, especially the man, who has to prove his manhood and fulfil intercourse with blood. When talking to men about this, it seemed that they feel a lot of pressure to fulfil his family's expectations towards him as a husband. Some said that it is also due to roughness and insensibility of the man. In some cases, the man may be much older and the wife young and rather immature. But it was also said that if the man is sensitised or sensible himself, he may give the girl time or knows how to make her feel comfortable. A young man explained,

> "[…] they don't know each other. So he will be afraid that she is scared of the pain and to be injured and she is afraid to have pain and tears. Before the wedding night, the father and married friends they will sit with him and talk to him. You will face this and that you have to manage. Everyone knows about it (sexual intercourse) all the details, even if they don't have done it (sexual intercourse) before. Also for educated people in the school, we studied the human body in biology."[14]

Another worrying information about these wedding tears came to light when we were told that in some cases young, unmarried girls were brought to the hospital. It was obvious that these girls were too young to have sexual intercourse and there was evidence that suggested sexual abuse. Apparently there are one or two cases a month.[15] In such a case the family explains that the girl fell down on a sharp object and they want the doctor to suture the hymen. Doctors said that they understand what happened and try to ask more detailed what happened but the families do not talk about it and the doctors affirmed they do not want to be involved in other families' matters.[16]

3.3.2. Pregnancy

The question, if or when a couple wants to have children, does not arise. Husband and wife have to fulfil the family's expectations, meaning the expectations of the family-in-law. The expectation is an immediate pregnancy after marriage. In very rare cases, I was told that the couple is free to decide if they want to have children right after marriage. Normally, pregnancy is expected within the first months after the wedding. If the woman does not get pregnant, high pressure is imposed on the couple but much more on the woman. In general, women bear the major stress of infertility. "This burden may include blame for the reproductive failing; emotional distress in the forms of anxiety, depression, frustration, grief, and fear" (Dudgeon and Inhorn 2004:1388). The pressure comes mainly from the mother-in-law, who will question the woman's fertility when she is not pregnant after a few months. Usually, the relationship between mother and son is very close and in most cases the son does not go against his mother. If a couple has no children, the man is allowed to quit his wife or take a second wife. Divorce takes place often and some say it is especially difficult, if the marriage is between cousins.

Women get to know that they are pregnant when they miss their period. In most cases, the woman tells it to her mother-in-law, to her husband, or she first goes to the PHC centre for a pregnancy test, which in many cases will be confirmed by a gynaecologist in a private clinic.

When the pregnancy is confirmed, only the husband, the mother-in-law, and the woman's mother will be informed. In the same way as Solomon describes it in her study of Arab women, women in Najaf avoid to talk about their pregnancy in the beginning as it is said that other envious people, who have the evil eye, could harm her baby. Solomon noted, "The woman is warned by her mother and sisters not to reveal the secret of the pregnancy lest she fall victim to the Evil Eye." (Solomon 1990:38).

Family planning

In the past, the only way to prevent conception was withdrawal or ejection of the semen outside the vagina. Many women I spoke to, who already had numerous children, mentioned that they either used or tried to practice family planning with the pill but then did not manage to take it regularly and became pregnant again. Others said they use the "external", which means that the man ejaculates outside the vagina. The only contraceptive used by most of the women I spoke to was the pill. One young woman, who already had five children, wanted a sterilisation to be done but was refused because she was considered too young:

> "Do you want to have more children?

[14] Interview 60, young unmarried man
[15] Please take this information with caution. It needs a profound, medical investigation.
[16] Interview 59, resident doctor

> NO, NO, NO, it's enough, I do not take the pill or so, he (the husband) does not like so much to sleep with me, we will do the external. I took the pill before; I missed a lot of pills that is why I got pregnant with this baby. I wanted to do the sterilisation before but the doctor told me you are too young, they refused."[17]

If a woman wants a sterilisation to be done, she needs her husband to sign the paper in the governmental hospital. He has to come to the hospital in person to agree to the sterilisation of his wife. If it is a private hospital, he may call and give his accordance.

> "I went to the private hospital because I wanted to do the sterilisation. I went here to the Al Zahra hospital but here they ask for a signature. We called him (husband) and we had a quarrel and he refused to sign. In the private sector, they only need a call from the husband. I borrowed from the teachers in the school and from the husband of my sister. The teachers gave me the money, 250,000 (~ 160€), the rest I got from my sister's husband. It was 600,000 IQD (~ 390€) but later with the money for the medication it was 700,000 (~ 460€).[18]

Another interesting detail emerged when talking about sterilisation. In different interviews women said that doctors told them they would do a sterilisation together with a CS. So somehow it appeared that doctors asked the women to get another child via CS and at the same time the gynaecologist would do the sterilisation.[19]

> "My sister was told to be pregnant again to do the sterilisation. The doctor said get pregnant then I will open your abdomen and make the sterilisation."[20]

Rules and regulations during pregnancy

In all the contexts I have worked in, be it in Africa, Asia, or the Middle East, women have to follow certain rules and regulations during pregnancy. These may range from restrictions on personal behaviour, such as abstinence during pregnancy, or limited movements to food prohibitions as these may harm the woman or the baby in the womb. Some of the regulations also serve, if not respected as an explanation for difficult deliveries, abortions or children born with malformations.

For women living in Najaf, some of the regulations are not to work too hard, not to carry heavy things, to avoid certain food, and in general not to eat too much so that the baby is not too big for delivery.

> "At the beginning of pregnancy the mother-in-law asks to eat honey, not to eat too much, and not to eat three times a day but to eat little foods over the day. Don't go upstairs and downstairs a lot, don't carry heavy things, don't lie down on the back, it is for the baby to stay in the uterus and not go up. At the beginning you don't tell that you are pregnant, even when she doesn't know and want to tell it to her friends, the mothers tell them not to tell."
> Why don't you tell it?
> "It is because of the evil eye. The woman doesn't go for the amusement park, even when she goes, it is not good for the baby, she doesn't go to the cemetery, some people don't go to the funeral at the beginning of pregnancy."[21]

From a religious point of view, a pregnant woman should not feast during Ramadan but has to make up these missed days after delivery. There are no special prohibitions for sexual intercourse, it is even recommended towards the end of pregnancy to provoke labour.

Protection of the pregnancy

As we have said before, women do not speak about their pregnancy in the beginning to avoid the evil eye of other jealous or envious women, who could harm the baby in the womb.

Apart from this precaution, all the women I spoke to use some kind of protection during pregnancy. Mostly, it is Koran verses or Koran prayers written on a paper, wrapped in a peace of (green) cloth, and worn around the belly (Fig. 11). Women go to the *Gaaim* or *Saida* to ask for these amulets. The *Gaaim* is a religious person (Fig. 12), who lives at the Holy Shrine; the *Saida* are descendants of the prophet Mohammed. In one interview, a woman spoke about a "red" stone she uses to avoid bleedings during pregnancy. This red stone found in Yemen is worn around the breast.

[17] Interview 27, home visit, young woman
[18] Interview 10, mother in paediatrics ward
[19] This information needs further investigation as it was mentioned only in a few interviews with women who asked for a sterilisation.
[20] Interview 12, woman gynaecology ward, private sector
[21] Interview 13, nurse gynaecology ward

Fig. 11: Woman with amulets wrapped in green cloth

Fig. 12: *Gaaim* at the Holy Shrine

This amulet also serves to protect the women and her pregnancy from the *dohsa*, the follower. Some women specified that the amulet should be carried at the back as it is the back that holds the pregnancy. A weak back may provoke an abortion.

> "It is said when you have an abortion, you have a weak back, so if you have a strong back, you will keep the baby. I think I have a strong back. Before I was in the high school, my period came very late at the age of 16. My mother took me to the doctor when I did not have my menstruation and he said no problem, she has a strong back. Normally you get your first menstruation at the age of 11."[22]

> "Yes, from the grandmother we have these things, at the beginning she did not have pregnancy for nine months, they brought this prayer, we went to some descendants, they have it and she put it on the back for the baby not to fall down (to abort). The baby when it is still small, it is facing the back of the mother, so we put it on the back."[23]

The *dohsa* – a female follower

In case of repeated abortions women spoke about the *dohsa*, which literally means the follower. It is a female person, appearing in a pregnant woman's dreams, preventing her from getting pregnant or if she is pregnant, to "make the baby fall down", which means to abort. At the same time, women also consult a gynaecologist to see what is wrong and to do some examinations.

> "My sister has the follower in the dream; she has three daughters and when she had the pregnancy again, five boys died after that; one in the ninth month, two in the fifth month, two in the third month. My sister had bad dreams.
> What was the doctor's explanation?
> The doctor told us she is fine and healthy but her back is weak."[24]

And again, religion plays an important role. Women travel to Kerbala to pray at Imam Hussein's shrine. This is mainly to get pregnant, if a woman never conceived and to protect a pregnancy, if a woman suffered from many abortions.

> "I was married for three years; the doctor told me, you will never be pregnant. We went to the shrine of Imam Hussein in Kerbala and after 40 days of his anniversary[25] I felt something and I was pregnant. After two years, the same day, 40th day after his birthday, I was pregnant again. […] Many people, if they go there, they ask for a pregnancy, they get pregnant."[26]

Outside Al Zahra hospital one can find a big picture (Fig. 13) of the Grand Ayatollah Mohammad Mohammad Sadeq al-Sadr (March 23rd, 1943 to February 19th, 1999), a prominent cleric of the rank of Grand Ayatollah.[27] Around the picture, patients and their relatives put flowers and presents to honour and respect the Grand Ayatollah. The patients staying in Al Zahra hospital come to ask for blessings to the Grand Ayatollah, they touch the picture and green cloth and pray for a good recovery (Fig. 14).

[22] Interview 32, home visit, wealthy family
[23] Interview 38, woman, gynaecology ward
[24] Interview 4, woman, gynaecology ward
[25] It is commemorated by Shi'a Muslims as a day of mourning for the martyrdom of Hussein, the grandson of Mohammed, at the battle of Kerbala.
[26] Interview 38, woman, gynaecology ward
[27] http://en.wikipedia.org/wiki/Mohammad_Mohammad_Sadeq_al-Sadr (last accessed on January 4th, 2013)

Fig. 13: Grand Ayatollah

Fig. 14: Woman asking for blessings to the Grand Ayatollah

Support during pregnancy

Usually, the family-in-law should take care of the pregnant woman and support her as she lives in her husband's house. This support may very much depend on the pregnant woman's relationship to her mother-in-law and sisters-in-law. Support was always connected with the personal relationship to the family-in-law. Women, who had problems during pregnancy, explained in numerous cases that these problems emerged, because they had to work hard and carry heavy things. Also for abortions and stillbirths, women sometimes blamed their family-in-law for not helping them.

During the first pregnancy, women try (if the husbands agree) to go back to their mothers' home to stay there until the delivery and for the postpartum period of 40 days. It was clearly expressed that they are better cared for by their own mother.

> "If she has someone at home, they can help her, like the sister-in-law or mother-in-law. Or she will go to her family to help her; some women live in a separate house with their husband and kids and she has to work and clean and take care of her kids and her husband. If her husband is employed, he is out the whole day. If she doesn't have a sister to come to help her, she suffers during pregnancy."[28]

Women also talked about their husbands' support during pregnancy. They clearly expressed their expectation that the husband should help his wife with the housework. Some women, who were happy in their relationships with their husbands, said that they get help from them. These were also the women, who said that the husbands come to visit them frequently, which is equally considered as support and encouragement. But at the same time, many women portrayed an inverse picture and complained bitterly about the husbands' lack of respect.

Fig. 15: Image of Imam Hussein

[28] Interview 13, nurse, gynaecology ward

Antenatal care (ANC)
All women I talked to confirmed some sort of ANC. Being a medical anthropologist, I do not evaluate antenatal care in medical or MSF terms but I analyse it from an anthropological perspective. From this perspective, all women did take care of their pregnancy in terms of ANC. All of them either went to a PHC centre[29], to a gynaecologist in his private clinic, to an OPD in a hospital, to a traditional midwife (TMW) with licence, or did any other preventive visits, be it in a religious or traditional way. These latter ones also include visits to a *Gaaim* in the old city, to the Holy Shrine of Imam Ali in Najaf, or Imam Hussein (Fig. 15) in Kerbala, which is also considered as taking care of the pregnancy.

An interesting finding was confirmed by the gynaecologists and through participant observation in the OPD of Al Zahra hospital. Women often come directly to the OPD in the hospital and bypass the PHC centre.[30] In several cases, doctors turned women away and told them to go to the PHC centre first and only come to the hospital when they refer them.

After going to a formal ANC visit in a private clinic or to the PHC centre, women spoke about the tests they did and the ultrasounds they got. The frequency women visited the medical institutions differed very much and were dependent on the gynaecologists' advices. Another influential factor in relation to the frequency of visits to the gynaecologist was the women's health condition. Many talked about high blood pressure, or high blood sugar, anaemia, pelvic presentation or any other health problem. Some women said they went monthly, others said they only went twice. The ones, who went to the doctor just a few times, mainly did US, and only when the doctor prescribed it, they did blood or urine tests. A further determining factor was the financial situation of the family, as they had to pay extra for every visit and every test. A visit to the private clinic of a gynaecologist ranges from 10,000 to 20,000[31] IQD, blood and urine tests between 10,000 to 15,000 IQD, and US generally costs 15,000 IQD. US was one of the most important but also attracting features in ANC. All the women, both from the countryside and from urban contexts, from poor or wealthier background, stressed the meaning of US and related it to the recognition of the baby's gender.
One senior doctor complained about "ultrasound shopping" by the women and the numerous US they do when she was asked how she perceives her patients:

> "They trust us but they don't respect us. In my private clinic I take 10,000 (IQD). To remove the eyebrows, you pay also 10,000, for a tattoo of eyebrows you pay 100,000. Patients take a lot of US because it is cheap. They don't bring the picture of former US (to the consultation) because it is cheap, so they just do another one."[32]

A preference for boys was expressed by most of the women but this favouritism initially comes from their spouse. The husband may get angry and disappointed when they only have baby girls. If so, it is the woman's fault. Generally, after the third girl the husband is not interested in his children anymore. Some women stated that they got beaten by their husbands for that. The importance to have a baby boy was stressed when a woman already had several daughters and was desperately waiting for a boy. In the opposite situation, couples, who only had boys, said that they wish for a girl. In an ideal situation, the first-born should be a boy. This preference for a boy is also expressed by the celebration of the birth, for a boy usually a sheep is slaughtered, which is not always done for girls.

Preparation for delivery
Generally, formal preparation or information exists neither for young women, nor for young men. Women informally talk about delivery experiences and about what they have heard from others. In some cases, the mother and other female relatives, like aunts, talk to the young woman. The same is true of the wedding night, there is no formal or traditional preparation for the girl/woman or boy/man.
In Al Zahra hospital, women cannot come to the maternity ward for delivery with a caretaker, which has a huge impact on the primipara's perception of her first delivery. It would make an enormous difference for the young woman, if she could bring one relative with her. Personal observation in the maternity ward confirmed what women expressed in the interviews; they appeared anxious, uncertain, unconfident, and were often screaming loudly for help and support while their mothers were waiting outside, also worried about what happens to their daughters. Also from their point of view it is very unnatural that a woman has to deliver "alone".

[29] The main PHC centre should have a gynaecologist.
[30] This feature was already mentioned in the TOR.
[31] 10,000 IQD = 6,6 €, (http://www.xe.com/ucc/convert/?Amount=10000&From=IQD&To=EUR, last accessed on January 4th 2013)
[32] Interview 64, senior gynaecologist at OPD

3.3.3. Health seeking behaviour

Before understanding health-seeking behaviour (HSB), we as health workers must make sure that we "understand the social, cultural, economic and environmental bases of health and illness in a given society. Knowledge of how local people view their own lives and health, and the strategies they use to get their needs met, are also important (Kiefer 2007:234).

In the context of women in Najaf, health-seeking behaviour or where to go for delivery is a women's thing, men do not intervene. The woman will talk with her husband and inform him, but he will not question her decisions or interfere. This is in strong contrast to the HSB for a sick child. The husband and other family members will be included in the decision making process where to go. If it is evaluated to be necessary, the family will go to a tertiary hospital specialised in paediatrics.

> "He (the husband) does not know anything about these things, he knows where I am going but it's not a permission."[33]

> "Most of the time it is the mother of the lady. I know the daughter, it is my daughter, I know her best. Sometimes the mother-in-law or family-in-law cannot interfere. Eg, some ladies, their daughters are married in Baghdad or Kerbala, but they bring their daughters here to me because they trust me."[34]

Where to go for delivery is a decision, which is influenced by different factors. In the Najaf context, access to and perception of health institutions do not play such an important role, if people expect qualitative specialised health care. Therefore, the hospital may be far away or it its maternity ward may have a bad reputation but people still come because of the specialised care, where a woman is said to be safe, if any complications emerge during delivery.

> "It is a specialised in women's and child health. If something happens it is their specialisation."[35]

It was the answer given by almost all the women, when asked why they have come to Al Zahra hospital, be it for a vaginal delivery, Caesarean section, or with their sick children. Transport is not a problem, as they said "there is always someone, who will provide transport".[36] Either the family itself has a car, or they have a neighbour or relative, who can drive them, or they take a taxi. This stands in strong contrast to rural contexts in other countries, where people lack transport or cannot provide for it and therefore often do not have access to health care (Burtscher 2004, 2005, 2011, 2012).

Where the woman will finally deliver, depends very much on what she did before in terms of ANC. The decision is very much based on trust, former experience, and recommendations by other family members, relatives, or female friends. As it is stated by the traditional midwife in the quote before, women go to the midwife they trust, if they have the option. Some referred to "the midwife of the family", which means that the mother has already delivered with this midwife, so naturally the daughter will also go to the same one. The gynaecologist is chosen in a similar way. It is often a recommendation of another woman or a certain gynaecologist has a particular reputation.

If the woman chose to consult a traditional midwife with licence, she will deliver with this midwife, given that there are no complications during pregnancy. In other cases the gynaecologist of a private clinic may ask the women to deliver in the hospital where she works. In a different situation a woman may come to that very hospital, where she knows a midwife, and she will deliver there. Or this same midwife has, besides her job in the hospital, a private clinic and prefers the woman to deliver in the hospital. These trained midwives may have a private clinic at home and carry out uncomplicated deliveries there.
Most of the women arrive at the hospital in time but one traditional midwife said:

> "The places we live in is far away from the hospital. Many deliver in emergencies in the car in the street and then I go to the family for the delivery. The DOH is not providing with anything."[37]

One of the significant characteristics, why women like to go to a TMW, is the fact that she gives them time for the delivery, she comforts and talks to them. Beyond that the women are not exposed, like in Al Zahra maternity ward, and most important they are not alone, because they can bring their

[33] Interview 5, woman, post delivery room
[34] Interview 39, home visit, traditional midwife with licence
[35] Interview 11, woman, gynaecology ward
[36] Interview 62, nurse, small PHC centre behind Kufa
[37] Interview 39, home visit, traditional midwife with licence

relatives. In a study on women's perspective of maternity services in the UK, the women's privacy was also a main characteristic and some women chose to wear the *hijab* throughout their labour.[38]

When it comes to health professionals (nurses, pharmacists, and doctors) it is interesting that they themselves also choose to deliver in Al Zahra hospital. Gynaecologists deliver in Baghdad or in a hospital specialised in tertiary care, like Al Zahra for example. In one case a male paediatrician emphasised that his wife, who is a gynaecologist, would deliver in Baghdad. Apparently, health professionals get good attention and appropriate care at Al Zahra hospital, if the staff knows that the patient is a health professional. As one pharmacist put it:

> "I go to the PHC for the vaccination but also to the private clinic of the gynaecologist. Even here our maternity, if I tell them that I am a pharmacist, here in the hospital they treat me in a good way, if not they may beat me."[39]

Nevertheless, the most significant factor, which is of great interest for this review, is in which way the women are going to deliver. Normally the women know this before but sometimes they do not.

When women know beforehand that they will have CS, the hospital options are limited– it will be either a private one or a governmental one. For the private hospital in Najaf, I was told that it is not really an option as the situation and care there is worse than in the governmental ones. If women can afford it, they will go to Baghdad anyway as there is highly recommended private Christian hospital.

> "They don't take good care. The private hospital is worse than here (Al Zahra), cleaning is not good, anaesthesia drugs are cheap, the care is the same, the nurses working here work also in the private hospital. There is nowhere good care, also not in the private sector. If you want to have good care, you go to Baghdad but it is expensive."[40]

In case of a CS, the question, if the woman will deliver with a midwife, trained or untrained with license, does not arise, because a gynaecologist will perform the operation.

3.4. Delivery: vaginal or natural delivery versus *ameliya*[41] or Caesarean section

Finally, we come to the most important question of this review, which is why Najaf and Iraq as a whole have such a high number of Caesarean sections. In the following, I will present the findings I got from interviews with women in and outside Al Zahra hospital and will confront these findings with the information and perception I got from the professional's side (ie, doctors, nurses, and pharmacists).

3.4.1. Vaginal delivery

In the interviews almost all women said they prefer a vaginal delivery (VD) because women "recover more quickly". They can take care of their babies, they can breastfeed, and can leave the hospital earlier. This is in strong contrast to the perception of Brazilian women, who consider VD a risky and negative experience (Béhague 2002:2). Normally, women, who had a first VD, choose natural delivery again. In one case, a woman, who had three vaginal deliveries, delivered her first baby in the private clinic of a trained midwife with a high reputation but then went to the hospital for the second child because she heard that a woman died in the clinic of this midwife. Later on, she said it turned out that it was not the midwife's fault and she went back for her third delivery. Some mothers, who had several VD with "their midwife", had finally deliveries in the hospital only because the midwife moved away or died.
In some rare cases, these mothers spoke about their daughters and said they needed a CS because they couldn't bear the pain. But at the same time, these mothers supported very much the advantage of VD. A 40-year-old woman, who had two CS and seven VD, stated,

> "I have both experiences and for sure the natural delivery is the best. Because after the VD I can walk and I am fine; the CS is the contrary."[42]

A trained midwife said,

[38] Compare with the study of the Maternity Alliance 2004:13.
[39] Interview 31, FGD pharmacists
[40] Interview 10, woman, paediatrics ward
[41] In all the interviews respondents expressed CS as *ameliya*, which means operation.
[42] Interview 4, woman, gynaecology ward

> "Most of the time, when ladies come in pain, they want to go for a CS, they think it is less pain, usually this decision is the woman and her family, but the husband and his family they want to have natural delivery, because they think she will recover fast and some they cannot pay for the CS. The final decision is for the doctor, the senior doctor or the midwife to whose clinic the woman goes."[43]

One negative feature of VD, when done in Al Zahra hospital, was the bad reputation of the maternity ward. From the findings it appeared that all Najaf knows about the maternity ward in Al Zahra hospital and the midwives working there. Despite its bad reputation in terms of care, the decisive factor to go to this hospital is because the woman is safe there, if complications during delivery arise. The bad reputation refers to the unfriendly and harsh behaviour of the midwives. Women are insulted during delivery, "for intercourse you open your legs and here you don't want to open them"[44] or "for intercourse you did not cry, now you cry" or "who asked you to get pregnant" etc. The women felt very ashamed to repeat these abuses in the interview. Respondents recounted that the maternity ward is crowded; everybody shouts at you, nobody listens to you, you are exposed, you cannot bring a caretaker, and last but not least women mentioned that they would be cut (episiotomy). The following quote describes this widespread picture of the Al Zahra maternity:

> "After the delivery I went inside; they cut my daughter and she was bleeding and no one was taking care of her. I asked them to do the suture, they were eating and ignoring me. Finally, they did the suture. There was another lady near my daughter, who could not speak, she had pain but could not express herself. I told them to come to this lady to help her, they said you have nothing to do with it."[45]

> "People like to come to the midwife because we treat them well, in the hospital they let them alone and they cut them, they cut all the ladies."[46]

The maternity ward of Al Hakim hospital seems to have a better reputation in terms of behaviour but it is not a specialised tertiary hospital.

Women, who want to have many children, may make a choice of a first vaginal delivery because it is said that they can only have up to five Caesarean sections. A widespread opinion confirms the feature "once a Caesarean sections always a Caesarean section" which in Tatar et al.'s study was specified being "unfortunately a predominant view among Turkish obstetricians (Tatar et al. 2000:1232).

The women, who do not come to the hospital, deliver either in the private clinic of a trained midwife or in the private clinic of a TMW. There are only a few PHC centres with delivery facilities (17 out of 54) and in general the PHC centres are not very much trusted. Therefore, these health centres are not an option.

3.4.2. Caesarean section

Only very few women choose by themselves to have a Caesarean section. In most cases the gynaecologist tells the women that they need one. Hopkins concludes in her study "Are Brazilian women really choosing to deliver by cesarean?" that doctors clearly have more decision making power in the hospital birthing situation. Their medical expertise and authority is often marshalled to convince a woman to "choose" a Caesarean (Hopkins 2000:725).
The doctor indicated a Caesarean because the woman was waiting for a long time for a pregnancy or had several abortions before. In that case, the doctor's motivation was to safe the baby as a vaginal delivery was evaluated to be too risky. Or the women were told that "the water is finished", "the womb is so thick", or the "back is too weak".

> "The doctor told us she couldn't deliver because her uterus is so thick. The doctor gives injections for the patient. Most of the gynaecologists give the pregnant woman this injection to fix the baby in the womb and this injection make the baby thick and the womb goes up. I think they make the injections to have an excuse for CS."[47]

> "The conditions here are different from other countries, wars, everything is contaminated, and also women in Iraq are tired they have a difficult life. It is not the women's choice, it is the case. When the women have

[43] Interview 9, trained midwife
[44] Interview 52, young woman, paediatrics ward
[45] Interview 38, FGD women, gynaecology
[46] Interview 57, home visit TMW with licence
[47] Interview 61, woman, home visit Kufa

> US, they (the gynaecologists) tell the woman the baby is tired and there is little water and then the woman asks for a CS, she wants to safe the baby."[48]

Regarding the timing of CS, it is again the gynaecologist who decides at what time the CS should be done, according to her work schedule in the hospital, more precisely in the OT (eg, in one case the doctor told the woman on the 10th day of the ninth month that the CS has to be done now as she is on call in the OT and would be in Baghdad the following week. In other interviews it was also mentioned that it was the doctor's decision.

All the other CS that are not elective are called emergency CS. One woman came to the maternity for delivery and finally had a CS. She was told that she had "no dilation", so she needed a CS. In this case time was the factor leading to a CS – the doctors do not give women enough time for a VD. In her study in Brazil where women prefer CS, Béhague et al. found that "older experienced women argued that induction often helped in acquiring a caesarean section, since increased pain from oxytocin and failed induction provided 'hard' proof that labour would not succeed. Conversely, obstetricians believed that induction helped prevent caesarean sections" (Béhague et al. 2002:4). In Al Zahra hospital, this could apply as well as many women said that they received induction with oxytocin but then finally had a CS.
From the women's point of view, the advantage of a CS is no pain during delivery and it is projectable. The disadvantage is that it takes long to recover from the operation and the woman suffers from the pain for a long time. Lobel and DeLuca confirm this finding that women undergoing Caesarean sections experience more pain after childbirth as well as longer and more difficult postpartum recovery (Lobel and Deluca 2007:2273). The baby's mother cannot take care of the newborn, as every movement would hurt her; she is not able to walk and in many cases she cannot breastfeed the child. In general, it was said that vaginal delivery goes with breastfeeding and Caesarean section with formula feeding.

> "I do not breastfeed because I do not have enough milk.
> Is it because of the CS?
> Yes, I was in pain, after six days of the CS I found my breasts dead." [49]

Only in a few cases women said that they preferred CS. When it came to younger ones, they said it is because of the pain and this characteristic was supported by their mothers.

> "Most of the young ladies, they are afraid of the pain and with the anaesthesia they will not feel any pain but later they suffer. My neighbour she had her first delivery (CS) because she was not open (she had no dilation). She has a lot of pain."[50]

Another woman said the same when asked about her delivery and why she had a CS. She said she had no dilation, no opening. This was the answer in general when women came to the hospital for a VD and finally ended up having a CS. It was always because they had no dilation. This finding refers to the information I got beforehand about women in Iraq and the high number of CS. It is because women are not given time for their natural delivery. And apart from the lack of time, they also lack moral support and consolation when in labour.

A trained midwife puts it as follows,

> "Sometimes it is the patient, they want it (CS), sometimes the doctor. From the private sector, they want it. The doctors are afraid of the family of the patient. If something happens to the baby, they go to blame her. They say you did not do your job properly. So they do CS to safe the baby. Also in the hospital they blame the doctor."[51]

In most other cases, the doctor told the women to do a CS for the different reasons we have discussed before. Officially and from a legal point of view, women need a medical indication to have a CS in the governmental hospital. Elective CS are only done in the private sector and the women have to pay for it. The prize for a CS may range from 500,000 in a private hospital in Najaf to 2.5 Mio IQD in the private Christian hospital in Baghdad.

[48] Interview 25, woman, gynaecology ward, private sector
[49] Interview 10, woman, paediatrics ward
[50] Interview 4, woman, gynaecology ward
[51] Interview 9, trained midwife

> "The gynaecologist said she finished her water and it is better to do a CS but I think it is because we offered her a lot of money to go to the private hospital and she could get more money for the CS."[52]

In general, women expressed that they were not happy about the experience of their Caesarean section, as in most of the cases they did not have an elective one but were told by the doctor to do so. Especially primiparous women were not aware of the painful consequences and long recovery period of a Caesarean section. In their study Lobel and DeLuca explore the psychosocial sequel of Caesarean delivery in detail and say "caesareans adversely influence women's moods and perceptions by restricting the control that they can exercise over birth and by violating expectations about childbirth" (Lobel and DeLuca 2007:2272). Essén et al. describe how Somali women try to avoid Caesarean sections in going to the hospital only very late when they have a dilation of up to 9 cm to be sure to have a vaginal delivery because "the majority of Somali women in our study supported a strong association between Caesarean birth and maternal death" (Essén et al. 2010:14).
In the case of health professionals it differed very much; some of them decided for an elective CS, others had VD and CS, and some others said they needed CS because of medical indications. Among the doctors I talked to, a preference towards elective CS could be observed.

3.4.3. General or spinal anaesthesia

Normally, it is the gynaecologist who decides which kind of anaesthesia the woman should get for the operation. In some cases the gynaecologist asks the woman what she prefers. Among the women I spoke to rumours emerged that spinal anaesthesia provokes back pain.

> "They did CS with spinal anaesthesia, since then I have pain in my legs. They did not ask me about what I want, they just give me the spinal all the three with CS."[53]

For that very reason women go for general anaesthesia, if they can decide.

3.4.4. Perinatal care

The women put particular emphasis on talking about who came to visit them in the hospital and for how many times. It was very important as it was seen as a sign of affection and sympathy. It reflects the woman's relationship to her mother-in-law. In most cases women referred to the husband and his family, as their own family would always come, as long as they did not live too far from Najaf.
From my observation I could witness a possessive and competitive behaviour of the mother-in-law towards the newborn and the baby's mother. The mother-in-law is always the one who holds the baby and who has the power over it. The baby's mother has to leave it to her and has not much to say. This also affects the kind of protection that will be done for the baby, how and for how long it has to be wrapped, how the baby will be educated, and which name it will be given to. Sometimes my translator and I were present during these discussions in the post delivery room, while women or mothers-in-law were on the phone with their husbands. Usually, the husband will not object to his mother. Asked about how they feel regarding this strong influence, the women said it is "normal" and "ok", they know it and accept it.

3.4.5. Post-partum care

After delivery the woman is considered to be impure for forty days. Only after she has taken a ritual purifying bath, she is allowed to have sexual intercourse with her husband. During this time the woman also does not pray. As we said earlier, sometimes younger women stay at their mother's place during this postpartum period. In general, men do not like their wife to be away and will then stress to have her back.

3.5. Post-natal care – the newborn baby

How a woman can take care of her baby depends very much on the way she delivered. After a vaginal delivery, women have to stay in the post delivery room for at least two hours, only then they are allowed to go home. After the baby has been dressed in the baby reception room, the mother receives her baby. Accompanied by at least two women, the mother may use this opportunity to rest.

[52] Interview 32, woman, home visit
[53] Interview 7, woman, gynaecology ward

Participant observation indicated that it is the mother or mother-in-law who together or in competition take care of the baby.

3.5.1. The *azan* – prayers whispered to the baby's ears

The very first religious practice that is done to the baby is whispering the *azan* (prayers) into its ears. As it is said, the first words the baby should hear are the words of God. This ritual should be carried out during the first seven days and is usually accomplished by a male relative, the baby's father, his uncle or grandfather, only in some occasion it is a woman. Whispering to the baby is an honour for the person, who is asked to do it.

Fig. 16: Mother-in-law with newborn baby

Fig. 17: Male relative whispering to the newborn

3.5.2. Ritual bath

The baby should get some ritual purification and protection baths, which are performed on the third, seventh, tenth and 40th day. One mother said that they do the ritual bath also on the 20th and 30th day. It was emphasised that it depends on the family, when and how the bath is executed. Usually, the baby's grandmother or grandaunt takes the initiative and decides what substances she will put into the bath. These can be leaves, green leaves for the baby to have a "green" (good) life, roots and plant powders.

> "We put into the water Cumin, soap, and a red powder. It is good for the baby to protect from the evil eye and *dosah*."[54]

Cumin is also given to the baby to clean the stomach and the intestines. Therefore, cumin is put into boiled water and given to the baby to drink. Like a mother explained, the stool of a newborn baby is black and needs to be cleaned.
People buy these medicinal powders in the *Atar* shops in the old city; these shops sell, among other items, plant powders, objects for protection, pills, spices, perfumes, soap, etc; the *Atar* shops are no pharmacies but can be comparable to drugstores.

Fig. 18: *Atar* shop in the old city

[54] Interview 2, woman, gynaecology ward

3.5.3. Name-giving ceremony

The baby receives its name on the seventh day; some do it on the third day. For that occasion normally the baby's head is shaved and the family will celebrate its birth. Again, how this celebration is done depends very much on the financial means of the family and whether it is a boy or a girl, the firstborn or a baby after many others. Usually, the family prepares a special meal, slaughters a sheep, if it is a boy, and invites relatives and neighbours.

3.5.4. Circumcision

Circumcision is compulsory for all boys but the time, when it is done, varies a lot. Some do it shortly after birth or some months later, on the seventh day or on the 40th day, after one year or when the boy is three to seven years old. From all the answers I got I cannot give a general timeframe as the families decide individually. The circumcision is done at the home of the boy's family. Usually, a male nurse is called to perform the operation with either a razor blade, scissors or a circumcision machine, which respondents recently talked about. Perceptions about this circumcision machine differed. Some said they don't like it as it is harming the boy or cutting too much. In none of the interviews I was told that the circumcision was done in a hospital or private clinic.

3.5.5. Protection of the newborn

The bath is already part of the practices done to protect the newborn baby. As soon as the baby is wrapped into its cloth, the family puts some amulets on its chest (Fig. 19 and 20). These amulets contain beads in different colours and shapes, which intend to protect against distinct dangers, a safety pin, or any other iron object and sometimes a golden ring. If a family has twins, nothing different is done but the family will put the same amulets on both babies. Some families put a small Koran under the baby's pillow. One mother said they put a clove of garlic on the baby to take away its yellow colour. In another situation we found yoghurt put on the baby's side to take away the jaundice.

Fig. 19: Newborn baby with beads amulet

Fig. 20: Newborn baby with a golden ring amulet

> "We put beads (green ones) on a security needle on the chest of the baby to protect it against the *al aien* (evil eye) and against the *dosah*. It is like to protect the next pregnancy/baby, not to be tired or sick, to be healthy. We believe that there are some visitors with bad intention, so if relatives come and she is a female and also have a small baby, she can bring the *dosah* to her.[55]

The yellow bead protects against jaundice, the white one is for the milk, and the dark coloured ones as well as the safety pin protect against other evil forces, like sudden frightening of the baby. The blue beads protect against the evil eye, because the colour blue incurs the evil eye, which thereby is averted from the baby. The golden ring or any other golden object is put on the baby when it has an allergy or pimples on the skin. Explanations of respondents differed somewhat but basically meant the same:

> "Like there is a loud sound or screaming or something falls down on the floor and it could affect its health. Eg, the daughter of this (sick) lady delivered in this hospital. Here in a room like this one the box of the milk

[55] Interview 2, woman, gynaecology ward

fall down on the floor next to the baby, the baby got so frightened and now the baby is four years old but until now her health is not so good. She looks smaller than her age."[56]

"We will put the beads and each one is protecting (the baby) from something. One for the jaundice (*abun sufar* = the father of yellow), this bead is usually yellow; a white bead for the milk, one for the evil eye, one against birds. There is a kind of bird that has a loud voice, it comes at night and has a loud voice, so we put a bead for this bird, this bead should be green. For the evil eye, the bead is blue. We put the iron against *dosah*, this iron is going to absorb (the bad intention of other people). The *dosah* is when someone comes to the house of the woman who gave birth. She also has a child and she has come to visit and may have bad intentions. The baby is going to be sick and the mother will not have babies anymore."[57]

The baby will wear the beads for 40 days. The beads then are not thrown away but will be used for the next baby. Usually, it is the grandmothers, who bring the beads for the firstborn.
Apart from these traditional and religious measures to protect the baby, mothers are called to come to the PHC centre to do all necessary vaccinations for the baby. When the woman has delivered with a traditional midwife, she goes to the PHC centre with the mother to register the baby and get the vaccinations.

Part of the baby's protection is also how the mothers wrap the baby (Fig. 19 and 20). It was said that the baby could not be carried (when wearing a black *Abaya*) without being wrapped. It helps the baby to sleep; it strengthens the bones and makes the baby strong; it protects its shoulders, and it hinders the baby to hurt its face, as the baby cannot scratch it with its fingers or nails. Usually, the baby is tightly wrapped like this for six months. The mothers emphasised that they open the cloth up to four times a day. When the baby is sleeping, it is always put on the back or on the side but never on the belly, as in that position the newborn would not be able to breathe. Women generally affirmed that they avoid carrying the baby too often, as they do not want the baby to get used to it. In most cases, the baby was lying on the mother's side (Fig. 21) or was hold by the mother-in-law.

The baby is always wrapped into a white cloth, the colour white having an important signification not only for a child but also in Muslim culture as a whole. Muslim men for example wear white for their Friday prayers.

"The baby has a white heart when it comes out of the mother, so we brought a new white cloth for it."[58]

"It is like this baby came from heaven and the baby is like a white sheet. It is innocent, without any sin."[59]

"Because it is a white object, when the baby is born, the first day of life it should wear white and for marriage white and when it dies also white, the baby is like an angel."[60]

"It is a newborn from the sky, it has no sins like a white sheet. People who go to Mecca they wear white and there they wash all their sins."[61]

White is associated with purity, innocence, and peace. A newborn baby is seen with these positive characteristics – to be an untouched, innocent, clean, pure, and angelic human being.

As we said earlier, Imam Hussein helps a woman to get pregnant. When she has a baby, she puts a green fabric from Imam Hussein's shrine around the baby to get blessings for the child (Fig.21). One mother explained that Imam Hussein is close to God in the same sense the green rag will bring her baby close to God.

[56] Interview 12, woman, gynaecology ward, private sector
[57] Interview 18, woman, gynaecology ward
[58] Interview 21, woman post-delivery
[59] Interview 30, woman, home visit Kufa
[60] Interview 42, woman, NSNU
[61] Interview 61, woman, home visit Kufa

Fig. 21: Baby with green cloth for blessings

In a study on Muslim women in Great Britain and their maternity experience, women and men expressed their wish to get more information on religious aspects, like when to shave the baby's head, when to do circumcision for boys, and how and when to recite the prayers in the baby's ear (The Maternity Alliance 2004:16). The paper highlights the importance of these Islamic practices and the important role they play in the wellbeing of mother and child. Generally, women turned to female friends and relatives or to their husbands, who in turn consulted with relatives or scholars to receive such information.

3.5.6. Breastfeeding and caring for the baby

Breastfeeding is seen as the normal and best way to feed a baby. As mentioned before, in some cases the baby's stomach has to be cleaned before it will be breastfed.
When the mother had a Caesarean section, sometimes she is not able to breastfeed and gives formula milk. As we said earlier in chapter 3.4.2. Caesarean section, the opinion that a baby born through vaginal delivery will be breastfed, while a baby born through a Caesarean section will get formula feeding is widespread.
Babies are breastfed for up to two years, whereas solely breastfeeding is only done for three to six months. Later on, the baby gets juice, soup, or "simple food" to eat.
Normally, women start breastfeeding immediately after birth, only when the baby is put to the sterile neonatology, its mother cannot breastfeed and has to wait. Primiparous mothers sometimes appeared unconfident during breastfeeding in the sterile neonatology and needed support and guidance on how to nurse their baby, especially when it was a premature birth.

A major concern is how women are able to take care of their babies in the hospital, mainly when the baby is put to the sterile neonatology unit. Women spoke of the baby being "tired", when it needed medical attention after birth.

> "Some people have their sight and some are not. Sometimes you cannot do anything and help. Most of the tired babies are from the maternity. They leave the patient suffer in pain until the baby also suffers, until it is tired and dies."[62]

The expression "tired" baby is used by nurses, doctors, and mothers when speaking about a sick baby. The family either goes to a PHC with the sick baby or, in case of an emergency, to the hospital. The care in the hospital is perceived as not good. Most of them do not understand what the child is suffering from (doctors and nurses do not inform them as they think they will not understand). This is one of the reasons why many leave the hospital before they are discharged by the doctor. But since Al Zahra hospital is a tertiary hospital for paediatrics, people still go there.

Women, who had a Caesarean section and have their babies in the sterile neonatology, feel worried and distant to their babies. They have to stay on the second floor of the hospital in the gynaecology ward and when they want to breastfeed their baby, they have to go down the two floors.[63] Breastfeeding the baby is thus the only way to "see" the baby while it is in the sterile neonatology. Breastfeeding is more than only feeding the child, "it is an aspect of 'mothering' and the culturally constructed bonding between a mother and her child" (Moran and Gilad 2007:251). When the mother

[62] Interview 35, nurse SNICU
[63] An elevator is available but the physical distance is big and it is difficult after a CS.

cannot breastfeed the baby, it is let alone in the incubator for most of the time. Though it depends on how long the baby has to stay in the sterile neonatology, from discussions with other MSF staff it appeared that these babies lack skin to skin contact and the natural body contact of a mother with her child. "Skin to skin contact and Kangaroo Mother Care (KMC) can contribute much to the care of the premature baby. Even babies on oxygen can be cared for skin to skin, and this helps reduce their needs for oxygen, and keeps them more stable in other ways as well" (Newman 2005).[64] Skin to skin contact is not only recommended by the WHO for premature babies but for all newborns.[65] All the mothers showed a tender and warm behaviour with their babies. This compassionate and loving affection could also be observed with the babies' fathers and other (male) relatives in the post delivery room.

3.5.7. Perception of a dead baby – abortions

From a religious point of view, the baby in the womb is considered to be a human being after three month of pregnancy, only then it is said to have a soul. An abortion would therefore be allowed, also from an Islamic viewpoint, if a medical indication is given or the mother's life is in danger.
If the baby dies within these three months, the family will not do a funeral as it is considered to be a natural abortion. Respondents specified that they do a small funeral when the baby is born dead but already fully developed with legs and arms, fingers and eyes, nose and ears, etc. In Al Zahra hospital in case of a "normal" death (without malformations and fully developed) or dead born baby, the corpse is given to the family in a carton box. Such a dead baby will still receive a name and a funeral. In general, it is the men going to the cemetery. There the baby is washed and buried but without a big ceremony, only the nuclear family will participate. Sometimes women are excluded, as their screaming and crying would disturb the burial.
Occasionally, the family does not pick up the dead baby in the SNICU. This can be due to the time of death (during, shortly after birth or stillbirth) or the distance between the hospital and the family's home. Furthermore, it could be observed that families who do not pick up the dead baby are often rather poor, with many children already, and from an uneducated background. In their opinion it is better, if the hospital takes care of the dead body.
The medical staff in the SNICU takes time to inform the family about the death of a baby, as this is still a sad experience. The staff does not feel comfortable doing that, even though they (among themselves) do not really appear emotionally affected, as – like they said –they are watching dead babies every day. In any case, the nurses will try to do everything to save the baby to avoid being blamed for anything.

Generally, the loss of a baby is perceived less painful than the death of an adult person. Still, it is a hurtful experience for the woman and her husband. Friends and relatives will comfort the mother in saying that it is God's will, that she should not be too sad and that she will have another child. A woman who had delivered a dead baby in Al Zahra hospital the same day narrates,

> "It is something related with God. If God wanted him to live, he is going to live. It is something out of our hands. Most people are comforting us and they are saying the same, it is God's will.
> […]
> How do you deal with the dead baby?
> We bury it, we give him the name, and for us, even if it is four months, we give him a name because we believe it is a bird in the paradise now. Whenever a baby dies, we are comforting the family in saying it is a bird in the paradise now, don't cry. We wash it and we put it in a white sheet and we bury it here in Najaf.
> Who is doing the wrapping and washing?
> One person of the family takes him to the place near the cemetery where you wash dead babies. They wash them and put the white cloth. We take the body to the cemetery; there is somebody doing the burying and the family is standing there. Some let the women come, some others don't want them because they say they are screaming and we cannot handle the scene of burial."[66]

In most cases a family will say that it is the will of God, when a baby dies, but in some particular circumstances the baby's mother may be blamed for the death of the child. One mother explains how her family-in-law blamed her for the death of her little child,

> "They (the family-in-law) blame me a lot. They have only a garden and I worked a lot in the garden. I did not breastfeed because I was working and gave him formula milk, so they said it is because I did not take

[64] http://www.naturalchild.org/guest/jack_newman2.html (last accessed on January 4th, 2013)
[65] http://www.who.int/mediacentre/factsheets/fs342/en/ (last accessed on January 4th, 2013)
[66] Interview 45, woman, post delivery

care of the baby and the bottle was not clean and they thought the baby got poisoned and that is why it has died."[67]

As we said earlier, the relationship with the family-in-law is always complicated. In general, women are blamed for any problem with the child. A twenty-two year-old mother, pregnant in the eight month, who was in the paediatrics ward with her two-and-a-half-year-old, brain-damaged daughter[68] recounts:

"Did ever anyone blame you for the condition of the child?
They are telling me now, if this pregnancy is the same like the girl, we are going to marry your husband to another woman. And my husband has the same opinion. Everything is my fault."[69]

In general, we can conclude from the interviews that women who have a difficult rapport with their family/mother-in-law cannot count on any support of their husbands as they will never oppose to their mothers.

3.6. The staff in Al Zahra hospital

Since I was working mostly in Al Zahra hospital in different wards, I could practice "participant observation"[70] at all times while doing the interviews in the different wards. The following data draw from these observations and from interviews with patients, caregivers, midwives, nurses, and doctors.

As a general finding, I would like to mention the reciprocal blaming from staff and patients. The patients and their caregivers particularly assert that they do not receive sufficient information about the patient's condition and the medication to take. They report that they receive neither information nor any answers to their questions. I could observe the doctors' behaviour in the different wards. In one situation the doctor screamed loudly, "Did you hear what she was asking me?", when a caregiver asked her where she could find the wheelchair for her daughter, who had a caesarean section. It appeared as if the doctors felt insulted and disrespected when asked – in their opinion – irrelevant questions.
The staff on the other side blames the patients, their caregivers, and relatives to be the "troublemakers", like they call them. Not all the doctors have the same opinion, some state, "the patient is a patient", but affirm that they experience an impolite, unfriendly, and sometimes inappropriate behaviour from the caregivers' side.
Likewise it was observed that resident doctors appear more arrogant towards the patients than senior doctors. On the other side, most senior doctors were accompanied by their resident doctors when they got to the wards for the morning round or came only to look for their private patients. It must be mentioned that the resident doctors face a difficult situation in the hospital as they are sometimes left alone in the ward and do not have senior doctors to guide them, which causes feelings of obstruction and in consequence influences their conduct and behaviour with the patients.

Furthermore, respondents reported that the contact with the doctors and nurses is in general friendlier in the PHC centre than in the hospital. This is also due to the fact that the staff sometimes knows the patients as they live in the same neighbourhood. On the other side, people do not prefer to go to PHC centres for doing tests or any other medical analysis out of lack of trust.[71]

Nurses appear to be in the most difficult situation as they lack respect from all sides, from the patients' and caregivers' perspective as well as from the doctors' side – we may say from the public in general. Iraqi nurses in Al Zahra hospital also mentioned that MSF staff talks to doctors in a different way than they talk to nurses, the tone towards doctors being perceived more respectful. This fact represents an additional frustration for the nurses. But much worse seems to be the general notion in Iraqi communities that the nursing profession was and still is perceived to be a menial occupation. From an article we know that during Saddam times nursing was declared an unnecessary field. He even said, "Iraq would do without nurses". In some areas army deserters or petty criminals were pressed into public service as 'nurses' (Garfield et. al 2005:180). These statements and actions influenced the public opinion for a long time. Not only from a political viewpoint but also from a cultural attitude, working as a nurse was considered to be an inappropriate job for a woman when nursing included caring for male patients and, to use Garfield and Martone's words, "to deal with the physical needs of

[67] Interview 53, woman, gynaecology ward
[68] She was in the paediatrics ward in Al Zahra hospital several times and was told that the girl had jaundice.
[69] Interview 52, woman, ER PAED ward
[70] Participant observation is a qualitative, ethnographic methodology.
[71] We have discussed this matter earlier when talking about doing pregnancy tests in the PHC centres.

unrelated people". This perception is still prevalent in the communities and is even shared by some of the nurses.

> "Even for me, the neighbours do not have a good impression about me. Before, even when I went to study the diploma of nursing my family refused."[72]

Nowadays, however, they say that this attitude changes and nurses get better education in nursing schools.

As described in the beginning of this chapter, women are generally seen as wives and mothers. In their article on nursing in Iraq Boyle and Salman say, "Islamic nurses, primarily women, have had to struggle against considerable odds to overcome many social barriers to advance their career and professional status. Chief among them is that in Islam, the natural progression or development for women is tied to marriage and their families (Boyle and Salman 2003:293). They write onwards that also nightshifts may cause a problem, as women were not allowed to stay out overnight. And because nurses were women, they faced disrespect and census from other health professionals, administrators, and often patients as well.

To get better care in terms of interpersonal contact and behaviour of hospital staff, patients affirmed that they bribe – even though it was reported that it did not guarantee better care in some cases. Generally, bribing is accepted and perceived as an unpleasant but unavoidable culture in the hospital. Bribing is mostly relevant for the maternity ward and the OT. Mothers pay to be allowed to stay with their daughters during delivery, when the delivery is at night, and additionally they give money to the staff to take good care of the parturient. As an example, a family paid 50.000 IQD to the midwife, to other midwives 15.000 IQD, and to the cleaners 5.000 IQD. This was said when asked if the private sector would be a better option. The respondent then affirmed, "You have to pay everywhere" and brought in the example mentioned above. In general, the cleaners get money from the caregivers without questioning, as they are perceived as poor people whom you have to help. When the patient has some relatives or friends in the hospital, she will receive kind attention.

In the interviews with nurses some mentioned their struggle for more respect and appreciation by patients and staff. Even though they have better education now, they are still suffering from the idea that nurses are not well-educated:

> "Why did you choose your job?
> I want to continue my studies on nursing. We choose it because it is a guaranteed job.
> How do you feel as a nurse and its perception?
> We are not really respected or appreciated in the right way from the people outside and inside the hospital.
> Do you know why it is so?
> Because before nurses had no education they were trained six months like a nurse and that's all, so people have a bad impression. We still have these nurses in the hospital, they are assistant nurses."[73]

The solutions proposed by the staff in Al Zahra hospital were interesting. In more than one interview it was mentioned to "exchange ALL the staff", otherwise there would never be any change. This was particularly meant for the maternity ward. It was also noticed that with new staff employed in a certain ward slight changes appeared but finally the newly recruited staff was quickly absorbed by "the old system", which means they adapted the same behaviour.
Explanations why they are not able to perform in a different way, given by the MoH staff, ranged from complaints about the extensive workload to lack of staff in the hospital in general. Like this doctor puts it,

> "Nurses should not be complained by the patients, they should be more educated, they have poor education. We have limited staff here and a high number of patients. It is because of the workload, the nurses do not perform well. In this case also the patients will not respond well to me. Also my work is very heavy, I sleep only two hours a night. You should have one nurse for three babies in the SNCIU."[74]

Harsh and inhuman behaviour was not only observed in the maternity ward with the parturient but also in the baby reception room and in the sterile neonatal unit with newborn babies. In the baby reception and sterile neonatology mostly male nurses are employed. On several occasions it could be observed that these male nurses showed a rude, indifferent, insensitive and cold-hearted behaviour towards the

[72] Interview 15, nurse SNICU
[73] Interview 34, FGD female pharmacists and nurses, PAED ward
[74] Interview 46, resident doctor, paediatrician

babies – which was in strong contrast to their fear of being blamed by the babies' families if anything happened to the babies.[75]

This described behaviour completely contradicts the Islamic code of ethics, which says that patient care means "understanding the concerns of the patient and his family, consoling and comforting the patient and his family" (Rassool 2000).

When it comes to relatives, neighbours, or the own family, the same staff has a completely different behaviour. As we have mentioned earlier, when you personally know someone working in the hospital, the treatment you receive may be much better.

As in other different contexts (on-going fighting in DRC, the genocide in Ruanda, World War II), war and violence in Iraq have influenced people's lives. Individuals have been humiliated and consequently traumatised. Bearing this in mind, a certain degree of dehumanisation in dealing with patients may have developed. "The essence of dehumanisation is the denial of a distinctively human mind to another person. It refers to any situation in which one person has diminished appreciation for another's mental state." (Haque and Waytz 2012:176) In the context of Iraq and the Najafi people, we can see this dehumanisation in regard to the suppression people had to endeavour during Saddam times. As a coping mechanism they have tried to detach themselves from emotional feelings in their nursing job. Dehumanisation is a psychological process whereby opponents view each other as less than human and thus do not deserve moral consideration (Jews in the eyes of Nazis and Tutsis in the eyes of Hutus are only two extreme examples). Not considering the patient as a person anymore but "only" as a patient helps to keep an emotional distance, which results in not seeing her/him as human any longer. This interpretation of dehumanisation denying humanness towards others helps us understanding the Al Zahra hospital context. In this sense the dialogue approach should help medical staff in Al Zahra hospital viewing patients as human beings again.

Concerning nurses being inhuman and harsh with their – often female – patients, we can see similar inhuman behaviour in other different contexts, as described in Jaffré and Sardan's in-depth research in governmental health centres in five west-African capitals (Jaffré & Sardan 2003).

[75] The described behaviour refers to observed actions; eg, in the maternity ward midwives shouted with the parturient when they cried for help; in the baby reception room male nurses left the babies unobserved while sitting in front of the ventilator because it was hot; male nurses lifted up the newborn babies with one hand, like lifting up a cat; they pinched into the newborn's belly or back when it became immobile.

4. Recommendations

Knowledge of the cultural context and intercultural perspectives assist in facilitating relations among provider cultures, which is us, MSF, the community of Najaf, patient cultures in Al Zahra hospital, and institutional cultures, like the Ministry of Health.
This review intends to provide a better understanding of health-related behaviour of women in Najaf, their relationship with doctors and nurses, and subsequent their adapted coping mechanisms. Finally, interactions between provider culture and institutional culture should be fostered in a way that makes a mutual and constructive dialogue and cooperation possible.
In that sense, coming back to one of the conclusions given by MSF in the TOR stated as "resistance to change" and how we could change this resistance, a "dialogue approach" is recommended. This method is based on the understanding that actions, behaviour, and conduct are empirically influenced and culturally constructed.
In the following chapter, this dialogue approach is discussed. It is important not to change the resistance directly. Changes shall be understood and practiced by the hospital staff to be of benefit for the patients AND themselves. MSF should step back from a top-down one-dimensional intervention and give the doctors and nurses a voice to become appreciated partners, who reinforce their dignity and self-esteem and empower all actors to work together.

What can we, as MSF, do to engage in a dialogue for more acceptance of our intended changes to achieve a culturally and medically appropriate care, which fulfils qualitative requirements, and to finally attain our objective to reduce neonatal mortality?[76]

The local and cultural perspectives described above inform us about how individuals, women and mothers, their caregivers and relatives, and medical staff deal with pregnancy, childbirth, and childcare, and what factors influence their behaviour and perception. Understanding people's personal and social life in relationship to sexual and reproductive health will help us to engage in an open-minded and tolerant dialogue with the medical staff in Al Zahra hospital. Culturally sensitive approaches are benefitting for the communities by helping MSF accommodate itself to people's concerns about alienation, powerlessness, distress, and despair. Cultural approaches empower women and men by providing perspectives that enable them to respond to interpersonal and institutional aspects of health promotion (Winkelman 2009:11). In that sense, both sides should be empowered: Women should get more knowledge on delivery options and related health risks and medical staff should be empowered to accept exchange with MSF.

The following recommendations have to be seen in terms of the already mentioned concern that MSF talks to nurses and doctors in a different way.

The overall general recommendation is to engage in a dialogue approach between MSF staff and staff in the Al Zahra hospital. Additionally, if MSF intends to stay for a longer period a health promotion (HP) programme should be thought of to inform women about reproductive health and delivery topics.

These recommendations are drawn from analysis of the field research, exchanges with national and international MSF staff working in Najaf, discussions with the MSF HoM and medical coordinator in Amman. Informal discussions with colleagues and particularly with the translator are also integrated in the analysis. An extended literature review of books and articles related to Caesarean section, women's reproductive health in Arabic and Islam cultures was done prior to the field research and continued after the mission. Finally, my own field experience with MSF leaves its mark on data analysis and recommendations.

[76] This report cannot provide an immediate solution but can give propositions about how to tackle the problem with the expectation to be effective. The dialogue approach will help to sensitise staff towards the importance of taking good qualitative care of patients in terms of human care. This strategy should, together with health promotion messages given to the patients, lead to a reduction of the neonatal mortality rate and a decrease of the number of CS.

4.1. Health promotion for mothers and caregivers[77]

OCB defines health promotion as a set of activities of health education and health services improvement that are intending to better develop the use of health care services (patients and population).[78] In different organisations as well as in MSF sections different names for the health promotion activities are used, such as I.E.C (information, education, and communication), B.C.C (behaviour, change, communication), health communication, health education, patient education, etc. But they all aim at reinforcing knowledge and skills related to health (disease, treatment, and prevention) in order to allow the patient to take decisions and actions towards her/his health. Health promotion encourages comprehensive interventions that combine approaches such as anthropology, sociology, education, training, and communication for healthy behaviour adaptation. For more information on behaviour change model please refer to M. Varasso's "Behaviour Change towards HIV/AIDS" and the Health Belief Model.[79]
It is recommended to have a health promotion component on pregnancy, child birth and delivery options, and risks realted to VD and CS for women and caregivers in Al Zahra hospital. This health promotion activity, done for women only, can be applied in an open manner. It should be performed in a closed room with women only and with a female teacher. When HP lessons are held for women together with other family members or with their husbands we have to be sensitive in the way we talk and the wording we are using. But in general, if it concerns women's reproductive health men do not want to be present. As it was also mentioned earlier, men do not influence women's decisions about SRH issues.

Likewise, the public in the waiting area should get some information on how to deal with medical staff and to appreciate the job of doctors and nurses in order to create a contact of mutual respect. This HP activities could take place in the waiting areas of OPD, in front of the maternity ward, and at the ER of paediatrics and gynaecology.
Apart from these places, specific HP should be done in the feeding room in the SNCIU to help young mothers to breastfeed their babies. For example, mothers should be allowed to be with their babies for some time every day, even if they do not breastfeed. They should be able to visit their babies and put them on their chest like the breastfeeding mothers.

I do not recommend to extend any activities towards the PHC centres, on the one hand because some of them do their own health promotion activities and on the other hand because women do not trust the services they provide. Furthermore, since movements are restricted and MSF does not know how long we will stay, it would form a limited possibility to achieve leverage on women's SRH.

4.2. Dialogue approach with medical staff in Al Zahra hospital

Dialogue approach should be implemented separately for doctors and nurses and for the different wards. The idea, like it was projected in the HP approach, is to sensitise MoH staff for the idea that the doctor-patient-relationship as such already has a huge impact on the physical recovery and the psychosocial well-being of the patient.
The same notion applies to the nurse-patient-relationship, with a particular focus on strengthening their confidence in the nursing profession and therefore promoting appreciation and mutual respect.
In parallel and to be fair, we will also talk to the patients and caregivers to sensitise them for how difficult a nursing and doctor's profession is and how important it is to appreciate their work in order for them to finally benefit from a better care. This can be included in the HP activities of SRH.

[77] This recommendation will only make sense, if MSF's engagement is planned medium-term.
[78] Refer to the HP policy of MSF OCB 2009:5.
[79] OCB Health Promotion Policy 2009: Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals.

Additionally, we will ensure effective information and sensitisation for all health professionals (especially expatriate health professionals) on religious and cultural issues that influence patients' attitude and behaviour.
The following illustration shows a diagram of how the interaction between MSF, MoH staff, and the beneficiaries could be realised and how it could, indirectly through MSF and directly through the MoH staff, have an impact on patients' and caregivers' well-being in the hospital. Finally, this dialogue should also have an impact on patients' and caregiver's attitude towards doctors and nurses.

This dialogue approach should enable an exchange about how ideally MSF medical staff should engage in relationships with patients. The attitude of teaching the MoH staff how to behave or whatever conduct is expected to be convenient should be avoided. This means we try to avoid a top down attitude and rather engage in a dialogue with the MoH staff that is based on mutual respect. This should be the core element of the dialogue approach; engaging doctors and nurses in a workshop on how to deal with patients, to perceive patients as persons, and convince them that their behaviour with the patients has already an impact on their cure.

The approach will start with the field integration course (FIC) kit[80], which informs MoH staff about how MSF works, what our organisation's principles, values, and norms are. The FIC, which has to be adapted to the local context, includes a chapter on how to deal with the beneficiaries. This part could serve as an example to show the impact of a health professional's relationship with the patient. This sensitisation should finally reach an attitude to accept changes proposed by MSF and in this respect tackle the objective to impact on resistance to change.

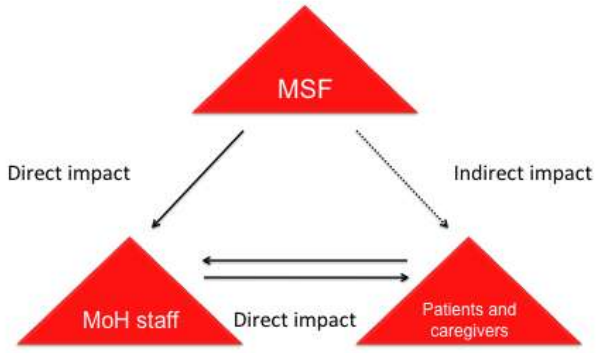
4.2.1. MSF expatriate staff

In order to start with ourselves, I recommend having a cultural briefing on the experience of attitudes, behaviour, and interaction/relationship of doctors, nurses, patients, and caregivers for all the expatriate staff working in Al Zahra hospital.[81] This should help to be sensitive towards MoH staff and to avoid talking to nurses in a dictatorial way. The expatriate staff will also get a briefing on the main cultural characteristics concerning women and SRH.[82]

In terms of skills for the expatriate staff, it is highly recommended to favour a person with strong interpersonal and communication skills. Experience has shown that staff is more responsive towards a person with the ability to engage in a relationship that is based on mutual respect and appreciation, both personally and professionally. Besides, the soft skills of the expatriate should be convincing in terms of professionalism.

4.2.2. Maternity

In the maternity ward the approach mentioned above is adapted to the caregiving of midwifes, especially in case of primiparas, giving the example of how trained midwives and traditional midwives with licence successfully perform in their private clinics. In this regard, the example of their own culture is used to impact on their attitude inside the Al Zahra hospital structure. Midwives recounted how deliveries are performed in the private clinics of a trained or untrained midwife. They all stressed the fact that this same midwife supports the woman who delivers psychologically, talks to her in a friendly



[80] The FIC is a training kit, which can be compared to a small PPD. Experiences in other MSF projects show that this training or workshop is very well accepted, creates a better understanding of MSF, and motivates national staff. It is done for doctors and nurses, midwives from the maternity ward, and nurses from the SNICU separately.
[81] Ideally, the person, who has worked with expatriate staff in different wards and with the anthropologist during her study, will carry out these briefings. The person I recommend is Hadeel Aljabiri.
[82] Two articles, listed in the bibliography, should be given in the briefing: "Experiences of Maternity Services" from The Maternity Alliance and "The crescent and Islam: healing, nursing and the spiritual dimension" from G. Hussein Rassool.

way, and comforts her. In discussions with the midwives in Al Zahra hospital it was stated that women like to go to private clinics because of the more human and better “treatment” there.

Particularly in terms of the maternity ward, MSF should attain that the hospital director and the responsible of the maternity ward allow one caregiver to be with the parturient, providing a strong briefing to the caregiver on how to “behave” in the maternity ward so as not to create discord with the midwives. This caregiver will be with the woman who delivers to support her emotionally and psychologically, to still her fears, and to calm her down, especially in the case of primiparas).

4.2.3. Sterile neonatal unit

In the sterile neonatal unit this dialogue should focus on the subject of the importance of skin to skin care for the newborns, like the Kangaroo Mother Care (KMC). Additionally, nurses will be guided how to deal with the newborns in the baby reception room.
The recommendation to do skin to skin care may sound contradictory to the finding that women do not want to spoil their babies by holding them in their arms. As we do it when we talk about plumpy nut, we will also talk about skin-to-skin care as an essential treatment the baby needs. In this way we can detach it from the notion of spoiling the child.

4.2.4. Gynaecology and paediatrics ward

The wards are mentioned for the dialogue approach, especially focusing on the nurses and doctors and their relationship with or attitudes towards the patients.

Concluding remarks

In this project MSF is focusing on a tertiary care hospital for paediatrics and gynaecology. Direct contact with patients is limited for the expatriate staff. In the recommendations mentioned before we have proposed only two major activities, one focusing on the patients and caregivers, the other one directed to the MoH staff in Al Zahra hospital.
MSF will engage in HP activities within the hospital in the waiting areas and in a dialogue approach with a team-building workshop to improve working relationships between MoH staff in Al Zahra hospital and MSF expatriate and national staff.
The coordination team in Amman together with the cell in Barcelona should draw their own conclusions out of this report in order to further plan operational activities in Najaf in the future.

The assertion that success or failure of health programmes depends on how well they adapt to the characteristics and needs of the population has to be extended here to the quality of cooperation with the MoH staff. The success of this project is derived from the population accepting it as well as from the staff's response to proposed alterations of professional performance.

With an open-minded attitude and respect to the people and their culture, we will be able to create a fruitful collaboration with the medical staff in Al Zahra hospital in Najaf and finally improve obstetric and neonatal care for the patients.

Glossary

Arabic (Iraq)	English
A sunna	Prayer, what the prophet has done
Abaya	Long wide black cape/gown
Abun sufar	The father of yellow = jaundice
Al aien	The evil eye
Al nur	The light
Ameliya	Operation, Caesarean section
Atar	Person selling medicinal items, like herbal plant powders, stones, beads, etc.
Azan	Prayers
Chudetsch	Incubator
Djinn	Spirit living in the air, daemon in Arabic beliefs
Dosah	A woman, who gave birth within the last 40 days, visiting another woman, who also gave also birth within the last 40 days, can bring the *dosah*, as a consequence the child becomes sick and the mother will not get pregnant anymore
esqat	Following down, abortion
Fetech baten	Caesarean section
Gaaim	Religious person working in the Holy Shrine who writes Koran verses and prayers to wear as an amulet
Haram	What is not allowed or forbidden from the religion, impure, sin, immoral
Harmal	Fumigation, to chase away bad forces, in the house, and for a good income
Herez	Amulet
Hijab	Protection, scarf
Jede	Midwife
Kabele	Midwife
Molde	Midwife
Mumareda	Nurse
Saida/Sadr	Descendants of the prophet Mohammed
Shems	Sun
Sonar	Ultrasound
Taaba	Follower, a woman seen in the dream, the follower is only female
Tahur	Boy's circumcision, literally purification
Wulade tabiea	natural delivery, vaginal delivery

Bibliography

Bahar, Zuhal, Hale Okçay, Seyda Özbiçakçi, Ayse Beser, Besti Üstüm and Meryem Öztürk (2005): The effects of Islam and traditional practices on women's health and reproduction. In: Nursing Ethics, 2005, vol 12 (6).

Béhague, Dominique, Cesar G. Victora, Fernando C. Barros (2002): Consumer demand for caesarean sections in Brazil: informed decision making, patient choice, or social inequality? A population based birth cohort study linking ethnographic and epidemiological methods. In: BMJ papers Vo 324, 29 April 2002.

Brikci, Nouria and Judith Green (2007): A guide to using qualitative methods. MSF UK.

Boyle Joyceen S. & Khlood Salman (2003): Nursing in Iraq. In: Nancy H Bryant (ed): Women in Nursing in Islamic Societies. Oxford University Press, New York.

Dudgeon, Matthew R. & Marcia C. Inhorn (2004): Men's influence on women's reproductive health: medical anthropological perspectives. In: Social Science and Medicine Vol. 59, 1379-1395.

Essen, Birgitta, Pauline Binder & Sara Johnsdotter (2011): An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers and caesarean birth. In: Journal of Psychosomatic Obstetrics & Gynaecology, March 2011, Vol. 32 (1), 10-18.

Garfield R., Faan & C.F. McCarthy (2005): Nursing and nursing education in Iraq: challenges and opportunities. In International Council of Nurses, International Nursing Review, Vol. 52, 180-185.

Haque, Omar Sultan and Adam Waytz (2012): Dehumanization in Medicine: Causes, Solutions, and Functions. In: Perspectives on Psychological Science Vol. 7, No.2, p. 176-186.

Helman, Cecil G. (2000): Culture Health and Illness. Fourth edition, Hodder Arnold, London.

Hopkins, Kristine (2000): Are Brazilian women really choosing to deliver by cesarean? In: Social Science and Medicine, Vol. 51, 725-740.

Jaffré Y. et J.-P. Olivier de Sardan (2003): Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest. Karthala, Paris.

Kiefer, Christie W. (2007): Doing Health Anthropology. Research Methods for Community Assessment and Change. Springer Publishing Company, New York.

Lobel, Marci & Robyn Stein DeLuca (2007): Psychosocial sequelae of cesarean delivery: Review and analysis of their causes and implications. In: Social Science and Medicine Vol. 64, 2272-2284.

Moran, Lia and Jacob Gilad (2007): From Folklore to Scientific Evidence: Breast-feeding and Wet-Nursing in Islam and the Case of Non-Puerperal Lactation. In International Journal of Biomedical Science 3 (4) 251-257, Dec 15 2007.

Rassool, Hussein G. (2000): The crescent and Islam: healing, nursing and the spiritual dimension. Some considerations towards and understanding of the Islamic perspective on caring. In: Journal of Advanced Nursing, Vol. 32, No. 6, 1476-1484.

Solomon, Julia Ellis (1990): Prenatal and postpartum health care beliefs and practices of Arab women. The university of Arizona Dissertation UMI Ann Arbor, Michigan.

Tatar, Mehtap, Serdar Günalp, Sonem Somunoglu, Aygül Demirol (2000): Women's perceptions of caesarean section: reflections from a Turkish teaching hospital. In: Social Science and Medicine Vol. 50, 1227-1233.

The Maternity Alliance (2004): Experiences of maternity services: Muslim women's perspectives.

Winkelman, Michael (2009): Culture and Health. Applying Medical Anthropology. Jossey-Bass, San Francisco.

Internal MSF documents and reports

Burtscher, Doris (2004): Searching for health care after 10 years of war. The Mende and Kissi in Kailahun district, Sierra Leone. Internal Report MSF OCP.

Burtscher, Doris (2005): "You cannot break the culture of silence". Health-seeking behaviour and ideas about Benson Hospital and its services with a special focus on SGBV and its perception in the community. Monrovia, Libera. Internal Report MSF OCBA.

Burtscher, Doris (2011): “It is not a disease but we treat it as a seriousness”. The perception of malnutrition and health-seeking behaviour of the Maithili Biraul Block, Darbhanga District, Bihar State, India. Internal Report MSF OCBA.

Burtscher Doris (2012): Si tu n’es pas mort tu auras une cérémonie après la guérison. Local perception of Female Genital Cutting. Salamt region, Am Timan District, Chad. Internal Report MSF OCA.

MSF OCB Health Promotion Policy Final March 2009

MSF medical report Iraq March 2012

MSF nursing review TESACO July 2011

MSF paediatrics first report June 2011

Anthropologist's work schedule

Saturday	1 September	Departure from Vienna to Amman

WEEK 36

Sunday	2 September	Briefing in Amman with HoM and MedCo
Monday	03 September	Departure to Najaf
Tuesday	04 September	Arrival in Najaf, briefing with FieldCo
Wednesday	05 September	Hospital tour, I 1: woman/PAED ward
Thursday	06 September	I 2: women/Gyn, I 3: women/Gyn ward, I 4: women/Gyn ward
Friday	07 September	Lit review
Saturday	08 September	

WEEK 37

Sunday	09 September	I 5: 2 women post-delivery, I 6: Dr. Nedal health visitor programme, I 7: 4 women NGD gynaecology, I 8: ICRC visit,
Monday	10 September	I 9: midwife maternity, I 10: woman PAED ward, I 11: 2 women Gyn ward, I 12: Gyn ward privat sector 4 women
Tuesday	11 September	I 13: nurse Gyn ward, I 14: Gyn ward 2 women, I 15: SNICU nurse, I 16: post-delivery 3 women, I 17: post-delivery 3 women
Wednesday	12 September	Visit PHC Kufa Dr. Nedal, I 18: Gyn ward 2 women + 3 men, I 19: PAED ward 2 women, I 20: PAED ward 1 woman, I 21: post-delivery 3 women, I 22: FGD midwives maternity
Thursday	13 September	I 23: Gyn ward 2 women, I 24: nurse Gyn ward, I 25: Gyn ward private sector, I 26: FGD 2 midwives
Friday	14 September	Lit review
Saturday	15 September	

WEEK 38

Sunday	16 September	I 27: home visit Wafa area, I 28: post-delivery 3 women, I 29: Gyn ward NGD 6 women,
Monday	17 September	Visit PHC Kufa, I 30: home visit 2 women, I 31: FGD pharmacists, I 32: home visit 1 woman,
Tuesday	18 September	I 33: NSNU 1 woman, I 34: FGD PAED ward nurses, I 35: SNICU 1 male nurse, I 36: SNICU feeding room 2 women, I 37: post-delivery 2 women 1 man
Wednesday	19 September	I 38: FGD Gyn ward 6 women, I 39: home visit TBA private clinic, I 40: Paediatrician, I 41: Gynaecologist
Thursday	20 September	I 42: NSNU woman, I 43: Paediatrician, I 44: SNICU feeding room 1 woman, I 45: maternity 2 women, I 46: Paediatrician, I 47: ER PAED 1 woman
Friday	21 September	Lit review
Saturday	22 September	

WEEK 39

Sunday	23 September	I 48: home visit 1 woman, I 49: home visit 1 woman, I 50: home visit 1 women, I 51: ER PAED family 2 women, 5 men, I 52: ER PAED 1 woman
Monday	24 September	I 53: Gyn ward 2 women, I 54: Gynaecologist, I 55: PAED ward 2 women, I 56: PAED ward 2 women, I 57: home visit TBA private clinic
Tuesday	25 September	I 58: Visit old city, Holy Shrine, Gaem and Atar, I 59: Gynaecologist
Wednesday	26 September	Visit to the health post Al Esa behind the rifer, I 60: young man, I 61: home visit in Al Esa 1 woman, I 62: PHC Al Rakhina in Al Esa behind the river, I 63: Visit to a PHC Alqadisia
Thursday	27 September	I 64: + observation OPD Gynaecology
Friday	28 September	
Saturday	29 September	Flight from Najaf to Amman

WEEK 40

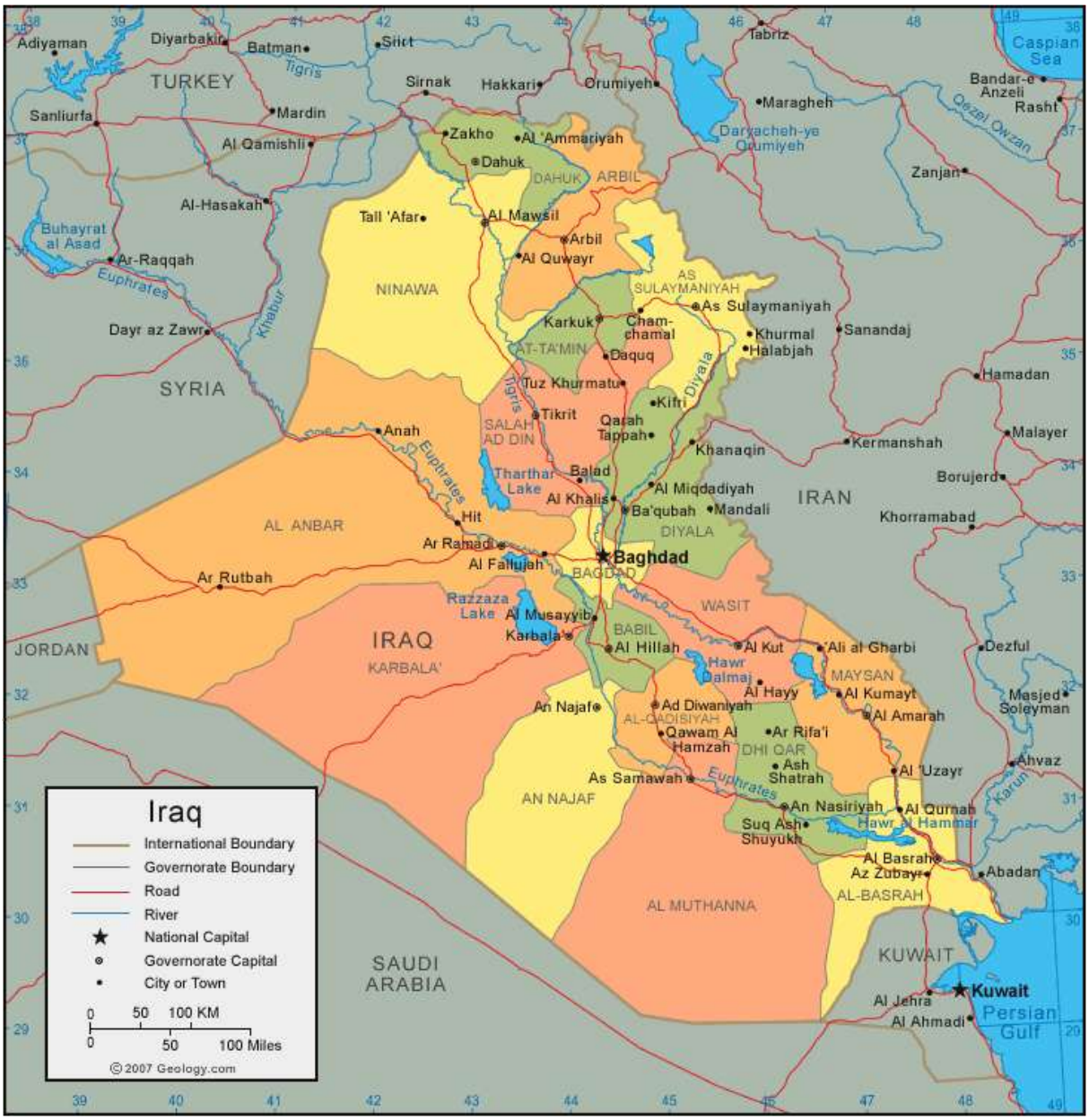
Sunday	30 September	Debriefing Amman Co Team
Monday	01 October	Discussion HoM and MedCo
Tuesday	02 October	Visit to Petra
Wednesday	03 October	Visit to Petra
Thursday	04 October	Office and Departure to Vienna

List of interviewees' profiles

DATE	PLACE	ITW	INTERVIEW PROFILE	MALE	FEMALE	TOTAL
WE Sep 5	Hospital	1	ER paediatrics		1	1
TH Sept 6	Hospital	2	Gynaecology		3	3
		3	Gynaecology		3	3
		4	NGD gynaecology ward		2	2
SU Sep 9	Hospital	5	Post-delivery		2	2
		6	Dr. Nedal health visitor program		1	1
		7	Gynaecology		4	4
		8	ICRC visit	3		3
MO Sep 10	Hospital	9	Midwife maternity		1	1
		10	Paediatrics		1	1
		11	Gynaecology		2	2
		12	Gynaecology private sector		4	4
TU Sep 11	Hospital	13	Nurse gynaecology		1	1
		14	Gynaecology		2	2
		15	SNICU nurse		1	1
		16	Post-delivery		3	3
		17	Post-delivery		3	3
WE Sep 12	Kufa/PHC		Visit to PHC in Kufa with Dr. Nedal			
	Hospital	18	Gynaecology ward	3	2	5
		19	Paediatrics		2	2
		20	Paediatrics		1	1
		21	Post-delivery		3	3
		22	FGD midwives maternity		5	5
TH Sept 13		23	Gynaecology ward		2	2
		24	Nurse gynaecology		1	1
		25	Gynaecology private sector		4	4
SU Sep 16		26	FGD midwives maternity		2	2
	Wafa' area	27	Home visit		1	1
		28	Post-delivery		3	3
		29	NGD gynaecology ward		6	6
MO Sep 17	Kufa/PHC		Visit to PHC Kufa			
	Kufa area	30	Home visit		2	2
	Hospital	31	FGD pharmacists			
	Office area	32	Home visit		1	1
TU Sep 18	Hospital	33	NSNU		1	1
		34	FGD paediatrics nurses		3	3
		35	SNICU nurse	1		1
		36	SNICU feeding room		2	2
		37	Post-delivery	1	2	3
WE Sep 19		38	FGD gynaecology ward		6	6
	El Askary	39	TBA private clinic		1	1
		40	Dr. paediatrics ward	1		1
		41	Dr. gynaecology ward		1	1
TH Sep 20	Hospital	42	NSNU		4	4
		43	Dr. paediatrics ward		1	1
		44	SNICU feeding room		1	1
		45	Maternity		2	2
		46	Dr. paediatrics ward	1		1
		47	ER paediatrics		1	1
SU Sept 23	El Olema	48	Home visit		1	1

		49	Home visit		1	1
		50	Home visit		1	1
		51	ER paediatrics	5	2	7
		52	ER paediatrics		1	1
MO Sep 24	Hospital	53	Gynaecology ward		2	2
		54	Dr. gynaecology ward		1	1
		55	Paediatrics ward		2	2
		56	Paediatrics ward		1	1
	El Ansar	57	TBA private clinic		6	
TU Sep 25	Old City		Old city, Holy Shrine, Gaema and Atar		1	
		58	Gaem and Atar	2		2
		59	Dr. gynaecology OT			
WE Sep 26	Al Esa	60	Young man	1		1
		61	Home visit		1	1
		62	Visit to PHC Al Esa	3		3
		63	Visit to PHC Alqadisia	1		1
		64	OPD gynaecology		3	3
			TOTAL	**22**	**117**	**139**

Iraq map


Iraq
International Boundary
Governorate Boundary
Road
River
National Capital
Governorate Capital
City or Town
0 50 100 KM
0 50 100 Miles
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TURKEY
SYRIA
IRAQ
IRAN
JORDAN
SAUDI ARABIA
KUWAIT
Caspian Sea
Persian Gulf
Baghdad
Kuwait
Euphrates
Tigris
Diyala
Khabur
Razzaza Lake
Tharthar Lake
Hawr Dalmaj
Hawr al Hammar
Karun
Dezful
Ahvaz
Abadan
Masjed Soleyman
Khorramabad
Borujerd
Malayer
Hamadan
Kermanshah
Sanandaj
Zanjan
Rasht
Tabriz
Maragheh
Orumiyeh
Darvacheh-ye Orumiyeh
Bandar-e Anzeli
Qezel Owzan
Diyarbakir
Batman
Siirt
Sirnak
Hakkari
Mardin
Sanliurfa
Adiyaman
Al Qamishli
Al-Hasakah
Buhayrat al Asad
Ar-Raqqah
Dayr az Zawr
Zakho
Al 'Ammariyah
Dahuk
Tall 'Afar
Al Mawsil
Arbil
Al Quwayr
Karkuk
Cham-chamal
Daquq
Tuz Khurmatu
Kifri
Tikrit
Qarah Tappah
Khanaqin
Anah
Balad
Al Khalis
Al Miqdadiyah
Ba'qubah
Mandali
Hit
Ar Ramadi
Al Fallujah
Ar Rutbah
Al Musayyib
Karbala'
Al Hillah
Al Kut
'Ali al Gharbi
Al Hayy
Al Kumayt
Al Amarah
An Najaf
Ad Diwaniyah
Qawam Al Hamzah
Ar Rifa'i
Ash Shatrah
As Samawah
Al 'Uzayr
An Nasiriyah
Al Qurnah
Suq Ash Shuyukh
Al Basrah
Az Zubayr
Al Jehra
Al Ahmadi
As Sulaymaniyah
Khurmal
Halabjah
NINAWA
DAHUK
ARBIL
AS SULAYMANIYAH
AT-TA'MIN
SALAH AD DIN
DIYALA
AL ANBAR
BAGHDAD
BABIL
KARBALA'
WASIT
AN NAJAF
AL-QADISIYAH
DHI QAR
MAYSAN
AL-BASRAH
AL MUTHANNA

Najaf city map