Reframing caesarean births: challenges, transitions, and politics

Abstract book

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Why So Much Cutting? An Exploration of (Un)Necessary Cesareans and Obstetric Violence

We have seen a recent surge of scholarly and medical attention given to the cesarean "epidemic," in particular cesareans deemed medically unnecessary. Efforts have arisen to try to understand the underlying causes of this increase in surgicalization of the birthing body as well as the mechanics underlying decisions. Additional attention has been paid to obstetric violence as a form of gender-based violence arising out of a complex intertwining of medical culture, patriarchy, and hierarchy. Obstetric violence frequently arises out of unequal power between patients and providers. When combined with additional inequities—such as lack of support and caregiving—the violence is compounded. This talk will provide an overview of some of the various threads that weave together to create these systems of birthing violence, examining how medical spaces, and those who practice in them, can socially reproduce (whether deliberately or unintentionally) the broader structures of inequity and inequality, ultimately affecting the most vulnerable. The talk will address some of the challenges of understanding (un)necessary cesareans and the potential opportunities for addressing this issue.

Cecilia McCallum (Anthropology Department, UFBA-Federal University of Bahia, Brazil); Ana Paula dos Reis (Institute of Collective Health -ISC/ UFBA); Mario do Carmo Leal (FIOCRUZ)

C-Section in Brazil in Intersectional Perspective

This paper approaches C-Section in Brazil from an intersectional perspective through a focus on indigenous women's birth experiences. C-Section is the principal form of childbirth for all women in Brazil, and its prevalence amongst indigenous women has grown exponentially in the past two decades. Successive state programs since the 1980s have not reduced the high national rate, which was reinforced during the COVID-19 pandemic in both public and private care. This paper analyses the results of two studies conducted between January 2020 and October 2021 (Repgen); and in 2022-2023 (NB2), considering both qualitative and qualitative data: Firstly, results from the NB2 study (Nascer no Brasil II or 'Born in Brazil II'), a national survey with a planned sample of 22.050 of women admitted for childbirth in 465 institutions averaging 100 or more births a year. Of these to date results show that 176 of the women surveyed self-declared as indigenous, and all of whom gave birth in public hospitals. Semi-structured interviews conducted with 13 of these women provide an insight into indigenous experiences in the hospital environment. Secondly, results of an online survey conducted by the RepGen Collective[1] in the second half of 2021, when 8,313 women in Brazil responded to questions about their reproductive health and healthcare. Among these 307 women gave birth, 177 by C-section and 130 by 'normal' delivery. Analysis of semi-structured interviews with 13 women who gave birth in public hospitals during 2020 to 2021 provides contextualization, along with consideration of the quantitative analysis, enabling an intersectional understanding of the indigenous women's experiences. This provides a basis for an appreciation of reproductive governance in Brazil.

Selen Göbelez (EHESS-Marseille, Centre Norbert Elias)

Double-edged sword of caesarean births: traumatic cesarean delivery narratives and the governmental attempts to combat against the cesarean epidemic in Turkey

Over the past decades childbirth practices in Turkey have become progressively influenced by normalization of medical technology and ideology. My PhD thesis in-progress on "Childbirth Narratives of Women in the Face of Medicalization of Childbirth in Turkey", deals with the debates around the controversial "caesarean law", enacted in 2012 making Turkey the first country to prohibit elective C-sections to combat against the national cesarean epidemic. The inefficiency of this law to reduce the caesarean births is examined vis-à-vis the multiple dimensions and the dynamics of the high C-section rates. The percentage of births by caesarean section rose from 21% in 2002 to 58.4% in 2021(OECD; 2021), making the country the champion of caesarean births.

Detailed interviews are conducted with a sample of forty women as well as midwives, obstetricians and doulas. These mothers have given birth within the last 25 years at private institutions, public hospitals or at home, vaginally or via C-section, providing a plurality of experiences. They belong to differing social classes, with various educational levels from illiterate to PhD graduate and varying age at first birth between 16 and 40. Participant observation in childbirth practices as well as doula training has also been used as a research methodology.

This presentation analyses the choice (or non-choice) of women from various sections of the society in the present obstetric culture dominated with over-medicalization and commercialization of healthcare within the neoliberal, neoconservative and pronatalist governance. The main focus is traumatic childbirth experiences and obstetric violence examples within the fieldwork.

Chiara Quagliariello (Ecole des Hautes Etudes en Sciences Sociales of Paris)

Techno-births trends in Italy and France: a comparative study on caesarean section "choice" and Black birthing experiences

In this paper I will reflect on caesarean section "choice" and technocratic births trends in Italy and France. Moving from ethnographic research works I have carried out in both countries, I will first explore the multiple factors (organization of work within the hospital setting, defensive medicine and legal anxieties about birth management, evolving risk cultures, money-making practices and hospital economies, feminist and other political struggles about medical interventions during labor and delivery) leading to a different—and even opposite—representation and use of caesarean section in the two national contexts. At the same time, I will investigate how, in both countries, Black mothering experiences appear as an exception compared to caesarean section "choice" and techno-birth trends in Italy and France.

Alicia Murrieta Marquez (Instituto Mora, Mexico)

Communicating Vessels: Dialogue Between Researchers and Public Policy Managers on Cesarean Sections in Mexico

The aim of this communication is to update the analysis of the publications of the Revista Salud Pública de México, from 1980 to 2024. I seek to analyze how this journal, close to the world of researchers and public policy decision makers, has been modifying its perception of cesarean sections.

I analyze whether a critical discourse has been developing with respect to cesarean sections. I detect the ways in which these issues have been raised with respect to the increase of this procedure and the reasons (medical and non-medical) that have been at the basis of such decisions. It is precisely relevant to reflect on the non-medical reasons that appear in the articles.

The review I have already carried out shows that some of the issues are: the increase in cesarean sections (a series of non-medical criteria were detected); the idea that cesarean sections are partly produced by the medical world and that women accept them because they have a perception of well-being about them; furthermore, that there are views of cesarean sections that associate them with certain economic power, related to a class dimension, because their practice would mean a certain prestige; The articles also reflect that there is a certain induction of demand, coinciding with research that associates cesarean section with the primordial role played by the medical personnel and especially the attending physicians.

An important assumption I will make in the paper is that the development that has occurred in the articles has a certain relationship, echoes, with claims and disputes about cesarean section developed in other public arenas, very close to the places where public policy decisions are made. To analyze this phenomenon I use Eliseo Veron's notion of intertextuality.

Sezin Topçu (CNRS, EHESS, France)

Technology failure or obstetric violence ? An ethnographic study of non-anesthetized C-section experiences

The French debate on obstetric violence, which has become very lively since 2017, has brought to the fore a medical, public and feminist issue that had hitherto received little media coverage and scientific recognition: non-anesthetized C-sections. Because of the experience of extreme pain and suffering they engender, these types of caesarean sections are most often the cause of profound trauma in the parturients who undergo them. In a country like France, where the widespread use of epidurals (82% of deliveries in France take place under this anesthetic) has ushered in the «post-dolorist» era of childbirth in the collective imagination, non-anesthetized C-sections are also difficult to name and explain, their very reality being the subject of controversy. Those who experience surgical deliveries without sufficient anaesthesia must therefore go through a series of ordeals, firstly to assess the abnormal situation they have been confronted with, secondly to overcome their traumatic birth, and thirdly to act as victims in order to obtain reparation. Were they the victims of an unforeseeable technological failure, a kind of «accident of fate», or rather a particular form of systemic obstetric violence? What is the role of organizational factors and those relating to «caregiver-caretaker» relationships in the occurrence of non-anesthetized C-sections? Above all, what do the various forms of interaction at work between parturients and hospital staff (midwives, obstetricians, anesthesiologists) in delivery and operating rooms tell us about the management - and denial - of childbirth pain by the medical profession? Through an ethnographic reconstruction of two non-anesthetized caesarean section experiences, which occurred in 2013 and 2019 in two French maternity units, this paper will seek to answer these major questions. This study is part of a larger research project on the historical and contemporary experiences of and debates and controversies over obstetric violence that I conducted between 2017 and 2023.

Lucia Gentile (CN2R, Institut Convergences Migration, France)

'After the caesarean you will always have some problems in life' C-section avoidance practices in North India

In India, the institutionalisation of childbirth has corresponded to its biomedicalisation and an increase in caesarean rates (from 8.5% in 2005-06, to 21.5% in 2019-20). Several studies highlight how C-section has risen among wealthy high class/caste women with better education, who give birth in private facilities. However, the rapid increase in caesarean has also shaped a new birth paradigm for women of other social classes. As mistrust of allopathic treatments and biomedical technologies remains widespread, new practices of negotiation and avoidance have developed among families of different social classes, in order to favour vaginal delivery. The aim of this communication is to highlight how representations and experiences of caesarean delivery are shaped in North India, through the experiences of women living in the Kacch district of Gujarat. The data comes from an ethnographic survey conducted between 2015 and 2018 in medical settings (a public hospital and a private clinic) and in the homes of women from different social and religious backgrounds. The research shows how one of the main reasons of the C-section avoidance is the importance of the post-partum period: traditional caring of the new mother could not be applied. The communication presents the practices that are recommended in order to prepare the body for vaginal delivery. These techniques are recommended by the *dāī*, or traditional birth attendant. Presenting themselves as the protectors of vaginal childbirth, the *dāī* - a profession that is disappearing in urban areas - have found a new way to rebuild their own legitimacy in an environment now dominated by biomedicine.

Halima Akhter (Durham University, UK)

C-section Dominance: Navigating Birth Challenges in Bangladesh

Introduction: The dramatic rise in CS rates from 3% in 2000 to 45% in recent years in Bangladesh necessitates an urgent review of maternal healthcare policies to minimise unnecessary CS. This research utilised Brigitte Jordan's concept of «authoritative knowledge» while delving into the decision-making process of C-sections (CS) in Bangladesh, revealing a complex interaction between sociodemographic, obstetric, and healthcare dynamics.

Methods: This mixed methods research surveyed 132 mothers nationwide who underwent C-sections, along with 20 obstetricians in Bangladesh. Furthermore, in-depth interviews with mothers (20), healthcare professionals (10), and focus group discussions with spouses (4) and senior female family members (2) were conducted. This study employed snowball sampling and conducted remote interviews via Zoom or WhatsApp during COVID-19, analysing data using SPSS v28.0, Microsoft Excel v2308, and NVivo R1 (2020).

Findings: 38% of surveyed mothers chose elective CS, primarily based on doctor recommendation (71%). Many decided well in advance, with 33% choosing one month prior and 27% even earlier. Urban educated mothers showed a stark disparity, with 76% opting for CS compared to 24% of rural mothers. Private facilities notably influenced CS rates, with 87% of mothers opting for CS, of whom 79% also received antenatal care there. Qualitative data indicates that mothers' decisions are influenced by safety concerns and a lack of accurate childbirth information.

Conclusion: The findings provide a basis for informed policy adjustments and interventions promoting prudent CS utilisation, emphasising the importance of balanced midwifery deployment and enhanced access to comprehensive birthing information to reduce high CS rates in Bangladesh.

Yuqi Zhuang (University of Florida USA)

Exploring High Cesarean Birth Rates in Shanghai: Cultural Beliefs, Economic Motives, and Policy Impacts

This study explores the high cesarean birth rates in Shanghai, China, where the occurrence significantly exceeds the global average with the cesarean birth rate reaching up to 68% compared to the World Health Organization's suggested limit of 15%. In doing so, this study explores how cultural preferences, economic motives, medical practices, and China's birth planning policies all converge to drive the high cesarean birth trend. Through literature review and qualitative interviews and analysis, this study reveals that cultural beliefs in auspicious birth timings, a blind medical belief regarding the safety of cesarean versus natural birth, and economic motivations within the healthcare system encourage medical staff to persuade mothers to choose cesarean births are major factors. This study further explores the negotiation process women go through in deciding how to give birth, it also examines how healthcare providers influence women's laboring decisions, and the risks and challenges cesarean birth poses to women's health and future pregnancies. This research aims to deepen the understanding of structural and cultural factors affecting childbirth choice, reduce unnecessary cesarean births, improve maternal care practices, increase public understanding of cesarean births, and provide references for relevant policy-making and medical practices.

Ayodele Foster-McCray (Stanford University, USA)

Outside the Warehouse of Risk: Caesarean Violence, AntiBlackness, and Illegal Home Birth Culture in Urban and Rural Georgia, USA

Since the mid-2010s, legislators, public health entities, philanthropic funders, and political candidates have focused interest on what has been called a "crisis" or "epidemic" of Black maternal mortality in the United States (Martin and Montagne 2017; Nash 2021). Black birthing people's suffering under structures of anti-Blackness has been routinely interpreted in medical research and practice as a "risk factor" for poor health outcomes. Medicalized racialization of African American women, sometimes in response to concerns about their specific structurally-driven vulnerability to maternal death, exposes them disproportionately to obstetric violence and racism (Davis 2019). Such violence often takes the form of heightened forced clinical management of the birth process, including higher rates of Caesarean birth among Black women (at 36.6%) (Roth and Henley 2012; March of Dimes 2024), which in the most extreme cases results in legally designated homicide (Mascarenhas 2024). In the southern U.S. state of Georgia, with one of the country's highest maternal mortality rates, Black mothers and birthworkers have described coerced Caesarean as a form of racialized violence that they worry strips them of reproductive rights and exposes them to mortality rather than preventing it. In response, communities of Black birthing people refuse hospital birth altogether due to concerns of discrimination and coercion and choose instead to participate in midwifery-led home birth, which is illegal in the state. This paper, drawing from ethnographic fieldwork conducted in several sites across Georgia between 2019 and 2024, examines what birth "choice" looks like for populations encountering layered crises, both longstanding and recent.

Nicole Daniels (Cape Town University, South Africa)

Medico-legal entanglements: C-sections and ultrasound scans as risk rituals in South Africa

In this talk I examine the power of litigation to shape and inform medical and maternal decision-making. I draw upon data from a two and a half year, multisite ethnography that traced fourteen women and seven obstetricians' corresponding experiences of private-sector childbirth in Cape Town, South Africa.

I connect the routine use of ultrasound technology at every prenatal consultation with obstetricians to the 77% c-section rate. I do so by outlining the high-risk context implicit in the political, cultural, and moral economy of private-sector childbirth in South Africa. Here, risks to the foetus constitute the greatest medico-legal threat to private-sector obstetricians.

Two broad trends form the basis for understanding the ways a feto-centric litigious culture is connected to high c-section rates. Firstly, the foetus has been identified as the basis of almost all legal claims against obstetricians. Secondly, in medico- legal litigation *failure to perform a c-section* is amongst the most common, avoidable error for which obstetricians are sued.

Legal processes, risk aversion institutional practices, and technocratic obstetric care delineate the unborn as a contested risk object that 1) places obstetricians in danger of litigation for negligence 2) places women in danger of delivery by c-section within high-risk birthing cultures, and 3) reconfigures birthing interventions as normal and necessary.

In this way I show that c-sections are continuous with and connected to prenatal practices, forming a coherent, high-risk obstetric trajectory that begins when pregnancy is confirmed, and women initiate care with private-sector obstetricians.

Victoria Gallion Licata (CY Cergy Paris Université, France)

Peruvian Quechua women against the rise of unnecessary c e s arean births since the 90 s

The percentage of cesareans have quadrupled in the last 30 years in Peru. In 1996, it represented 13% of births in urban areas compared to only 2,5 % in rural ones . In 2021, the total number of cesareans in urban areas was 42% twice as much as in rural areas (ENDES, 2021) and much higher that the World Health Organization recommendation of 10 to 15% 15%. Cesareans are advantageous for hospitals and private clinics where they are especially high as it takes less time than a natural birth, it can be programmed and brings more money (NAVARRO, 2022). From privileged urban women's point of view, it is often considered to be more modern and easy . On the contrary, due to the geographical and cultural distance of indigenous rural women from hospitals, many would rather use ancestral techniques to avoid cesareans. The *manteo* for example moves the baby inside the belly using a *manta*—blanket when in breech position (LINGAN, 1995). During my fieldwork in Cusco, a Quechua woman told me about her bad experience when doctors planned a C-section at 32 weeks against her will. She expressed her concern to her mother, who performed the *manteo* technique to reposition the baby, successfully. She was eventually able to have a head-down, vaginal birth. This paper argues that delivery choice is not self determined but the result of a system that pushes women often through fear to opt for a cesarean for financial and practical reasons and looks down on indigenous women needs and practices.

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Rachelle Chadwick (University of Bristol, UK)

Changing the Frame: Birth, Labour, and the Politics of Caesareans

In this lecture, I use current controversies surrounding caesarean birth to think about the state of contemporary and global feminist birth politics. Returning to Katherine Beckett's (2005) analysis of the politics of choice in relation to caesarean section, I ask what sense we can make of these contestations in the present moment. Have we developed new ways of thinking about the politics of caesarean birth that help us to think beyond the celebration of 'choice' or the script of (internalized) oppression? In order to change the frame, and to reorient our thinking about how we make sense of caesareans, we need to move beyond debates that are framed in relation to individual choice and autonomy, and/or the idealisation of natural birth. In this lecture, I suggest that we need to find a way of proceeding that does not reduce caesarean politics to narrow questions of moral rightness/wrongness. In an effort to change the frame, I suggest that rethinking birth seriously as a *matter of labour* can open new ways of thinking about caesarean birth, and disrupt persistent bioromanticism, moralizing judgements, and reorient our understanding of what it means to enact freedom in the sphere of birth.

Jean Lukinson, Mislor Dexai, Marc-Félix Civil (State University of Haïti), Ketleine Charles and Marie-Claire Red (Laval University, Canada)

Grossesse et accouchement chirurgical : trajectoires obstétricales, représentations et expérience vécue de femmes césarisées

Selon les données de l'enquête démographique et de santé, le taux de césarienne pratiquée en Haïti serait de l'ordre de 5,4% en 2017 contre 1,6% des naissances vivantes en 1995. Sans grande surprise, le phénomène devrait continuer de croître pour atteindre aujourd'hui les 6% des naissances vivantes au niveau national. À y regarder des plus près, certains hôpitaux affichent un taux de césarienne annuel avoisinant, pour 3000 à 3500 naissances annuelles, les 15 % préconisés par les experts de l'Organisation mondiale de la santé.
Ces données nous amènent aux interrogations que voici :
Comment s'organisent les trajectoires des femmes césarisées et dans quelle mesure celles-ci s'en trouvent-elles impactées ? Quelles représentations ont-elles de la césarienne et en quel sens peut-on dire que ces deux facteurs influent sur l'expérience vécu de l'accouchement chirurgicale ?

À partir d'une enquête de terrain reposant sur des entretiens semi-directifs conduits en milieu hospitalier auprès femmes ayant déjà accouché par césarienne (n=38), cette communication entend examiner plusieurs éléments :

1. D'abord, les trajectoires obstétricales entendues comme chaîne d'organisation de soins obstétricaux, autrement dit, toutes les étapes médicales (notamment les services) par lesquelles les parturientes a dû passer soit par prescription, soit selon une démarche personnelle, durant la période de grossesse, mais aussi le « retentissement » que ces étapes ne manqueront pas d'avoir sur elles ;
2. Ensuite, les représentations que les parturientes ont de l'accouchement chirurgical, que celui-ci soit programmé ou d'urgence et de leur état de santé en général ;
3. Enfin, dans quelle mesure le vécu de la césarienne est influencé, entre autres choses, par les différentes étapes des trajectoires ainsi que par les représentations des patientes obstétricales.

Mots-clés : Accouchement chirurgical - Césarienne/ État de santé/ Expérience vécue/ Parturiente/ Représentation/ Trajectoire obstétricales

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Carole Brugeilles (Paris Nanterre University, France)

Césarienne et stérilisation ; quelle est la place de la chirurgie dans la vie reproductive des Mexicaines nées entre 1962 et 1997 ?

Le Mexique fait partie des pays qui ont connu un accroissement intense de la proportion d'accouchements par césarienne. Elle est passée de 12,4% des naissances en 1987 (ENFES, 1987) à 46,1 % en 2018 (Enadid 2018), dépassant largement la recommandation de l'OMS. L'augmentation du recours à la césarienne est amplement associée à un dogme de 1916 « Césarienne une fois, césarienne toujours ». Remis en cause par des études internationales, il est fortement respecté au Mexique jusqu'à ces dernières années. Il se combine à une autre norme biomédicale : plus les cicatrices sur l'utérus sont nombreuses, plus la grossesse est risquée. Ainsi, au-delà de trois césariennes, il est préférable de stériliser la femme afin de ne prendre aucun risque. La multiplication des interventions et leur répétition chez une même femme mettent de nombreuses mères en situation de renoncer à une grossesse en raison d'un risque médical, réel ou supposé, et d'accepter une stérilisation. Cette communication propose, grâce à une enquête démographique rétrospective de 2017 (EDER-2017), de documenter la dynamique de diffusion de l'accouchement par césarienne chez les Mexicaines nées entre 1962 et 1997, ainsi que ses variations sociales. Il d'agit à la fois d'analyser l'influence de chacune des normes biomédicales sur les « trajectoires obstétricales », et les conséquences sur la vie reproductive des femmes, à savoir leurs pratiques contraceptives, notamment l'usage de la stérilisation, et leur fécondité.

Priscille Sauvegrain (INSERM, France)

Protocoles de types «Happy Césarienne»: qu'en est-il en suites de couches?

Basée sur des observations cliniques dans un service de suites de couches parisiens, la présentation analysera grâce aux concepts de la sociologie de la santé en quoi les protocoles de réhabilitation précoce en suites de couches post-opératoires vont à l'encontre de ceux d'accompagnement mis en place dans les salles de naissance et les blocs opératoires adjacents, ce qui se lit en creux des représentations autour de la «bonne mère» lors du séjour d'hospitalisation, et en quoi les relations interethniques inter- minoritaires entre les patientes et les soignantes (point aveugle des ethnographies hospitalières françaises) viennent souvent réifier des relations de soins inégalitaires.

Nicolas Mottet (University Hospital of Bezançon, France)

Achieving Caesearean Section Rates Below 15%: Lessons From An Observational Study Using The Robson Classification System In A Single Tertiary University Hospital In France

Questions remain about the appropriate CS rate to insure the best maternal and neonatal outcomes, particularly in settings with optimal access to obstetrical care. The Robson classification is recommended by the WHO to monitor and compare CS rates, both longitudinally within the same maternity and transversally between different care structures. The aim of this study was to describe the pattern of use and trends of CS using the Robson classification at a French tertiary university hospital and to assess maternal and perinatal outcomes by Robson group. A total of 19 082 women gave birth during the study period. The 7-year mean CS rate was 14.4% (n=2753) A significant reduction of the overall CS rate from 15.4% to 13.0% (2.4% ;95%CI 0.5-4.2%) was observed between 2020 to 2023. This reduction was related to a significant reduction in overall CS rate among group 5.1 (women with a previous cs) and an important trend towards reduction in group 6 (nulliparous; single breech pregnancy) and 2a (nulliparous, induction of labour).

Alexandra Othenin-Girard and Hélène Legardeur (Lausanne University Hospital - CHUV)

Participative cesarean : to go beyond surgery and enhance recovery

Participative cesarean redefines the conventional approach to cesarean birth by considering the emotional and physical needs of both the mother and partner. Unlike the traditional view of cesarean birth as a strict and impersonal surgical intervention, this approach aims to restore a sense of control, intimacy, and connection from the moment of birth.

Beyond the principles of safety and hygiene inherent in any surgical procedure, it focuses on maternal fears such as pain and separation from the newborn, as well as potential challenges related to breastfeeding initiation.

In the often stressful and technical environment of the operating room, participative cesarean aims to create a space where the mother and her partner can feel involved and supported. Despite the presence of multiple caregivers, the couple's intimacy is preserved, providing an environment conducive to birth and the creation of a family unit from the earliest moments. It also aims to enable the mother to perceive her birth experience as just that—an experience of birth, rather than a mere medical procedure.

Moreover, participative cesarean promotes maternal well-being by enhancing postnatal recovery. By minimizing maternal pain and facilitating quicker recovery, this approach helps strengthen the mother-child bond from the start, facilitating early and successful breastfeeding initiation.

Participative cesarean represents a shift in how we approach cesarean birth, emphasizing compassion, respect, and the active involvement of the mother and her partner, all while upholding essential medical standards and enhanced rehabilitation.

Rabeya Khatun (university of Alabama), Holly Horan (University of Alabama at Birmingham)

The Political Economy behind the Increasing Rates of Cesarean Birth

Within biomedical birthing contexts, there is a significant but frequently overlooked association between cesarean birth and maternal mortality. The World Health Organization estimates that only 10-15% of the birthing population needs to birth surgically; however, in the United States more than one in three birthers receive a cesarean. Besides, lower- and middle-income countries such as Bangladesh has experienced a 51% increase in the rate of cesarean births in recent years. Given the growing global practice of cesarean birth, we compared the social, biological, and political-economic factors connected to the high rates of cesarean birth in Bangladesh and the United States. This comparison illustrates how anthropological concepts, such as the obstetric imaginary have shaped providers' and patients' perceptions of the necessity of cesarean birth in low and high resource contexts without the proper infrastructure to support this clinical practice in evidence-based ways. Early ethnographic pilot research in these two contexts, which included the perspectives of physicians who performed cesarean births and patients who received them, indicate that in Bangladesh, a significant number of primary cesarean births are performed by physicians without specialized training in maternal health care. There are also limited opportunities for vaginal birth after cesarean, driving up the total cesarean birth rate - similar to many parts of the United States. Cesarean birth in both contexts is frequently performed in the absence of shared decision making, informed consent, and post-operative care education. Providers and patients identify strategies for de-coupling this sometimes-necessary medical procedure from poor perinatal health outcomes so that it can be respected as an essential, lifesaving procedure when used ethically.

Caroline Daelemans (Geneva University Hospitals) and Alexandre Farin (Riviera-Chablais Hospital - HRC)

How can we adapt the obstetric culture around surgical birth ?

Preparation, communication, a supportive environment, team training, fexibility in policies and practices, feedback and continuous improvement are some of the crucial ingredients to create a more family-centered and positive birthing experience in case of a cesarean section.

Robbie Davis-Floyd (Rice University, USA)

The Rituals Of Hospital Birth: Cesearean Sections As The Ultimate Technocratic Rituals

During this powerpoint presentation, I will analyze obstetrical procedures—from electronic fetal monitoring to cesarean sections—as rituals that convey the core values of technocratic societies to birthing women and their partners/families. I will present my definition of "rituals" and will show that typical hospital births have become rites of initiation (which constitute a series of transformative rituals) into the belief and value systems of technocracies and will also present my definition of a "technocracy." I will analyze cesarean sections as the ultimate technocratic rituals because they obviously interfere the most with the normal physiology of birth, and because a very high percentage of the cesareans that are performed globally are unnecessary and are not evidence-based.
I will demonstrate that, ultimately, obstetricians' motivations for performing unnecessary cesareans can be summed up in four words: money, convenience, fear, and control, which I will explain fully during my presentation. I will also briefly describe "the technocratic, superficially humanistic, deeply humanistic, and holistic paradigms of birth and health care," and will illustrate the differences among the rituals that enact each of these paradigms/models. I will also demonstrate that the alternative rituals of births in homes and in freestanding birth centers enact holistic belief and value systems that are radically different from those of the hegemonic technocratic paradigm and that result in far fewer interventions in the normal birthing process, which includes the performance of far fewer cesareans.