“Restoring the Sacred Part of Birth”: Doula Care and Cesarean Birth in Switzerland

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ABSTRACT

At 32.3%, Switzerland ranks among countries with the highest rates of cesarean deliveries in Europe. Because cesareans generally negatively influence the birth experience, parents turn to holistic therapists to heal somatic and emotional disorders not addressed by standard biomedical follow-ups. Doula care is still emerging in Switzerland. Although doula activities are not allowed in the operation rooms, they support parents before birth and during the postpartum period. They aim at improving the birth experience by restoring intimate, “sacred” elements of birth through symbolic and spiritual practices. Based on interviews with doulas, I explore their experiences and practices regarding surgical birth.

As in most industrialized countries, delivery care in Switzerland is driven by a risk-oriented approach to childbirth (Maffi 2012; Maffi and Gouilhers 2019), resulting in a predominantly technocratic culture of maternity care (Davis-Floyd 2001; Davis-Floyd et al. 2018). Almost one-third (32.3%) of childbirths in the country are cesarean births (Federal Statistical Office 2019), placing the Swiss cesarean rate among the highest national rates in Europe (Euro-Peristat Project 2018) and well over the 10–15% range previously recommended by the World Health Organization (WHO 2015).¹

Interestingly, despite the high rate of surgical births in Switzerland, women² complain about a lack of information regarding the postpartum period and cesarean recovery. Consistent with a “child-centered” approach and an “intensification” of parenting (Blum 1999; Chautems 2022; Douglas and Michaels 2005; Hays 1996; Wolf 2011), maternal recovery seems secondary; the priorities are the child’s health and well-being (Davis-Floyd 2022; Lupton 2012; Maffi 2012). As a result, and also because of its “normalization” (De Koninck 1990), cesarean is viewed by health professionals not as a major surgery requiring specific recovery care (Sargent and Stark 1989), but rather as just another mode of delivery.

In addition, the current social context in Switzerland promotes vaginal birth, which is perceived as the “normal” mode of delivery by laypersons as well as by most health professionals (Maffi 2014; Maffi and Gouilhers 2019). Hence, women often perceive undergoing cesarean as their “failure” to give birth “naturally,” fostering feelings of guilt and disillusionment (Davis-Floyd 2022). On the other hand, some women request a cesarean birth without any obstetrical indication. Literature suggests that this phenomenon remains marginal and often results from tokophobia (fear of childbirth) or a previous traumatic birth experience (Fenwick et al. 2010; Wiklund et al. 2007). If their health providers and relatives favor vaginal birth, these women may feel insecure and unsupported in their choices. As a result, there is an increasing demand for complementary and alternative medicine (CAM) and holistic postpartum therapies to heal the somatic and emotional disorders that can be caused by surgical birth and unaddressed by standard biomedical follow-up care.

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Media Teaser Doula care is emerging in Switzerland, where the cesarean rate is very high. How can doulas improve the experience of parents giving birth by cesarean?

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Furthermore, the medicalization of birth and the “dehumanization” (Kukla 2005; Oakley 1984) it induces have been challenged in Europe and North America since as early as the 1950s by the natural childbirth movement, which emphasizes the idea of pregnancy and delivery as “natural” physiological events (Hazell 1976 [1969]; Rothman 1991 [1982]; Wertz and Wertz 1989 [1977]). The emergence of doulas is part of this movement of valuing women’s experiences and highlighting the importance of giving birth on one’s own terms with the birth attendants of their choice (Castaneda and Johnson Searcy 2015). However, the natural childbirth model is also loaded with normative expectations and injunctions to parents (Chautems 2022; Malacrida and Boulton 2014; McCabe 2016). Therefore, in line with neoliberal regimes based on an ideology of self-determination, women have increased accountability regarding the “success” of delivery.

As birth companions, doulas are neither CAM practitioners nor holistic therapists per se. However, in addition to their doula training, they generally receive certifying training in holistic care approaches (e.g. hypnotherapy, acupuncture and massage), which they use as additional tools in their practices depending on the situation and the parents’ wishes. Providing postpartum care, doulas also offer services specific to their approach, including, among others, Blessing Way ceremonies, placenta preparation, rebozo care, yoni steams and “restorative baths.” These types of care services often include a spiritual approach to help mothers overcome the disappointment, and sometimes trauma, of not having been able to give birth vaginally. These practices, aiming at a revalorization of maternal body processes even in the case of surgical birth, also appear as spaces of self-care for women, which is subversive in a context where they are usually regarded primarily as children’s caregivers, their own recovery and well-being secondary.

Doula care is inclusive of holistic spiritualities, defined by Sointu and Woodhead (2008, 259) as ’those forms of practice involving the body, which have become increasingly visible since the 1980s, and that have as their goal the attainment of wholeness and well-being of “body, mind, and spirit.” Such practices are now pervasive within New Age and, to a large extent, neo-pagan communities, and extend beyond them to shade into the realm of complementary and alternative health care practices.’ From this perspective, I argue that doula care blurs the lines between childbirth care, spirituality, wellness, self-development, and CAM practices. According to my interviews, most doulas identify as “spiritual but not religious” (Fuller 2001); they claim to take a spiritual or “sacred” approach to childbirth, identified in their discourses on “energy” and rituals aiming at honoring femininity, yet do not take part in an established religion.3

Doulas’ training is generally focused on “natural,” “physiological” childbirth and favors a discourse emphasizing birth choices, which reflects the informed choice ideal and reduces choices to the individual level (Apfel 2017; Ruhl 2002). From this perspective, and in line with the neoliberal ideal of self-determination, it would be the parents’ responsibility to wisely choose their birth attendants and delivery location if they want to access a positive birth experience and/or avoid a cesarean delivery. At the same time, doulas convey an inclusive approach aimed at caring for women’s reproductive health wherever they are in their journey – abortion, medically assisted reproduction, perinatal grief – and whatever their birth choices are, regardless of the level of medicalization, from home births to on-demand cesareans, thereby defending their clients’ right to self-determination (Castaneda and Johnson Searcy 2015). As nonmedical birth companions, doulas provide continuous emotional, practical, and informational support throughout the birth process, from prenatal to postpartum care and including attending the delivery. Among other benefits, doula care, in particular the continuity of support provided to laboring women, has been shown to lower cesarean birth rates (Bohren et al. 2017; Hodnett et al. 2013; Kozhimannil et al. 2016). Apart from this favorable connection, doula care is hardly ever addressed in the relevant literature in the context of cesarean birth. In my fieldwork, some women believed that doulas are only for women planning to have home births or, at least vaginal deliveries with little to no medical intervention.

Through interviews with doulas whose clients gave birth by cesarean in the French-speaking part of Switzerland, I explore doula care experiences and practices around surgical birth, and examine how doulas are working toward constructing meaning and restoring the emotional, “sacred” part of birth
into cesarean births. This intent includes the rehabilitation of an embodied birth experience, either during childbirth through a participative approach to cesarean, or after, with rituals intended to enhance the maternal body. This emphasis on the body can be recontextualized in a series of measures aimed at bodily rehabilitation (e.g. skin-to-skin contact and breastfeeding) implemented in maternity hospitals in Europe and North America since the 1990s (Memmi 2014).

Methods and materials

During my previous fieldwork on breastfeeding and holistic care in Switzerland (Chautems 2022), I had the opportunity to meet some doulas. I kept in touch with one of them, whom I contacted at the beginning of this study to discuss her follow-up experiences with women who had given birth by cesarean and their families. After asking for their interest and consent, she suggested that I speak with two of her colleagues, who she knew had cared for women who had given birth by cesarean and had developed an interest in this topic. I contacted other doulas using the snowball method. Fifteen doulas participated in this research, including four doulas involved in Swiss French-speaking doula training. Each doula I interviewed had at least one experience of a cesarean follow-up, by which I mean that these doulas provided prenatal and postpartum care both in the hospital and later in their homes to clients who had cesarean births. These interviews took place from December 2020 to November 2021. Because of the COVID-19 pandemic, the interviews were conducted mainly via video conferences. I conducted in-depth interviews, which revolved around doulas’ professional trajectories, their experiences of taking care of women before, during and after a cesarean birth, as well as their conception of cesarean birth and their understanding of the specific needs of cesarean women. Each interview lasted between one and two hours. All my interlocutors spoke French, and I translated their words into English. I secured informed consent from my interlocutors before the interviews. This research was approved by the Swiss cantonal ethics committee on research involving humans (CER-VD). All names used in this article are pseudonyms, and identifying details have been modified.

The doulas whom I interviewed were all cisgender women between 30 and 59 years old. They had diverse backgrounds prior to their doula training, but I noticed a prevalence of occupations related to childcare or health care. Most of these doulas had other part-time work aside from their doula practices. They were adamantly about the fact that it is currently not possible to earn a living solely by practicing as a doula in Switzerland. Each of them was living with a working partner – except one, whose partner was a stay-at-home father. One doula was Mexican; the others were Swiss. One of them had trained in the United States, one had trained in Canada, and the others had completed their training in Switzerland. All the doulas graduated from their doula trainings between 2003 and 2020. As an extension of my interviews, reviewing the different means of online communication that doulas use enriched my ethnographic material and allowed me to more deeply understand and contextualize their care approaches.

Doula care in Switzerland

In Switzerland, the French-speaking doula training, Formation Doula Suisse romande, was created in 2005, whereas the German-speaking doula training was created in 2001. Initially, the training was intended for only women who had given birth. This condition was removed in 2019, and the training is now open to all women who have completed a certified apprenticeship (a post-compulsory school professional training) or received a high school diploma. The training consists of theoretical modules on the following topics: the physiology of pregnancy and delivery; the psychology of pregnancy and postpartum; sexuality; the partner’s role; and perinatal bereavement. Two additional modules focus on doulas’ work, their rights and duties, and the “benevolent marketing” of doula services. The program also includes readings of authors affiliated with the natural childbirth movement, such as Michel
Odent and Ina May Gaskin. Additionally, students must attend prenatal classes and perinatal support groups sessions (for example, La Leche League) and carry out two doula follow-ups of women they cared for during their training.

In addition to their initial training, doulas usually receive certifying training in holistic birth care approaches, such as haptonomy (a technique aiming to establish contact with the fetus through touch and light pressure on the mother’s abdomen), placenta preparation, rebozo care, hypnosis, acupuncture, and massage. Interestingly, eight of the 15 doulas I spoke with had followed the same online doula training despite having completed their Swiss doula training. This online training is offered by a doula from Quebec, who trained and worked as a midwife and uses the online alias “Quantik Mama.” This doula founded her “Quantik School” in 2020, claiming a “quantik” perspective on childbirth. For this doula, the term “quantik” designates a space “between science and the sacred;” what my interlocutors described as a shared belief in the importance of the “invisible” aspects of birth. One such aspect is the idea that positive thoughts and visualization increase the likelihood of a positive birth experience. However, three of my doula interlocutors criticized these spiritual beliefs, considering them “occult” and fearing that such discourses could harm the reputation of the doula profession, especially among the biomedical community.

All the doulas I interviewed affirmed that they rely on neuroscience to explain the benefits of a physiological birth, including the positive impact on the mother–child bond. For example, Michel Odent (2001), frequently quoted by my interlocutors, insists on the importance of the natural oxytocin secreted by women during labor and birth (if the labor is not altered by artificial oxytocin) and of disengaging the neocortex during labor by surrendering to, instead of resisting, the pain of contractions, so that women can enter an altered state of consciousness that many English-speaking midwives, especially in the US, call “laborland” (Cheyney 2011; Davis-Floyd 2022). In this altered state, Odent (2001) states that laboring women can go deep inside themselves and simply flow from one contraction to another without conscious thought.

Additionally, I noticed the influence of ecofeminism and the idea of a “return to nature” in doulas’ discourses. As described by Pasche Guignard (2020), this “return to Nature [occurs] through its resacralization, through learning the physiological rhythms of women’s bodies and of the seasons, or through reappropriating old and creating new rituals centered on women’s bodies or on seasonal calendars” (197). From this perspective, childbirth is perceived as an empowering event for women (Apfel 2017). The influence of ecofeminism is present even in the highly medicalized events that are cesarean births, manifested through doulas’ efforts to restore the embodied and “sacred” dimension of childbirth. Moreover, like the ecological activists studied by Becci et al. (2020), whose research was also conducted in French-speaking parts of Switzerland, my doula interlocutors do not claim the ecofeminist label for themselves. As an alternative, Becci, Farahmand, and Granjean propose the notion of “gendered spiritual ecology” (Becci et al. 2020), which I find relevant to my fieldwork as well. For example, in attempting to enhance women’s physiological ability to give birth, doulas offer eco-spiritual rituals to honor their clients’ reproductive organs, using herbal preparations and natural elements such as water and stones. The restorative bath, which I develop further in this article, is an emblematic example of these rituals.

Although doulas autonomously complete follow-ups, doulas practising in the French-speaking part of Switzerland frequently share discussions, information, and inspirations using, among other channels, a dedicated social media group. In this sense and through these connections, doulas form a childbirth care “community of practice” (Jordan 2014). Some doulas also regularly collaborate on their follow-ups – for example, to perform the rebozo ritual (described below), which requires two caregivers.

As nonmedical birth practitioners, doulas have an important responsibility to identify specific issues, such as postpartum depression, and to refer their clients to appropriate professionals when necessary. When they cannot independently address their clients’ issues, Doulas also refer clients to other local resources, such as therapists specializing in postpartum care and cesarean recovery.
All the doulas who participated in my research have curated websites, including self-presentations and details regarding their services and rates.\(^6\) In addition to their websites, most doulas have Instagram accounts. As I noted above, reviewing these various means of communication allowed me to understand and contextualize their care approaches more deeply. Doulas often favor an aesthetic inspired by natural elements they collect, such as flowers, feathers, driftwood, and stones. The rituals and services they offer are also visually elaborated and well-suited to be enhanced by social media centered on pictures. For example, some doulas perform “belly paintings:” they draw on a pregnant woman’s stomach and take photographs. They also craft objects using the placenta or umbilical cord aside from placenta transformation such as placenta encapsulation or placenta-based homeopathy, oriented toward medicinal purposes because of benefits attributed to placenta consumption. These objects include “placenta prints,” made by soaking the placenta in paint and pressing it to paper, dream catchers made of an umbilical cord, or small drums made of a placenta membrane. These productions are then photographed and posted on their Instagram accounts.

In Switzerland, the status of doulas remains tenuous. Doulas are not always welcome in maternity wards and are rarely allowed in operating rooms. Many institutions allow the presence of only one birth companion, requiring the birthing woman to choose between her partner and her doula. Furthermore, doula care is usually not covered by health insurance (which is paid by individuals and is mandatory for everyone in Switzerland).\(^7\) According to one of my interlocutors, who has worked as a doula since 2005 and teaches in the French-speaking Swiss doula training, the situation of doulas has improved over the past decade, as “contacts with hospital institutions are much less uncertain. Also, getting paid used to be complicated, and now it goes without saying.” Doula care is even covered by some insurance companies. However, she considers that nothing can ever be taken for granted and warns her students about this persistent uncertainty. Although some hospitals theoretically accept doulas, acceptance in practice ultimately depends on the hospital staff on duty at the time of birth and the delivery’s specific circumstances. The exact percentage of Swiss births that doulas attend is not known, but what is known is that it is low.

**Reclaiming surgical birth for women**

In line with the notion of “respected childbirth” (Odent 2004), doulas often referred to “respected cesarean birth.” From their perspective, hospital staff often share insufficient information with parents regarding their options concerning cesarean births, a gap that doulas then fill. When a cesarean birth is planned, doulas suggest that parents prepare a birth plan and negotiate with the medical staff to reclaim the birth of their child by having a “gentle cesarean,” as I further discuss below. Doulas also provide detailed information about the hospital and operation protocols, and make suggestions to help parents adapt the procedures used to their needs and desires. Even when parents are preparing for a vaginal birth, including a home birth, doulas always mention the possibility of a cesarean delivery in anticipation of a potential emergency. As explained by a doula named Carole, “What I really try to avoid is that all of a sudden, they find themselves helpless, having a cesarean that is not planned at all, not at all anticipated. I want them to be informed about the protocols and the procedure, the alternatives, and to know what really matters to them.” Carole believes that such information gives parents the opportunity to fully prepare for and appropriately react to an unplanned cesarean birth.

For a planned cesarean birth, doulas insist on the importance of creating a birth plan to present and discuss with birth professionals before childbirth. For example, doulas mention to parents the options of arriving at the operation room on foot, reducing the light, having their music played in the operation room, and experiencing skin-to-skin contact between mother and baby immediately after birth. These propositions are aimed at empowering parents, especially mothers, to feel in control over the birth process, and to reclaim their birth experience. This is also the ambition of the “natural” or “gentle” cesarean, a technique created by the British obstetrician Fisk and his team, aimed at mimicking the context of a vaginal delivery (Smith et al. 2008). This technique, intended to enable parents’ participation, has been recently introduced in Switzerland. It offers mothers the chance to
“push” during the extraction, to watch their baby come out, and to have the baby immediately placed on the mother’s chest. In general, my interlocutors spoke enthusiastically about gentle cesareans and saw them as a way for women to retain some power and agency over the birth process. For example, Julie commented:

It’s a real shift from being a spectator to becoming an active participant even if with a vaginal birth, you can also be a spectator of your delivery… When she [the mother] is able to push the baby, the mother is the one giving the energy, the impulse to the baby for the birth, and that changes everything. It’s not a doctor who is going to tear her baby out of her guts. And also, being able to see the birth of the baby, because it is often stolen from women, from couples, but that must be discussed beforehand. Sometimes they [the medical staff] offer the mother the option to hold the baby, once she or he is gone out a bit. […] In general, they pay attention to the time of separation, to pull them [the mother and the baby] apart as little as possible, to create an atmosphere more conducive to attachment.

As mentioned by Julie, non-gentle cesarean births usually involve mother – child separation after birth, contrasting with the now-common medical practice of early skin-to-skin contact between mother and newborn. This period of separation is generally a negative experience for mothers, who find themselves alone with the surgical team until the end of the intervention while their partner is invited to leave with the newborn to enjoy skin-to-skin time in a more temperate room. Although doulas usually are unable to attend cesarean births because of the one-companion rule, they often take over from the partner at the mother’s side during the suturing. Laura observed that her clients appreciated her presence: “I felt my presence brought comfort. At that stage, no one talks to mothers anymore, and the fact that we have previously built a bond allows them to dare crying; someone is there for them.” Some doulas also encourage mothers to stay connected with their baby during the separation through what they called “the bond of the heart.” One doula explained, “Even though they are no longer in the room – daddy and baby – they [the mothers] can stay connected with them. The baby is able to feel this bond through the walls.” From this perspective, which sees babies as conscious beings both inside the womb and out, doulas also emphasized the importance of preparing the unborn baby before the surgery, by explaining to the baby what is about to happen and the reasons why the mother is having a surgical birth. Marie commented, “I make them [the parents] realize that there is a little being who is going to arrive. I help them create a bubble before birth, so that they are connected to their baby. […] They need to understand that they are going to give birth, that even though it’s a surgery, it’s still a birth.” Some doulas propose performing a ritual before the cesarean, to help parents connect with their baby and inform the baby of the imminent birth, in the firm belief that preborn babies are conscious beings. These rituals are inspired by doulas’ holistic birth care approaches, such as haptonomy and hypnosis, which they use to guide parents to access this connection through visualization. As explained by one doula:

It is important to let parents know that they don’t have to give it [their birth plan] up. Just because there’s a cesarean birth doesn’t mean they have nothing more to say. And also that it remains a celebration and a joy because one difficulty with a cesarean is that it cuts off the magical side of birth, the unexpected side, and this is often sad for parents. We restore this festive and sacred side through these rituals.

Yet, cesarean births are not de-ritualized per se. On the contrary, through routine obstetrical and surgical procedures, they are highly ritualized events (Cheyney and Davis-Floyd 2022; Davis-Floyd 2022). The rituals surrounding cesarean births reflect a technocratic birth culture, which considers the human body as a machine (Martin 2001), whereas doulas’ rituals are intended to enhance women’s agency and empowerment.

In line with the gentle cesarean, doulas also emphasized the importance of feeling the embodied experience of giving birth, which they linked in particular to the release of endogenous oxytocin. This idea summarizes the arguments of the natural-childbirth proponents, especially those of Michel Odent (2001), based on the reasoning that artificially inducing or augmenting labor with synthetic, exogenous oxytocin would prevent the laboring body from producing its own endogenous oxytocin. From this perspective, Sarah mentioned that it is important for women to “release their oxytocin potential
before the cesarean;” in her eyes, this release could positively influence not only the cesarean experience but also the mother – child bonding process and breastfeeding initiation. To this purpose, she advises women to also “indulge themselves to the fullest” during the last weeks of pregnancy, such as by having sex or going to a restaurant. Another doula told me about her follow-up with a couple preparing for a vaginal birth after cesarean. She joined the parents at home to support them during their third night of pre-labor. The mother was very tired. “I massaged the woman for a good part of the night, creating a cocoon around them, with the little candles, as if they [the parents] really were in labor.” In the morning, the woman was in early labor, and they went to the hospital, but the contractions stopped. The mother eventually gave birth by cesarean a second time, but the mother had no regrets regarding this outcome and expressed her satisfaction with her doula regarding their intimate time at home: “She told me that she got what she wanted to experience. She had it with me during the night; she had this oxytocin moment.” On the importance of an embodied birth experience, the doula concluded, “It’s important to feel it in your body, the hormones, the highest peak of oxytocin in your life, when you give birth. If nothing has happened on the bodily level, it is difficult for the woman to feel that she has given birth.” In this doula’s opinion, by making them passive, a cesarean birth deprives women from an embodied birth experience. Restoring it, at least partially, would therefore be key to improving their overall feelings regarding childbirth, and also regarding their own personal and individual childbirth experiences.

Vaginal seeding is another practice often suggested by doulas to parents, as a way to regain agency over their delivery and to somewhat reintegrate the initially planned script of a vaginal birth. Several studies have found that cesarean birth negatively influences an infant’s microbiome and long-term general health (see for examples Dominguez-Bello et al. 2016; Mueller et al. 2015). To compensate for the lost potential benefit to infants’ microbiomes, medical scientists have suggested the still-controversial vaginal seeding technique to expose the baby to maternal vaginal microbiota after birth (Dominguez-Bello et al. 2016). Doulas relay this information, encouraging parents to negotiate this procedure with their caregivers. Similarly, doulas suggest that parents’ birth plans should include the collection of the placenta for later transformation (see above), an achievement that is never straightforward in the hospital but can be particularly tricky in the context of a cesarean birth. For doulas, this is part of the notion of a “respected cesarean birth.”

Cesarean recovery and the “babymoon”

My interlocutors highlighted cesareaned women’s high need for support during the postpartum period. The doulas mentioned providing logistical support, for example, by bringing meals, but they especially emphasized their emotional support. They typically offer parents a debriefing discussion to revisit how the birth unfolded. More broadly, doulas insist on the importance of listening to mothers, encouraging them to unburden themselves, and reducing any negative representations that they may have of their cesarean delivery. Doula Solange commented:

In our training, we are particularly trained in active listening: We welcome feelings, and we allow mothers to open up. We reassure them by saying that childbirth is not a competition, that we are there to meet their needs, and that we are not there to impose any values. Verbalizing these elements relieves them. I would say it’s through our active listening, our benevolence [that we help]. We tell them that they shouldn’t compare themselves to other women. We can control certain things, but there are a lot of things that we cannot control, and we remind them of that. Not having control is very hard to accept, but I believe that we help a lot to free them of guilt. It actually lifts a weight that they put on their shoulders themselves. They did the best they could, and this must be remembered during the postpartum period as well. Our role is to welcome their feelings and help verbalize them.

In this excerpt from our interview, Solange highlighted the feelings of guilt and failure often expressed by her clients, and criticized the self-determination discourse, which interprets the mode of delivery as a consequence of women’s choices and determination (Apfel 2017). In a more practical
way, doulas generally encourage parents to prepare for the postpartum period before birth and help them secure favorable circumstances for maternal recovery. On the need for rest after a cesarean, Melissa commented:

They [the medical staff] want us to walk outside right away, but the mother should stay in bed as much as possible. The perineum also suffers a lot during a cesarean. It’s a pretty violent act – opening up all the tissues, pulling on the stomach if the baby is stuck, stretching the tissues, pressing on the organs – the perineum hurts. The woman really should take some time for the babymoon. I tell them, “If you can, try to organize yourself so that you will never have to get up.”

This advice may appear as contradicting the biomedical approach, which advocates rapid mobilization after the operation to prevent thrombosis. However, since women start their “babymoon” after their hospital stay, during which they receive daily anticoagulant injections, and are encouraged by medical staff to rapidly get up after the surgery, the actual risks of postpartum thrombosis are mitigated. Doulas also consider this proposition to “never get up” as theoretical: in practice, they are aware that it is not achievable in regards to daily life chores and requirements, so that the “babymoon” would not cause a threat to their cardio-vascular health. The “babymoon” was described by my interlocutors as a period during which women who gave birth, whether vaginally or by cesarean, are invited to focus on their convalescence and their newborn and to delegate all other domestic or parental tasks. This proposition is presented as “woman-centered” (not child-centered), yet it also follows the “ethics of maternal availability” (Garcia 2011). In this perspective, the babymoon is in line with the precepts of psychological theories of attachment, suggesting maintaining constant physical, ideally skin-to-skin, contact with the baby; contact which is also seen as a way to secure the initiation of breastfeeding (see for example Norholt 2020).

Doulas also pay careful attention to cesarean scars and how women feel about them; according to my interlocutors, women’s relationships with their scars provide a relevant measure of their overall perceptions regarding their cesarean births. Julie commented, “At first, women often do not want to see it. They cannot touch it.” If her clients wish, she accompanies them in the first touch of their scar. She stated, “We can ritualize the relation to the scar. When the mother is about to touch it for the first time, we can light a candle, choose a particular oil that we have prepared, to be able to welcome what is happening at that time.” For doulas, women touching or massaging their scar is a matter of “reconnection” with their body and of regaining consciousness of their stomach. Doulas also emphasize the importance of valorizing the scar, as a mark of women’s strength and bravery after enduring the operation. Some doulas use hypnosis and visualization to “heal” the scar on an emotional level, as described by Claire:

I work a lot with hypnosis to bring light and calm around the scar. I have really good results with this technique. For me, this is a valuable tool because it can be used by a lot of people. It is also important to take care of the uterus that has been so energetically opened, and it can also be healed through hypnosis by picturing that we are closing the uterus up, that we are taking care of it. To cause the uterus scar to become luminous, I often use a golden filament, and we imagine sewing it with a very soft seam, and we thank this organ for all the work it has done and allow it to find harmony.

Other doulas propose that women symbolically talk to their scar, “tell it that it is strong, that it is tough, and to thank it.”

**Doula healing rituals and the restorative bath**

Aside from caring for their scars, doulas often offer mothers specific rituals for emotional recovery and for reuniting with their bodies during the postpartum period. For example, the rebozo ritual, inspired by traditional Mexican midwives, is a three-hour care performed by two doulas. First, the doulas give a four hands massage to the postpartum woman, then she is invited to enter a hot bath or a sauna to sweat. After this, the doulas wrap her in a rebozo, a large woven shawl originating from Mexico, which they pull tightly around seven parts of her body (feet, knees, thighs, pelvis, stomach, shoulders, head)
moving from feet to head. Using the rebozo, doulas intend to “close” the body, after it has opened completely to give birth. The doulas also prepare a hot spicy tea that they offer to the woman throughout the treatment. This ritual aims at marking and celebrating the transition to motherhood. In my interlocutors’ discourses, this event is often described as a “rite of passage,” in line with Van Gennep (1909) or Turner (1979) classic anthropological concept, though it would be more appropriately called a “rite of integration.” By offering and performing this ritual, doulas also attempt to make up for other rituals that have been removed because of the surgical birth process.

As explained by doula Julie: “Rebozo treatment has several benefits. It allows you to let go on an emotional level. It allows you to close the body and also to close a story. We [doulas] do this a lot after a birth, but it can be done for other life transitions.” Rebozo care is also described by doulas as an opportunity for mothers to become one with their post-cesarean bodies, as it allows them to relax, to focus on their bodies and reconnect with their sensations, in the safe space created by their doulas. For example, some women are able to touch and massage their scar after the ritual, while it was too upsetting for them before experiencing that ritual.

Several doulas also told me about the “restorative bath” ritual, which they perform with women who have braved traumatic childbirths, often after emergency cesareans. The doulas who shared their restorative bath experiences with me first discovered this ritual at a workshop organized by the Swiss doula association. Quantik Mama also practices this ritual and described it in a blog post. From these sources, this ritual has spread among French-speaking Swiss doulas through peer sharing.

The restorative bath ritual, based on hypnosis, visualization, and suggestion techniques, aims to revisit the birth experience to positively reclaim it. Again, the maternal body is at the center of the ritual, which consists of leading the woman to feel the embodied sensations of labor before symbolically re-birthing her child. Then, the baby and mother are reunited, naked, sometimes in a bath and other times in the parental bed, depending on the method preferred by the doula and by the mother. This ritual usually takes place in the first weeks or months after delivery at the mother’s home or, sometimes, at the doula’s home. In addition to the doula, the mother is accompanied by her baby and her partner or a friend. In the first stage, the mother gives a detailed birth account while drinking tea prepared by the doula. Some doulas mentioned choosing raspberry leaf tea, known to stimulate the uterus. As explained by Sarah, “It is a session where women confide; they often cry.” After this narration, the doula and the mother move to the bathroom, and the baby stays with the other companion. The bathroom is prepared and decorated by the doula beforehand, with candles, flowers, and other natural elements. The doula also plays music chosen in advance with the mother. The doula starts running a bath and then, using hypnosis, she suggests to the mother that she is in labor – again. Sarah explained to me that she relies on the mother’s story: “I take all the elements of the birth story and I modify them positively.” In parallel, she replicates the kind of support she would offer during real labor, such as massaging the woman. ‘I say, “The uterus starts to contract.”’ The woman ends up feeling them [the contractions], so she says “It’s getting too strong,” and I propose, “Do you want to get into the bath?” When they enter the bath, I quietly fetch the baby, without them noticing.’ Sarah then applies some heavy baby cream onto the baby to mimic vernix, and slips the baby between the mother’s legs in the tub, while carefully maintaining their head at the surface. According to Sarah and to the other doulas who shared their experiences, when the mother takes hold of her baby, she experiences this touch as if it were the first time. In the case of a breastfeeding mother, doulas also report the intensity of the first feed after the bath “as if it were the first ever.” For Laura, the restorative bath is a process of “restoration:” “Whatever she was not able to experience at the time of birth, she can have it now.” Another doula, Anne, commented, “It’s magic: It allows the mother to experience the childbirth she had dreamed of so much while also leaving her space, earlier [when she recounts the birth], to discharge her feelings.” Doulas also ascribe long-term benefits to the ritual regarding the mother–child bond, as expressed by Marie: “The mother–baby relationship improves. Babies’
behavior changes too. So far, I have always observed that.” In this perspective, the restorative bath offers an opportunity to reintegrate the ideal script of immediate skin-to-skin contact after birth and an early feed.

**Conclusion: reintegrating surgical birth into maternal Bodies**

Based on doulas’ discourses and experiences, in this article I have examined how they work with parents to create meaning and to restore the emotional and sacred dimensions of birth to cesarean births. This process involves a reintegation of surgical birth into maternal bodies, which is in line with the gentle cesarean approach but can also take place after birth. This focus on the maternal body, intended to support the transition into motherhood, is consistent with a “revenge of the flesh” observed since the 1990s (Memmi 2014), characterized by a range of body-centered practices introduced in maternity wards in Europe and North America. This revalorization of an embodied motherhood is underpinned by the idea that mother – child bonds are forged through physical proximity.

Swiss doulas’ approaches are also influenced by the model of natural childbirth and the work of Michel Odent (2001), which is reflected in a discourse on hormones, especially on the virtuous effects of oxytocin. Yet the rhetoric of natural childbirth has been criticized for its elitist character. On the one hand, this model favors economically and culturally privileged, predominantly white women. On the other hand, it imposes normative expectations on parents by cultivating an ideology of self-determination, positing that the outcome of childbirth depends primarily on women’s choices (Apfel 2017; Malacrida and Boulton 2014; McCabe 2016). This vision, characteristic of neoliberal regimes, ignores socioeconomic constraints as well as local and institutional obstetric cultures. These tensions were palpable in my interlocutors’ discourses. For example, one doula claimed to be a specialist in emotional support for vaginal birth after cesarean, which she considered the only way to completely “heal” from a cesarean. In any case, my interlocutors overwhelmingly advocated an inclusive approach, supporting women in whatever birth choices they might prefer, and were highly critical of a moral hierarchization of delivery modes. In addition, they offered to adjust their rates and to stagger payments to accommodate families’ socioeconomic circumstances. More broadly, doulas are also important contributors to the European and North American reproductive justice movement, which promotes inclusivity in childbirth care and fights against reproductive discrimination, such as racism, homophobia, and transphobia (Apfel 2017). My interlocutors’ commitment toward the reproductive justice movement reflected on their social media content, for example by promoting a queer friendly and gender inclusive language about reproduction, and highlighting queer people’s reproduction experiences.

According to my interlocutors, doulas’ care approaches have a spiritual dimension, characterized by a bodily anchoring and a ritualization of the reproductive processes. This dimension inscribes doulas in the field of holistic spiritualities, delineated by the centrality of the interconnections among mind, body, emotions, and spirit (Davis-Floyd 2022; Davis-Floyd et al. 2018; Sointu 2006). From this perspective, birth is viewed as a moment of empowerment for women (Apfel 2017) regardless of their mode of delivery. Here, I again noted contrasting positions, and that a minority of doulas feared that an “overly” spiritual approach could discredit them, especially among biomedical professionals. Given that doulas’ status remains precarious in Switzerland, including regarding their access to hospitals, these doulas believed that remaining discreet about their spiritual practices might be necessary for the professionalization of doula care. However, the vast majority of my interlocutors saw these rituals as important tools allowing them to give meaning to women’s reproductive experiences and to help mothers “connect with their feelings,” to quote one doula. This doula also emphasized the harmless-ness of these rituals and their compatibility with biomedical care: “As long as it doesn’t go against science and it doesn’t harm anyone.” This assertion echoes Quantik Mama’s motto: “Giving birth between science and the sacred.”
On the other side, cesarean births are also loaded with techno-medical rituals (Cheyney and Davis-Floyd 2022; Davis-Floyd 2022). These rituals, sustaining technocratic values, do not “connect women with their feelings;” quite the opposite, they perpetuate a mechanistic and fragmented conception of birthing bodies (Martin 2001).

Doulas’ rituals aim to mark not only significant milestones in women’s reproductive paths, such as childbirth, but also other, less-valued moments, such as the first time a woman touches her cesarean scar. In this sense, these rituals match anthropologists Van Gennep (1909) and Turner (1979) classic definition of a rite of passage (see also Davis-Floyd 2022). At the same time, the rituals performed by doulas also appear as replacements of other rituals (for example the immediate skin-to-skin contact after childbirth) that have been removed because of the non-gentle cesarean birth.

Finally, a convergence may be noted between the enthusiasm for these rituals and the influence of therapeutic culture, which results from a neoliberal and psychological conception of the individual, thought of as a territory of self-realization and personal development (Rose 1998). Doula practices and rituals around childbirth can be understood as spaces of self-exploration through a revalorization and sacralization of female reproductive processes.

Notes

1. WHO recommendations having recently shifted from rate targets to an individual- and woman-focused approach regarding the mode of delivery (World Health Organization 2021).

2. For the sake of legibility, in this publication I use the terms “women” or “mothers” to signify pregnant, birthing, or postpartum individuals.

3. Interestingly, I spoke with one self-proclaimed “Christian doula,” who offers a “Christian spiritual preparation for birth and parenthood.” In my fieldwork, she was an exception; other doulas did not present themselves as religious. Based on current literature (see for example Castaneda and Johnson Searcy 2015), doulas do usually not openly identify with any religion.

4. According to an interview with a founder, Formation Doula Suisse romande was the first doula training available in French in Europe. Most of my interlocutors graduated from Formation Doula Suisse romande; however, a second doula training, Faculté Doula Cybèle, inspired by a Quebec training, operated during a few years (2018–2020).

5. The training is open to anyone interested, without prerequisites, except for the fees of 4,700 CAD (3,700 USD). In comparison, the Swiss training fees amount to 3,800 CHF (4,100 USD) for 14 days of in-person classroom training and online support.

6. Rates for holistic doula care (continuous follow-up from the prenatal period to the postpartum period, including attending the delivery) fluctuate between 800 CHF to 1,600 CHF, and, most of the time, are about 1,000 CHF (1,100 USD). It is also possible to have a partial follow-up, for which only prenatal or only postnatal doula sessions are included, with no delivery attendance. For a partial follow-up, rates range from 300 CHF to 800 CHF. All follow-up options include permanent phone support for the women they are caring for. The majority of the doula interlocutors also mentioned that their rates can be discussed and adjusted if a family cannot afford them.

7. At the moment, only one supplementary health insurance provider partially reimburses doula care. In June 2021, one Swiss politician submitted an interpellation to the Council of States to consider the recognition of doula care and enable its coverage under mandatory basic health insurance. The proposal was rejected.

8. A more recent study suggests that the mode of delivery does not influence infants’ microbiomes (Chu et al. 2017), whereas another study indicates that newborns’ microbiomes could be partially restored by breastfeeding after cesarean births (Cheng et al. 2020).

9. This invitation to massage their scar occurs after the scar was closed and examined by a midwife.

10. https://quantikmama.com/guerir_un_accouchement_trumatique/.

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References
Apfel, A. 2017 Donner naissance. Doulas, sages-femmes et justice reproductive. Paris, France: Éditions Cambourakis. Becc, I., M. Farahmand and A. Granjean 2020 The (b)earth of a gendered eco-spirituality. Globally Connected ethnographies between Mexico and the European Alps. In Secular Societies, Spiritual Selves? The Gendered Triangle of Religion, Secularity and Spirituality. Fedele A. and K. E. Knibbe, ed., Pp. 109–30. Oxon, UK; New York: Routledge. Blum, L. M. 1999 At the Breast. Ideologies of Breastfeeding and Motherhood in the Contemporary United States. Boston, MA: Beacon Press. Bohren, M. A., G. J. Hofmeyr, C. Sakala, R. K. Fukuzawa and A. Cuthbert. 2017 Continuous support for women during childbirth (review). Cochrane Database of Systematic Reviews 7 (7):Art. No.CD003766. Castaneda, A. N. and J. Johnson Searcy 2015 Doulas and Intimate Labour. Boundaries, Bodies and Birth. Bradford, ON: Demeter Press. Chautems, C. 2022 Negotiated Breastfeeding. Holistic Postpartum Care and Embodied Parenting. Oxon, UK; New York: Routledge. Cheng, G., Z. Qian, L. Muxia, Z. Letian, X. Lei, Z. Ying, L. Dongfang, Wang, YE, Dai, W., Li, S., Zhang, L., et al. 2020 Breastfeeding restored the gut microbiota in caesarean section infants and lowered the infection risk in early life. BMC Pediatrics 20(1):532. doi:10.1186/s12877-020-02433-x. Cheyney M. 2011 Reinscribing the Birthing body: Homebirth as ritual performance. Medical Anthropology Quarterly 25 (4):519–42. doi:10.1111/j.1548-1387.2011.01183.x. Cheyney, M. and R. Davis-Floyd 2022 Rituals and rites of childbirth across cultures. In The Routledge Handbook of Anthropology and Reproduction S. Han and Tomori C., eds., Pp. 480–93. London; New York: Routledge. Chu, D. M., J. Ma, A. L. Prince, K. M. Anthony, M. D. Seferovic and K. Aagaard 2017 Maturation of the infant microbiome community structure and function across multiple body sites and in relation to mode of delivery. Nature Medicine 23(3):314–26. doi:10.1038/nm.4272. Davis-Floyd, R. 2001 The technocratic, humanistic, and holistic models of birth. International Journal of Gynecology & Obstetrics 75(Supplement 1):S5–S23. doi:10.1016/S0020-7292(01)00510-0. Davis-Floyd, R. 2018 The technocratic, humanistic, and holistic paradigms of birth and health care. In Ways of Knowing About Birth: Mothers, Midwives, Medicine, and Birth Activism. R. Davis-Floyd, Colleagues, eds. Pp. 3–44. Long Grove, IL: Waveland Press. Davis-Floyd, R. 2022 Birth as an American Rite of Passage. 3rd ed. Abingdon, Oxon: Routledge. De Koninck, M. 1990 La Normalisation de la césarienne, la résultante de rapports femmes-experts. Anthropologie Et Sociétés 14(1):25–41. doi:10.7202/015110ar. Dominguez-Bello, M. G., K. M. De Jesus-Laboy, N. Shen, L. M. Cox, A. Amir, A. Gonzales, NICHOLAS A Bokulich, Song, S J., Hoashi, M., Rivera-Vinas, J I., Mendez, K., Knight, R., Clemente, J C. 2016 Bokulich 2016 partial resaturation of the microbiota of cesarean born infants via vaginal microbial transfer. Nature Medicine 22 (3):250–53. doi:10.1038/nm.4039.
Douglas, S. J. and M. W. Michaels 2005 The mommy myth. The idealization of motherhood and how it has undermined all women. New York: Free Press.

Euro-Peristat Project 2018 European perinatal health report. Core Indicators of the health and care of pregnant women and babies in Europe in 2015. https://www.europeristat.com/images/EPHR2015_Euro-Peristat.pdf

Federal Statistical Office 2019 Accouchements et santé maternelle en 2017. Neuchâtel: Federal Statistical Office.

Fenwick, J., Staff L., Gamble J., Creedy D. K. and Bayes S. 2010 Why do women request caesarean section in a section, healthy first pregnancy? Midwifery 26(4):394–400. doi:10.1016/j.midw.2008.10.011.

Fuller, R. C. 2001 Spiritual, but Not Religious: Understanding Unchurched America. Oxford, UK: Oxford University Press.

Garcia, S. 2011 Mères sous influence. De la cause des femmes à la cause des enfants. Paris, France: La Découverte.

Hays, S. 1996 The Cultural Contradictions of Motherhood. New Haven, CT: Yale University Press.

Hazell, L. D. 1976 [1969] Commonsense Childbirth. New York: Berkley Medallion Books.

Hodnett, E. D., S. Gates, G. J. Hofmeyr and C. Sakala 2013 Continuous support for women during childbirth (review).

The Cochrane Database of Systematic Reviews 7:CD003766. doi:10.1002/14651858.CD003766.pub5.

Jordan B. 2014 Technology and social interaction: Notes on the achievement of authoritative knowledge. Talent Development and Excellence 6(1):95–132.

Kozhimanil, K. B., R. R. Hardeman, F. Alarid-Escudero, C. A. Vogelsang, C. Blauer-Peterson, and E. A. Howell 2016 Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. Birth 43(1):1. doi:10.1111/birt.12128.

Kukla, R. 2005 Mass Hysteria. Medicine, Culture and Mothers’ Bodies. Lanham: Rowman & Littlefield Publishers.

Lupton, D. 2012 “Precious cargo”: Foetal subjects, risk and reproductive citizenship. Critical Public Health 22(3):329340. doi:10.1080/09581596.2012.657612.

Maffi, I. 2012 L’Accouchement est-il un événement? Regards croisés sur les définitions médicales et les expériences intimes des femmes en Jordanie et en Suisse. Mondes Contemporains 2:53–80.

Maffi, I. 2014 Les cours de préparation à la naissance dans une maternité suisse. Entre logiques institutionnelles, postures des sages-femmes et autonomie des jumelles. En Agagner la naissance. Terrains socioanthropologiques en Suisse romande C. Burton-Jeangros, R. Hammer, and I. Maffi, eds., Pp. 175–97. Lausanne: Giuseppe Merrone Éditeur.

Maffi, I. and S. Goullhers 2019 Conceiving of risk in childbirth: Obstetric discourses, medical management and cultural expectations in Switzerland and Jordan. Health, Risk & Society 21(3–4):185–206. doi:10.1080/13698575.2019.1621996.

Malarca, C. and T. Boulton 2014 The best laid plans? Women’s choices, expectations and experiences in childbirth. Health 18(1):41–59. doi:10.1177/1363459313476964.

Martin, E. 2001 The Woman in the Body: A Cultural Analysis of Reproduction. Boston: Beacon Press.

McCabe, K. 2016 Mothercraft. Birth work and the making of neoliberal mothers. Social Science & Medicine 162:177–84.

Memmi, D. 2014 La Revanche de la chair. Essai sur les nouveaux supports de l’identité. Paris, France: Éditions du Seuil.

Muler, N. T., E. Bakcs, J. Combellick, Z. Grigoryan and M. G 2015 Dominguez-Bello 2015 the infant microbiome development: Mom matters. Trends in Molecular Medicine 21(2):109–17. doi:10.1016/j.molmed.2014.12.002.

Norholt, H. 2020 Revisiting the roots of attachment: A Review of the biological and psychological effects of maternal skin-to-skin contact and carrying of full-term infants. Infant Behavior and Development 60:101441. doi:10.1016/j.infbeh.2020.101441.

Oakley, A. 1984 The Captured Womb: A History of the Medical Care of Pregnant Women. Oxford: Blackwell.

Odent, M. 2001 L’Amour scientifié. St Julien-en-Genevoix. France: Editions Jouveneu.

Odent. M. 2004 Le fermier et l’accoucheur. Paris, France: Medicis.

Pasche Guignard, F. 2020 Back home and back to nature? Natural parenting and religion in francophones contexts. Open Theology 6(1):175–201. doi:10.1515/opth-2020-0013.

Rose, N. 1998 Inventing Our Selves. Psychology, Power and Personhood. Cambridge, UK: Cambridge University Press.

Rothman, B. K. 1991 [1982] In Labor. Women and Power in the Birthplace. New York: W. W. Norton and Company.

Ruhl, L. 2002 Dilemmas of the will: Uncertainty, reproduction, and the rhetoric of control. Journal of Women in Culture and Society 27(3):641–63. doi:10.1086/337940.

Sargent, C. and N. Stark 1989 Childbirth education and childbirth models: Parental perspectives on control, anesthesia, and technological intervention in the birth process. Medical Anthropology Quarterly 3(1):36–51. doi:10.1525/maq.1989.3.1.02a0030.

Smith, J., F. Plaat, N.M. Fisk 2008 The Natural caesarean: A woman-centred technique. British Journal of Obstetrics and Gynaecology 115(8):1037–42. doi:10.1111/j.1471-0528.2008.01777.x.

Sointu, E. 2006 The Search for wellbeing in alternative and complementary health practices. Sociology of Health & Illness 28(3):330–49. doi:10.1111/j.1467-9566.2006.00495.x.

Sointu, E. and L. Woodhead 2008 Spirituality, gender, and expressive selfhood. Journal of the Scientific Study of Religion 47(2):259–76. doi:10.1111/j.1468-5906.2008.00406.x.

Turner, V. 1979 Betwixt and between: The liminal period of rites of passage. In Reader in Comparative Religion W. A. Lessa and E. Z. Vogt, eds., Pp. 234–43. New York: Harper & Row.

Van Gennep, A. 1909 Les rites de passage : étude systématique des rites. Paris, France: E. Nourry.
Wertz, Richard W. and D. C. Wertz 1989 [1977] Lying-In. A History of Childbirth in America. New Haven, CT: Yale University Press.

Wiklund, I., Edman G. and Andolf E. 2007 Cesarean Section on maternal request: Reasons for the request, self-estimated health, expectations, experience of birth and signs of depression among first-time mothers. Acta Obstetrica et Gynecologica 86(4):451–56. doi:10.1080/00016340701217913.

Wolf, J. B. 2011 Is Breast Best? Taking on the Breastfeeding Experts and the New High Stakes of Motherhood. New York: New York University Press.

World Health Organization 2015 WHO Statement on caesarean section rates. WHO/RHR/15.02. Geneva, Switzerland: World Health Organization, Department of Reproductive Health and Research, Pp. 1–8.

World Health Organization 2021 Cesarean section rates continue to rise, amid growing inequalities in access. World Health Organization, Departmental News. https://www.who.int/news/item/16-06-2021-caesarean-section-rates-continue-to-rise-amid-growing-inequalities-in-access.