Human childbirth is rarely simply a biological event. All known human societies channel the physiologic process of giving birth into pathways imprinted with their cultural worldview. Sheila Kitzinger (1980: 115) noted that the rituals surrounding birth point “as sharply as an arrowhead” to the core values of a given culture, and as Jordan (1993: 4) stated, “birth is everywhere socially marked and shaped.” In addition, because birth is often considered a time of vulnerability—even ritual danger—societies structure both the ideology and the performativity of childbirth as a means of managing existential uncertainty (Cheyney et al. 2019). “It is not surprising, therefore, that—whatever the details of a given birthing system—its practitioners will tend to see it as the best way, the right way, indeed the way to bring a child into the world” (Jordan 1983: 2). This, Jordan argued, is precisely why cross-cultural analyses are so critical—for “normal” is simply what we have grown accustomed to. Cross-cultural anthropological comparisons provide information we can use to construct a deeper understanding of the multiplicity of ways in which the processes of childbirth may be historically and socially shaped—a depth of understanding that Jordan (1983) argued is never available from the inside point of view of any singular system or community.

Thus the anthropology of birth provides an invaluable lens through which to see and interpret the core values that shape a society. Employing various cross-cultural examples, in this chapter we describe the rituals and rites of childbirth that people have designed over time and space to culturally shape the physiologic processes of birth. It is commonly held that the de-ritualization of birth—its “liberation” from ancient superstition and taboo—accompanied the advent of scientific medicine and the movement of birth into the hospital. However, in this chapter, we argue that in fact, the application of biomedicine and the movement of birth into the hospital in so many societies did not actually function to de-ritualize birth, but rather to re-ritualize it via the proliferation of a new set of elaborate rites and rituals; through these, we can continue to read the core values of contemporary societies. In birth’s contested spaces, we can also see how some re-ritualized practices, and especially those that move along the edges of “normal” or “acceptable” standards of care, function to challenge, resist and reshape dominant (and dominating) approaches (Cheyney 2011).

Childbirth, rituals, and rites of passage

A ritual has been defined as a patterned, repetitive, and symbolic enactment of a cultural (or individual) belief or value (Davis-Floyd 2003; Davis-Floyd and Laughlin 2016), and the primary
Rituals and rites of childbirth

Purpose of ritual is often described as the alignment of an individual’s belief system with that of society (ibid.). Rituals are commonly thought of as religious, but they can enact secular beliefs and values as effectively as religious or spiritual ones. A rite of passage is a series of rituals that convey individuals from one social status to another (for example, from girlhood to womanhood, boyhood to manhood, unmarried to married), thereby transforming both society’s definition of the individual and the individual’s self-perception. A central feature of initiatory rites of passage is that they place their participants in a transitional realm that has few of the attributes of the past or coming state (Turner 1979), facilitating the gradual psychological opening of the initiates to profound interior change. Thus, rites of passage are often designed to restructure a person’s beliefs and value systems in accordance with the dominant beliefs and values of the society or group into which they are being initiated. By making the physiologically transformative process of birth into a cultural rite of passage for the birthing person, a society attempts to ensure that its basic values will be transmitted to the next generation, as those who give birth are also often centrally responsible for instilling these values in the minds of their children—society’s new members and the guarantors of its future.

Anthropological interpretations of birth as a heavily standardized rite of passage (Davis-Floyd 2003; Cheyney 2011) draw upon the work of early symbolic anthropologists like van Gennep (1960) and Turner (1969, 1974, 1979), who argued that major life transitions tend to be intensively ritualized. This ritualization is often hidden, invisible, and normalized for members of a society, in part because it emerges from a society’s conceptual foundations, which are so ingrained in belief systems that only via the process of de-familiarization can participants come to see the deeper meanings communicated through ritual transformations (Cheyney 2011). During a rite of passage, participants are situated in a transitional realm that is unlike the previous or coming state (Turner 1979). Turner argued that the non-ordinary nature of this state facilitates a psychological opening in participants that society may capitalize on to communicate, reaffirm, and validate core values and beliefs. Birth is arguably such a process as it embodies the three stages of a rite of passage originally outlined by van Gennep (1960): 1) Separation of the individual from her normal or previous social state (a non-pregnant woman); 2) a period of transition where participants exist in a liminal space where they are not clearly one thing or another (a pregnant and laboring mother-to-be); and 3) an integration phase where individuals are gradually reintegrated back into society replete with a new social status (the mother of a new baby).

In addition, because childbirth is at least somewhat challenging for most parturients, it is likely to be a time when participants are open to the guidance of others, and particularly to those considered “experts.” By exploiting the inherently transformative properties of the birthing process, a society can attempt to guarantee that its core values will be transmitted to participants. The ritualized practices characteristic of technocratic birth, which include the donning of the hospital gown, administration of intravenous (IV) fluids and medications, epidural anesthesia, and electronic fetal monitoring, communicate the supremacy of technology in the birthplace and a “birth-as-medical-event” perspective. The final result may be a person who “believes in science, relies on technology, recognizes her inferiority (either consciously or unconsciously), and so, at some level, accepts the principles of patriarchy” (Davis-Floyd 2003: 152–153).

However, humans are not automatons and, thus, the extent to which participants in the birth process actually emerge with the intended ideals depends on the individuals involved. Hospital care providers can capitalize on birthing processes to transmit core values to participants. However, because their ritual interventions are, in most cases, non-essential, a window exists that women may slip through, avoiding the full extent of technocratic socialization. Butler (1997) refers to this process of avoiding norms or of performing “wrong norms” as “slippage,” and notes that it provides the potential for resistance. As birthing people globally sidestep
culturally normative standards of care, they engage in a performativity of “wrong norms” that challenges the hegemony and authoritative knowledge (Jordan 1993) of medicalized birthing care (Cheyney 2011).

Such interpretations of obstetric procedures as ritualized practice emerge from the semantic or semiotic schools of ritual analysis developed in the 1960s by theorists like Turner (1979) and Geertz (1973), who emphasized a ritual-as-language analogy that stressed the role of communication of the attitudes and values that rituals transmit. More recent approaches to ritual interpretation, including the performance approaches that emerged in the 1970s (see Bell 1997; Davis-Floyd and Laughlin 2016: 225–262), recast questions about the message content of ritual by asking how symbolic activities employed in rituals enable participants to appropriate, modify, or reshape cultural values and ideals (Wirtz 2007). Performance models focus on actors as active, rather than passive, as constructors of ritual and not simply as receivers of messages. Views of ritual as a performative medium are based on the assumption that ritual does not simply mold participants but, rather, that participants actively create rituals and use them to modify their worlds (Kang 2006; Norget 2006; Davis-Floyd and Laughlin 2016: 327–368).

Practice approaches, with their focus on ritualization as political praxis (Paulson 2006; Robins 2006; Nash 2007), have also expanded the scope of ritual analysis in anthropology. Practice theorists cast ritual as paradigmatic engagement, or as an activity that showcases cultural patterns. In these approaches, researchers focus on processes of large-scale historical and social change and are often particularly attentive to the political dimensions of ritual, emphasizing how positions of domination and subordination are variously constituted, modified, and resisted through ritual. Thus, the rituals of birthing are not simply about communicating a set of values. They also provide a critical platform for resisting the cultural normativity of medically managed births that have become commonplace cross-culturally over the last 100 years. Just what this means for individual participants, however, differs, as each mother and her caregivers co-construct the meanings and nuances of pregnancy, labor, and postpartum care in accordance with their own unique needs, beliefs, and values. Birthing rituals are, therefore, “flexible strategies” (Bell 1992: 121), calling forth both consent and resistance (Klassen 2001).

Birth and sociality

Evolutionary anthropologists Wenda Trevathan and Karen Rosenberg (Rosenberg 1992; Rosenberg and Trevathan 2001; Trevathan 2011) have long postulated that midwifery evolved along with human birth (see Rosenberg and Trevathan, this volume). The presence of other women is likely to have enhanced the success of the birth process as these women acquired skills such as turning the baby in utero to ensure the optimal position for birth, assisting rotation of the head and shoulders at birth, massaging the mother’s uterus and administering herbs to stop postpartum bleeding, and facilitating breastfeeding. Rosenberg and Trevathan (1995, 2002) suggest that as fetal heads became larger and the mechanisms of delivery more complex, there would have been selective advantages to having an attendant present. As more mothers and babies survived with assistance, midwifery skills and traditions developed, providing a distinct evolutionary advantage over solitary birth. Such co-evolution of biological and cultural features opened up possibilities for the ritualization of birth as it became an increasingly social event.

For most mammals (including primates), birth is a solitary event. However, among human primates, there are very few cultures or subcultures where solitary birth is valued or commonly performed. And yet, birth is still ritually marked and shaped by cultural beliefs even in these societies (Cheyney and Davis-Floyd 2020a, 2020b). Such cultures included, or still include:
Rituals and rites of childbirth

- The Ju/'hoansi (formerly known as the “!Kung,” or “San”) of the Kalahari desert in Botswana and Namibia, who described a cultural ideal of going into the bush alone and returning with their newborn babies. Biesele (1997) stresses that such women were honored for performing this courageous rite of passage on their own, in the same way that young men who returned from a hunt after having killed their first large animal were honored—as valiant and brave.

- The Bariba of rural Benin, for whom solitary birth in their own homes was similarly valued; they too were honored for their heroism and stoicism during labor and birth (Sargent 1989).

- The Tarahumara (Rarámuri) of the Northern Mexico Sierra Madre (Miller 2021), who either go outside their huts to give birth alone on the mountainside or, as drug and human trafficking makes that more dangerous, give birth in their huts accompanied usually only by their husbands. This ritualistic practice, according to Miller, enacts their core cultural values on privacy, modesty, self-reliance, and fear of strangers.

- The women of Misima Island of Papua New Guinea (Byford 1999), who commonly give birth alone in their homes or perhaps with their husbands present. They often throw a shawl or other piece of fabric over a roof beam and pull on it to help them to squat and give birth in an upright position. For them, solitary birth enacts cultural values on fortitude and self-sufficiency.

- A very small sub- and counter-cultural group of women in the United States and other high-resource countries (who sometimes identify as “freebirthers”), who plan to give birth unattended because they do not wish their births to be affected by the presence of any sort of professional attendant. They make the ideological choice to birth at home, in the ocean, in a cabin in the woods—with only their partner present (Moran 1981; Shanley 1994; Williamson and Matsuoka 2019; Ozhiganova 2021), thereby enacting their individual beliefs in the capability of their own bodies, their trust in the process of birth, and their distrust of trained practitioners, who in their view interfere with the natural flow of birth.

Although there are more examples (see Selin and Stone 2009 for several), it remains the case that solitary birth is rare for humans.

Childbirth and women’s status

The social nature of birth and its importance for survival ensure that this biological and intensely personal process will carry a heavy cultural overlay: Where, how, with whom, and even when a woman gives birth are heavily socially shaped and culturally determined. Where women’s status is high, a rich set of nurturant traditions tends to develop around birth; where it is low, the opposite may occur. For example, in the patriarchal Islamic society of Bangladesh, in which the status of women is low, childbirth (like menstruation) was traditionally regarded as highly polluting (Blanchet 1984). Women gave birth on dirty linens, with the baby set aside on a pile of rags until the placenta was delivered, as that was considered the moment of greatest danger. As a result, rates of maternal and neonatal mortality were (and remain) high, due partially to such cultural beliefs, but also to poverty and malnutrition, which (unlike such cultural traditions) still continue today. In contrast, in matrilineal societies such as those of Milne Bay in Papua New Guinea and of Micronesia, where the status of women is high and food is abundant, pregnant women are pampered and nurtured (Ward 2004). Skilled midwives administer frequent massages during pregnancy and have a rich repertoire of techniques for assisting women during labor and birth.
Cross-cultural examples of birth ritualization

**Similarities in traditional and contemporary homebirth practices**

In home settings across cultures, childbirth flows according to the natural rhythms of labor and women’s daily routines. In early labor, birthing people move about at will, stopping their activities during the minute or so of each contraction, and then continuing to be active—which may include doing chores, cooking, chatting, walking, eating, singing, and dancing. Such activities subside as they begin to concentrate more on the work of birthing, often aided by massage and emotional support from their labor companions—usually midwives, doulas, and relatives. Many cultures have rich traditions about who should be present (sometimes the father, sometimes only women, sometimes the whole family and/or friends), how labor support should be provided, what rituals should be performed to invoke the help of deities and/or ancestral spirits, and what herbs and hand maneuvers may be helpful to assist a birth or stop a postpartum hemorrhage. When birth is imminent, those who give birth at home in most cultures usually assume upright positions, squatting, sitting, standing, or on hands and knees, often pulling on a rope or pole or against the embraces of their companions, as they work to give birth and are rewarded by a baby in their arms. Midwives kneel down in front of the upright mothers to receive their babies. These practices are consonant with our evolved biology; they work to facilitate the normal physiology of birth and there is now a large body of scientific evidence supporting their use (see Gupta et al. 2017; Badi et al. 2019; Cheyney and Davis-Floyd 2020a, 2020b).

However, not all historical traditional birthing rituals were viable. Traditional midwives in India, called *dais*, used to put cow dung on the umbilical cord to dry it; and as Jordan (1993) documented, the *parteras tradicionales* of Mexico’s Yucatan often encouraged the woman to push too early in labor, resulting in a painfully swollen cervix. Yet the vast majority of traditional practices were so physiologically sound that many contemporary midwives incorporate them into their practices. These include the hands-and-knees position, also known as the Gaskin maneuver (Meenan and Gaskin 1991; Kovavisarash 2006), named after famed community midwife Ina May Gaskin, who learned this technique from the traditional midwives of Guatemala. They explained to her that they had learned it from simply watching laboring women whose babies presented breech (bottom- or feet-first) or had shoulder dystocias (when the head is born, but the baby’s shoulder is trapped behind the public bone), instinctively fall into this position, which is highly physiologic because it opens the pelvis 1–2 cm more than other positions, including squatting and standing (ibid.).

**Cultural differences in pre- and postnatal practices**

Although traditional birthing practices have many similarities as described above, both pre- and postpartum practices vary widely in terms of food taboos (see Laderman 1983) and ritual practices—such as being careful not to tie knots so the umbilical cord will not become knotted or not to stand in a doorway so the baby will not get stuck in its transitional process. Some cultures encourage early breastfeeding, whereas some consider colostrum to be harmful and feed the baby other fluids until the breastmilk comes in—a potentially dangerous practice, as many babies die from contaminated water. Most especially in low-resource countries, long-term breastfeeding is essential for infant survival. Steam and herbal baths, and periods of postpartum confinement, are often culturally prescribed, varying in length from a few to 40 days. Similarities among traditional postpartum practices include newborns being kept with their mothers skin-to-skin for warmth and long-term exclusive breastfeeding (Montague 1971; Trevathan and McKenna 1994; see also Tomori, Quinn and Palmquist and Rudzik, Tomori, Ball, and McKenna, this volume).
The movement of birth into hospitals around the world, and its concurrent domination by obstetricians, has resulted in a rupture of birth’s normal physiology, as (mostly) viable cultural traditions were replaced by what quickly became biomedical “traditions.” Thus, since the majority of births in most countries now take place in biomedical facilities—hospitals and clinics—the rest of this chapter will focus on the rituals of hospital birth, which have deeply shaped birthing processes in ways that are quite different from the rituals developed in societies prior to technocratic obstetrics.

**The characteristics of ritual and its roles in hospital birth**

A technocracy, as Davis-Floyd has long defined it (2003), is a hierarchical, capitalistic, bureaucratic, and patriarchal society organized around an ideology of progress through the development of ever-higher technologies, the institutions that control and disseminate them, and the global flow of information via such technologies. High-resource technocratic societies, and especially the US, have exported their model of facility birth to low- and middle-income countries (LMICs) around the world, and their hegemonic practices have become globally pervasive. Ritual is a powerful tool for perpetuating technocratic values, including those related to birth. The effectiveness of ritual results from some of its primary characteristics, which include the following.

**Symbolism.** Ritual sends its messages through symbols. A symbol, most simply, is an object, idea, or action loaded with cultural meaning. Symbols are felt in the body and through the emotions; their meanings are often internalized without conscious awareness. Objects or procedures may function powerfully as symbols even if the conscious intent of their performers is instrumental, not symbolic. A blood pressure cuff both records blood pressure and symbolizes technocratic medicine—specifically the value it places on quantifiable information. The stethoscope a physician wears around her neck both enables her to listen to a patient’s breathing and also symbolizes her authoritative status.

In addition to their instrumental functions, routine obstetrical procedures—the rituals of hospital birth (Davis-Floyd 2003, 2018a)—convey symbolic messages to birthing people, to their companions, and to hospital practitioners. For example, to be seated in a wheelchair, as many laboring women are, is to receive through their bodies the symbolic message that they are disabled; to be put to bed is to receive the symbolic message that they are sick. Intravenous (IV) lines make an especially powerful symbolic statement: They are umbilical cords to the hospital. The long cord connecting her body to the fluid-filled bag places the woman in the same dependent relation to the hospital as the baby in her womb is to her. By making her dependent on the institution for her life, the IV conveys to her one of the most profound messages of her initiation experience: We are all dependent on institutions for our lives.

**A cognitive matrix.** Rituals are not arbitrary; they emerge from within the belief system of a group and serve to enact and transmit that belief system into the emotions, minds, and bodies of their participants. The belief system enacted by the rituals of hospital birth is the technocratic model of reality (Davis-Floyd 2003), which forms the philosophical basis for both US-style biomedicine and larger US social values and norms. Within this model, the human body is viewed as a machine that can be segmented and then re‐unified (Martin 2001). The male body is held to be the prototype of the properly functioning body‐machine, and the female body, insofar as it deviates from the male, is regarded as inherently defective—a metaphor that eventually formed the philosophical basis of modern obstetrics (Rothman 1982). This view led to the development of tools and technologies for the manipulation and improvement of what came to be seen as the inherently defective mechanical process of birth.
Rhythm, repetition, and redundancy: Ritual drivers. For maximum effectiveness, a ritual concentrates on sending one set of messages that it will repeat over and over again in different forms, “driving” the message home (Davis-Floyd and Laughlin 2016). Such redundancy facilitates the neural entrainment of the individual. Many routine obstetrical procedures (such as electronic monitoring, performing frequent cervical exams, and administering medications to speed labor or reduce pain) convey in different forms the same basic message: That the woman’s birthing body (read: Machine) is defective, and she is therefore dependent on the institution and its technology to fix or manage it. An additional message is that technologically obtained (read: Objective) information and institutional schedules are much more important than the woman’s internal rhythms and personal experience of labor. As in much of technocratic life, the individual is subordinated to the institution.

Use of tools and technologies. All rituals employ specific tools, artifacts, and technologies to achieve their purposes: Altars and candles, the shaman’s drum and rattle, the priest’s robes and Communion cup, the diviner’s tea leaves, and Tarot cards. From the Navajo hogan to the Internet, ritual technologies both construct the spaces within which ritual happens and assist in effecting the external and internal transformations it can achieve. As noted above, ritual technologies often fulfill both utilitarian and symbolic functions: For example, the Communion cup both holds liquid and evokes the Last Supper. In healing rituals, the healer often perceives the patient through the medium of the technology (herbs, smudging, rattling, sandpainting; X-rays, EEG printouts, vital signs monitors). As with much of everyday social life, humans mediate their experience through the technologies they create. This technological mediation influences participants’ perceptions of reality in myriad ways. Their use in the heightened, set-apart, and formalized structures of ritual make them especially effective at achieving the neural entrainment of the participants, en face or at a distance, with the rhythms of the ritual and with the symbolic messages it sends.

Of the multiple technologies employed in hospital birth, the most salient is the electronic fetal monitor, a machine that records both the baby’s heartbeat and the strength and length of the laborer’s contractions. This machine becomes a focal point of attention during birth. The rhythmic tracings on the computer screen and the amplified fetal heartbeat can be hypnotic. As one mother said: “Once I was hooked up to the monitor, everyone kept looking at the computer screen and not me. Pretty soon I started staring at it too, and then got the feeling that it was having the baby, not me” (quoted in in Davis-Floyd 2003: 107). And from a nurse: “I know it’s irrational, but I always get the feeling that if I unhook the monitor, the baby’s heart will stop beating” (quoted in Davis-Floyd 2018b: 53). Thus, despite numerous studies showing that routine use of these machines does not improve most outcomes, but may significantly raise cesarean rates (Alfiveric et al. 2017), the psychological sense of dependence they generate makes it extremely difficult for practitioners to minimize their use.

The framing of ritual performances. Rituals are framed, set apart from everyday life, often in spaces reserved solely for their performance. This ritual framing works to ensure that participants will keep their attention focused on a limited stimulus field, a practice that facilitates their entrainment with the ritual’s symbolic messages. In the limited stimulus field of the hospital room, the birthing person, her support companions, medical practitioners, and the machines and technologies that surround her penetrate both her physical body and her consciousness.

Order and formality. Ritual actions are generally performed in a specific order and with a degree of formality that separates ritual from everyday life. The careful sequencing of ritual performances enhances the strength of this stimulus field and further works to set rituals apart from other modes of social interaction.
Rituals and rites of childbirth

A sense of inviolability and inevitability. Once a ritual performance begins, its order and formality can generate a sense of inevitability and inviolability (Moore and Myerhoff 1977), meaning that ritualized practices must proceed to their conclusion through a pre-established sequence of events. To perform a series of rituals is often to seek to induce a particular outcome; rituals thus create a sense of safety in the presence of danger. Just as the Trobriand sea fisherman trusts that, if he performs prescribed rituals in precise order, the gods of the sea will do their part to bring him safely home (Malinowski 1929), so the obstetrician trusts that if he precisely follows procedure, a healthy baby will result. In both cases, the rituals provide a sense of control that gives individuals the courage to act in the face of the challenge and caprice of nature.

But the inevitability of ritual can be a double-edged sword when applied as an overlay on a process such as birth: One obstetric procedure often appears to necessitate the next, and the next—a process referred to as the “cascade of interventions,” which operates like a ritual “train.” Once you are on it, it becomes very difficult to get off. This “snowball effect” of intervention results in care that Miller and colleagues (2016) have characterized as “too much too soon” (TMTS), in contrast to care that is “too little too late” (TLTL). Due to rampant inequality, TMTS and TLTL systems of care can coexist in a given country. We have argued that TMTS and TLTL care must be replaced by RARTRW—care that is provided in the right amount at the right time in the right way (Cheyney and Davis-Floyd 2020b)—where the “right way” means respectful care for all people (Cheyney and Peterson 2018).

The order and precision of ritual, combined with its repetitious nature, can be highly effective at habituating individuals to doing things a particular way. The obstetricians Davis-Floyd interviewed in the US (between 1985 and 2018) often described how their learning process was channeled into what one described as a “narrow riverbank” in which the water can flow only one way. Another said, “You do it, and you do it, and you do it again, until you forget there was ever any other way of doing it” (quoted in Davis-Floyd 2003: 264). Habituation to this one way works to preclude the likelihood that care providers will be open to evidence that contradicts their deeply internalized manners of practice.

Performance: Acting, stylization, and staging. Ritual is performed in stylized manners and like many performances, often intensifies toward a dramatic climax. As the climax of birth approaches, the number of ritual procedures performed upon the woman intensifies. These procedures heighten the emotional affect that birth already carries and focus the attention of the ritual actors on the physician as protagonist. The lower part of the woman’s body becomes the stage upon which the doctor performs the drama of birth. An episiotomy, if performed, both speeds the birth, enhancing hospital efficiency, and reiterates the ritual message that the mother could not give birth without the help of a technical expert. Yet episiotomy rates in the US have dropped significantly—from 20.3% in 2002 to 9.4% in 2011 (Kozhimannil et al. 2017) and continue to drop—showing that it is possible to change technocratic childbirth rituals as evidence and consumer voices intersect to shape the complex landscape of birth as gendered performance.

Yet in many LMICs that adopted the technocratic model wholesale, including almost all Latin American nations, Romania, Bulgaria, Croatia, and others, the episiotomy rate for vaginal birth is close to 100% (Davis-Floyd, personal observation; see also Graham et al. 2005), because obstetricians in these countries are taught that the baby will not come out without the episiotomy and/or that “the perineum will explode” (Davis-Floyd and Georges 2018). Thus, in these countries nearly all birthing women experience either the ritual “cut below”—episiotomy—or the “cut above”—cesarean section—unless they reject obstetrics altogether and choose to give birth in community settings.
Few of these routine procedures/rituals make scientific sense, but, like the lithotomy position, which compresses the pelvic outlet by up to a third (Gupta et al. 2017) and is also still widely used in LMICs and in some high-resource hospitals (Davis-Floyd, personal observation), they do make cultural sense, both within the occupational culture of obstetrics and within the wider culture, because they consistently enact and display a core technocratic cultural value—dominating and controlling nature via technology (Davis-Floyd 2003, 2018b). Just as rivers are dammed to control flooding, so the flow of labor is modified to control the process. In imposing technological control over labor and birth, these rituals themselves may become iatrogenic (Liese et al 2021) through what we (Cheyney and Davis-Floyd 2019: 7) have called the obstetric paradox—causing harm to birthing people and babies by interfering with the normal physiology of birth in an effort to make birth safer.

This obstetric paradox culminates in the performance of unnecessary cesarean births (CBs). The World Health Organization has shown that a national cesarean rate below 10% means deaths from lack of access to this lifesaving operation. But when the rate is higher than 15%, many cesareans are neither necessary nor lifesaving, and can even cost lives due to their iatrogenic sequelae; these include infection, blood loss, blood clots, and problems in future pregnancies (WHO Statement on Cesarean Rates 2015). Yet, in far too many countries, CB rates are above 40%.

The surgical removal of the fetus from the uterus via cesarean is the ultimate ritual culmination of birth by obstetrician, rather than by mother. The cesarean gives the doctor total control over the birth, along with a sense of confidence and mastery. It can save obstetricians from spending hours in the hospital waiting for a vaginal birth and thus is vastly more profitable for them, whether they are paid more for CB or not. And once told by the practitioner that her “pelvis is too small,” or because she wants her child born on an auspicious date, or simply because she is afraid of labor, in many countries 6% to 8% of mothers choose to schedule cesareans (Althabe and Belizan 2017) for that same sense of mastery and control.

At times, violence is linked to ritual behavior and rites of passage. Veena Das (2010) has discussed how ritual practices can be used to emphasize societal control over an individual. For example, a cesarean scar can constitute the inscription of a woman’s role in her initiation ritual. It may also serve as an obstacle to forgetting her experience and as an affirmation of the authority of the physician as a ritual elder. Such violent medical procedures “become a necessary part of creating a common narrative and legitimizing society” (Das 2010: 564–565). Sadly, the ritual authority exercised by practitioners is often further affirmed by the more overt forms of obstetric violence, disrespect, and abuse that are often perpetrated on laboring people, most especially in LMICs but also in some high-resource hospitals (Vedam et al. 2019). In such cases, the human rights of birthing individuals are completely disregarded along a “spectrum of obstetric iatrogenesis” (Liese et al 2021) as they are forced to labor unsupported, coerced into ritualized procedures they do not want, and/or are insulted, demeaned, yelled at, and sometimes hit or slapped (Sadler et al. 2016).

**Effects of ritual**

When rituals work, they can achieve the cognitive transformation of their participants—here, the belief system enacted in the rite and the belief system of the initiate become one. Of the 100 women Davis-Floyd (2003) interviewed about their birth experiences, approximately 75% entered the hospital already believing fully in the technocratic model; for them, the rituals of hospital birth served not to transform, but rather to intensify, a preexisting belief system. But about 25% of those women entered the hospital believing deeply in natural childbirth and in
their ability to give birth without drugs or interventions. About half of those succeeded in this goal—they were able to utilize Butler’s “slippage” to maintain their beliefs in the face of their technocratic socialization, often because their labors proceeded rapidly and/or because they were supported by a doula or a midwife. In contrast, the other half of the women who started out wanting natural childbirth experienced a gradual process of conceptual fusion with the messages sent by the rituals of hospital birth, making it a transformative rite of passage.

The first step in this process is the breakdown of the initiate’s prior belief system through techniques such as strange-making (making the commonplace appear strange by juxtaposing it with the unfamiliar) and symbolic inversion—turning things upside down and inside out (Babcock 1978). Birthing women are made strange to themselves through hospital gowns, ID bracelets, and by being hooked up to machines. Frequent cervical checks symbolically invert their most private and intimate parts into medical property and reaffirm their helplessness in the face of obstetric violence when those often painful checks are unconsented. Throughout labor, routine obstetric procedures cumulatively work to map the technocratic model of birth onto the birthing person’s perceptions of her labor experience. If these rituals are successful in a cognitive sense, she will begin to experience her own body as a defective machine incapable of birthing without technology and the institution.

The women in Davis-Floyd’s study who started out wanting natural childbirth were psychologically traumatized when their births were heavily technocratized instead. But they do not represent the majority of American women. It is important to understand that most American women—in fact, many women in many countries—do not object to the technocratic ritualization of birth. Rituals often enhance courage, and the rituals of hospital birth give practitioners a sense of confidence in the face of the unknowns of birth. They often do the same for birthing women. Ritual stands as a barrier between cognition and chaos (Davis-Floyd 2018c). As full participants in the postmodern technocracy, many contemporary mothers place a great deal of faith in high technology and believe that its application to their labor processes will ensure a positive outcome. Thus, in spite of a great deal of scientific evidence showing that the TMTS overuse of obstetrical procedures often does more harm than good, women associate them with an increased chance of a positive outcome and thus may find them reassuring. The rituals of hospital birth generate the feeling that it is the rituals/standard procedures that ensure the birth of a live baby, not the woman herself, and not the evolved physiologic processes of birth.

Other important effects of ritual include preservation of the status quo and, paradoxically, social change. Through explicit enactment of a culture’s belief system, ritual both preserves and transmits that belief system, and so becomes an important force in the preservation of the status quo in any society. As previously noted, the status quo in technocratic societies heavily involves the supervaluation of high technologies and the sense of control over nature that they provide. US society is deeply invested in the myth of technological transcendence (Davis-Floyd 2003, 2018b)—the idea that through our technologies, we will eventually transcend the limits of nature and free ourselves from its vagaries and whims. Our multiple successes in this endeavor are leveraged and intensified in the reproductive arena (Davis-Floyd 2021). Assisted reproductive technologies hold out the promise of giving children to the infertile, preventing the births of babies with anomalies through prenatal diagnostic testing and abortion, and enabling parents to choose the sex of their children. The rituals of technocratic hospital birth constitute but one slice of the “transcendence through technology” pie. They promise the outcome we all hope for—a live and healthy child.

But in fact, other countries that are less interventionist have better birth outcomes; the Netherlands and New Zealand are prime examples (Davis-Floyd et al. 2009; Cheyney et al. 2019; Georges and Daellenbach 2019). Yet medical authorities in many countries ignore the
Melissa Cheyney and Robbie Davis-Floyd

evidence and continue to intensify the technocratic ritualization of hospital birth, introducing untested new drugs and technologies into the birth process at a rapid pace. In this way, the US and the countries that have adopted its technocratic model have transformed the natural process of birth into a cultural process of the reproduction and perpetuation of cultural values and notions of “progress.”

Paradoxically, in spite of its effectiveness at preserving the status quo, ritual can also be an important factor in social and individual change (Cheyney 2011; Davis-Floyd and Laughlin 2016). Alternate belief and value systems, often developed to resist dominating ideologies, are effectively spread through new rituals designed to enact and transmit them; conversely, entrenched belief and value systems are effectively altered through changes in long-standing cultural rituals. For thousands of traditional cultures, the institutional takeover of birth has resulted in significant cultural change and often the destruction of valuable traditional birth ways. And in many countries, in this cultural arena of birth, some of technocratic societies’ most visible battles over core values are being waged. Medical personnel, sometimes pressured by the threat of malpractice suits, are attempting to develop increasing control over the birth process and placing an ever-greater reliance on technology. Meanwhile, many women and thousands of birth activists around the world are demanding humanistic births in which women are the protagonists and compassionate, evidence- and human-rights-based midwifery and doula care prevail.

Around 1–2% of families in many high-resource countries reject technocratic socialization and choose to give birth at home or in a freestanding birth center. Cheyney (2011) has argued that during homebirth as a rite of passage, midwives deliberately manipulate ritual in an attempt to communicate the sufficiency of nature over the supremacy of technology. They capitalize on the semiotic potential, heightened emotion, and the liminality of the birth itself as they intentionally attempt to overturn mechanistic views of the faulty female body in need of medical management. These notions are replaced with the language of connection, celebration, power, transformation, and birthing people and their babies as inseparable units. In this way, homebirth practices are not simply evidence-based RARTW care practices (Cheyney 2011), but also, and simultaneously, intentionally formulated rituals of technocratic subversion designed to re-inscribe birthing bodies and to re-territorialize childbirth spaces (home) and authorities (midwives and parents). Thus choosing to birth at home can be understood for many as a ritualized act of “thick” resistance (Ortner 1995) wherein participants actively appropriate, modify, and co-create new meanings in childbirth. The persecution that those who choose birth at home (and to some extent in freestanding birth centers) and their caregivers sometimes experience from physicians and legal authorities (see Davis-Floyd 2018c for examples) is an indication of the degree to which their models differ from, and provide challenges to, the hegemony of dominating technocratic models. The ritual elaboration of birth outside the hospital highlights the potential of ritual not only as a medium for social control through the transmission of core values and messages, but also as a form of resistance.

Conclusion

In this chapter, we have described inter- and cross-cultural variations in birth ritualization, while also noting the many similarities in both traditional and contemporary technocratic birthing practices. Our cross-cultural examples illustrate how the anthropology of birth can provide a critical lens through which to see and interpret the core values that shape a society. We have challenged the belief that the de-ritualization of birth—its “liberation” from ancient superstition and taboo—accompanied the advent of scientific medicine and the movement of birth into the hospital. We have shown that this huge cultural shift re-ritualized birth via the proliferation of a
new set of elaborate techno-medical rituals and rites. Through these, we can continue to read the core values of contemporary societies. Yet in birth’s contested spaces, we can also see how some re-ritualized practices, and especially those that move along the edges of “normal” or “acceptable” standards of care, function to challenge, resist, and reshape dominant (and dominating) approaches.

We conclude this chapter with a call for more equitable systems of knowledge that recognize birth as much more than a clinical event. Birth is culturally constructed as a powerful rite of passage that can be heavily medicalized, or wherein individuals and communities can enact their rights to cultural self-determination and bodily autonomy. All birthing people everywhere should have the respect, freedom, and resources they need to negotiate the complexities of birth on their own cultural and communal terms as they actively appropriate, modify, and co-create meaning in childbirth.

References


Moore, Sally Falk, and Barbara Myerhoff, eds. 1977. Secular Ritual. Assen and Amsterdam: Van Gorcum and Co.

Rituals and rites of childbirth


Van Gennep, Arnold. 1960. The Rites of Passage. Chicago, IL: University of Chicago Press.


