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Circulation and Exportation of the Japanese Childbirth Model in Southern-East Asia Preliminary Insights from Cambodia

Abstract

Globally, maternal health matters and birthing ideologies and practices still generate much controversy. On the one hand, those who are promoting the medicalization of childbirth argue that the mortality and morbidity risks justify the imposition of biotechnological standards and practices. On the other hand, activists for demedicalization of birth are denouncing gynecological and obstetric violence, and pointing the pathologies induced by overuse of technologies. These movements, which are part of the current's feminist calls, advocate a women's reappropriation over their own bodies. The paper, based on long term and more recent ethnographical investigations aims to explore these political, cultural and social controversies by examining the recent initiatives in reproductive health domain carried by Japanese cooperation in South-East Asia. Since the 2000s, JICA (Japanese agency for international cooperation), as part of its infrastructure development, institutional strengthening and training programs, has indeed carried out numerous initiatives. One aims at improving the quality of maternal health care with two main objectives: the reduction of cesarean section rates and the humanization of birth.

Keywords: *SEA, Japan, Cambodia, childbirth, maternal health care, social policy*

1. Introduction

During the past decades giving birth has been increasingly medicalized widely and pregnancy and birth have been conceptualized as pathologic processes in need of an intensive medical monitoring (Davis-Floyd & Sargent, 1997). This shift in birth management, examined since the year 1960's, is conceptualized as 'technobirth' (Davis-Floyd & Sargent, 1997). Today, the extend use of technologies during childbirth is still a controversial matter. While some women in the world, mostly living in the most deserved areas, are still giving birth with no or a very limited medical assistance, the vast majority is birthing within a growing use of biotechnology: caesarean section, induced labour, amniotomy, episiotomy, recordings of fetal heart activity, ultrasound, epidural anaesthesia. In the early 2000s, this paradigm has spread to all fields of medicine with a shift from a medicine aiming at treating unwell bodies (medicalization) to a biomedicine aiming at the management, the administration and the transformation of bodies, in especially through the development of the pharmaceutical industry and the development of biotechnologies (biomedicalization) (Clarke et al., 2000). Although globally dominant, technobirth is not a uniformed biomedical model, and its various social forms are operationalized by heterogeneous actors, in different contexts. caesarean sections have been adopted on a massive scale in countries such as China, the United States, Brazil, Italy, Turkey and Mexico, while epidural analgesia is widely used in France, Canada and the United Kingdom (Topçu & Brown, 2019).

Today, the biomedicalisation of childbirth is widely legitimated at the international level and movements going in the opposite direction are scarce. However, in some very limited social and geographical spheres, some actors are promoting the 'de-technicalization' of birth. Such initiatives are launched with the objective to humanize childbirth aiming at limiting the unnecessary use of biotechnological practices or their systematic deployment. The genealogy, the implementation, the impacts and the effects of these marginal crusades need to be documented.

This is the case of the programs implemented by the Japan International Cooperation Agency (JICA) in various southern countries, included Cambodia where we both conduct research in the field of human reproduction (Hancart Petitet, 2012; 2014; 2015; 2017; Hancart Petitet et al., 2014; Hancart Petitet, 2010; Schantz, 2015, 2016). In this paper we aim to provide some preliminary thoughts and insights on our

recent investigations related to the promotion of humanized childbirth initiatives implemented by JICA in one maternity hospital in Phnom Penh. Our driving questions are as follows: What about the genealogy of the JICA maternal health programs promoting humanized birth in South-East Asia? What about their local variations? How do these initiatives take place within the political, cultural, and social controversies related to childbirth 'biomedicalization' and 'de-technicalization'? Does this model, arouse ownership or resistance from health institutions, caregivers, and patients in the hosting countries? What are the interferences between the Japanese model, the state's models, and the United Nations global agenda of reducing maternal mortality? At first, we need to draw the theoretical frame of our purpose and to define the concept of humanized childbirth.

2. History of the Concept of Humanized Childbirth

In recent decades, two historical trends have turned the way of approaching pregnancy and childbirth: the 'pathologization' of the maternal body and its 'techno-bio-medicalization' (Topçu & Brown, 2019). This dominant approach refers to the notion of 'risk' which justifies the use of medical treatment of childbirth to limit and reduce maternal and infant mortality and morbidity rates (Carricaburu, 2005, 2007; Topçu & Brown, 2019). Early, in reaction to the complete domination of the management of births by obstetricians, feminist anthropologists, began to conduct research on birth matters (Kitzinger & Davis, 1978; Cominsky, 1982; Jordan, 1989). These authors denounced the biomedical management of childbirth as a way of depriving women of their bodies and their childbirth (Davis-Floyd & Sargent, 1997). Mostly implemented in Europe by male obstetricians since the end of the 19th century (Schlumbohm, 2002; Carol, 2011), the excessive biomedicalization of birthing practices was seen as a result of the men reappropriation of the women's bodies and has been denounced. As early as the 1950s, isolated militant women movements raised their voice and lead campaigns in opposition to this technobirth model. In France, similar dissidence began in the 1970s and was notably carried by the second feminist wave, which claimed the right of women on their bodies (Akrich & Laborie, 1999). This movement fight for the autonomy of women and leads a battle against a medical power applied without sharing the decision-making process. Pregnancy and childbirth were reclaimed as a physiological event which concerns the private prior

to the medical sphere (Akrich & Laborie, 1999). Internationally, especially in South America, the claim for the demedicalization of childbirth were gradually being heard. In the 1990s, women's associations requested perinatal medicine based on evidence (evidence-based medicine). The notion of humanization of birth was born, especially in Brazil with the constitution in 1993 of a humanization collective of birth (ReHuNa – Network for the Humanization of Childbirth) (Diniz et al., 2018).

The World Health Organization (WHO) supported this movement. In 1996 WHO published international recommendations to limit technical acts during physiological childbirth (World Health Organization 1996). In 2000, the International Conference on the Humanization of Birth was held in Fortaleza, Brazil (Quattrocchi, 2019). The need for a humanized model of birth as opposed to the technocratic model of birth (Davis-Floyd, 2001) was raised. This model advocated for the inclusion of midwives in the support of physiological deliveries; the right to be accompanied during childbirth; freedom of position during labour and delivery; the right to eat and drink; the preservation of the integrity of a woman's body by limiting invasive acts (Diniz et al., 2018).

Since the 2000s, reverse movements towards the demedicalization of childbirth have taken place in many northern countries, where women can now give birth outside the medical institution (i.e. at home or in a birth centre). France, for example, despite a high level of biomedicalisation of childbirth at national level, has launched the experimentation of 8 birth centres since 2016 (Chantry et al., 2019). In these care settings women give birth in absolute safety attended by a midwife, without any use of biotechnology. The opening of 12 additional birth centres is planned in 2021.

3. Japan: A low use of biotechnology during childbirth in a high-tech country

Japan is a 'post-industrial hyper technological consumerist society', and yet the use of biotechnology during childbirth in the country is low, even though all (or almost all) deliveries take place in institutions (public and private hospitals) (Ivry, Takaki-Einy & Murotsuki, 2019).

Japan is very interesting to study regarding these issues of medicalization/demedicalization. Indeed, it is a case apart, as it is one of the industrial countries with the best indicators for maternal and child health, while recourse to biotechnology around childbirth is low (low

episiotomy, epidural analgesia and caesarean section rates) (Behruzi et al., 2010). Studying childbirth in Japan adds complexity to the issue of the adoption of biotechnology in different contexts (Topçu & Brown, 2019). The low rate of epidural analgesia can partly be explained as in Japanese culture, pain is perceived as both an inevitable and required experience of the physiological childbirth process. The delivering woman 'must' suffer in order for the mother-child bond to take place (Ivry, Takaki-Einy & Murotsuki, 2019).

There is need for additional research to be conducted in this field to analyse the emergence, determinants and the declinations of low use to biotechnology in this high-tech country. Exploring the JICA humanized birth expansion project can be a good start.

4. History of JICA

JICA was established in 1974 because of the merger of the OTCA (Overseas Technical Cooperation Agency) and several other organizations. This agency has the responsibility for executing Japan's official development assistance. In 2008, JICA has become one of the largest donors in Asia due to the merger between old JICA and the Japan Bank for International Cooperation (JBIC). Due to ambitious projects implemented in the field construction of infrastructures, JICA major recipients are South Asian countries. In the 1990s, it became the most powerful cooperation agency in the world and decided to expand its projects to Africa (Kato, 2016). Today, while Southeast Asia remains the main arena for its development activities, its presence in Africa is steadily increasing (JICA, 2018). More generally, Japanese cooperation means the construction of infrastructure, the sending of Japanese experts, volunteers and consultants to the field and the training of local staff in solving practical problems through a specific method. The Japanese discipline the '5S Kaizen', a philosophy and a way of organizing and managing the workspace and workflow partly inspires the JICA development approach. Its intents are to improve efficiency by eliminating waste, improving flow, and reducing process unreasonableness which aims to optimize working conditions and time by ensuring the organization, cleanliness and safety of a work plan. This approach was generalized in the 1980s in manufacturing sector in Japan, specifically by the Toyota Production System, were '5 S activities' were set as one of its bases. In 2007, this approach was adapted to the

health sector; it is now distributed to hospitals internationally through JICA (Hasegawa & Karandagoda, 2013).

Since the 2000s, the government of Japan through the JICA and the Bureau of International Medical Centers in Japan (IMCJ), has sought to improve the quality of maternal health care in Japan and around the world. Watching the self-promoting movie of what JICA and the Japanese midwife community wants to export is very useful to understand the cultural representation of birth behind the JICA project implementation (ref film). Such position is very relevant to investigate as the Japanese women/families who choose natural birth facilities introduced at the beginning of the movie belong to a tiny minority.

The humanized childbirth targeted countries have been Brazil (1996–2001), Armenia (2004–2006), Benin (2006–2010, 2011–2016), Madagascar (2007–2010), Senegal (2009–2011, 2012–2018), Bolivia (2010–2014), Cambodia (2010–2015), and Mozambique (2016–2019) (JICA).The main goals of these humanizing childbirth projects are promoting basics of ideal midwifery care, not intervening more than necessary and implementing care through evidence-based medicine) avoiding unnecessary medical interventions (unnecessary caesarean section and episiotomy (Misago et al., 2001; Behruzi et al., 2010; JICA, 2008). How are such initiatives constructed socially and implemented locally? Let us examine the case of Cambodia.

5. Maternal Healthcare in Cambodia

After more than a hundred years of failed regulations intending at medicalizing childbirth under the French Protectorate (1863–1953) (Schantz, 2021), Cambodia is recently and massively adopting biotechnologies surrounding childbirth. Indeed, the 1990s national sexual and reproductive health care policies have been reframed under the global injunction for the biomedicalisation of childbirth, to which the United Nations Millennium Development Goals (MDGs) (2000–2015) have contributed significantly. Among these MDGs, the MDG 5 aiming at 'Improving maternal health' follow several indicators including increasing the rate of births attended by skilled health personnel. These policies have a very strong impact on maternal and newborn health care in Cambodia. Successive Demographic Health Surveys (DHS) in Cambodia attest the very speedy shift from home birth to hospital birth. While in 2000, 'skilled' health personnel

assisted 10% of births, this rate rose to 89% in the 2014 DHS (National Institute of Statistics, Directorate General for HealtDHS Program 2015). In other words, at the national level, at the beginning of the 2000s, 9 out of 10 women gave birth at home; Fifteen years later, it was only the case for one in 10. This sudden transformation of birthing practices causes major social changes.

The practice of episiotomy is systematic in Phnom Penh since the rate of episiotomy exceeds 90% in a lot of maternity units (Schantz et al., 2015). On the one hand, organizational factors are the reasons behind the systematic use of this practice. Within overcrowded delivery rooms care providers working under pressure use biotechnology to save time. Indeed, cutting the perineum of women with scissors avoids waiting several long minutes for the perineum to soften under the pressure of the foetus (most often under the pressure of the foetal head). In the largest maternity hospital in Phnom Penh (Calmette hospital), the number of deliveries has increased from 3.220 deliveries per year in 2003 to 11.080 deliveries per year in 2015 (Schantz, 2020). Despite ongoing efforts to improve the infrastructure with countless new buildings, the delivery rooms are congested, and the caregivers use perineotomy as an adjustment variable for their time. On the other hand, sociocultural factors also explain this practice in Cambodia. First, the common popular representation of an extremely narrow and rigid 'Khmer vagina' lead caregivers to legitimize the use of episiotomy. Two, a tight vagina is one of the criteria of female beauty and sexual scripts based essentially on penetrative sexuality, also contribute to the success of this practice as it would increase male sexual pleasure (Schantz, 2020).

The practice of caesarean sections is also widespread and on the rise in the capital. In four maternity wards in Phnom Penh, the caesarean section rate rose from 9% to 27% between 2000 and 2015. Various non-medical factors determine this practice and contribute to the construction of a 'social demand' for caesarean sections: the belief that caesarean section is safer for the mother and child than a vaginal delivery; the wish to maintain a narrow vagina; the fear of vaginal delivery; and the pain of uterus contractions during labour. Lastly, given the concern of many Khmer people for astrological determinants, the possibility of choosing the date (and often the time) of childbirth is perceived as a great benefit (Schantz et al., 2016).

6. JICA and Maternal Health in Cambodia

Since 1992, the National Center for Global Health and Medicine (NCGM) of Japan has worked with the Ministry of Health in Cambodia in maternal and child health. In Phnom Penh, the Cambodian capital, the National Mother and Child Hospital Center (NMCHC) is also commonly called 'Japanese hospital' (pet japan) for its strong link with Japan. The Japan Official Development Assistance (ODA) built the NMCHC in 1997. The NMCHC is both an administrative centre for maternal, neonatal and paediatric health, a referral hospital (MCH) and a national training centre.

Between 1992 and 2016, JICA carried out 7 technical cooperation projects in Cambodia (JICA, 2014) in focussing on hospital governance, management and improvement of obstetric care, medical training including prevention of maternal-fetal transmission of HIV. Since the 2000s, thanks to the political stability found in Cambodia and its socioeconomic development, many private health facilities have emerged. However, the NMCHC differs from other hospital structures in making known and visible its good quality care to the 'poor population' (NCGM Japan–NMCHC Cambodia. Joint Technical Collaboration Office, 2015, p. 7).

Since 2010, wide-ranging training courses (offered by Japanese experts) have aimed to provide care that insures courteous and pleasant environment for birthing women ('women-friendly care') and promote a high respect for the labour and childbirth physiological process. Training programs highlight the variety of birthing positions to be allowed for labouring women to adopt, the importance of family member presence during labour and birth, and the reduction episiotomy rates. This emphasis given to physiology and to restrictive use of episiotomy has significantly reduced the rate of episiotomy at NMCHC in recent years. This rate fell from 58% in 2010 to 15% in 2015 (Schantz, 2015). In December 2012, Cambodia and Japan signed a Memorandum of Understanding (MOU), further strengthening the ongoing collaboration between the two countries and by establishing exchange, training, research and technical cooperation. The NMCHC has a very clear and well-maintained database, developed with assistance from JICA, for tracking the use of biotechnology. In 2015, 7.240 deliveries took place at the NMCHC. The delivery rate has been stable since it opened. In February 2016, a new building was under construction, supported by the JICA.

7. Conclusion and perspectives

Brigitte Jordan developed the concept of authoritative knowledge in obstetrics in her book 'Birth in Four Culture' (1978). This concept makes it possible to analyse the process of legitimizing a practice, surrounding birth, in a given social context. Her major theoretical insight is as follows. When, during the birth event, a biomedical knowledge system is confronted with a 'popular system', only one, the biomedical system, will be recognized as legitimate. This legitimized knowledge is defined as an authoritative knowledge (the knowledge that makes authority) and shapes all decisions and all actions surrounding childbirth care. Jordan shows that in a high-tech birthing system, the distribution of power is unfairly made among people encircling the birthing woman. The legitimacy to decide follows a hierarchy based on the mastery of the technical tools developed by modern obstetrics. On the contrary, in a low-tech birthing system, the birthing mother get more power somehow equally shared among others. Jordan shows that studying the 'birth arena' (means the rules of conduct and practices dedicated to the pregnant body) is a prism to observe different areas of human experience (social organization, gender relations, representations of bodily fluids, etc.).

The concept of authoritative knowledge is very relevant to examine the humanized childbirth model implemented by JICA experts in Cambodian maternity hospitals. The drastic reduction of episiotomy rates in the NMCHC Hospital in Phnom Penh raise various questions that we will need to investigate further. How the concept of 'humanized childbirth', based on low use of technologies became the authoritative knowledge in the daily practice in delivery room? At first, how the Japanese experts manage to promote the non-use of episiotomy as 'the authoritative knowledge' to Cambodian midwives and obstetricians who were trained and used to do it systematically? Similarly, to the study conducted by Behruzi et al. (2010), this experience may be explored in examining the barriers and facilitators encountered by the humanized birth practice and categorized into four main groups: Rules, Regulations and Strategies, Physical Structure, Contingency Factors, and Individual Factors. From our perspective, we would be more inclined to analyse the reduction of episiotomy rates as a social fact and from others stand points.

One aspect drives specially or attention. Who are the Japanese experts who came to work in the Maternity Hospital in Phnom Penh? What about their profiles and biographies? How the decision to come, work and live

in Cambodia took place in their life trajectories and professional careers? What about their perceptions and discourses apropos the encounters and interactions with Cambodian colleagues? Similarly, what about these issues from the Cambodian midwives and obstetricians? How did these encounters impact both their lives and careers? Here we make the hypothesis that the concept of 'turning point' (Abbott, 2001) may provide a useful tool to examine the predictability and unpredictability of life courses and careers.

Secondly, the birth humanization programs carried out by JICA in Cambodia as additionally to be seen as a 'merchant and non-merchant transfer'. As Bouté et al. (2021) proposed it will be necessary to name and signify non-market transfers; classify the forms of non-market transfers; and describe the articulations of non-market transfers with market and state spheres. Then, studying the transferred things, but also their actions, their identities, their statuses, their ideologies, their imaginations, and the social relations in which they evolve may provide meaningful insights. As Bouté et al. (2021) quote, 'It will be a question of observing the different tangles (opposition, competition, combination, complementarity, porosity, coexistence, separation, etc.) between non-market forms of flow and market and state circulation regimes.

In Japan today, caesarean section, episiotomy use rates are among the lowest in the world and the promotion of the humanized birth model is expanding widely (Behruzi et al., 2010). Paradoxically, several Japanese voices are rising to alert the opinion and the authorities about the high rate of suicide of pregnant and post-partum women, mostly in the main Japanese cities (Shigemi et al., 2020; Kubota et al., 2020). Additionnal field investigations are required, both in Japan and in their programs hosting countries to analyse further these issues within a comparative approach. For example, given our arena of observations we wonder why the JICA humanized childbirth project has been a success in Cambodia with concrete achievement (reduction in the rate of episiotomies) while it didn't take root in Benin (Shantz, forthcoming). Obviously, what the exportation of the Japanese birth models drives, makes and generate needs to be documented. Also exploring the 'social construction' and the 'social production' (Fassin & Eideliman, 2012) of a low-tech humanized birth model by a high-tech and in some circumstances too often dehumanized society open new research fields for the anthropology of human reproduction.

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