

Women's Reproductive Autonomy: Cesareans, Technological Interventions, and Loss of Choice

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Abstract

Worldwide, women are undergoing increasingly more caesarean sections. Recent strategies to lower rates have appeared in Canada, Australia, the United States, India, Latin America, and Turkey (Walker, Turnbull, and Wilkinson 2002). Rates in the United States lead the world's developed countries. In 1990 the U.S. introduced a program called Healthy People 2000 with the goal of reducing its national first-time caesarean delivery rate to 15% by the year 2000. Its goal was never reached. Healthy People 2010 aims for the same goal; so far, caesarean section rates have moved 133% away from that target (Healthy People 2010). While it seems that such programs are needed if caesarean rates are to reduce rather than increase, some argue that setting such targets "is an authoritarian approach to health care delivery. It implies that women should have no say in their own care..."(Sachs *et al* 1999). Introducing targets to reduce cesareans *might* compromise women's autonomy if women truly desired cesareans in increasing numbers. However, this is not the situation we are currently facing. Women do *not* typically desire a caesarean section birth. The overwhelming evidence points to the contrary. Worldwide, most women desire a natural, unassisted birth (Block 2007). Moreover, it is remarkable that explanations *why* cesareans are more common do not directly reference women's own preferences. What is going on? Do women have any say in their own health care when it comes to labor and birth?

My aim is to show that women's autonomy is imperilled by dominant health care approaches to labor and birth. Both physician preferences and social pressures to use medical technologies during labor and birth influence attitudes in ways compromising laboring women's autonomy. Increased use of reproductive technology makes it difficult for women to refuse its use during labor and birth; yet, increased use of technology is linked to increased caesarean rates. So, laboring women might not be able to avoid a caesarean delivery *unless* medical interventions during childbirth and labor are reduced. Their reduction challenges expectations presuming that medical technology is needed to ensure the safety and wellbeing of the fetus; that laboring women ought to be willingly self-sacrificial proponents of its use; and that women ought to defer to others' authority over their own births. Such expectations limit those options possible to pursue during labor and birth. Laboring women's options are further compromised by social contexts undermining self-trust and self-confidence, each of which prove obstacles to women's ability to resist oppressive expectations, thereby inhibiting autonomy. The upshot of my view is that setting target rates to reduce cesareans can remove obstacles to women's autonomy, but only if doing so includes a serious effort to reduce use of reproductive technology during labor and birth.