Towards Reproductive Justice: The Human Rights Implications and the Constitutionality of the No Home Birthing Ordinances

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I. INTRODUCTION

A. Background of the Study

In 2008, the Department of Health (DOH) issued Administrative Order No. 2008-0029 entitled "Implementing Health Reforms for Rapid Reduction of

Maternal and Neonatal Mortality."[1] The Administrative Order aims to encourage facility-based child births in response to the need to achieve the Millennium Development Goal (MDG) of increasing the accessibility of health services, and of lowering maternal and neonatal mortality.[2] The policy was updated in 2011 through the implementation of the Maternal, Newborn, and Child Health and Nutrition (MNCHN) strategy as provided in the MNCHN Manual of Operations (MNCHN MOP).[3]

Section 7.2.2 (Regulatory Measures) of the MNCHN MOP states that "[t]he adoption of the MNCHN strategy in each identified priority province or city requires a number of executive issuances and/or legislations to facilitate and sustain its implementation[,]"[4] and that the policy directive adopting the MNCHN package of interventions should "promote and enforce regulations supportive of MNCHN goals and objectives, such as: (a) promotion of facility-based deliveries, and prohibition of TBA-assisted deliveries[.]"[5] TBA stands for Traditional Birth Attendants, and covers *hilots* and *babaylans* in Indigenous people (IP) communities.

B. Home Birth Prohibition in the Exercise of Police Power

The Administrative Order and the MNCHN MOP do not contain any provision prohibiting home births.[6] The two executive issuances merely require local government units (LGUs) to promote facility-based births because one of the MDGs' indicators of accessibility of health services is the number of women who avail of maternal health care services.[7] In an interview, Dr. Honorata Catibog, director of the DOH Family Health Office, denied that DOH has a home birth prohibition policy.[8] Dr. Catibog

1. Department of Health, Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality, Administrative Order No. 2008-0029 [A.O. No. 2008-0029] (Sep. 9, 2008).
2. A.O. 2008-0029, gen. princ.
3. Department of Health, MNCHN Strategy Manual of Operations, at 3 (Mar. 27, 2011).
4. *Id.* at 63.
5. *Id.*
6. *See* A.O. 2008-0029 & MNCHN Strategy Manual of Operations.
7. United Nations, Millennium Development Goals: 2014 Progress Chart (A Progress Report on the Achievement of the Millennium Development Goals as of 2014), *available at* http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20Progress%20Chart_English.pdf (last accessed Nov. 30, 2018).
8. Ana Santos, Are Home Births Being Banned?, *available at* http://www.rappler.com/moveph/30016arehomebirthsbeingbanned (last accessed Nov. 30, 2018).

said that facility-based delivery is the gold standard for giving birth.[9] However, she recognized that, given the restrictions on geography and resources in the Philippines, a ban on home births and the institutionalization of childbirths would not be feasible.[10] Dr. Catibog stressed that the DOH is merely encouraging facility-based births.[11]

Nevertheless, pursuant to the DOH policy, several LGUs enacted ordinances prohibiting mothers from giving birth at home.[12] The ordinances were enacted in the exercise of the delegated police power of LGUs under the General Welfare Clause, the statutory basis of which is Section 16 of the Local Government Code.[13] The police power measures aim to achieve two goals: first, the prohibition of childbirth assistance by traditional birth attendants;[14] and second, the prevention of maternal deaths through emergency obstetric care.[15]

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9. *Id.*

10. *Id.*

11. *Id.*

12. *See, e.g.*, Municipal Ordinance No. 02-2011, *Sangguniang Bayan* of Magallanes (Sorsogon), An Ordinance Regulating the Practices of Trained Birth Attendants and Health Workers Involved on Safe Motherhood/Maternal and Child Health Program in the Municipality of Magallanes [Municipal Birth Attendance and Safe Motherhood and Child Health Care Ordinance of 2011], § 7 (Feb. 7, 2011); City Ordinance No. 2171-2012, *Sangguniang Panlungsod* of Quezon City, An Ordinance Prohibiting Home Births in Quezon City, Prohibiting Traditional Birth Attendants to Deliver Babies and Requiring All Professional Health Practitioners to Deliver Babies Only in Health Facilities and Providing Penalty for Violation Thereof, § 1 (Sep. 3, 2012); & City Ordinance No. 02-2011, *Sangguniang Panlungsod* of Tacurong (Sultan Kudarat), An Ordinance Requiring All Pregnant Women in the City of Tacurong to Give Birth at the Birthing Clinic, Rural Health Unit, Barangay Health Station and Hospital [City Ordinance of Facility-Based Deliveries of All Pregnant Women of the City of Tacurong], § 8 (a) (Mar. 21, 2011).

13. Batangas CATV, Inc. v. Court of Appeals, 439 SCRA 326, 338 (2004) (citing United States v. Salaveria, 39 Phil. 102 (1918)).

14. The ordinances of the following cities, and municipalities have the abovementioned goal: Magallanes (Sorsogon), Quezon City, Catbalogan (Samar), Pola (Oriental Mindoro), Tacurong (Sultan Kudarat), President Carlos P. Garcia (Bohol), Naujan (Oriental Mindoro), Clarin (Bohol), and Cagayan de Oro. Municipal Birth Attendance and Safe Motherhood and Child Health Care Ordinance of 2011, § 7; City Ordinance No. 2171-2012, § 1; City Ordinance of Facility-Based Deliveries of All Pregnant Women of the City of Tacurong, § 8(a); & City Ordinance No. 2015-163, *Sangguniang Panlungsod* of Iloilo City, An Ordinance Mandating Pregnant Women to Deliver at the Birthing Clinic/Health Facility, Prohibiting Home Deliveries, Restricting the Practice of Traditional

The ordinances impose different penalties on different persons. These ordinances can be categorized into four groups:

(1) Category A — Ordinances which absolutely prohibit home births and which impose penalties on the woman who gave birth at home, her relatives, and the traditional or skilled birth attendant who assisted her with her child birth;[16]

(2) Category B — Ordinances which impose penalties on the same set of persons mentioned above but provide exceptions for emergency cases and/or for women living in far-flung areas;[17]

(3) Category C — Ordinances which penalize skilled or traditional birth attendants but provide exceptions for emergency cases and/or for women living in far-flung areas;[18] and

(4) Category D — Ordinances which absolutely prohibit home births and which impose penalties on traditional birth attendants.[19]

While the penalties of the ordinances vary, all the ordinances have provisions prohibiting home births, and requiring expectant mothers to give birth at a health facility.

This Note aims to establish that the LGU ordinances prohibiting home births violate the right of women to reproductive self-determination — a

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Birth Attendants (Hilot/Paltera), Skilled Birth Attendants and Strictly Imposing Newborn Screening (NBS) in All Newborns, and Providing Fees and Penalties for Violation thereof [Iloilo City Ordinance No. 2015-163], § 5 (Mar. 17, 2015).

15. The ordinances of the following cities, and municipalities have the abovementioned goal: Quezon City, Pres. Carlos P. Garcia (Bohol), Pola (Oriental Mindoro), Roxas (Oriental Mindoro), and Bacolod City. City Ordinance No. 2171-2012, whereas cl. & City Ordinance No. 602-2012, *Sangguniang Panlungsod* of Bacolod, An Ordinance Regulating the Practice of Traditional Home Deliveries or Delivery Attended by a Traditional Birth Attendant or *Paltera* [Homebirth Regulation Ordinance], whereas cl. (Sep. 5, 2012).

16. The ordinances of the following cities, and municipalities fall under this category: Magallanes (Sorsogon), Quezon City, Catbalogan (Samar), Pola (Oriental Mindoro), Tacurong (Sultan Kudarat), Pres. Carlos P. Garcia (Bohol), Naujan (Oriental Mindoro), Roxas (Oriental Mindoro), Iloilo City, Dasmariñas (Cavite), and Kananga (Leyte).

17. The ordinances of the following cities, and municipalities fall under this category: Marikina City, Bacolod City, Socorro (Oriental Mindoro), Oton (Iloilo), Socorro (Oriental Mindoro) and Plaridel (Misamis Occidental).

18. The ordinance of Dingle (Iloilo) falls under this category.

19. The ordinances of Clarin (Bohol) and Cagayan de Oro city fall under this category.

right protected under our laws and under international human rights instruments. Police power measures aiming to improve reproductive health must be deemed circumscribed by the principles of non-discrimination and non-coercion. The ordinances likewise violate the right of indigenous peoples to religious freedom, and to culturally-sensitive health services. Further, this Note seeks to prove that the ordinances are unconstitutional as they do not meet the requirements of substantive due process.

Nevertheless, the need to protect the human rights of pregnant women does not preclude regulation of childbirth. Thus, this Note aims to provide a legal framework to carry out the public policy of reducing maternal deaths in a manner consistent with the requirements of due process and without unreasonable intrusion into the reproductive rights of pregnant women. Permissible regulations on childbirth will be determined. The role of traditional birth attendants in the health system shall also be delineated.

II. HOME BIRTHS

> *Historically, the home was the woman's realm, and most births occurred at home. Certainly, a law requiring a woman to leave home to give birth would have seemed the utmost affront to the wives of the founding fathers.*
>
> — Amy Cohen[20]

In developed countries, women give birth at home mainly because of dissatisfaction with facility-based births. Women choosing home births usually do so because they want to be in control of the birthing process; they want to be treated as autonomous individuals in one of the most important moments in their personal development and one of the most important experiences they would share with their child.[21] In the United States, for example, an increasing number of parents choose home birth because of the controlled and medical manner childbirths are handled in health facilities, wherein women feel that they are not in control of the birthing process and that childbirth decisions are imposed upon them by medical practitioners.[22] Planned home births have lower intervention rates, and lower morbidity and mortality rates.[23] Home births also

20. Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 874 (2005).

21. *Id.* at 875.

22. Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POLITICS POL'Y & L. 814 (1994).

23. *Id.*

provide a more comfortable environment, and women feel more in control of the situation, resulting in a less stressful delivery.[24]

In other developed countries, such as the Netherlands, women choose to give birth at home not because of dissatisfaction with facility-based births, but because they adopt the midwifery view on pregnancy — a normal bodily process and should be as intervention-free as possible.[25] Compared with the United States which has a little over one percent home birth rate, nearly one-third of childbirths in the Netherlands are home births;[26] yet its maternal and neonatal mortality rates are 60% lower than those of the United States.[27] The Dutch government encourages home births and provides an incentive system to encourage women to give birth at home.[28]

In developing countries, home birth is not optional, but inevitable. Thus, home births are more prevalent in developing countries. The reasons why women give birth at home in developing countries range from economic, cultural, to geographical.[29] In a multi-country study, researchers found out that most of women in developing countries deliver at home because they consider facility-based births as unnecessary.[30] The belief that giving birth at a health facility is unnecessary is likely to be influenced by social and cultural beliefs.[31] Cost and accessibility of health facilities also remain as barriers to facility-based deliveries.[32]

In the Philippines, there has been an increase in facility-based births, from 44% in 2008 to 61% in 2013.[33] The Philippine Statistics Authority

24. *See* Debora Boucher, et al., *Staying Home to Give Birth: Why Women in the United States Choose Home Birth*, 54 J. MIDWIFERY & WOMEN'S HEALTH 119, 121–22 (2009).

25. Lammert Hingstman, *Primary Care Obstetrics and Perinatal Health in the Netherlands*, 39 (4) J. NURSE-MIDWIFERY 379, 380 (1994).

26. BIRTH MODELS THAT WORK 31 (Robbie Davis-Floyd, et al., eds., 2009).

27. Hafner-Eaton & Pearce, *supra* note 22.

28 . *See* Hingstman, *supra* note 25, at 380.

29. World Health Organization, *Care in Normal Birth*: *A Practical Guide*, at 10, WHO/FRH/MSM/96.24 (1996).

30. Meghan A. Bohren, et al., *Facilitators and Barriers to Facility-based Delivery in Low- and Middle-income Countries: A Qualitative Evidence Synthesis*, 11 REPRODUCTIVE HEALTH 1, 5 (2014).

31. *See* Dominic Montagu, et al., *Where Do Poor Women in Developing Countries Give Birth? A Multi-Country Analysis of Demographic and Health Survey Data*, 6 PLOS ONE 1, 6 (2012).

32. *Id*. at 7.

33. Philippine Statistics Authority, National Demographic and Health Survey 2013 (A Summary of the Findings of the 2013 Philippine National Demographic and

reported that facility-based births are more common for first-time mothers, and for women who belong to the highest wealth quintile.[34] Conversely, women who belong to the lowest wealth quintile are more likely to give birth at home, with a home birth rate of 66% as opposed to the 8.2% home birth rate of those in the higher socio-economic classes.[35]

Facility-based births are also concentrated in the National Capital Region.[36] Births in rural areas are still more likely to take place at home.[37] Home births are still common in the rest of the country, particularly in Cagayan Valley, MIMAROPA, Bicol, Western and Eastern Visayas, Zamboanga Peninsula, Northern Mindanao, SOCCSKSARGEN, CARAGA, and in the Autonomous Region of Muslim Mindanao.[38]

A. Financial Inaccessibility

Filipino women choose to give birth at home primarily because of the high cost of giving birth in a health facility.[39] A normal delivery in Fabella Memorial Hospital, the National Maternity Hospital, costs between ₱3,000 to ₱5,000 — an amount which is beyond the reach of many Filipinos.[40]

Mothers are required to pay ₱2,500 to ₱3,500 to give birth in a barangay health center, whereas they can pay in installment or in kind through goods if they give birth at home with the assistance of TBAs.[41] PhilHealth cards become useless as "most barangay health stations are not PhilHealth[-] accredited."[42] In fact, almost 60% of health expenditures are out of pocket and are not sourced from government funds.[43] The DOH reports that

Health Survey) at 106, *available at* https://dhsprogram.com/pubs/pdf/FR294/FR294.pdf (last accessed Nov. 30, 2018).

34. *Id.*

35. *Id.* at 107.

36. *Id.*

37. *Id.*

38. *Id.*

39. Philippine Statistics Authority, *supra* note 33, at 108.

40. Santos, *supra* note 8.

41. Council for Health and Development, No Home Birth Policy: Higher Maternal and Neonatal Deaths, *available at* http://chdphilippines.blogspot.com/2013/08/no-home-birthing-policy-higher-maternal.html (last accessed Nov. 30, 2018).

42. *Id.*

43. Department of Health, National Objectives for Health 2011-2016 (Health Sector Reform Agenda Monograph No. 12) at 4, *available at*

"[m]ajority of patients from both public and private utilize out of pocket during confinement[,] but it is significantly higher among patients confined in public facilities."[44]

B. Geographical Inaccessibility

Transportation is also a problem for women in Geographically Isolated and Disadvantaged Areas (GIDAs). [45] These women are separated by mountainous terrains, steep slopes, and dangerous rivers from the birth centers.[46] Traveling to the birth center can take days.[47]

The health landscape is even worse for IPs. They comprise 13% of the entire Philippine population and are among the most disadvantaged when it comes to access to health services.[48] According to the DOH, municipalities and provinces which "have a large GIDA and IP population have poor health indicators compared to municipalities and provinces that are more accessible."[49] The distance and isolation of IPs from health centers and facilities contribute to their lack of access to health services. [50] A research conducted in 2012 revealed that one of the primary reasons why IPs do not avail of health center services is the far distance of health centers from their homes.[51]

C. Lack of Health Facilities and Skilled Birth Attendants

The lack of access to health services is exacerbated by the inadequacy of birthing facilities. Out of the 42,027 barangays in the Philippines, only 17,000 have barangay health stations. [52] In Iloilo, one Basic Emergency Obstetric Care (BEmONC) facility serves 45 barangays and pregnant

https://www.doh.gov.ph/sites/default/files/publications/noh2016.pdf (last accessed Nov. 30, 2018).

44. *Id.*

45. *See* Department of Health, National Commission on Indigenous Peoples, and Department of the Interior and Local Government, Guidelines on the Delivery of Basic Health Services for Indigenous Cultural Communities/Indigenous Peoples, DOH-NCIP-DILG Joint Memorandum Circular No. 2013-01 (Apr. 19, 2013).

46. *Id.*

47. H. Res. No. 236, 17th Cong., 1st Reg. Sess. (2016).

48. DOH-NCIP-DILG Joint Memorandum Circular No. 2013-01, at 1.

49. *Id.*

50. *Id.*

51. *Id.*

52. H. Res. No. 236.

women have to travel three days to reach the birthing station.[53] One pregnant mother had to travel for 16 hours just to get to the nearest birthing facility.[54] The same situation is true for the provinces of Nueva Ecija, Bicol, Iloilo, Zamboanga, and CARAGA.[55]

The quality of care delivered by government health facilities is likewise inadequate. Official government data from the DOH states that 56% of government health facilities have very limited capacity and are comparable only to infirmaries.[56] Hospitals with "higher service capabilities are highly concentrated in Region 3 and in the National Capital Region[.]"[57]

The lack of midwives also compels women to turn to TBAs for assistance. In some places in the country, a midwife is assigned to several *barangays* and would have to cross vast bodies of water to get to pregnant women in need.[58] According to a United Nations Children's Fund (UNICEF) official, "[o]nly 60[%] of births in the Philippines are supervised by a skilled birth attendant[.]"[59] Thus, a substantial number of home births in the country are assisted by TBAs, which are generally not included in the category of skilled birth attendants.[60] In 2013, 26% of births in the country were attended by TBAs, with most of these occurring in rural areas.[61] The National Capital Region, on the other hand, has a 91% rate of births assisted by health professionals, i.e., doctors, nurses, and midwives.[62]

D. Cultural Insensitivity and Religious Barriers

In the Philippines, culture plays an important role in the accessibility and acceptability of health services. Dr. Junice Melgar, the Executive Director of the Likhaan Center for Women's Health, said that the barriers to facility-based births are not merely economic, but also cultural.[63] Filipino women are not comfortable giving birth in a hospital because some health

53. *Id.*

54. *Id.*

55. *Id.*

56. Philippine Statistics Authority, *supra* note 33, at 5.

57. *Id.* at 6.

58. IRIN, Maternal mortality rates "not making sufficient progress", *available at* http://www.irinnews.org/report/83609/philippines-maternal-mortality-rates-not-making-sufficient-progress (last accessed Nov. 30, 2018).

59. *Id.*

60. *Id.*

61. Philippine Statistics Authority, *supra* note 33, at 108.

62. *Id.* at 111.

63. Santos, *supra* note 8.

professionals look down on them.[64] TBAs are more caring in their approach to childbirth as TBAs can massage the woman when she's in pain, and even clean up the house and take care of the children while the mother is recuperating.[65]

Home births are also common in IP communities. They observe childbirth rituals and traditions distinct from the rest of the population, with most of these carried out at home.[66] In some IP communities, women are discouraged from taking their babies out of their houses after birth to prevent the latter from being exposed to bad spirits.[67] Further, IP women trust only TBAs when it comes to childbirth because they believe that being a *babaylan*, a spiritual leader, is a special position.[68] According to a study conducted by the National Commission on Indigenous Peoples (NCIP), "health care providers are not sensitized to IP traditions and preferences at the time of childbirth,"[69] which discourage women from giving birth in healthcare facilities.[70]

Nonetheless, IP women are not prohibited by their tribal leaders from availing the services of a healthcare facility. In case of complications during delivery, the *babaylan* will perform rituals and then determine whether the situation is still manageable.[71] If not, the husband of the pregnant woman will then inform the tribal council to organize transport. The woman will be transported to the hospital facility using a hammock.[72]

E. Home Births, Maternal Mortality, and Neonatal Mortality

1. Causes of Maternal and Neonatal Mortality

64. *Id.*

65. *Id.*

66. National Commission on Indigenous Peoples, Knowledge, Attitudes, Practices, Health Seeking Behaviour and Health Service Needs of Indigenous Cultural Communities/Indigenous Peoples with Regard to Maternal, Neonatal, Child Health and Nutrition, *available at* http://www.ipmnchnprojectmindanao.org/wp-content/uploads/2015/10/Report-1-1-3-KAP-study-final.pdf (last accessed Nov. 30, 2014).

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

72. National Commission on Indigenous Peoples, *supra* note 66.

Among the different health indicators, maternal and early neonatal mortality rates are the ones most affected by birth conditions.[73] According to the DOH, majority of maternal deaths are attributable to pregnancy-related complications, such as hypertension, infection, hemorrhage, and other medical problems arising from malnutrition, having successive pregnancies, unsafe abortions, and poor birth spacing.[74] Having concurrent infections from tuberculosis, malaria, and sexually transmitted diseases can also contribute to maternal death causes.[75] Lifestyle diseases like hypertension, and diabetes can likewise cause maternal death.[76] On the other hand, neonatal deaths within the first week after delivery are mainly due to infections, congenital diseases, asphyxia, tetanus, and prematurity.[77]

There is a positive correlation between the increase in maternal mortality rates, and higher neonatal mortality rates.[78] This relationship is a result of the fact that determinants of neonatal mortality rate overlap with maternal death determinants, as most early neonatal deaths occur within the first two days of life.[79]

A positive correlation between increase in facility-based births, and a reduction in maternal or neonatal mortality rates is yet to be established. In the Philippines, official government statistics fail to show a relationship between facility-based births and maternal mortality. The maternal mortality rate per 100,000 live births has sharply increased from 162 in 2006 to 221 in 2011 despite an increase in facility-based births (from 44.2% in 2008 to 55% in 2011).[80] Likewise, the neonatal mortality rate has remained relatively stagnant notwithstanding increase in facility-based births.[81]

Several studies in other jurisdictions also negate the existence of a relationship between home births and maternal and neonatal mortality.[82]

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73. *See* MNCHN Strategy Manual of Operations, *supra* note 3, at 7–8.

74. *Id.* at 8.

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. MNCHN Strategy Manual of Operations, *supra* note 3, at 8.

80. National Statistics Office, 2011 Family Health Survey, *available at* https://www.scribd.com/doc/98939199/Maternal-and-Child-Health-Family-Health-Survey-for-2011 (last accessed Nov. 30, 2018).

81. *Id.*

82. Most researches on the safety of home births only cover planned home births, wherein mothers actively chose to give birth at home, as compared to unplanned home births, which are most often the result of unexpected labor.

The largest study settling the advantages and disadvantages of home births versus facility-based births was published in 2009. The study found out that for low-risk women, or those with no known pregnancy complications, home births are as safe as facility-based births.[83] The quality of care received by the mother and the child during childbirth determines their safety, whether birth occurs at home or in a facility.

Some studies even suggest that more medical interventions associated with facility-based births actually increase neonatal mortality rates and stillborn rates, due in part to the "overuse of fetal monitors and drugs."[84] Conversely, neonatal mortality rates are lower when the pregnant woman gives birth in an environment where there is less intervention, such as at home.[85]

Even with high-risk pregnancy cases, some jurisdictions have successfully implemented home birth schemes. In Kentucky, for instance, a group of trained TBAs assisted home births in the Appalachian Mountains without medical backup.[86] Pregnancies in the area are considered high-risk as pregnant women suffered from malnutrition, and the mountainous areas are impoverished.[87] Nevertheless, in a period of thirty years, the TBAs have assisted 10,000 home births with only 11 maternal deaths; the national maternal mortality rate at that time was 36 deaths.[88] Twenty years after the first period, no maternal deaths were recorded in over 8,000 home births.[89]

III. RIGHT TO REPRODUCTIVE SELF-DETERMINATION: THE RIGHT OF MOTHERS TO CHOOSE BIRTH METHODS

The discussion of reproductive rights and State obligations in the next three Chapters will focus on two aspects of human rights – negative and positive.

Ank de Jonge et al., *Perinatal Mortality and Morbidity in a Nationwide Cohort of 529 688 Low-Risk Planned Home and Hospital Births*, 116 BJOG: INT'L. J. OBSTET. & GYNAEC. 1177, 1177-78 (2009).

83. *Id.* at 1181.

84. Suzanne Hope Suarez, *Midwifery is Not the Practice of Medicine*, 5 YALE J.L. & FEMINISM 315, 341 (1992).

85. Marjorie Tew, *Do Obstetric Intranatal Interventions Make Birth Safer?* 93 BR. J. OBSTET. & GYNAEC. 659, 670 (1986).

86. Donna M. Peizer, *A Social and Legal Analysis of the Independent Practice of Midwifery: Vicarious Liability of the Collaborating Physician and Judicial Means of Addressing Denial of Hospital Privileges*, 2 BERKELEY WOMEN'S L.J. 139, 158 (1986).

87. *Id.*

88. *Id.*

89. *Id.*

This Chapter will focus on the negative aspect of reproductive rights, which requires government restraint from interfering with an individual's life and privacy. The next Chapter will focus on the principles of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in the context of reproductive health laws and policies. The subsequent Chapter will focus on the positive aspect of reproductive rights, which requires fulfillment by the State of certain obligations it has assumed under statutes and international instruments.

The Author adopts a framework by which reproductive health and reproductive rights will be discussed. This framework aims to encapsulate the concept of choice and the obligation of States to respect such choice. The following are the three branches of reproductive health and reproductive rights clustered according to the negative and positive aspects of human rights.

Reproductive rights are a subset of human rights, and reproductive self-determination is a subset of reproductive rights. Reproductive self-determination is concerned with the negative aspect of human rights which pertains to individual liberty.

Reproductive health refers to the right of women to reproductive health services and the obligation of the State to provide such services. The concept of reproductive health is concerned with the second concept of human rights – social entitlement.

Reproductive justice is concerned with how social and institutional policies affect a woman's capacity to exercise reproductive self-determination. Reproductive justice represents the interplay between the first two – how the exercise of reproductive rights is affected by reproductive health.

Reproductive rights and reproductive self-determination will be discussed in this Chapter.

A. Reproductive Rights as Human Rights

The enactment of the Responsible Parenthood and Reproductive Health Act of 2012 (RH Law)[90] reinvigorated the advocacy for reproductive health and women's rights. After protracted debates on the constitutionality of the law, the Supreme Court ultimately ruled that the RH Law, except for a few provisions, is constitutional, recognizing the rights of Filipinos to reproductive health.[91]

90. An Act Providing for a National Policy on Responsible Parenthood and Reproductive Health [The Responsible Parenthood and Reproductive Health Act of 2012], Republic Act No. 10354 (2012).

91. *See* Imbong v. Ochoa Jr., 721 SCRA 146 (2014).

Reproductive health is defined under the law as

> [t]he state of complete physical, mental[,] and social well-being[,] and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. This implies that people are able to have a responsible, safe, consensual[,] and satisfying sex life, that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. This further implies that women and men attain equal relationships in matters related to sexual relations and reproduction.[92]

The definition under the RH Law is a restatement of the definition under the International Conference on Population and Development (ICPD) Program of Action.[93]

Rights relating to reproductive health are internationally known as reproductive rights. These rights encompass a broad spectrum of rights relating to the reproductive system — from conception of the unborn to death of the mother or of the child.

The concept of reproductive rights is not expressly provided in the Universal Declaration of Human Rights (UDHR).[94] It was only 20 years later, at the Tehran Conference, that concern over reproductive health first became the subject of discourse in the international community.[95] The right then recognized was only with respect to family planning that "[p]arents have a basic human right to determine freely and responsibly the number and spacing of their children[.]"[96] The Tehran Conference was held at a time when population control was an emerging issue in the international community.[97]

The focus on reproductive rights then shifted from population control to women's rights. The first international document recognizing reproductive rights in the context of autonomy was the 1975 International

92. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (p).

93. International Conference on Population and Development, Cairo, Egypt, Sep. 5-13, 1994, *Programme of Action of the International Conference on Population and Development*, ¶ 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (Sep. 13, 1994). [hereinafter ICPD Program of Action].

94. Lynn Freedman & Stephen Isaacs, *Human Rights and Reproductive Choice*, 24 STUD. FAMILY PLANN. 18, 20 (1993).

95. *Id.*

96. *Id.* (citing Final Act of the International Conference on Human Rights, Teheran, Iran, Apr. 22-May 13, 1968, *Proclamation of Teheran*, ¶ 16, U.N. Doc. A/CONF.32/41 (May 13, 1968)).

97. Freedman & Isaacs, *supra* note 94, at 21.

Women's Year Conference Report.[98] The provision on the right of spouses and individuals to make choices concerning family planning was placed after the provision recognizing the inviolability of the human body and respect as a fundamental element of human dignity and freedom.[99] Reproductive rights were then recognized as an offspring of the right to autonomy and dignity and their application expanded beyond the context of family planning.[100]

The scope of reproductive rights further expanded in the International Conference on Population and Development (ICPD). Years after the adoption of the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the ICPD was held in Cairo in 1994. The ICPD Programme of Action (ICPD PoA) defined the scope of reproductive rights as those that

> embrace certain human rights that are already recognized in national laws, international human rights documents[,] and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing[,] and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion[,] and violence, as expressed in human rights documents.[101]

The ICPD's definition of reproductive rights affirms the principle of interdependence, indivisibility, and interrelatedness of human rights, that is, reproductive rights are comprised of various rights recognized under different international instruments.[102] The ICPD merely clustered all the rights relating to reproductive health under an umbrella term. Thus, reproductive rights are considered as a subset of human rights.[103]

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98. *Id.* at 23.

99. International Women's Year Conference, Mexico, Mexico, June 19-July 2, 1975, *Report of the World Conference of the International Women's Year*, ¶¶ 11 & 12, U.N. Doc. E/CONF.66/34.

100. *Id.*

101. ICPD Program of Action, *supra* note 93, ¶ 7.3.

102. *See* RUTH DIXON-MUELLER, POPULATION POLICY & WOMEN'S RIGHTS: TRANSFORMING REPRODUCTIVE CHOICE 3-4 (1993).

103. Beatrice Okpalaobi & Helen Onyi-Ogelle, *Global Trend Towards the Reproductive Health Right of Nigerian Women: The Health Promotion Perspective*, 2 J. EMERG. TRENDS EDUC. RESEARCH & POL'Y STUD. 418, 426 (2011).

The rights embraced in reproductive rights include the right to the enjoyment of the highest attainable standard of physical and mental health, the right to life, the right to privacy, the right to liberty and security of the person, the right to dignity, the right to equality and non-discrimination, the right to be free from sexual and gender-based violence, and the right to access sexual and reproductive health education.[104]

Under the abovementioned definition, reproductive rights can be broken down into three branches:

(1) The right to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so;

(2) The right to attain the highest standard of sexual and reproductive health; and

(3) The right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human rights documents.[105]

The United Nations Human Rights Office of the High Commissioner interpreted the first branch to include the right to have "access to contraception and to the necessary information on reproductive health issues."[106] The first branch also includes "the right not to be married before reaching adulthood and the right not to be forced to marry."[107] The second branch is concerned not only with issues relating to pregnancy and childbearing, but also "securing a safe and satisfying sex life."[108] Access to reproductive health services is also included in the second branch.[109] The third branch includes the right of persons with disabilities, ethnic minorities, and other groups in situation of vulnerability or exclusion to have access to the same sexual and reproductive health services as all other groups.[110] It also includes freedom from harmful practices such as female genital mutilation,

104. *Id.*

105. United Nations Office of the High Commissioner for Human Rights, et al., Reproductive Rights are Human Rights A Handbook for National Human Rights Institutions at 22-23, *available at* https://www.ohchr.org/Documents/Publications/NHRIHandbook.pdf (last accessed Nov. 30, 2018).

106. *Id.* at 23.

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

early or forced marriages, coercion into entering into bearing children, and gender-based violence.[111] The third branch will be discussed further below.

The third branch of reproductive rights grants individuals the right to make decisions concerning reproduction "free of discrimination, coercion[,] and violence, as expressed in human rights documents."[112] This autonomy in making reproductive health choices is at the core of individual self-determination, and is also known as reproductive self-determination.[113]

The right to reproductive self-determination is said to have two aspects: negative, i.e., "freedom from," and positive, i.e., "freedom to."[114] The negative aspect of reproductive self-determination includes the right to liberty and the right to privacy, that is, freedom from unreasonable interference.[115] The positive aspect of reproductive self-determination is autonomy, or freedom to make choices concerning reproductive health.[116] The right to autonomy is derived from the fundamental human right of liberty.[117]

B. Scope of Reproductive Self-Determination

The scope of reproductive self-determination used to be narrow, reflecting the old view focusing on population control and treating women as mere instruments to implement population programs.[118]

The ICPD PoA expanded the definition of reproductive self-determination by putting emphasis on women empowerment and women's health.[119] It recognized that reproductive rights include the "right to make decisions concerning reproduction free of discrimination, coercion[,] and violence, as expressed in human rights documents."[120] Chapter VII of the ICPD PoA articulated the principle of autonomy central to women

111. United Nations Office of the High Commissioner for Human Rights, et al., *supra* note 105, at 23.

112. ICPD Program of Action, *supra* note 93, ¶ 7.3.

113. *See* Freedman & Isaacs, *supra* note 94, at 19.

114. Carmel Shalev, *Rights to Sexual and Reproductive Health: The ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women*, 4 HEALTH HUM. RTS. 38, 46 (2000).

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.* at 39-40.

119. *Id.* at 40.

120. ICPD Program of Action, *supra* note 93, ¶ 7.3.

empowerment.[121] The same definition was adopted in the RH Law, with the added provision that reproductive rights do not contemplate abortion.[122] The framework for reproductive rights shifted from population control to women's rights.[123]

Thus, reproductive self-determination now includes: (1) the right to plan one's family; (2) the right to freedom from interference in reproductive decision-making; and (3) the right to be free from all forms of violence and coercion affecting women's reproductive lives.[124] The right to non-interference in reproductive decision-making relates to broader principles of bodily autonomy.[125] Such right arises from the right to human dignity, liberty and security of the person, and the right to privacy.[126] The right to physical integrity protects women from "unwanted invasion or intrusion of their bodies and other non-consensual restrictions on women's physical autonomy."[127]

The concept of reproductive self-determination has then expanded to cover internationally recognized human rights in all matters relating to reproduction, such as access to, and respect for, non-harmful cultural reproductive practices, the right to choose home birth, freedom from sexual violence and abuse, universal access to reproductive health services, family planning, voluntary choice in marriage, freedom from discrimination, and right to confidentiality with respect to reproductive health information and services.[128] Thus, reproductive rights include the consequences of one's pregnancy, including prenatal care and birthing options.[129]

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121. Shalev, *supra* note 114, at 41.

122. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

123. Shalev, *supra* note 114, at 40.

124. CENTER FOR REPRODUCTIVE LAW AND POLICY, REPRODUCTIVE RIGHTS 2000: MOVING FORWARD 9 (2002).

125. *Id.*

126. *Id.*

127. *Id.*

128. Anne Gallagher, Integrating Reproductive Rights into the Work of National Human Rights Institutions of the Asia Pacific Region: A Preliminary Study of Current Views and Practices, Challenges and Opportunities (Consultant's Report to the United Nations Population Fund and the Asia Pacific Forum of National Human Rights Institutions) at 50–51, *available at* http://asiapacific.unfpa.org/en/publications/integrating-reproductive-rights-work-national-human-rights-institutions-asia-pacific (last accessed Nov. 30, 2018).

129. Sara Hayden, *The Business of Birth: Obstacles Facing Low-Income Women in Choosing Midwifery Care after the Licensed Midwifery Practice Act of 1993*, 19(1) BERK. WOMEN'S L. J. 257, 267 (2004).

The rationale for respecting a woman's autonomy over her own reproductive health decisions was explained by Justice Teresita Leonardo-De Castro in *Imbong v. Ochoa, Jr.*,[130] as follows — "[t]he policy of centrality of women's human rights in the matter of reproductive health care finds its rationale in the biological function and anatomical makeup of the woman in relation to reproduction."[131] Reproductive health rights are more significant for women than men as "she is the one who gets pregnant, bears the unborn child in her womb for nine months, and gives birth to the child."[132]

1. Basis in International Law

Both the negative and positive aspects of reproductive self-determination are guaranteed by various international human rights documents.

a. The Convention on the Elimination of All Forms of Discrimination Against Women

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[133] is considered as one of the most comprehensive international documents on women's rights in general, and women's reproductive rights in particular. In fact, the ICPD PoA's language was inspired by the provisions of the CEDAW.[134]

Reproductive autonomy "was first defined as a human right in international law by the CEDAW."[135] The CEDAW is replete with provisions comprising women's right to reproductive self-determination, among which are the right to marry and found a family,[136] the right to private and family life,[137] the right to health care,[138] the right to non-discrimination,[139] and the right to receive and impart information.[140]

130. Imbong v. Ochoa, Jr., 721 SCRA 146 (2014).

131. *Id.* at 428 (J. Leonardo-De Castro, concurring opinion).

132. *Id.*

133. Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 [hereinafter CEDAW].

134. Shalev, *supra* note 114, at 42.

135. LENE SJØRUP & HILDA RØMER CHRISTENSEN, PIETIES AND GENDER 59 (2009). *See* CEDAW, *supra* note 133, arts. 12.1, 14.2 (b) & 16.1 (e).

136. CEDAW, *supra* note 133, art. 16.

137. *Id.*

138. *Id.* arts. 11 (f), 12 & 14 (b).

139. *Id.* arts. 1-5.

140. *Id.* arts. 10 (e) & 16 (e).

Further, the preamble of the CEDAW provides that "*the role of women in procreation should not be a basis for discrimination*[.]"[141]

The CEDAW is one of the only two human rights treaties that mentions family planning.[142] Article 16 of the CEDAW provides that women have "the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education[,] and means to enable them to exercise these rights."[143]

Article 15 of the CEDAW also reaffirms the full legal capacity of women.[144] In the context of reproductive rights, Article 15 includes the right of women to make informed decisions about their own bodies and health care and to refuse alternatives, such as refusal of health treatments.[145] The arrangement of the provisions in the CEDAW follows that of the Report on the International Women's Year Conference where reproductive rights were considered as springing from autonomy. As mentioned earlier, the CEDAW reflects the shift in advocacy in reproductive rights from population control to emphasis on women's rights.

b. The Universal Declaration of Human Rights

Autonomy over one's own body and health can be traced back to the right to dignity, which is the common string tying it together with international human rights law.[146] The basis of dignity lies in the "autonomy of self and a self-worth that is reflected in every human being's right to individual self-determination."[147]

The Preamble of the founding charter of the United Nations provides that the peoples of the United Nations reaffirm "faith in fundamental human rights" and in "the dignity and worth of the human person[.]"[148] Likewise, the Preamble of the UDHR[149] recognizes the "inherent dignity" of the

141. *Id.* pmbl. (emphasis supplied).

142. Shalev, *supra* note 114, at 44.

143. CEDAW, *supra* note 133, art. 16 (e).

144. *Id.* art. 15.

145. Shalev, *supra* note 114, at 45.

146. Rex D. Glensy, *The Right to Dignity*, 43 COLUM. HUM. RTS. L. REV. 65, 106 (2011).

147. *Id.* at 67-68 (citing Matthias Mahlmann, *The Basic Law at 60 — Human Dignity and the Culture of Republicanism*, 11 GERMAN L.J. 9, 30 (2010)).

148. U.N. CHARTER pmbl.

149. Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. Doc A/81 (Dec. 10, 1948) [hereinafter UDHR].

human person.[150] Article 1 of the UDHR expresses the principle that "[a]ll human beings are born free and equal in dignity and rights."[151] While the UDHR has no binding effect at its inception, state practice has since then rendered it a "binding norm of customary international law."[152]

The right to liberty and security of the person and the right to privacy are likewise protected under the UDHR.[153]

c. The International Covenant on Civil and Political Rights

The right to reproductive self-determination also stems from the broader rights to liberty and privacy, which are protected under the International Covenant on Civil and Political Rights.[154]

d. The International Covenant on Economic, Social, and Cultural Rights

The International Covenant on Economic, Social, and Cultural Rights (ICESCR)[155] embodies one of the most important principles in health law, incorporating reproductive self-determination in the context of reproductive health. General Comment No. 14 of the U.N. Committee on Economic, Social and Cultural Rights provides that the right to health includes "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference[.]"[156]

2. Basis in the Constitution

The Philippine Constitution declares as a state policy that "[t]he State values the dignity of every human person and guarantees full respect for human rights."[157] From this State policy springs various guarantees in the Bill of Rights which serve as legal bases for reproductive self-determination.

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150. *Id.* pmbl.

151. *Id.* art.1.

152. Glensy, *supra* note 146, at 103.

153. UDHR, arts. 3 & 12.

154. International Covenant on Civil and Political Rights arts. 6 & 17, *adopted* Dec. 19, 1966, 999 UNTS 171 [hereinafter ICCPR].

155. International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 19, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].

156. U.N. Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art.12), ¶ 8, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter ICESCR General Comment No. 14].

157. PHIL. CONST. art. II, § 11.

a. The Right to Liberty and the Right to Privacy

The positive aspect of the right to reproductive self-determination — autonomy — is protected under the 1987 Philippine Constitution through the negative rights of liberty and privacy.[158] These two rights restrict unjust interference with one's freedom to make reproductive health decisions.

Article III, Section 1 of the 1987 Philippine Constitution expressly provides that no person shall be deprived of liberty without due process of law.[159] The constitutional guarantee of liberty gives individuals the right to expect that their decisions on their affairs will be respected.[160] Thus, liberty includes the right to be free from unlawful and arbitrary restraint in the enjoyment of one's own facilities.[161]

Liberty is not limited to freedom from arbitrary restraint. The Supreme Court, citing Justice William O. Douglas, has ruled that liberty goes beyond non-interference by the State but also includes the right to privacy.[162] The Supreme Court went on further to cite that "[t]he right to be let alone is indeed the beginning of all freedom."[163]

The constitutional right to privacy was first recognized in this jurisdiction in *Morfe v. Mutuc*.[164] The Court held that the right to privacy is independent of the right to liberty, and deserves constitutional protection on itself.[165] Notably, *Morfe* introduced the fundamental right to privacy in Philippine jurisprudence by citing *Griswold v. Connecticut*,[166] a case involving decisional privacy in the context of reproductive rights.[167] Decisional privacy refers to one's "independence in making certain kinds of important decisions."[168]

158. *See* Shalev, *supra* note 114, at 46.

159. PHIL. CONST. art. III, § 1.

160. City of Manila v. Judge Laguio, Jr., 455 SCRA 308, 338 (2005).

161. *Id.* at 337.

162. Morfe v. Mutuc, 22 SCRA 424, 442 (1968) (citing Public Utilities Commission v. Pollak, 343 U.S. 451, 468 (1952) (J. Douglas, dissenting opinion)).

163. *Id.*

164. Morfe v. Mutuc, 22 SCRA 424 (1968).

165. *Id.* at 445.

166. Griswold v. Connecticut, 381 U.S. 479 (1965).

167. *Morfe*, 22 SCRA at 444 (citing *Griswold*, 381 U.S. at 484).

168. Oscar Franklin Tan, *Articulating the Complete Philippine Right to Privacy in Constitutional and Civil Law: A Tribute to Chief Justice Fernando and Justice Carpio*, 82 PHIL. L.J. 78, 89 (2008) (citing Whalen v. Roe, 429 U.S. 589, 599-600 (1977)).

Under the 1987 Philippine Constitution, the right to privacy was only mentioned in the context of communication and correspondence, and unreasonable searches and seizures.[169] Decisional privacy in Philippine law is almost always subsumed under the right to liberty.[170] While there is no mention in the Constitution of the right to privacy or liberty in the context of reproductive health, the Supreme Court has ruled that the rights to liberty and privacy extend to all aspects of an individual's life.[171] These rights encompass decisions concerning marriage, family relationships, and child rearing.[172] In fact, jurisprudence on privacy developed by recognizing the strong privacy interests of individuals in matters which are of "profound significance in [their] personal [lives.]"[173] These matters implicate "traditional societal values of marriage, procreation, and childrearing."[174] Even the most "trivial" of liberties is protected by the Constitution, to wit —

> Still, the Bill of Rights does not shelter *gravitas* alone. Indeed, *it is those 'trivial' yet fundamental freedoms* [—] *which the people reflexively exercise any day* without the impairing awareness of their constitutional consequence that accurately reflect the degree of liberty enjoyed by the people. *Liberty, as integrally incorporated as a fundamental right in the Constitution, is not a Ten Commandments-style enumeration of what may or may not be done*[.][175]

Further, most of the provisions under the Bill of Rights are mere aspects of the right to liberty.[176] The concept of informed consent, recognized as a legal right in health law, also springs from the right to privacy and liberty.[177]

Childbirth clearly falls within the realm of marriage, family, and procreation — matters which have long been established to be protected by the right to privacy. Childbirth decisions trigger strong privacy interests of the pregnant woman.[178] Thus, considering that childbirth decisions are one of the most personal and intimate decisions a woman can make in her

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169. PHIL. CONST. art. III, §§ 2 & 3.

170. *See*, *e.g.*, White Light Corporation v. City of Manila, 576 SCRA 416, 439 (2009).

171. *Judge Laguio Jr.*, 455 SCRA at 337 (citing Lawrence v. Texas, 539 U.S. 558 (2003)).

172. *Id.*

173. Barbara McCormick, *Childbearing and Nurse-Midwives: A Woman's Right to Choose*, 58 N.Y.U. L. REV. 661, 684 (1983).

174. *Id.*

175. *White Light Corporation*, 576 SCRA at 439 (emphases supplied).

176. People v. Hernandez, et al., 99 Phil. 515, 551 (1956).

177. Ann Catchlove, *Informed Choice, Consent & the Law: The Legalities of "Yes I Can" & "No I Won't"*, BIRTH MATTERS, June 2010, Volume No. 14, Issue No. 2, at 4.

178. Cohen, *supra* note 20, at 853.

private life, the constitutional right of privacy must likewise encompass a woman's freedom to choose among safe childbirth alternatives.[179]

b. The Right to Religious Freedom

Religious freedom is one of the main facets of the right to reproductive self-determination. The weight of religion in making reproductive health decisions is recognized under the RH Law.[180] The 1987 Philippine Constitution protects religious freedom under Section 5, Article III, which provides that "[t]he free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever be allowed."[181] Unlike other fundamental rights — such as the right to life, liberty or property, which are qualified by the requirement of "due process," "unreasonableness," or "lawful order," the religious freedom clauses in the Constitution are stated in absolute terms.[182]

Religious freedom is comprised of two parts: the freedom to believe, and the freedom to act on one's belief.[183] The former is absolute, while the latter is "subject to regulation where the belief is translated into external acts that affect the public welfare."[184]

3. Statutory Basis

The RH Law makes a categorical expression of the right of individuals to make decisions in all matters relating to reproduction.[185] Section 2 of the law provides that all persons have the right to make decisions for themselves "in accordance with their religious convictions, ethics, cultural beliefs, and the demands of responsible parenthood."[186] The obligation of the State to respect and to protect one's religious and cultural beliefs is likewise set forth under the Indigenous Peoples Rights Act[187] and under The Magna Carta of Women.[188]

179. *Id.* at 862.

180. *See* The Responsible Parenthood and Reproductive Health Act of 2012, § 2.

181. PHIL. CONST. art. III, § 5.

182. Estrada v. Escritor, 492 SCRA 1, 79 (2006).

183. Gerona, et al. v. Secretary of Education, et al., 106 Phil. 2, 9-10 (1959).

184. *Imbong*, 721 SCRA at 328 (citing Ebralinag v. Division Superintendent of Schools, 219 SCRA 256 (1993)).

185. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

186. *Id.* § 2.

187. *See* An Act to Recognize, Protect and Promote the Rights of Indigenous Cultural Communities/Indigenous Peoples, Creating a National Commission on Indigenous Peoples, Establishing Implementing Mechanisms, Appropriating

The RH Law adopted the definition of reproductive health rights under the ICPD PoA which recognizes the principles of non-discrimination and non-coercion — individuals have the right to make decisions concerning reproduction "free of discrimination, coercion[,] and violence."[189]

Further, one of the guiding principles in the implementation of the RH Law is the recognition that "[t]he right to make free and informed decisions, which is central to the exercise of any right, shall not be subjected to any form of coercion and must be fully guaranteed by the State, like the right itself[.]"[190]

C. Childbirth Decision as a Form of Reproductive Self-Determination

Choosing where and how to give birth is one of the most personal, intimate, and important choices a parent can make.[191] However, in the context of reproductive rights, the right of pregnant women to make decisions concerning their own bodies and their own health is at the less popular end of the discourse. Abortion and family planning stole the spotlight for many years, especially with the controversy surrounding the enactment of the RH Law.[192] Thus, many health-related policies contravene the basic human rights of pregnant women to autonomy and non-discrimination, despite the

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Funds Therefor, and for other Purposes [The Indigenous Peoples' Rights Act of 1997], Republic Act No. 8371, §§ 29 & 34 (1997).

188. *See* An Act Providing for The Magna Carta of Women [The Magna Carta of Women], Republic Act No. 9710, § 17 (a) (2009).

189. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

190. *Id.* § 3 (a).

191. Leandra Carrasco, Seeking Reproductive Justice: Written Practice Agreements and the Lack of Home Birth Choice, *available at* http://www.udclawreview.com/wp-content/uploads/2011/05/Carrasco.pdf (last accessed Nov. 30, 2018).

192. *See* Roe v. Wade, 410 U.S. 113 (1973). The United States Supreme Court held that the right to privacy includes the right of a pregnant woman to decide whether she will continue or terminate her pregnancy. This right is qualified by the State's interest in regulating abortion for the interest of public health and prenatal life. *Id.* at 153-154. *See also* Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983) & Planned Parenthood Association v. Ashcroft, 462 U.S. 476 (1983). The United States Supreme Court nullified statutes which required pregnant women to have their abortions on hospitals. It held that there was no reasonable relationship between the requirement of the statutes and the State's interest in maternal health and medical regulation. *Akron*, 462 U.S. at 450. *See also Griswold*, 381 U.S. 479 & Eisenstadt v. Baird, 405 U.S. 438 (1972). The United States Supreme Court nullified laws that prohibited persons from obtaining contraceptives as said laws unlawfully intrude into zones of privacy. *Griswold*, 381 U.S. at 485 & *Eisenstadt*, 405 U.S. at 455.

increased international recognition of gender equality, women empowerment, and women's reproductive rights.[193]

The United States Supreme Court and the Supreme Court of the Philippines have yet to decide a case concerning the exercise of a mother's right to reproductive self-determination in the context of home births. The first case concerning home births was decided by the European Court of Human Rights.

1. *Case of Ternovszky v. Hungary*: Reproductive Self-Determination Includes the Right to Choose the Circumstances of One's Childbirth

The first case concerning home births was decided by the European Court of Human Rights in *Case of Ternovszky v. Hungary*[194] in 2010. In *Ternovszky*, a pregnant woman from Hungary claimed that her right to privacy has been violated by a Hungarian law penalizing health professionals for assisting with home births.[195] Article 8 of the European Convention on Human Rights provides that everyone has the right to privacy and that such right may only be interfered with when there is a compelling state interest, such as public health, or for the protection of the rights and freedom of others.[196] Hungary has no legislation prohibiting home births, but its Health Care Act provides that the State shall determine the rules and conditions governing births outside health facilities and the causes for excluding home births.[197]

The European Court of Human Rights ruled that privacy and autonomy demand respect for the decision to become a parent or not to become a parent,[198] "[*T*]*he right* [ ] *to become a parent includes 'the right of choosing the circumstances of becoming a parent,* [...] [*and*] *the circumstances of giving birth incontestably form part of one's private life*[.]"[199] Pregnant women are thus entitled to an institutional and legal environment which enables them to exercise such choice, except when restriction of the right is necessary to protect other rights.[200]

While the Court took notice that there is still a debate as to whether home births are safer than facility-based births, it said that a proper balance

193. Diya Uberoi & Maria de Bruyn, *Human Rights Versus Legal Control Over Women's Reproductive Self-Determination*, 15 HEALTH & HUM. RTS. 161, 161 (2013).

194. Ternovszky v. Hungary, Application No. 67545/09, Judgment, Eur. Ct. H.R., ¶ 17 (Dec. 14, 2010).

195. *Id.* ¶ 12.

196. *Id.* ¶ 13.

197. *Id.* ¶ 10.

198. *Id.* ¶ 22.

199. *Id.* (emphases supplied).

200. *Ternovszky*, Application No. 67545/09, ¶ 24.

should be struck between societal interests and private rights.[201] The Court noted that the right to privacy and self-determination is not only violated by the law sanctioning health professionals for assisting with home births, but also the lack of regulation on home births prevented mothers from fully exercising their childbirth choices.[202]

2. *Dubská and Krejzova v. The Czech Republic*: The State Has No Positive Obligation to Fund Home Births

While *Ternovszky* held that the right to parent or not to parent includes the circumstances of being a parent, and that Hungary has a duty to provide an environment by which this right can be protected, a different conclusion was reached by the court in *Dubská and Krejzová v. The Czech Republic,*[203] which was decided in December 11, 2014.

Šárka Dubská wanted to deliver her second child at home since her experience of giving birth at a health facility was unsatisfactory and stressful, with medical personnel urging her to undergo unnecessary medical procedures.[204] However, she was unable to find a midwife willing to assist her with her home birth.[205] Dubská gave birth to her son unassisted by any midwife or health professional.[206] She claimed that her right to privacy was violated because she was denied the choice of giving birth at home.[207]

The same situation happened to Alexandra Krejzová, who refused to give birth at a health facility because doctors would not heed her request to not be subjected to needless medical intervention.[208] The pregnant women followed the case of *Ternovszky* and argued that the choice of where to give birth is a matter within the purview of the right to privacy as provided for in Article 8 of the European Convention on Human Rights.[209]

Czech law does not prohibit home births, but its Medical Services Act provide that a person can only provide medical care if in possession of a license, and one of the conditions for granting a license is appropriate technical

201. *Id.*

202. *Id.* ¶ 26.

203. Dubská and Krejzová v. The Czech Republic, Application Nos. 28859/11 & 28473/12, Judgment, Eur. Ct. H.R. (Dec. 11, 2014).

204. *Id.* ¶ 10.

205. *Id.*

206. *Id.* ¶ 14.

207. *Id.* ¶ 15.

208. *Id.* ¶ 18.

209. *Dubská and Krejzová*, Application Nos. 28859/11 & 28473/12, ¶ 69.

equipment in the premises where the medical assistance would be given.[210] Private homes do not meet this requirement, as the Government contended.[211]

The European Court of Human Rights held that the issue concerning the scope of the right to self-determination is not whether it covers the right to give birth at home with the assistance of a midwife, but "whether the right to define the circumstances in which to give birth falls within the scope of Article 8[.]"[212] It recognized that giving birth is "a particularly intimate aspect of a mother's private life[,]" and the decision where to give birth is within the scope of the mother's right to privacy.[213] While the Court acknowledged that the impossibility of midwives to attend home births constitutes an interference with their right to privacy, the interference was foreseeable, a core requirement for the validity of a statute under European Union Law, and its purpose lawful, that of protecting the health of the mother and of the child.[214]

The European Court of Human Rights also examined whether the interference was proportionate to the end pursued by balancing the right of mothers to choose where to give birth, and the interest of the State in public health.[215] It said that majority of the studies concerning the subject do not show that there is an increased risk for home births as compared to facility-based births, provided that certain conditions are present, such as low-risk pregnancy, the presence of a trained midwife, and possibility of a transfer to a health facility in case of complications.[216] However, it also noted that there might be unexpected difficulties during childbirth and immediate medical response might be necessary.[217] Thus, the burden imposed on the mothers is not disproportionate and excessive.[218] It ultimately ruled that the right to privacy of the mothers is not violated by the law prohibiting midwives to assist home births.[219]

In a dissenting opinion, Judge Paul Lemmens opined that the case should be viewed as an issue involving *a positive obligation of the State, not its negative obligation of non-interference with private matters*, as Czech law does not

210. *Id.* ¶ 54.

211. *Id.* ¶ 115.

212. *Id.* ¶ 161.

213. *Id.* ¶ 71.

214. *Id.* ¶ 111.

215. *Dubská and Krejzová*, Application Nos. 28859/11 & 28473/12, ¶ 117.

216. *Id.* ¶ 75.

217. *Id.*

218. *Id.*

219. *Id.*

prohibit home births.[220] Judge Lemmens opined that there was a violation of the mothers' right to privacy as Czech law does not further public health, but on the contrary, endangers the lives of mothers who prefer to give birth at home but are forced to do so without professional assistance.[221] The Judge cited a decision of the Czech Constitutional Commission to argue that ensuring the safety of the mother and her child cannot be equated to a blanket preference for facility-based births, to wit —

> A modern democratic State founded on the rule of law is based on the protection of individual and inalienable freedoms, the delimitation of which closely relates to human dignity. That freedom, which includes freedom in personal activities, is accompanied by a certain degree of acceptable risk. *The right of persons to a free choice of the place and mode of delivery is limited only by the interest in the safe delivery and health of the child; that interest cannot, however, be interpreted as an unambiguous preference for deliveries in hospital.*[222]

D. The Limits of the Right to Reproductive Self-Determination

1. The Compelling State Interest in the Life of the Unborn

The scope of the rights to liberty and privacy are not as well-defined when it comes to pregnancy. During pregnancy, two lives are at stake — the mother's and the unborn's. The 1987 Philippine Constitution expresses one of the legal bases used by LGUs in the enactment of the ordinances — the interest of the State in the life of the unborn. Article II, Section 12 provides that the State "shall equally protect the life of the mother and the life of the unborn from conception."[223] Therefore, it is proper to analyze whether the State policy enunciated in said provision should be considered as a limit to the right to reproductive self-determination.

The Supreme Court has often referred to the records of the Constitutional Commission in determining the import of Constitutional provisions.[224] The deliberations of the Constitutional Commission on the abovementioned provision reveal that the protection afforded to the life of the unborn was not intended to justify intrusion into the privacy and liberty of

220. *Id.* ¶ 2 (J. Lemmens, dissenting opinion) (emphasis supplied).

221. *Dubská and Krejzová*, Application Nos. 28859/11 & 28473/12, ¶ 3 (J. Lemmens, dissenting opinion).

222. *Id.* ¶ 5 (emphasis supplied).

223. PHIL. CONST. art. II, § 12.

224. *See, e.g.*, Nitafan v. Commission of Internal Revenue, 152 SCRA 284 (1987); Romualdez-Marcos v. Commission on Elections, 248 SCRA 300 (1995); Lambino v. Commission on Elections, 505 SCRA 160 (2006); & Integrated Bar of the Philippines v. Zamora, 338 SCRA 81 (2000).

mothers. During the deliberations, Commissioner Bernardo Villegas was asked whether the provision contemplates "roving teams sponsored by the State to monitor the activities of women" to make sure that the life of the unborn will be unharmed.[225] Commissioner Villegas replied, "I do not think that is the idea. We will not have any intrusion into the privacy of any person."[226] Commissioner Wilfrido Villacorta even expressed his fears about the "extreme application" of the provision. [227] However, Commissioner Villegas countered that there are other articles in the Bill of Rights, specifically the right to liberty and privacy, which would safeguard the rights of mothers.[228]

The intention of the Constitutional Commission in the inclusion of the provision was straightforward. Section 12 of Article II was intended to limit the power of Congress in the enactment of pro-abortion laws as a response to *Roe v. Wade*.[229] The phrasing of the Constitutional provision in a general manner was resorted to in an effort to prevent getting into the technicalities of an anti-abortion law, which lies within the power of Congress —

> Mr. SUAREZ. So what kind of protection does the Commissioner have in mind in order that we can give life to this unborn child from the moment of conception?
>
> Mr. VILLEGAS. *'Protection' means any attempt on the life of the child from the moment of conception can be considered abortion and can be criminal.*
>
> Mr. SUAREZ. So, *principally and exclusively*, if I may say so, *what the Commissioner has in mind is only an act outlawing abortion*.
>
> Mr. VILLEGAS. Exactly, Madam President.
>
> Mr. SUAREZ. *So that is the real thrust and meaning of this particular provision.*
>
> Mr. VILLEGAS. That is right.
>
> Mr. SUAREZ. Can we not just spell it out in our Constitution that abortion is outlawed, without stating the right to life of the unborn from the moment of conception, Madam President?
>
> Mr. VILLEGAS. No, because that would already be getting into the legal technicalities. That is already legislation. *The moment we have this provision,*

225. IV RECORD OF THE 1986 CONSTITUTIONAL COMMISSION, NO. 85, 724 (1986). *See Roe*, 410 U.S.

226. *Id.*

227. *Id.* at 725.

228. *Id.*

229. JOAQUIN G. BERNAS, S.J., THE 1987 CONSTITUTION OF THE REPUBLIC OF THE PHILIPPINES: A COMMENTARY 84 (2009 ed.).

> *all laws making abortion possible would be unconstitutional. That is the purpose of this provision, Madam President.*[230]

The deliberations further clarified that the Constitutional provision only contemplates State interference in cases where there is a direct intent to harm the life of the unborn "because it is unwanted."[231] The Constitutional provision does not contemplate cases where the mother intends to carry her unborn to full term, and where there is no intent on the part of the mother to end the life of her unborn. Thus, the State's interest in protecting the life of the unborn is compelling enough to overcome autonomy only in the abortion context. Therefore, the constitutional provision does not limit reproductive self-determination in the context of childbirth, and cannot justify State interference, as will be discussed below.

2. Adversarial Pregnancy and the Legal Presumption in Favor of Maternal Decision Making

A misapplication of the compelling state interest in the life of the unborn outside the abortion context could lead to human rights violations.[232] The United States has justified coercive measures against pregnant women based on the compelling state interest pronounced in *Roe v. Wade* — that the pregnant woman's right to privacy is not absolute because the State has a compelling interest in protecting potential life.[233] These coercive measures include forced blood transfusions, [234] forced hospitalizations, [235] forced caesarean sections,[236] and termination of parental rights because of prenatal conduct.[237]

An analysis of these cases would show that there is a point in a woman's life where she is objectified, disempowered, and deprived of rights normally accorded to individuals — and such a period occurs during pregnancy.[238] Before pregnancy, every individual is entitled to the right to give informed

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230. IV RECORD, 1986 CONST. COMM., NO. 84, at 683 (emphases supplied).

231. *Id.* at 699.

232. *See* Rona Kaufman Kitchen, *Holistic Pregnancy: Rejecting the Theory of the Adversarial Mother*, 26 HASTINGS WOMEN'S L.J. 207, 208–209 (2015).

233. *Roe*, 410 U.S. at 155.

234. *See, e.g.*, Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421 (1964) (U.S.).

235. *See, e.g.*, Burton v. State, 49 So.3d 263 (Fla. Dist. Ct. App. 2010) (U.S.).

236. *See, e.g.*, Pemberton v. Tallahassee Memorial Regional Medical, 66 F.Supp.2d 1247, 1251 (Fla. Dist. Ct. 1999) (U.S.).

237. *See, e.g.*, Ankrom v. State, 152 So.3d 373 (Ala. Ct. Crim. App. 2011) (U.S.).

238. Cohen, *supra* note 20, at 867–68.

consent.[239] After pregnancy, the natural and primary right of parents to make decisions for their children is recognized.[240] However, during pregnancy, women are deprived of their rights to autonomy, liberty, and privacy, and the State interferes to protect the life of the unborn. To reiterate, such framework is a result of the misapplication of abortion doctrines to pregnancy cases and of the development of an artificial antagonism between the mother and her child.

State interference is justifiable in the context of abortion. In abortion, the State and the mother have different interests — the State wants to protect the unborn, while the mother wants to end her pregnancy.[241] The mother can be considered as a legal adversary to her own fetus, which led to the development of the adversarial concept of pregnancy.[242] The adversarial concept of pregnancy does not presume that the mother will act in the best interest of her child.[243] Rather, this concept presumes that the mother is hostile to her child and that the State is in a better position to protect her pregnancy and her child.[244] The conceptualization of pregnancy as being adversarial was necessary in the abortion context, so that the State can interfere and protect fetal life.[245] Thus, in the abortion context, which is inherently adversarial, state interference is justified.

However, the adversarial view towards pregnancy must be limited to the context of threatened pregnancies.[246] Wanted pregnancies, where the mother intends to carry her child to term and give birth, are not within the contemplation of *Roe v. Wade* and Section 12, Article II of the 1987 Constitution. The distinction between the two circumstances can be summarized in this manner —

> While the *Roe* framework is appropriate for early pregnancy, in late pregnancy the individual rights of the mother-to-be and [the] developing child cannot, and should not, be artificially disengaged from each other and balanced by the [S]tate, because the [S]tate is not in the best position to

239. *See* Farah Diaz-Tello & Lynn M. Patrow, NAPW Working Paper: Birth Justice as Reproductive Justice (A Working Paper for the National Advocates for Pregnant Women) at 4, *available at* http://advocatesforpregnantwomen.org/BirthJusticeasReproRights.pdf (last accessed Nov. 30, 2018).

240. *See* PHIL. CONST. art. II, § 12 & The Family Code of the Philippines [FAMILY CODE], Executive Order No. 209, arts. 209-223 (1987).

241. Kitchen, *supra* note 232, at 226.

242. *Id.* at 227.

243. *Id.* at 227-28.

244. *Id.*

245. *Id.* at 209.

246. *Id.*

> accurately balance and assess the interests involved. Instead, absent a showing of incompetence, a mother-to-be should be authorized to make joint health decisions for herself and the developing child, as she would be moments after birth.[247]

Adversarial policies necessarily create a false premise that promoting healthy births and protecting women's rights are inherently conflicting.[248] Such premise could dangerously lead courts and policymakers to believe that tradeoffs must be made between the "governmental objectives of protecting women's rights and improving maternal and fetal health."[249] The adversarial view of pregnancy is also called as the "male view" of pregnancy, because the State — the decision maker — makes choices on behalf of the woman and her child without special knowledge of the political, cultural, and religious concerns of the pregnant woman.[250]

Adversarial policies may seem to uphold healthy births but studies show that such policies not only infringe on women's rights, but also deter the necessary behavior for safe and healthy pregnancies.[251] It has been noted that "[c]oercive and punitive governmental policies that create conflict between women's liberty and the promotion of healthy births are unnecessary. Indeed, the most effective policies for improving the health of newborns are those that facilitate women's choices, not those that infringe on their liberty."[252]

The facilitative model can be differentiated from the adversarial model in this way —

> The second approach, which historically has been and today remains far more common, can be described as the 'facilitative model.' This model recognizes that women who bear children share the government's objective of promoting healthy births, but that existing obstacles — and not bad intentions — impede the attainment of this common goal.[253]

In other words, the facilitative model, unlike the adversarial model, supports the autonomy of women in making childbirth decisions.[254] Such

247. Cohen, *supra* note 20, at 880.

248. Dawn Johnsen, *Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty*, 43 HASTINGS L.J. 569, 613 (1992).

249. *Id.*

250. Cohen, *supra* note 20, at 865.

251. Johnsen, *supra* note 248, at 575-76.

252. *Id.* at 571.

253. *Id.*

254. *Id.* at 574.

model assumes that women, and not the government, are best situated to decide how to balance competing interests to arrive at a childbirth choice.[255]

Furthermore, there is an overwhelming consensus in the medical and public health community that adopting the adversarial model of pregnancy in health policies is not only ineffective, but "often disserves the governmental objective of promoting healthy births."[256] The threat of State interference and punishment tends to frighten away women who are in need of medical services, making them more unreachable in the public health system.[257]

From a strictly legal viewpoint, the adversarial policies would fail court scrutiny for the following reasons: (1) the government would not be able to demonstrate that it is better situated than the pregnant woman to make the "right" childbirth decisions because in the context of childbirth, there is no clear "right" choice but a complex judgment necessitating balancing of competing interests; and (2) adversarial policies do not satisfy the requirement that regulations be "narrowly drawn" to achieve their intended goal because "less restrictive alternatives" exist.[258] One study illustrated that there is no such thing as a "right" choice in the context of childbirth decisions. Such study showed that in six out of 15 court-ordered caesarean sections, the prediction of imminent harm by doctors were inaccurate.[259] The danger of adopting an adversarial policy based on medical advice is, "[t]he bigger concern in all these contexts is not which choice is correct, but that given the fact that medical science has so often been wrong and that these choices are of such personal importance and value-laden, it is the individual who should choose, not the doctor."[260]

Contrary to the adversarial view of pregnancy in the abortion context, Philippine law does not consider mothers and their children as adversaries. Rather, Philippine law recognizes the special relationship between mothers and their children;[261] it establishes therefore a presumption that mothers

255. *Id.*

256. *Id.* at 572.

257. Johnsen, *supra* note 248, at 589.

258. *Id.*

259. Cohen, *supra* note 20, at 866 (citing Veronica E.B. Kolder, et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1195 (1987)).

260. Cohen, *supra* note 20, at 862.

261. *See, e.g.*, People v. De Los Santos, 295 SCRA 583, 603 (1998). The Supreme Court took judicial notice that "no mother would go against her natural instincts unless she is forced to turn her back from the truth." *Id.* The Supreme Court held that a mother's maternal love should be respected and that a mother "could not exert a bad influence on [her] baby." Luna v. Intermediate Appellate Court, 137 SCRA 7, 20 (1985). The Supreme Court took judicial

would act in the best interest of their children. The recognition of the mother's special relationship with her children was the basis of Article 214 of the Family Code,[262] also known as the tender-age presumption, which provides that "[n]o child under seven years of age shall be separated from the mother, unless the court finds compelling reasons to order otherwise."[263]

The due deference accorded to parental authority and the presumption that parents will act in the best interest of their children must likewise apply to childbirth decisions, because the woman already "parents [her] child in her womb."[264] Thus, childbirth decisions should also be respected as parenting decisions.[265]

E. Analysis

From the foregoing, it has been established that reproductive rights are a subset of human rights and that reproductive self-determination is at the core of reproductive rights. The right to reproductive self-determination recognizes the right of individuals to make decisions concerning one's reproduction "free of discrimination, coercion[,] and violence[.]"[266] The right to reproductive self-determination finds its basis under the 1987 Philippine Constitution,[267] the UDHR,[268] the ICCPR,[269] the ICESCR,[270]

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notice that a mother's maternal instincts "may impel her to protect her son at all cost[s], even to the point of prevarication." People v. Dela Cruz, 573 SCRA 708, 721 (2008). The Supreme Court held that a mother's maternal desire to vindicate her daughter's honor precluded the finding that the mother gave false testimony. People v. Mariano, 124 SCRA 802, 805 (1983). The Supreme Court took judicial notice that maternal love is "without any doubt, universally considered the most sublime feeling nature has infused in human hearts." Villahermosa v. Commissioner of Immigration, 80 Phil. 541, 548 (1948). *See also* People v. Inocencio, 229 SCRA 517, 519 (1994); People v. Villorente, 210 SCRA 647, 660 (1992); & Tapucar v. Tapucar, 293 SCRA 331, 336 (1998).

262. MELENCIO S. STA. MARIA, JR., PERSONS AND FAMILY RELATIONS LAW 790 (5th ed., 2010).

263. FAMILY CODE, art. 214.

264. Cohen, *supra* note 20, at 866.

265. *Id.*

266. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

267. PHIL. CONST., art. III, §§ 1 & 5.

268. UDHR, art. 12.

269. ICCPR, *supra* note 154, art. 17.

270. ICESCR, *supra* note 155, art. 1 & ICESCR General Comment No. 14, *supra* note 156, ¶ 8.

the CEDAW,[271] and the RH Law.[272] ICESCR General Comment No. 14 affirms that the right to health includes "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference[.]"[273]

Because the right to reproductive self-determination encompasses all decisions concerning reproduction, the choice of mothers on where they would give birth must be respected. The right of mothers to give birth at home has been recognized by the European Court of Human Rights in *Ternovszky*. While not legally binding in the Philippines, the pronouncement of the case is in alignment with the principles of the RH Law and the constitutional guarantees to liberty and privacy.

Further, the right to reproductive self-determination cannot be circumscribed by mere invocation of the State's interest of protecting the life of the unborn. Section 12, Article II of the 1987 Philippine Constitution contemplates State interference to proscribe abortion, and not intrusion into the privacy and liberty of mothers in case of wanted pregnancies. The adversarial notion of pregnancy, where State interference is necessary to protect potential life from the harm imposed by the mother, is likewise limited to the abortion context. Outside the abortion context, Philippine laws have adopted the presumption that the mother will make decisions in the best interest of her child. This presumption can only be overcome upon proof of neglect, abandonment, drug addiction, maltreatment, affliction with a communicable disease, immorality, or insanity.[274] Thus, the State's interest in the life of the unborn is only compelling enough to overcome the mother's liberty in the abortion context.

The arguments in favor of maternal decision making can be summarized in this wise —

> When proper weight is given to the unique nature of pregnancy and the complex risk assessments involved in making pregnancy and birth health decisions, mothers (who have the 'inside' perspective on their pregnancies) and not the State (with its 'outside' perspective) should be regarded as the most appropriate well-informed decision makers. Women are best informed as to their own religious beliefs, personal situations, risk-averseness, and pregnancies. And it appears that even compared with doctors, women are the best authority on what is best for the child in light of the nascent parent-child relationship.[275]

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271. CEDAW, *supra* note 133, arts. 1-5; 10 (e); 11 (f); 12; 14 (b); & 16.

272. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

273. ICESCR General Comment No. 14, *supra* note 156, ¶ 8.

274. Pablo-Gualberto v. Gualberto V, 461 SCRA 450, 476 (2005).

275. Cohen, *supra* note 20, at 866.

Allowing the State to overcome the autonomy of mothers in childbirth decision-making would be tantamount to adopting the male view of pregnancy. Such view is inconsistent with the principles of women empowerment and respect for human rights. Further, women should be treated as autonomous individuals throughout their life. However, the adoption of the male view of pregnancy will result in the deprivation of women's rights during pregnancy, thereby disempowering women and treating them as mere vessels.

The respect that must be accorded to maternal decision making is likewise supported by the principle of parental authority and the natural and primary rights of parents in the upbringing of their children. Childbirth decisions "are essentially the first childrearing decision that parents make."[276] Therefore, the State is not in a position to overcome the choice of mothers among safe childbirth alternatives. Any balancing of rights and risks must be done by the woman, not by the State.

IV. THE PRINCIPLES OF THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN IN REPRODUCTIVE HEALTH LAWS AND POLICIES

To further contextualize the discussion on reproductive self-determination and adversarial pregnancy, this Chapter will discuss the principles of the CEDAW which are relevant in analyzing laws and policies violating the right of pregnant women to reproductive self-determination. This Chapter will show that the framework underlying these laws and policies are discriminatory against women and are contrary to the principles of the CEDAW.

A. The Fundamental Principles of the CEDAW

As discussed in the previous Chapter, for many years, women have been subjected to discrimination in reproductive health policies for many reasons — from being treated as mere instruments to implement population control measures to deprivation of autonomy in reproductive decision-making.[277] Biological differences between women and men in the area of reproduction resulted in "differences in the lives of women and men which created

276. McCormick, *supra* note 173, at 689.

277. Center for Reproductive Rights, Substantive Equality, Autonomy, and Reproductive Rights (A Factsheet that Provides a Background Information on How the Committee on the Elimination of Discrimination against Women and the Human Rights Committee can Fully Utilize the Principles of Substantive Equality and Autonomy), *available at* http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Substantive%20Equality,%20Autonomy%20and%20Reproductive%20Rights.pdf (last accessed Nov. 30, 2018).

inequalities legitimizing hierarchical relationships with males being dominant."[278] It would therefore be relevant to discuss the principles of the CEDAW underlying the provisions mentioned in the preceding Chapter and how these principles are contextualized in reproductive health issues.

The CEDAW has three fundamental principles which are of value in analyzing reproductive health policies and laws: (1) Substantive Equality; (2) Non-Discrimination; and (3) State Obligations.[279]

1. Substantive Equality

There are three approaches to equality: (1) formal equality; (2) the protectionist approach; and (3) substantive equality.[280] The CEDAW adheres to the principle of substantive equality. Nevertheless, to better comprehend the differences in these approaches, formal equality and the protectionist approach will also be discussed in this subsection.

The traditional approach to equality has been formal equality — treating men and women the same.[281] This approach gives individuals with similar attributes or who are similarly positioned equal or identical treatment. The approach does not question "the social contexts and history that created the differences or how the differences were treated."[282] An example of the application of the principle of formal equality would be appointing an equal number of men and women to the same positions in companies.[283] Formal equality does not focus on the actual outcome of the appointments, "whether or not the women appointed to the same positions have equal access to and opportunities for capacity and skill development, training and promotions with their male colleagues, and whether those women are

278. Shanthi Dairiam, Women's Right to Equality: The Promise of CEDAW (A Paper Commissioned by U.N. Women) at 14, *available at* http://asiapacific.unwomen.org/~/media/field%20office%20eseasia/docs/publications/2014/7/the%20promise%20of%20cedaw%20final%20pdf.ashx (last accessed Nov. 30, 2018).

279. ALDA FACIO & MARTHA MORGAN, EQUITY OR EQUALITY FOR WOMEN? UNDERSTANDING CEDAW'S EQUALITY PRINCIPLES 2 (2009 ed.)

280. HUMAN RIGHTS COMMISSION OF MALAYSIA, GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN 1 (2006 ed.).

281. *Id.*

282. Dairiam, *supra* note 278.

283. U.N. Women, The Principles of CEDAW, *available at* https://web.archive.org/web/20140925114338/http://www.unwomen-eseasia.org/projects/Cedaw/printprinciplecedaw.html (last accessed Nov. 30, 2018) (website accessed using the Internet Archive, a tool for looking back at old versions of defunct webpages).

equally accepted as leaders within their work environment and in society."[284] Further, pregnancy-based discrimination cannot be addressed by applying the formal approach to equality as men do not get pregnant; since there is no male comparator, equality rights do not exist.[285] Thus, formal equality "often ignores the differences between men and women as a result of obligations that society places on them, such as childcare and household duties" that consume the time of women.[286] These "differences" are reinforced by the formal equality approach and "those who were already advantaged were further advantaged."[287] Women had to be like men to be treated equal to men.[288]

The second approach to equality is the protectionist approach, "where laws and policies prevent women from taking part in work or activities seen as harmful to them."[289] Preventing women from participating in such work or activities can consequently prevent women from fully participating in society and can likewise result in discrimination.[290] Further, the protectionist approach does not examine the reasons behind why a particular work or activity is perceived as dangerous for women.[291] An example would be a law which prohibits pregnant women from working in shops with slippery floors, as falling may endanger them and their unborn.[292] Another example would be a law which prohibits women from doing nightshift work as it is considered unsafe for them to do so.[293] Differences between men and women are considered as weakness in women and the State does not consider special measures which could enable women to fully participate in such activities.[294]

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284. *Id.*

285. Dairiam, *supra* note 278, at 17.

286. U.N. Women, *supra* note 283.

287. Dairiam, *supra* note 278, at 15.

288. *Id.*

289. U.N. Women, *supra* note 283.

290. *Id.*

291. *Id.*

292. *Id.*

293. United Nations Development Fund for Women, Advancing Gender Equality using CEDAW and UN Security Council Resolution 1325 (A Training Module for Gender Equality Advocates) at 21, *available at* http://lastradainternational.org/lsidocs/389%20AdvancingGenderEquality.pdf (last accessed Nov. 30, 2018).

294. *Id.*

Lastly, the substantive approach to gender equality requires that the outcome of laws, policies, and programs be equal for men and women, as compared to the formal approach which focuses on treatment.[295] The substantive approach requires examination of the differences between men and women and the underlying assumptions of those differences which may result from "cultural norms to prejudices, mistaken beliefs[,] and political structures."[296] Applying the substantive approach to the examples mentioned above, it would not be enough that men and women are equally appointed to certain positions in the company, it is also necessary to determine whether women have equal access, opportunities, and benefits in the positions they are occupying.[297] Ensuring the safety of pregnant women in the workplace would require an assessment of the reasons behind workplace hazards and the elimination of such hazards.[298]

2. Non-Discrimination

Discrimination constitutes "any distinction, exclusion, restriction or preference or other preferential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise" of rights under the ICESCR.[299] The Magna Carta of Women defines discrimination against women as

> any gender-based distinction, exclusion, or restriction which has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field. It includes any act or omission, including by law, policy, administrative measure or practice, that directly or indirectly excludes or restricts women in the recognition and promotion of their rights and their access to and enjoyment of opportunities, benefits, or privileges.[300]

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295. Human Rights Commission of Malaysia, *supra* note 280, at 2.

296. U.N. Women, *supra* note 283.

297. *Id.*

298. *Id.*

299. U.N. Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights (art. 2, para. 2 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 7, U.N. Doc. E/C/12/GC/20 (July 2, 2009) [hereinafter ICESCR General Comment No. 20].

300. The Magna Carta of Women, § 4 (b).

Under the substantive approach to equality, "both direct and indirect discrimination must be eliminated."[301] Direct discrimination against women means "different treatment explicitly based on grounds of sex and gender differences."[302] Indirect discrimination against women occurs "when a law, policy, program[ ] or practice appears to be neutral in so far as it relates to men and women, but has a discriminatory effect in practice on women because pre-existing inequalities are not addressed by the apparently neutral measure."[303]

Further, both sex-based and gender-based discrimination are proscribed by the CEDAW.[304] "Sex" refers to "biological differences between men and women" while "gender" refers to "socially constructed identities, attributes[,] and roles for women and men and society's social and cultural meaning for these biological differences[.]"[305]

3. State Obligations

Article 2 of the CEDAW sets out the obligations of States Parties to the Convention. [306] The obligation to respect women's right to non-discrimination requires that States Parties must refrain from making laws, policies, and institutional structures that directly or indirectly result in the denial of the equal enjoyment of human rights by women.[307] The obligation to protect requires that States Parties must protect women from discrimination by private actors and take steps "directly aimed at eliminating customary and all other practices that prejudice and perpetuate the notion of inferiority or superiority of either of the sexes, and of stereotyped roles[.]"[308] The obligation to fulfill requires States parties Parties to ensure both de jure recognition of rights and de facto equality.[309]

301. Dairiam, *supra* note 278, at 22.

302. U.N. Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 28 on the Core Obligations of States Parties Under Article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women*, CEDAW/C/GC/28, ¶ 16 (Dec. 16, 2010) [hereinafter CEDAW General Recommendation No. 28].

303. *Id.*

304. *Id.* ¶ 5.

305. *Id.*

306. CEDAW, *supra* note 133, art. 2.

307. CEDAW General Recommendation No. 28, *supra* note 302, ¶ 9.

308. *Id.*

309. *Id.*

The Philippines, being a State Party to the CEDAW, has the obligation to comply with the policy measures mentioned above. States Parties must ensure that "women are not disadvantaged because they are women, or because they have physical attributes unique to women, such as child bearing, or cultural roles unique to women."[310]

B. CEDAW Principles in Reproductive Health Laws and Policies

Applying the principles mentioned above, the CEDAW Committee has noted that "States [P]arties [must] refrain from obstructing action taken by women in pursuit of their health goals[ ]" and that "States [P]arties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents[,] or health authorities, because they are unmarried or because they are women."[311] Among the circumstances that lead to a violation of women's rights include "requirements or conditions that prejudice women's access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent[,] or hospital authorities, distance from health facilities, and absence of convenient and affordable public transport."[312]

Dr. Carmel Shalev, a former expert member of the CEDAW Committee, noted that in the context of reproductive rights, the CEDAW provides the legal basis for the right of women to "personal reproductive autonomy and to collective gender equality as a primary principle in the development of reproductive health and population programs."[313] The principles of the CEDAW bring forth several important concepts in reproductive rights: personal autonomy, reproductive choice, informed consent, and gender equality.[314] The word "autonomy" is not expressly mentioned in the CEDAW, but autonomy is implicit in the fundamental freedoms guaranteed by the CEDAW, such as "liberty, dignity, privacy, security of the person, and bodily integrity."[315]

Autonomy refers to the right of women to make decisions concerning reproduction "free from coercion and violence."[316] The rights to informed

310. U.N. Women, *supra* note 283.

311. U.N. Committee on the Elimination of Discrimination against Women, *Report of the Committee on the Elimination of Discrimination Against Women*, ¶ 14, U.N. Doc. A/54/38/Rev.1 (June 7-25, 1999) [hereinafter CEDAW Report].

312. *Id.* ¶ 21.

313. Shalev, *supra* note 114, at 40.

314. *Id.* at 44.

315. *Id.* at 46.

316. *Id.* at 45.

consent and confidentiality are instrumental in ensuring autonomy.[317] The right to informed consent imposes a duty on healthcare providers to disclose information on the proposed healthcare measure, and the alternatives to such measure and to respect the right of the client to refuse treatment.[318] Further, autonomy also means that women should be treated as "individuals in [their] own right[,] the sole client of the health care provider, [and] fully competent to make decisions concerning [their] own health."[319] Therefore, the State must not substitute its own will for that of the client.

Emphasis must be made on the elimination of discrimination against women in the area of reproductive health, as discrimination against women is "closely associated with prejudices and stereotypes based on patriarchal notions of women's sexual and reproductive roles and functions."[320] In particular, the role of women in motherhood is often glorified by society in such a way that women's right to autonomy in exercising life choices is circumscribed. [321] For example, the health needs of women may be considered secondary to their children, or to their fetuses, and the State may deprive pregnant women of control over their own health, as discussed in the subsection on adversarial pregnancy.[322] In such case, women are reduced to aspects of their physical selves — as mere vessels giving way to another life.[323]

Thus, for a State Party to comply with its obligations under the CEDAW, its healthcare system must integrate the principles of the CEDAW in its healthcare policies —

> Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality[,] and is sensitive to her needs and perspectives. States [P]arties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's right to informed consent and dignity.[324]

Further, as a concrete recommendation, the CEDAW committee urged States Parties to ensure that "all health services be consistent with the human

317. *Id.*

318. *Id.*

319. Shalev, *supra* note 114, at 45-46.

320. *Id.* at 48.

321. *Id.*

322. *Id.*

323. *Id.*

324. CEDAW Report, *supra* note 311, ¶ 22.

rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and[,] choice."[325] Women must be able to make reproductive health choices "without the limitations set by stereotypes, rigid gender roles[,] and prejudices."[326] In *A.S. v. Hungary*,[327] the CEDAW committee considered the absence of informed consent as a violation of the right to health under Article 12 of the CEDAW.[328]

C. Analysis

The RH Law provides that the State has the duty to "eradicate discriminatory practices, laws and policies that infringe on a person's exercise of reproductive health rights."[329] Since the Philippines is a State Party to the CEDAW, the principles of the CEDAW on substantive equality and non-discrimination, as adopted by The Magna Carta of Women, must provide the criteria by which reproductive health laws and policies are to be evaluated.

Applying the substantive approach to equality and the principle of non-discrimination, reproductive health laws and policies must be consistent with the following rights: reproductive autonomy, privacy, confidentiality, informed consent, and choice.[330] Reproductive health laws and policies must treat women as autonomous beings with full legal capacity who can take control of their own reproductive lives.[331] Women must be able to make decisions on their own reproductive health on the basis of accurate and adequate information.[332]

Therefore, laws which curtail the right to reproductive self-determination of pregnant women, such as the ordinances prohibiting home births, are contrary to the principles of the CEDAW on two grounds: (1) for adopting the protectionist approach, as compared to the substantive approach to equality; and (2) for curtailing the rights of pregnant women based on gender stereotypes.

First, the ordinances prohibiting home births adopt the protectionist approach, as they prohibit women from choosing an activity which is

325. *Id.* ¶ 31 (e).

326. CEDAW General Recommendation No. 28, *supra* note 302, ¶ 22.

327. A.S. v. Hungary, CEDAW/C/36/D/4/2004, No. 4/2004, Communication (Committee on the Elimination of Discrimination against Women Feb. 12, 2004).

328. *Id.*

329. The Responsible Parenthood and Reproductive Health Act of 2012, § 2, para. 6.

330. CEDAW Report, *supra* note 311, ¶ 31 (e).

331. Shalev, *supra* note 114, at 59.

332. *Id.*

perceived to be dangerous to pregnant women or to their unborn children. While on their face, the ordinances may seem to have a laudable purpose, the ordinances deprive women of control and autonomy over their own reproductive health. In effect, the State substitutes its will for that of the pregnant woman by dictating which healthcare option the pregnant woman must choose and punishing those which do not choose such option. Further, the right to informed consent is violated as a healthcare option is imposed upon women without their involvement. Thus, the ordinances are discriminatory against women as women are prevented from fully participating in reproductive decision making based on a course of action predetermined by the State.

The rationale for the issuance of the home birth prohibition ordinances echo the justification made by the United States Supreme Court in the abandoned *Muller v. Oregon*[333] ruling. In *Muller*, the United States Supreme Court upheld the restriction on women's ability to work on the ground that such is necessary to promote the birth of healthy babies providing that, "as healthy mothers are essential to vigorous offspring, the physical well-being of women becomes an object of public interest and care in order to preserve the strength and vigor of the race."[334] The same protectionist approach is adopted by the ordinances. The *Muller* ruling has since been abandoned for being discriminatory against women.[335]

Thus, to be consistent with the provisions of the CEDAW, childbirth laws must not only respect the autonomy of pregnant women but must also consider the political, social, economic, and cultural reasons underlying the decision to choose home births and address such issues.

Second, deprivation of the right to reproductive self-determination based on one's pregnant status can be considered as gender-based discrimination. Childbirth is not a gender-neutral issue.[336] The existence of laws curtailing a pregnant woman's freedom to make decisions with regard to her own body and her own health springs from the gender stereotype of the "good mother" — one who is willing to sacrifice the exercise of her rights for the benefit of the safety of her unborn.[337] Despite the applicability of the doctrine of informed consent in this jurisdiction, informed consent is

333. Muller v. Oregon, 208 U.S. 412 (1908).

334. Johnsen, *supra* note 248, at 611 (citing *Muller*, 208 U.S. at 421).

335. *Id.*

336. *See* Dairiam, *supra* note 278, at 17.

337. Fleur van Leeuwen, *Milestone or Stillbirth? An Analysis of the First Judgment of the European Court of Human Rights on Home Birth*, *in* EQUALITY AND HUMAN RIGHTS: NOTHING BUT TROUBLE? 206-207 (Marjolein van den Brink, et al., eds. 2015).

disregarded in the context of pregnancy. As discussed, the role of women in procreation is so glorified by society that pregnant women are relegated as second-class citizens, without liberty and autonomy, to protect the life of the unborn. [338] The "good mother" gender stereotype reinforces the concept of adversarial pregnancy.

V. THE REPRODUCTIVE HEALTH OBLIGATIONS OF THE STATE AND REPRODUCTIVE JUSTICE

A. The Relationship Between Maternal Health, Reproductive Health, and the Right to Health

Maternal health is comprised of various basic human rights, such as the "rights to life, to be equal in dignity, to education, to be free to seek, receive[,] and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health."[339] Thus, maternal mortality is considered as a human rights violation. The World Health Organization even recognized that "the failure to address preventable maternal disability and death represents one of the greatest social injustices of our times."[340]

The problem of maternal mortality is considered as a reproductive health issue because maternal health is an integral component of reproductive health.[341] The entitlement to reproductive health implies that States have the duty to "enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[342] The RH Law adopts the same definition and also recognizes maternal health as a facet of reproductive health.[343]

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338. Shalev, *supra* note 114, at 48.

339. U.N. Human Rights Council, *Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights*, ¶ 8, U.N. Doc. A/HRC/14/39 (Apr. 16, 2010) [hereinafter Report of the Office of the U.N. High Commissioner for Human Rights].

340. *Id.* ¶ 7 (citing Rebecca J. Cook, et al., Advancing Safe Motherhood Through Human Rights at 5, *available at* http://apps.who.int/iris/bitstream/handle/10665/66810/WHO_RHR_01.5.pdf;jsessionid=7CB53751DE6B450ACB57CB50E8D75E4F?sequence=1 (last accessed Nov. 30, 2018)).

341. *See* ICPD Program of Action, *supra* note 93, ¶ 7.2.

342. *Id.*

343. The Responsible Parenthood and Reproductive Health Act, § 4 (q) (2).

Further, reproductive health is considered as within the realm of the general right to health. The inclusion of reproductive health as a component of the right to health is provided under the RH Law, and under the ICESCR.[344]

The relationships among the three concepts can be summarized as follows: maternal health is a component of reproductive health, and reproductive health falls under the general entitlements provided by the right to health. The State is therefore bound to apply the standards set under the Constitution, statutes, and international instruments on the nature of health obligations for the protection of maternal health.

B. Nature of the Health Obligations of the State

1. Constitutional Basis

The 1987 Philippine Constitution provides that the State shall "protect and promote the right to health of the people and instill health consciousness among them."[345] With respect to maternal health, the State is duty bound to protect the life of the mother and that of the unborn from conception.[346]

The criteria for a proper health care system set forth under the Constitution were intentionally interlocked with the provisions on Article XIII on Social Justice and Human Rights. Under Section 11 of said Article, it is the duty of the State to adopt "an integrated and comprehensive approach to health development, which shall endeavor to make essential goods, health[,] and other social services available to all the people at an affordable cost[,]" [347] priority being given to marginalized sectors of society.[348] An integrated health care system contemplates a mix between public and private health care providers and western medicine vis-à-vis traditional medicine.[349] Comprehensiveness requires State efforts on all matters affecting health, including education and nutrition.[350] The provisions of the Constitution on the health care system are self-executing, and are therefore immediately demandable as a State obligation.[351]

344. *Id.* § 2 & ICESCR General Comment No. 14, *supra* note 156, ¶14.

345. PHIL. CONST. art. II, § 15.

346. PHIL. CONST. art. II, § 12.

347. PHIL. CONST. art. XIII, § 11.

348. PHIL. CONST. art. XIII, § 11.

349. BERNAS, *supra* note 229, at 1270.

350. *Id.*

351. *Imbong*, 721 SCRA at 202.

2. State Obligations under International Human Rights Documents

a. Bases

The right to health is recognized under international human rights documents, such as the UDHR,[352] the ICESCR,[353] the CEDAW,[354] and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).[355]

The UDHR subsumes the right to health under the right to an adequate standard of living.[356] The ICESCR provides a more specific provision for health, imposing upon States the obligation to respect, protect, and fulfill the "highest attainable standard of physical and mental health" and the creation of conditions which would assure accessibility of health services.[357] The ICESCR gives particular emphasis on the obligation of States to reduce maternal mortality.[358]

The Convention on the Rights of the Child (CRC) also has a provision for maternal health, albeit with a focus on infant and child mortality.[359] The Committee of the CRC recognized the importance of reducing maternal mortality to improve infant and child health outcomes.[360] The Committee considered maternal mortality as a grave violation of women's right to health and as a preventable occurrence provided that proper risk assessment takes place.[361]

b. Interdependence with Other Human Rights

The interdependence and indivisibility of human rights make the right to health dependent upon the realization of other human rights, including, *inter*

352. UDHR, *supra* note 149, art. 25.

353. ICESCR, *supra* note 155, art. 12.

354. CEDAW, *supra* note 133, art. 12.

355. United Nations Declaration on the Rights of Indigenous Peoples, G.A. Res. 61/295, art. 24, U.N. Doc. A/RES/61/295 (Sep. 13, 2007).

356. UDHR, *supra* note 149, art. 25 (1).

357. ICESCR, *supra* note 155, art. 12.

358. *Id.*

358. *Id.*

359. Convention on the Rights of the Child art. 6, *adopted* Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC].

360. U.N. Committee on the Rights of the Child, *General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24)*, ¶ 51, U.N. Doc. CRC/C/GC/15 (Apr. 17, 2013) [hereinafter CRC General Comment No. 15].

361. *Id.*

alia, the right to human dignity, the right to life, non-discrimination, equality, and privacy.[362]

c. Obligation to Respect, Protect, and Fulfill

As a State obligation, the State is mandated to respect, protect, and fulfill the right to health.[363] The obligation to respect requires the State to refrain from direct or indirect interference with the said right.[364] The obligation to respect also requires the State to abstain from prohibiting or in any way hindering traditional healing practices and medicines and from applying coercive treatments, unless on exceptional grounds such as mental illness or to prevent communicable diseases.[365]

The obligation to protect mandates that the State must take measures to prevent third parties from interfering with the right to health.[366] The State must ensure that medical practitioners are well-educated and that women are not coerced to undergo patently harmful traditional practices, such as female genital mutilation.[367] Included within the obligation to protect is the duty of the State to protect the vulnerable or marginalized groups in society.[368]

Lastly, the obligation to fulfill requires that the State must adopt appropriate governmental measures towards the fulfillment of the right to health.[369] This may take the form of legislation or by way of appropriation from the national budget.[370] Public health facilities must provide reproductive health services, especially maternal health services, in isolated and rural areas.[371] Culturally appropriate health services must be provided by the State.[372] The State is considered to be in violation of its duty to fulfill if, among others, it fails to "take measures to reduce the inequitable distribution of health facilities, goods, and services" or fails to "reduce infant and maternal mortality rates."[373]

362. ICESCR General Comment No. 14, *supra* note 156, ¶ 3.

363. *Id.* ¶ 33.

364. *Id.* ¶ 34.

365. *Id.*

366. *Id.* ¶35.

367. *Id.*

368. ICESCR General Comment No. 14, *supra* note 156, ¶ 35.

369. *Id.* ¶ 36.

370. *Id.*

371. *Id.*

372. *Id.* ¶ 37.

373. *Id.* ¶ 52.

C. Right to Reproductive Health under Philippine Law

1. The Responsible Parenthood and Reproductive Health Act of 2012

The RH Law provides that the protection of women's rights is essential in the reproductive health efforts of the State.[374] The State guarantees access to reproductive health services and supplies and shall give special consideration to the needs of the marginalized sectors.[375]

To fulfill the State's obligations under the right to health, the RH Law mandates LGUs to hire health professionals sufficient in number to have a good health professional-to-patient ratio.[376] People from isolated or depressed areas should be provided with the same level of accessibility to maternal health services.[377] To reach this end, LGUs shall have Mobile Health Care Services (MHCS), where vehicles or other means of transportation are utilized to deliver health care services to the disadvantaged sectors and those living in isolated areas.[378] The MCHS shall be manned by skilled health professionals with proper equipment.[379] Home visits shall also be done to reach inhabitants of isolated areas.[380] The lack of skilled health personnel is addressed by delegating to LGUs the training of Barangay Health Workers (BHWs).[381]

3. The Magna Carta of Women

The Magna Carta of Women provides three requisites which the State must fulfill in the delivery of health care: (1) comprehensiveness, (2) cultural-sensitivity; and (3) gender-responsiveness.[382] LGUs have the duty to promulgate ordinances which fulfill these three requirements,[383] to wit —

> Section 17. Women's Right to Health. (a) Comprehensive Health Services. [ ] The State shall, at all times, provide for a comprehensive, culture-sensitive, and gender-responsive health services and programs covering all stages of a woman's life cycle and which addresses the major

374. The Responsible Parenthood and Reproductive Health Act of 2012, § 2.

375. *Id.*

376. *Id.* § 5.

377. *Id.*

378. *Id.* §§ 13 & 6.

379. *Id.* § 13.

380. The Responsible Parenthood and Reproductive Health Act of 2012, § 6.

381. *Id.* § 16.

382. Magna Carta of Women, § 17.

383. Rules and Regulations Implementing The Magna Carta of Women, Republic Act No. 9710, § 20 (6) (a) (2010).

> causes of women's mortality and morbidity: *Provided*, [t]hat in the provision for comprehensive health services, due respect shall be accorded to women's religious convictions, the rights of the spouses to found a family in accordance with their religious convictions, and the demands of responsible parenthood, and the right of women to protection from hazardous drugs, devices, interventions, and substances.[384]

Further, health programs affecting women should have the reduction of health risks faced by women, specifically pregnancy-related risks as their primary goal.[385]

The right of IP women to preserve and protect their cultural integrity is also recognized under the law, with a corresponding obligation on the part of the State to consult IPs in the adoption of any measure affecting the latter's rights.[386] On the other hand, the law also requires that the State must protect women "from the impact of cultural practices and norms that deny them of their full rights to health."[387]

3. The Indigenous Peoples Rights Act and Memorandum Circular No. 2013-01

The State is obliged to provide full access to maternal health services to indigenous women.[388] In developing health policies, the State must take into account the culture and traditions of IPs, which the State is required to "respect, recognize, and protect," thereby upholding their cultural integrity.[389] Further, IPs have the right to develop and protect their health practices.[390]

In 2013, the DOH, NCIP, and the DILG issued a Joint Memorandum Circular specifying guidelines for delivering health services to IPs. The circular acknowledged that inaccessibility of health care to IPs can be attributed to both geographical and socio-cultural factors.[391] To address this problem, the abovementioned government agencies made a policy declaration that health interventions should be implemented "in a manner that promotes the important rights of IPs to self-governance, empowerment and cultural integrity."[392] Health programs should give due consideration to the fact that IPs are located in GIDAs, with little to no means of

384. Magna Carta of Women, § 17.

385. *Id.*

386. Rules and Regulations Implementing The Magna Carta of Women, § 28.

387. *Id.* § 20.

388. The Indigenous Peoples' Rights Act of 1997, § 26.

389. *Id.* § 29.

390. *Id.* § 34.

391. DOH-NCIP-DILG Joint Memorandum Circular No. 2013-01, art. I, par. 3.

392. *Id.* art. II (2).

transportation and resources.[393] LGUs should therefore provide mobile clinics and culturally-sensitive birthing homes.[394]

Specifically, the guidelines require basic health services to be culturally-sensitive and traditional health practices to be integrated into the primary health care system.[395] Cultural-sensitivity of health care means that "policymakers and health workers acknowledge and respect cultural diversity among the populace."[396] It presupposes that health care providers should not see traditional and cultural beliefs and practices as an obstacle or barrier to health care.[397]

Health care providers are mandated to follow the L.E.A.R.N method of culture-sensitivity: "listening carefully to the ICCs/IPs perceptions; explain carefully the health service to be provided; accept the difference in perception if the explanation was not accepted; recommend; and negotiate for a mutually acceptable compromise."[398] IP health workers shall also be integrated to the health units of their respective LGUs with the aim of having a community-managed health care system.[399] Eligible IPs shall be trained to become Barangay Health Workers (BHWs) so that they can become part of public health teams.[400]

With respect to home births, the circular recognizes that home care is part of the traditions of IPs.[401] As part of the State's obligation to respect IP traditions, the circular directs that home practices be promoted, with the qualification that the home practices be "safe and beneficial."[402]

4. Maternal Health Care System in the Philippines

a. Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality

In 2008, the DOH issued an Administrative Order to fast-track the reduction of maternal deaths. The Administrative Order laid down the proposition that

393. *Id.* art. VII (E) (3).

394. *Id.* art. VII (C) (3).

395. *Id.* art. III.

396. *Id.* art. V (12).

397. DOH-NCIP-DILG Joint Memorandum Circular No. 2013-01, art. VI (2) (c).

398. *Id.* art. VII (B) (2) (5).

399. *Id.* art. VII (B) (2) (4).

400. *Id.*

401. *Id.* art. VII (G) (3).

402. *Id.*

the reduction of maternal mortality rates can only be achieved by giving importance to the two sides of the health care system: first is the demand side, which contemplates informed decision making and health seeking behavior by pregnant women who would use the services; and second is the supply side, which requires a health care system that is responsive to the needs of these women.[403] Informed decision making is hindered by poor awareness, lack of education, financial means, and geographic barriers; while responsiveness of the health care system is thwarted by insufficient provisions to answer for the health needs of recipients.[404]

b. Maternal, Newborn, and Child Health and Nutrition Manual of Operations

The guidelines provided in Administrative Order 2008-029 were updated in 2011 through the MNCHN MOP. Specific interventions to improve maternal health were specified in the strategy, including provisions for regular pre-natal checkups and the promotion of facility-based births attended by skilled birth attendants.[405] LGUs are required to adopt regulatory measures and legislations in furtherance of the goals of the MNCHN strategy, among which are the "promotion of facility-based deliveries and the prohibition of TBA-assisted deliveries."[406]

The promotion of facility-based births by the DOH was based on a shift in pregnancy management — from an approach of risk assessment to an approach that considers all pregnancies to be at risk.[407] According to the DOH, "the best intra-partum care strategy is likely to be one in which women routinely choose to deliver in health centers with midwives as the main providers but with other attendants working with them in a team."[408]

Three levels of care were established in the MNCHN's Service Delivery Network (SDN): first, the community-level health providers; second, BEmONC; and third, the comprehensive emergency obstetrics and newborn care (CEmONC).[409]

D. Reproductive Justice

Reproductive justice is the point of convergence between reproductive rights and reproductive health. This concept presupposes that the exercise of

403. A.O. No. 2008-0029, art. I.

404. *Id.*

405. *Id.* art. III.

406. MNCHN Strategy Manual of Operations, *supra* note 3, at 63.

407. *Id.*

408. *Id.* at 11.

409. *Id.* at 12.

one's reproductive rights is contingent on the fulfillment of the State's obligation to make such exercise possible; one is intrinsically codependent with the other.[410] The United Nations Human Rights Council asserted that "[t]he ability of women to survive pregnancy and childbirth is contingent upon their access to quality reproductive and maternal health care, freedom from social, cultural, economic and legal discrimination, and autonomy over decisions relating to their reproductive lives."[411] Thus, reproductive justice will be achieved "when women and girls have the economic, social[,] and political power and resources" to make healthy decisions about their bodies, sexuality and reproduction.[412]

Looking at reproductive health issues through the human rights lens is essential to the demandability of State obligations. An inherent danger exists in viewing reproductive self-determination purely in the context of liberty, privacy or autonomy as these negative rights only ensure freedom from interference by the State in one's reproductive choices, leaving out of the picture the State's positive duty of providing a legal and institutional environment where reproductive rights are effectively demandable and enforceable.[413] To illustrate, the exercise of one's reproductive autonomy imposes an obligation on the State to supply information on alternative health treatments, so that one can make an informed choice and refuse other alternatives, such as facility-based births.[414]

Despite the all-encompassing vision of reproductive justice, issues of pregnancy and childbirth receive little attention as compared to other issues, like abortion and family planning.[415] Literature and advocacy on birth justice, a facet of reproductive justice, are still on their early stages. The definition of the boundaries of birth justice continues to be evolving. A comprehensive and succinct definition of birth justice can be stated as including the following rights: the right to evidence-based maternity care,

410. DIXON-MUELLER, *supra* note 102.

411. Report of the Office of the U.N. High Commissioner for Human Rights, *supra* note 339, ¶ 23.

412. Diaz-Tello & Patrow, *supra* note 239, at 1 (citing Asian Communities for Reproductive Justice, A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights, and Reproductive Justice, *available at* https://web.archive.org/web/20150116214541/http://strongfamiliesmovement.org/assets/docs/ACRJ-A-New-Vision.pdf (last accessed Nov. 30, 2018) (website link accessible via Web Archive)).

413. Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1396 (2009).

414. Shalev, *supra* note 114, at 44.

415. Diaz-Tello & Patrow, *supra* note 239.

the right to accurate information about pregnancy, the risks and benefits of medical procedures, the right to choose whether or not to undergo these procedures, the right to competent and culturally-sensitive labor support, and the right to control birthing options free from fear, intimidation or interference from the State or due to poverty, race, ethnicity, or immigrant status.[416] The legal and political vision of birth justice is that "at no point during pregnancy does a woman lose her civil, constitutional, and human rights."[417] Birth justice supports pregnant women's right to reproductive self-determination, recognizing their ability to make intelligent and independent choices on their own health and respecting their dignity no matter what choice they made and regardless of the outcome.[418] The advocacy was a result of various policies, laws, and healthcare procedures adopting the adversarial model of pregnancy, where pregnant women are deprived of human rights and personhood for the sake of their unborn.[419]

Birth justice is also an intersectional issue. Studies show that majority of women who are subjected to coerced reproductive procedures are women of color, indigenous women, and those suffering from poverty.[420] Thus, in the Philippines, a closer scrutiny on how the home birth prohibition ordinances disproportionately affect marginalized groups is necessary.

Applying the birth justice framework, a healthcare system that provides a legal and institutional framework respecting reproductive rights must have the following characteristics:

(1) Comprehensive sex education must include information about pregnancy and childbirth;

(2) Access to reproductive healthcare must include access to evidence-based maternity care, vaginal birth after cesarean surgery, and out-of-hospital birth options;

(3) Women must have accurate, non-coercive informed consent for all reproductive health procedures;

(4) Intersectional issues on reproductive health must be analyzed by determining inequalities in access to health care and information, as discussed in Chapter II; and

416. *Id.* at 2.

417. *Id.*

418. *Id.* at 3.

419. *Id.* at 4.

420. *Id.* at 1.

(5) Abandonment of the adversarial model of pregnancy.[421]

E. Analysis

Maternal mortality is a human rights violation and is considered to be "one of the greatest social injustices of our times."[422] Under the 1987 Philippine Constitution and under international human rights documents to which the Philippines is a signatory, the State has the obligation to eradicate maternal mortality.[423] As a State obligation, the State is obliged to respect,[424] protect,[425] and fulfill[426] the right to health.[427] Further, the State is obliged to comply with standards set by international law: availability, accessibility, acceptability, and good quality.

While several laws and executive issuances have been promulgated to comply with the maternal health obligations of the State, these laws and issuances do not set forth the totality of the maternal health obligations of the State and the rights of pregnant women. Maternal health provisions were merely inserted as part of the RH Law, The Indigenous Peoples Rights Act, and The Magna Carta of Women. These laws have provisions on maternal health service delivery and resource allocation for maternal health. However, there are no provisions on reproductive rights in the context of pregnancy and maternal health; provisions of similar nature merely refer to reproductive health in general. Further, executive issuances aimed at reducing maternal mortality are merely directory. Thus, as the legal landscape now stands, Philippine laws do not comply with the standards set under international human rights documents.

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421. Diaz-Tello & Patrow, *supra* note 239, at 4.

422. Report of the Office of the U.N. High Commissioner for Human Rights, *supra* note 339, ¶ 7.

423. *Id.* ¶ 8.

424. The obligation to respect the right to health requires that the State must refrain from direct or indirect interference with the right, to abstain from prohibiting or hindering traditional health practices and medicines, and to abstain from applying coercive treatments. General Comment No. 14, *supra* note 156, ¶ 34.

425. The obligation to protect mandates that the State must take measures to prevent third parties from interfering with the right to health, to ensure that medical practitioners are well-educated, to ensure that women are not coerced to undergo patently harmful traditional practices, and to protect the vulnerable or marginalized groups in society. *Id.* ¶ 35.

426. The obligation to fulfill requires that the State must adopt appropriate governmental measures towards the fulfillment of the right to health, either by legislation or by way of appropriation from the national budget. *Id.* ¶ 36.

427. *Id.*

Consequently, local government units have unbridled discretion on the promulgation and implementation of maternal health measures. The ordinances to be discussed in the subsequent Chapters will show that the regulatory measures implemented by these local government units do not comply with the maternal health obligations of the State.

VI. THE POLICE POWER OF LOCAL GOVERNMENT UNITS

A. Nature of Police Power

One of the mechanisms by which the State fulfills its health obligations is through measures enacted in the exercise of police power.[428] Police power is considered as an inherent power of the State which gives the State the authority to regulate or "prohibit all things hurtful to the comfort, safety[,] and welfare of society."[429] By this definition, police power encompasses a broad range of subjects which are considered of public necessity, such as public health, public morals, and public safety.[430]

B. The General Welfare Clause

The national government, through the legislature, is the entity endowed with police power.[431] However, police power is also delegated to the LGUs.[432] The statutory basis of this delegation is Section 16 of Republic Act No. 7160, otherwise known as the Local Government Code of 1991,[433] is as follows —

> Section 16. *General Welfare*. — Every local government unit shall exercise the powers expressly granted, those necessarily implied therefrom, as well as powers necessary, appropriate, or incidental for its efficient and effective governance, and those which are essential to the promotion of the general welfare. Within their respective territorial jurisdictions, local government units shall ensure and support, among other things, the preservation and

428. BERNAS, *supra* note 229, at 102.

429. Rubi v. Provincial Board of Mindoro, 39 Phil. 660, 708 (1919) (citing Town of Lake View v. Rose Hill Cemetery Co. 70 Ill. 191, 194 (Ill. 1873) (U.S.)).

430. BERNAS, *supra* note 229, at 102.

431. United States v. Toribio, 15 Phil. 85, 93 (1910) (citing Commonwealth v. Alger, 7 Cush. 53, 85 (Mass. 1851) (U.S.)).

432. Land Transportation Office v. City of Butuan 322 SCRA 805, 816 (2000). The Court stated that "[p]olice power and taxation, along with eminent domain, are inherent powers of sovereignty which the State might share with local government units by delegation given under a constitutional or a statutory fiat." *Id.*

433. An Act Providing for a Local Government Code of 1991 [LOCAL GOV'T CODE], Republic Act No. 7160 (1991).

> enrichment of culture, promote health and safety, enhance the right of the people to a balanced ecology, encourage and support the development of appropriate and self-reliant scientific and technological capabilities, improve public morals, enhance economic prosperity and social justice, promote full employment among their residents, maintain peace and order, and preserve the comfort and convenience of their inhabitants.[434]

The devolution of health services accompanying the enactment of the Local Government Code transferred the management and delivery of health services from the national agencies to the LGUs. Thus, at present, the duty of respecting, protecting, and fulfilling the right to health is primarily vested on the LGUs.

C. Limits to the Exercise of Police Power

1. Due Process

As an overarching requirement, LGUs are considered as having validly exercised police power if the following requisites are present:

> (1) [T]he interests of the public generally, as distinguished from those of a particular class, require the interference of the State, and (2) the means employed are reasonably necessary for the attainment of the object sought to be accomplished and not unduly oppressive upon individuals. Otherwise stated, there must be a concurrence of a lawful subject and lawful method.[435]

The first requisite refers to the equal protection guarantee under the Constitution, while the second refers to the constitutional requirement of due process.[436]

The constitutional right to due process is enshrined in Section 1, Article III of the Constitution, which provides that "[n]o person shall be deprived of life, liberty[,] or property without due process of law, nor shall any person be denied the equal protection of the laws."[437] The right to due process has no precise definition, but its purpose is clear — that of preventing arbitrary government encroachment on the life, liberty, and property of individuals.[438]

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434. LOCAL GOV'T CODE, § 16.

435. Lucena Grand Central Terminal, Inc. v. JAC Liner, Inc., 452 SCRA 174, 185 (2005) (citing Department of Education, Culture and Sports v. San Diego, 180 SCRA 533, 537 (1989)) (emphases omitted).

436. Parayno v. Jovellanos, 495 SCRA 85, 93 (2006) (citing *Lucena Grand Terminal, Inc.*, 452 SCRA at 185).

437. PHIL. CONST. art. III, § 1.

438. White Light Corporation v. City of Manila, 576 SCRA 416, 435 (2009).

Two separate but related limits are imposed on government action — procedural due process and substantive due process.[439] Procedural due process requires that the proper procedure be followed before a person can be deprived of his life, liberty, or property, such as notice and hearing.[440] On the other hand, substantive due process inquires into the justification for the government's intrusion into private rights and the adequacy of the reason for such interference.[441]

The level of government intrusion permissible in a certain case depends on the level of scrutiny to be employed by the courts. In case of infringement of fundamental rights — such as the right to liberty,[442] privacy,[443] religious freedom,[444] and due process[445] — Philippine courts apply the strict scrutiny test, a test formerly used in equal protection challenges but has expanded to legislations regulating fundamental rights.[446] The strict scrutiny test is the most exhaustive of the three tests employed in testing the validity and constitutionality of State actions; the other two being the rational basis test and the immediate scrutiny test.[447]

In strict scrutiny, the presence of a compelling state interest coupled with the least intrusive means for achieving such interest are prerequisites for the validity of a law or ordinance.[448] Thus, LGUs have the burden to show that there are no other means that are less intrusive of private rights that can achieve the end sought to be attained and that there is a reasonable relation

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439. *Id.*

440. *Id.* (citing Lopez v. Director of Lands, 47 Phil. 23, 32 (1924)).

441. City of Manila v. Laguio, Jr., 455 SCRA 308, 331 (2005) (citing ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 523-24 (2d ed., 2002)).

442. *See White Light Corporation*, 576 SCRA at 438 & *Laguio, Jr.*, 455 SCRA at 336.

443. *See* Ople v. Torres, 293 SCRA 141, 158 (1998).

444. *See Escritor*, 492 SCRA 1, 63 (2006).

445. *See* Government of Hong Kong Special Administrative Region v. Olalia, Jr., 521 SCRA 470, 482 (2007).

446. *White Light Corporation*, 576 SCRA at 437 (citing Estrada v. Sandiganbayan, 369 SCRA 394, 463 (2001) (J. Mendoza, concurring opinion)).

447. *White Light Corporation*, 576 SCRA at 436. The rational basis test is used for reviewing economic legislation, while the immediate scrutiny test is used for evaluating distinctions made on the basis of gender or legitimacy. *Id.* (citing Craig v. Boren, 429 U.S. 190, 204 (1976) & Clark v. Jeter, 486 U.S. 456, 461-62 (1988)).

448. *White Light Corporation*, 576 SCRA at 437.

between the purpose of the police measure and the means employed.[449] The requirement of reasonableness means that rights can be affected "only to the extent that may fairly be required by the legitimate demands of public interest or public welfare."[450] In essence, substantive due process requires that the law must be "fair, reasonable, and just."[451]

Jurisprudence sets more specific requirements for ordinances enacted by LGUs to be valid. It provides that

> for an ordinance to be valid, it must not only be within the corporate powers of the local government unit to enact and must be passed according to procedure prescribed by law, it must also conform to the following substantive requirements: (1) must not contravene the Constitution or any statute; (2) must not be unfair or oppressive; (3) must not be partial or discriminatory; (4) must not prohibit but may regulate trade; (5) must be general and consistent with public policy; and (6) must not be unreasonable.[452]

Despite a legitimate purpose, such as public health, an ordinance may be declared invalid and unconstitutional if it is unreasonable or oppressive because of the means adopted to attain the valid purpose. An ordinance is considered unreasonable if the means used for attaining the purpose sought go beyond what is reasonably necessary and oppressive if the ordinance subjects individuals to fees or charges, or amounts to a deprivation of property.[453]

Further, the ordinance must not contravene the Constitution,[454] any existing law,[455] or go against public policy.[456] Hence, the principles discussed under the previous Chapters regarding the reproductive rights of

449. *Laguio, Jr.*, 455 SCRA at 332 (citing Balacuit v. Court of First Instance of Agusan del Norte, 163 SCRA 182, 191-93 (1988)).

450. *White Light Corporation*, 576 SCRA at 443.

451. Corona v. United Harbor Pilots, 283 SCRA 31, 39-40 (1997) (citing HECTOR S. DE LEON, TEXTBOOK ON THE PHILIPPINE CONSTITUTION 81 (1991 ed.)).

452. *Laguio, Jr.*, 455 SCRA at 326 (citing Tatel v. Municipality of Virac, 207 SCRA 157, 161 (1992); Solicitor General v. Metropolitan Manila Authority, 204 SCRA 837, 845 (1991); & Magtajas v. Pryce Properties Corp., Inc., 234 SCRA 255, 268-69 (1994)).

453. Rogelio E. Subong, Annotation, *Overbreadth: Unreasonable Ordinances*, 452 SCRA 193, 223 (2005).

454. *Laguio, Jr.*, 455 SCRA at 326 (citing *Tatel*, 207 SCRA at 161; *Solicitor General*, 204 SCRA at 845; & *Magtajas*, 234 SCRA at 268).

455. *Id.*

456. *Laguio, Jr.*, 455 SCRA at 326 (citing *Tatel*, 207 SCRA at 161; *Solicitor General*, 204 SCRA at 845; & *Magtajas*, 234 SCRA at 269).

women and the State's legal obligation to respect, protect, and fulfill the right to health can be considered as limitations which the police power measure must align with.

2. Reasonableness Requirement and the Overbreadth Doctrine in Police Power Cases

Reasonableness is considered to be the more preferred ground for striking down ordinances as invalid and unconstitutional. The jurisprudential requirement of reasonableness can pertain to several aspects of a legislative measure — the *means* used vis-à-vis the purpose of the police measure[457] and the *legal effects* of the ordinance upon the individuals affected by it.[458]

The Supreme Court encapsulated the requirement under the term "overbreadth" — a test mostly used in free speech cases but has extended to matters infringing fundamental rights.[459] A law or ordinance is said to be suffering from overbreadth if the means used to attain a purpose, no matter how legitimate, "go beyond what is reasonably necessary,"[460] amounting to a disregard of constitutional rights and human rights and an arbitrary intrusion into the private sphere of individuals' lives.[461]

The doctrine of overbreadth is often applied by courts in cases involving measures prohibiting, as compared to regulating, certain actions or establishments which would otherwise be protected under the Constitution.[462] In such cases, the Supreme Court has ruled that the

457. *See, e.g.*, *Laguio, Jr.*, 455 SCRA 308. The Supreme Court struck down as unconstitutional an ordinance of the City of Manila prohibiting the operation of certain establishments providing amusement and entertainment services. *Laguio, Jr.*, 455 SCRA at 333.

458. *See, e.g.*, *Lucena Grand Terminal, Inc.*, 452 SCRA at 188. The Supreme Court struck down as unconstitutional an ordinance of Lucena City which prohibited the operation of bus and jeepney terminals outside the city for being oppressive. *Lucena Grand Terminal, Inc.*, 452 SCRA at 188.

459. *Imbong*, 721 SCRA at 282 (citing Romualdez v. Commission on Elections, 573 SCRA 639, 645 (2008)); *White Light Corporation*, 576 SCRA at 432 (citing Chavez v. Commission on Elections, 437 SCRA 415, 425 (2004) & Adiong v. Commission on Elections, 207 SCRA 712, 719-20 (1992)); & *Romualdez*, 573 SCRA at 645.

460. Subong, *supra* note 453, at 223.

461. *Id.*

462. *See, e.g.*, De la Cruz v. Paras, 123 SCRA 569 (1983); *Laguio, Jr.*, 455 SCRA 308 (2005); *White Light Corporation*, 576 SCRA 416; & Lupangco v. Court of Appeals, 160 SCRA 848 (1988).

De la Cruz involved the constitutionality of an ordinance of the municipality of Bocaue which prohibited the operation of cabarets and night clubs in the

prohibitive measures constitute a "sweeping exercise"[463] of police power and do not satisfy the reasonableness requirement.[464]

As with prohibition, compulsory measures which infringe on constitutionally guaranteed rights are also frowned upon by courts. In *Imbong v. Ochoa, Jr.*,[465] the petitioners assailed provisions in the RH Law and its implementing rules and regulations requiring health facilities and health care providers to disseminate information on reproductive health services and programs and, in case of conscientious objection, to refer these patients to other health care providers within the same facility or another equally accessible provider even in non-emergency cases.[466]

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municipality with the aim of promoting public morals. The Supreme Court held that the "sweeping exercise" of police power by the municipality does not satisfy the reasonableness requirement and is suffering from overbreadth. Reasonable restrictions, rather than a prohibition, on the operation of cabarets and night clubs would have saved the ordinance from constitutional infirmity. *De la Cruz*, 123 SCRA at 578.

In *Laguio, Jr.*, the Supreme Court struck down as unconstitutional a City of Manila ordinance which prohibited the operation of certain establishments providing amusement and entertainment services. The Court used the constitutional guarantee to due process of law as a limitation to the police power of the city, holding that private rights can be affected "only to the extent that may fairly be required by the legitimate demands of public interest or public welfare" using the least intrusive of means. *Laguio, Jr.*, 455 SCRA at 331 (citing Homeowners' Asso. of the Phils., Inc. v. Municipal Board of the City of Manila, 24 SCRA 856, 861 (1968)).

In *White Light Corporation*, the Supreme Court struck down as unconstitutional an ordinance of the City of Manila which prohibited short-time and wash rate admission in lodging establishments. The Court noted that less intrusive measures, such as strict enforcement of laws on prostitution and drug trafficking, can achieve the end sought to be attained. Equating the operation of lawful businesses with the proliferation of immoral and illicit acts constitutes an arbitrary exercise of police power. *White Light Corporation*, 576 SCRA at 443.

In *Lucena Grand Terminal, Inc.*, the Supreme Court struck down as unconstitutional an ordinance of Lucena City which prohibited the operation of bus and jeepney terminals outside the city. *Lucena Grand Terminal, Inc.*, 452 SCRA at 188.

In *Lupangco*, the Supreme Court struck down as unconstitutional a resolution issued by the Professional Regulation Commission prohibiting examinees from reviewing days before the licensure examinations. *Lupangco*, 848 SCRA at 860.

463. De la Cruz v. Paras, 123 SCRA at 578.

464. *Id.*

465. Imbong v. Ochoa, Jr., 721 SCRA 146 (2014).

466. *Id.* at 320.

The Court ruled that such provisions are unconstitutional for unjustifiably infringing the right to religious freedom.[467] The Court held that between the interest of the State to provide access to reproductive health and the right to religious freedom of conscientious objectors, the latter must prevail.[468] The State failed to show that there are no less intrusive means to achieve the objective of improving accessibility of reproductive services and information.[469] The Solicitor General argued that the reduction of maternal deaths constitutes a compelling interest, which justifies the compulsory referral provision.[470] However, the Court noted that the maternal mortality rate even decreased from 1990 to 2008, a time when RH Law was not yet enacted.[471] Even assuming that the maternal mortality rate continues to increase, the Court held that the problem of maternal deaths cannot be solved by blind conformity to such legislative measure.[472] The Court maintained a strong stance against compulsion which results in infringement of fundamental freedoms, holding that "a person who is forced to perform an act in utter reluctance deserves the protection of the Court as the last vanguard of constitutional freedoms."[473]

In all of the abovementioned cases, the unreasonableness of laws or ordinances was used by the Supreme Court as a legal basis for declaring such laws or ordinances unconstitutional. However, the requirement of a reasonable relationship between the means used vis-à-vis the purpose of the legislative measure cannot be found anywhere in the Constitution. Some legal writers have speculated on the relationship between constitutionality and reasonableness as a jurisprudential requisite.[474] Then again, the cases discussed above show that the reasonableness requirement, as encapsulated in the overbreadth doctrine, is part and parcel of substantive due process. Necessarily, an ordinance which suffers from overbreadth must be deemed to have violated the constitutional guarantee to substantive due process, and is therefore unconstitutional.

3. Religious Freedom

Police power measures must likewise take into consideration the religious beliefs of those to be affected by the ordinances. The Supreme Court has

467. *Id.* at 335.

468. *Id.* at 336.

469. *Id.* at 342 (citing *Escritor*, 492 SCRA 1, 33 (2006)).

470. *Imbong*, 721 SCRA at 344.

471. *Id.* at 345.

472. *Id.*

473. *Id.* at 342.

474. *See* Subong, *supra* note 453, at 223.

ruled that in case of conflict between the free exercise clause and the State, the Court adheres to the doctrine of benevolent neutrality. In *Estrada v. Escritor*, [475] the Supreme Court held that "benevolent neutrality-accommodation, whether mandatory or permissive, is the spirit, intent[,] and framework underlying the Philippine Constitution."[476] In case of a facially neutral law, the application of the benevolent neutrality doctrine would not necessarily result in the pronouncement that the law is unconstitutional; an "exemption from its application or its burdensome effect" would be the legal consequence.[477]

If the exercise of religious freedom through conduct is burdened by government legislation or practice, the *strict scrutiny-compelling state interest test from a benevolent neutrality stance* finds application.[478] Not every interest of the State suffices to overcome religious freedom.[479] As cited in *Escritor*, "only the gravest abuses, endangering paramount interests, give occasion for permissible limitation."[480] Thus, the State must show the presence of a compelling state interest coupled with evidence that "no less restrictive alternative exists, and that a religious exemption would impair the State's ability to effectuate its compelling interest."[481]

4. Protection of Human Rights

Specific limits to the police power of the State are also provided in human rights documents to which the Philippines is a signatory. Article 4 of the ICESCR[482] provides that the State can only limit the rights therein insofar as the limitation is "compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society."[483] Further, General Comment No. 14 of the ICESCR Committee clarifies that

475. Estrada v. Escritor, 492 SCRA 1, 79 (2006).

476. *Id.* at 66 (citing Estrada v. Escritor, 408 SCRA 1, 158 & 169 (2003)). The Court explained the concepts of mandatory and permissive accommodation — "Mandatory accommodation results when the Court finds that accommodation is *required* by the Free Exercise Clause, i.e., when the Court itself carves out an exemption ... In permissive accommodation, the Court finds that the State may, but is not required to, accommodate religious interests." *Escritor*, 492 SCRA at 61 (emphasis omitted).

477. *Id.* at 42 (citing *Escritor*, 408 SCRA at 85).

478. *Escritor*, 492 SCRA at 62.

479. *Id.* at 44 (citing Sherbert v. Verner, 374 U.S. 398, 406 (1963)).

480. *Id.*

481. *Escritor*, 492 SCRA at 45.

482. ICESCR, *supra* note 155, art. 4.

483. *Id.*

the restrictions imposed by the State must be in accordance with law and strictly necessary to promote the general welfare.[484] The ICESCR Committee recognized that States sometimes use the goals of public health, national security or public order to limit the exercise of the rights expressed in the Covenant. However, the Committee clarified the scope of Article 4, which provides that "the Covenant's limitation clause, Article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitation by States"[485] — reiterating the primacy of protecting human rights over legitimizing exceedingly intrusive legislative measures. In other words, protection of human rights must be the general rule, and their infringement, no matter how justified, must be the exception.

The concept of proportionality is also a requirement for valid state action encroaching on rights recognized under the ICESCR.[486] Proportionality means that "the least restrictive alternative must be adopted where several types of limitation are available. Even when such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review."[487]

With respect to indigenous peoples, the UNDRIP provides that the rights of indigenous peoples recognized under the Declaration can only be limited insofar as the limitation is consistent with the State's human rights obligations, are not discriminatory, and are strictly necessary to protect and respect the rights of others.[488]

VII. REGULATION OF HOME BIRTHS

A. Birth Models

At present, there are four basic models for implementing maternal care depending on (1) the birth attendant and (2) the place of delivery: first, childbirth at home assisted by a Traditional Birth Attendant (TBA); second, childbirth at home assisted by a skilled birth attendant, including registered midwives and/or physicians; third, childbirth at a basic health facility (BEmONC) with the assistance of a skilled birth attendant; and fourth,

484. ICESCR General Comment No. 14, *supra* note 156.

485. *Id.*

486. ICESCR, *supra* note 155, art. 5 (1).

487. ICESCR General Comment No. 14, *supra* note 156, ¶ 29.

488. United Nations Declaration on the Rights of Indigenous Peoples, *supra* note 355, art. 46 (2).

childbirth at a hospital (CEmONC) assisted by a skilled birth attendant.[489] The ordinances prohibiting home births aim to exclusively implement the third and fourth models. However, in as early as 1996, the World Health Organization has recognized that models integrating home births provide a safe alternative for low-risk pregnancies —

> So where then should a woman give birth? It is safe to say that a woman should give birth in a place she feels is safe, and at the most peripheral level at which appropriate care is feasible and safe (FIGO 1992). For a low-risk pregnant woman, this can be at home, at a small maternity clinic or birth [center] in town or perhaps at the maternity unit of a larger hospital. However, *it must be a place where all the attention and care are focused on her needs and safety, as close to home and her own culture as possible*. If birth does take place at home or in a small peripheral birth [center], contingency plans for access to a properly-staffed referral [center] should form part of the antenatal preparations.[490]

The recognition of the safety of home births opened up avenues for making home births part of the healthcare and legal systems of other jurisdictions. Different countries have varying regulations on home births. However, it appears that no other country expressly prohibits home birth other than the Philippines. Developed countries, in particular, have issued regulations that are in alignment with the position of the World Health Organization.[491]

For instance, in 2014, 16 States in the European Union[492] allowed home births and home births are covered by national insurance under certain conditions, such as in uncomplicated births.[493] In the other 16 states,[494]

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489. M.A. Koblinksy, et al., *Organizing Delivery Care: What Works for Safe Motherhood?*, 77 BULLETIN OF THE WORLD HEALTH ORGANIZATION 399, 400 (1999).

490. World Health Organization, *supra* note 29, at 12 (emphasis supplied).

491. Suzan Ulrich & Tonya B. Nicholson, *Home Birth: Evidence and Controversy*, *in* BEST PRACTICES IN MIDWIFERY: USING THE EVIDENCE TO IMPLEMENT CHANGE 70 (Barbara Alice Anderson & Susan E. Stone, eds., 2013).

492. *Dubská and Krejzová*, Application Nos. 28859/11 & 28473/12, ¶ 60 (subsequently referred to and decided by the Grand Chamber). These include Austria, Belgium, France, Germany, Greece, Hungary, Italy, Latvia, Luxembourg, the Netherlands, Poland, Ireland, Sweden, Switzerland, and the United Kingdom. *Id.*

493. *Id.*

494. *Id.* ¶ 61. These include Albania, Bosnia and Herzegovina, Croatia, Estonia, Finland, Lithuania, Montenegro, Romania, Russia, Slovenia, Spain, Turkey, and Ukraine. *Id.*

home births are not expressly regulated by law.[495] Hungary used to have a law prohibiting home births but the law was amended in 1997 to the effect that home births shall only be regulated, but not prohibited. [496] The amendment was due to the recognition of pregnant women's right to reproductive self-determination.[497] In the United States, home birth is not illegal in any state and attendance of a physician is not legally required.[498] However, state laws in some states, like Nebraska and Alabama, forbid midwives from attending home births; unassisted home births or home births assisted by non-midwives are not prohibited.[499]

B. Philippine Ordinances Prohibiting Home Births Enacted in the Exercise of Police Power

The ordinances from the Philippines, that are the subject of this Note, were enacted in the exercise of police power, with the goal of reducing maternal mortality associated with lack of skilled birth attendance and absence of medical equipment.

The ordinances impose different penalties on different persons. These ordinances can be categorized into four groups: (1) ordinances which absolutely prohibit home births and which impose penalties on the pregnant woman who gave birth at home, her relatives, and the traditional or skilled birth attendant who assisted her with her child birth (Category A);[500] (2)

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495. *Id.*

496. *Ternovszky*, Application No. 67545/09, ¶ 17.

497. *Id.* ¶ 26.

498. *See* Midwives Alliance of North America, Midwife Laws State by State, *available at* http://mana.org/about-midwives/state-by-state (last accessed Nov. 30, 2018) (follow the link corresponding to each State mentioned herein).

499. *Id.*

500. The ordinances of the following cities and municipalities fall under this category: Magallanes (Sorsogon), Quezon City, Catbalogan (Samar), Pola (Oriental Mindoro), Tacurong (Sultan Kudarat), Pres. Carlos P. Garcia (Bohol), Naujan (Oriental Mindoro), Roxas (Oriental Mindoro), Iloilo City, Dasmariñas (Cavite), and Kananga (Leyte).

Municipal Birth Attendance and Safe Motherhood and Child Health Care Ordinance of 2011, §§ 7 & 13; Quezon City Ordinance No. 2171-2012, §§ 2 & 6; Maternal and Child Health Code of the City of Catbalogan, § 6, 12, & 13); Pola Homebirth Prohibition Ordinance, §§ 3 (a); & 9; City Ordinance of Facility-Based Deliveries of All Pregnant Women of the City of Tacurong, §§ 7, 8, & 10; Pres. Carlos P. Garcia Municipal Ordinance No. 12-233, §§ 37 & 38; Naujan Comprehensive Child Delivery Ordinance of 2014, §§ 5, 10, &11; Roxas Homebirth Prohibition Ordinance, § 9; Iloilo City Ordinance No.

ordinances which impose penalties on the same set of persons mentioned above but provide exceptions for emergency cases and for women living in far-flung areas (Category B);[501] (3) ordinances which penalize the skilled or traditional birth attendant but provide exceptions for emergency cases and for women living in far-flung areas (Category C);[502] and (4) ordinances which absolutely prohibit home births and impose penalties on traditional birth attendants (Category D).[503] Nevertheless, all these ordinances contain a provision that pregnant women are required to give birth at health facilities and are prohibited from giving birth at home.

The ordinances do not mention and consider the choice of the pregnant woman on the place of childbirth, nor any pregnancy-related risks and conditions. Most ordinances impose fees for delivering in a health facility, as LGUs are authorized to do so under the MNCHN MOP strategy.[504] PhilHealth membership or coverage by the national health insurance fund is also not a consideration in requiring facility-based births; pregnant women are required to give birth in a health facility regardless of whether they are covered by PhilHealth and regardless of whether the facility is PhilHealth-accredited.

The police power of the State is also used as a justification to regulate the practice of professions — particularly the health profession.[505] Regulatory measures are enacted with the goal of protecting patients or clients from incompetency of prospective professionals and as a shield against

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2015-163, §§ 5 & 7; An Ordinance on Maternal and Child Health Code of the Municipality of Kananga, Leyte, §§ 13 & 14.

501. The ordinances of the following cities and municipalities fall under this category: Marikina City, Bacolod City, Socorro (Oriental Mindoro), Oton (Iloilo), Socorro (Oriental Mindoro), and Plaridel (Misamis Occidental).

Marikina City Ordinance No. 031-2012, § 4; Bacolod Homebirth Regulation Ordinance, §§ 5 & 6 (Sep. 5, 2012); Oton Municipal Ordinance No. 2012-244, §§ 3 & 9; Socorro Municipal Ordinance No. 12-2012, §§ 4 & 5; Plaridel Municipal Ordinance No. 10-2014, § 9 (Apr. 7, 2014).

502. The ordinance of Dingle (Iloilo) falls under this category.

Iloilo Municipal Ordinance No. 2011-004, §§ 2, 3, 4, & 9.

503. The ordinances of Clarin (Bohol) and Cagayan de Oro city fall under this category. Clarin Safe Motherhood Ordinance, §§ 3 & 9 & Safe Motherhood Ordinance of Cagayan de Oro, §§ 3 (a); 3 (c); & 5.

504. MNCHN Strategy Manual of Operations, *supra* note 3, ch. 7.2.3 (2) (b).

505. *See Ventura*, 4 SCRA 208 (where the Court convicted a doctor for practicing "drugless" healing to his patients).

fraud.[506] With regard to maternal health, the State has exercised its police power to regulate who may assist pregnant women with childbirth.

Midwifery practice was one of the earliest professions to be regulated in the country. In 1901, the Board of Medical Examiners was formed by virtue of Act No. 310.[507] The Board of Medical Examiners was then the regulatory body for both the practice of medicine and of midwifery.[508] When the Medical Act of 1959 was enacted, the regulation of the practice of medicine was separated from that of midwifery, thereby recognizing midwifery as a separate and distinct profession.[509] A year after, Republic Act No. 2644 entitled, An Act Regulating Midwifery Training and Practice [510] was enacted. Midwifery practice was regulated through administering examinations and issuing certificates of registration.[511]

Despite the regulatory provisions in Republic Act No. 2644, TBAs who were unlicensed as midwives were allowed under the law to continue assisting with childbirths.[512] Section 28 of the Act, which sets out the prohibition against unlicensed midwifery practice, contained a proviso that TBAs registered with the Department of Health as having undergone midwifery training and TBAs in localities where there were no available physicians or midwives and who have safely handled at least 20 child deliveries may continue practicing their trade.[513] This proviso was deleted in Republic Act No. 7392, otherwise known as the Philippine Midwifery Act of 1992.[514] Republic Act No. 7392 expanded the definition of the practice of midwifery, [515] while retaining the prohibition against unlicensed

506. *Ventura*, 4 SCRA at 213.

507. *See, e.g.*, An Act Regulating the Practice of Medicine and Surgery in the Philippine Islands, Act No. 310, § 1 (1901).

508. World Health Organization, Philippine Nursing and Midwifery Data Bank, at 10, *available at* http://www.wpro.who.int/hrh/about/nursing_midwifery/db_philippines_2013.pdf?ua=1 (last accessed Nov. 30, 2018).

509. *Id.* at 11.

510. An Act Regulating Midwifery Training and Practice [Philippine Midwifery Law], Republic Act No. 2644 (1960) (repealed).

511. *Id.* art. III, §§ 11 & 12.

512. *Id.* § 28.

513. *Id.*

514. An Act Revising Republic Act No. 2644, as Amended, Otherwise Known as the Philippine Midwifery Act [Philippine Midwifery Act of 1992], Republic Act No. 7392 (1992).

515. Section 23 of the Philippine Midwifery Act of 1992 provides —

> The practice of midwifery consist in performing or rendering, or offering to perform or render, for a fee, salary, or other reward or

midwifery practice; this time, without the exception provided to TBAs in the old law.[516]

Notwithstanding the enactment and effectivity of the Philippine Midwifery Act of 1992, then Secretary of Health Juan Flavier issued a Department Circular in 1994 which allowed trained TBAs to attend normal

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> compensation, services requiring an understanding of the principles and application of procedures and techniques in the supervision and care of women during pregnancy, labor and puerperium management of normal deliveries, including the performance of internal examination during labor except when patient is with antenatal bleeding; health education of the patient, family and community; primary health care services in the community, including nutrition and family planning in carrying out the written order of physicians with regard to antenatal, intra-natal and post-natal care of the normal pregnant mother in giving immunization, including oral and parenteral dispensing of oxytocic drug after delivery of placenta, suturing perenial lacerations to control bleeding, to give intravenous fluid during obstetrical emergencies provided they have been trained for that purpose; and may inject Vitamin K to the newborn: *Provided, however*, That this provision shall not apply to students in midwifery schools who perform midwifery service under the supervision of their instructors, nor to emergency cases.

Id. § 23.

516. Section 27 of the Philippine Midwifery Act of 1992 provides —

> Any person who shall practice midwifery in the Philippines within the meaning of this Act without a certificate of registration issued in accordance herewith, or any person presenting or using as his/her own certificate of registration of another, or any person giving any false or forged evidence to the Professional Regulation Commission in order to secure a certificate of registration, or any person using a revoked or suspended certificate of registration or any person assuming, using[,] or advertising, as a registered midwife or a registered nurse-midwife or appending to his/her name the letters "R.M." without having been conferred such title by the Professional Regulation Commission or advertising any title description tending to convey the impression that he/she is a registered midwife, shall be guilty of misdemeanor and shall, upon conviction, be sentenced to a fine of not less than [₱10,000.00] nor more than [₱30,000.00], or to suffer imprisonment for a period of not less than two [ ] years nor more than seven [ ] years, or both such fine and imprisonment at the discretion of the court.
>
> The aforementioned penalty shall likewise be imposed upon any person found guilty of violation of any rule and regulation issued pursuant to the provisions of this Act.

Id. § 27.

home deliveries, particularly in areas lacking health professionals.[517] The Circular made express reference to the Philippine Midwifery Act while mandating that government entities take part in training TBAs.[518] The Circular recognized that most mothers prefer to be assisted by TBAs because the latter are more responsive to their cultural and spiritual needs, more caring, and are more readily available than skilled birth attendants.[519] At the same time, the lack of midwives in the country, especially in rural and isolated areas, necessitated the utilization of TBAs in the primary health care system to meet the unserved needs of pregnant women.[520]

By virtue of the Circular, more intensive government programs towards training TBAs were carried out by the Department of Health. Government efforts to train TBAs have put TBAs on a shaky and indefinite legal status. While there exists an express prohibition against unlicensed midwifery practice under the Philippine Midwifery Act of 1992, the Department of Health continued utilizing the services of TBAs to reach far flung places inaccessible to health care professionals.

Under Administrative Order 2008-029, TBAs are considered as "volunteer health workers," [521] which comprise the community level providers, alongside other health professionals.[522] TBAs are made part of the Women's Health Team in charge of recording pregnancies within the LGU's jurisdiction, helping pregnant women formulate a birth plan, and referring pregnant women to health facilities in case of high-risk pregnancies.[523] To facilitate the shift from home births to facility-based births, LGUs are encouraged to provide incentives to TBAs whenever the latter refer pregnant women to health facilities for childbirth.[524] Educational assistance may also be provided to TBAs to enable them to be licensed as midwives.[525] The same role was retained in the MNCHN MOP issued in 2011.[526]

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517. Department of Health, Allowing Trained Hilots to Attend Normal Home Deliveries Especially in Areas Where Services of the Registered Midwife or Licensed Trained Health Personnel is Not Available at all Times, Department Circular No. 69-A, Series of 1994 [Dept. Circ. No. 69-A, s. 1994] (Apr. 22, 1994).

518. *Id.* para. 4.

519. *Id.* para. 2.

520. *Id.* para. 4.

521. A.O. No. 2008-0029, part V, ¶ 2.

522. *Id.*

523. *Id.*

524. *Id.* part VIII, ¶ 8.

525. *Id.*

526. MNCHN Strategy Manual of Operations, supra note 3, ch. 5.1.1., para. 3 (1).

From the foregoing, it appears that the Department of Health has shifted the role of TBAs from being childbirth attendants to being advocates for facility-based births and liaisons between the community and the government health team. However, studies show that the emphasis on childbirths assisted by SBAs would only reduce maternal mortality if governments prioritize the training and deployment of these SBAs.[527] Where SBAs are not mobilized into rural areas, there was either no change in the maternal health situation or the situation worsened; individuals located in rural areas have no access to these SBAs, and with the policy change, also have no access to TBAs.[528]

A move to address the scarcity of midwives in the country, mainly caused by the concentration of midwives in urban areas and by the brain drain phenomenon, seeks to utilize a form of task shifting through the training of Barangay Health Workers (BHWs). BHWs are community-level health workers who provide primary health care services in their communities after undergoing training in any accredited government or non-government organization.[529] BHWs are accredited by the local health board in accordance with guidelines issued by the Department of Health.[530]

BHWs are considered to be at the frontline of primary health care in the community level. However, their roles are not clearly delineated under Republic Act No. 7883 nor at the MNCHN MOP. There are over one million BHWs in the country, which represents an untapped human resource.[531] A bill filed in Congress[532] seeks to train BHWs to become midwives through an 18-month program followed by mandatory community work for six months.[533]

A bill was also filed to train tribal health workers to address system gaps in the current BHW program.[534] Many tribal communities are not served by

527. Tami Rowen, et al., *Evaluation of a Traditional Birth Attendant Training Programme in Bangladesh*, 27 MIDWIFERY 229, 230 (2011).

528. *Id.*

529. An Act Granting Benefits and Incentives to Accredit Barangay Health Workers and for Other Purposes [Barangay Health Workers' Benefits and Incentives Act of 1995], Republic Act No. 7883, § 3 (1995).

530. *Id.*

531. An Act Creating the Barangay Health Worker Education and Training Program, Appropriating Funds Therefor and for Other Purposes, H.B. No. 514., explan. n., para. 4, 15th Cong., 1st Reg. Sess. (2010).

532. H.B. No. 514.

533. *Id.* explan. n. paras. 7-8.

534. An Act Strengthening the Healthcare System in Cultural and Indigenous Communities by Institutionalizing the Training and Employment of Tribal

BHWs, especially during the night, holidays, and on weekends.[535] The isolated ancestral domains of IPs make delivery of health services far harder than in urban areas.[536] The bill seeks to establish tribal health workers as the primary health care providers in their respective IP communities.[537] Tribal health workers shall undergo the same training as BHWs, with the added qualification that they must be members of the IP community where they will be rendering their services.[538]

VIII. ANALYSIS

> *[A]ng may-katawan na daraan sa paglilihi, pagbubuntis[,] at maaaring ikapeligro ng sariling buhay ay nararapat na pakinggan ng pamahalaan. Maaaring imungkahi ng kapamilya, kasama na ng kanyang asawa, ang alternatibong paraan upang harapin ang sitwasyong pangkalusugan. Ngunit sa bandang huli, ang pasiya ng may katawan ang dapat manaig.*
>
> — Former Chief Justice Maria Lourdes P.A. Sereno[539]

Childbirth is one of the most significant yet private aspects of a woman's life. From the time the Philippines became a party to the CEDAW up until the enactment of the RH Law, childbirth has been considered as one of the main facets of reproductive health. Consequently, decisions concerning childbirth constitute an exercise of the right to reproductive self-determination. However, this form of reproductive self-determination has been neglected for many years as issues on family planning and abortion took the spotlight. The dormant childbirth rights movement in the Philippines[540] has casted a false illusion that while a person cannot be compelled or prohibited from availing of a family planning method, a person can be coerced with regard to the circumstances of one's own childbirth — when both fall under the concept of reproductive rights.[541] Many

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Health Workers and for Other Purposes, H.B. No. 2678, 16th Cong., 1st Reg. Sess. (2013).

535. *Id.* para. 4.

536. *Id.* para. 5.

537. *Id.* § 6.

538. *Id.*

539. *Imbong*, 721 SCRA at 378 (C.J. Sereno, concurring and dissenting opinion).

540. Other jurisdictions have human rights movements specifically addressing reproductive rights in childbirth. These include Birth Rights Bar, Improving Birth, Human Rights in Childbirth and BirthRights. No such organization exists in the Philippines.

541. *See* Rebecca A. Spence, *Abandoning Women to their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights*, 19 CARDOZO J.L. & GENDER 75, 75-76 (2012).

reproductive health policies contravene the basic rights of pregnant women to autonomy[542] and non-discrimination, despite the increased international recognition of gender equality and women empowerment.[543]

In light of the enactment of the ordinances prohibiting home births, several legal issues arise: first, are childbirth decisions made in the exercise of reproductive self-determination a proper subject of police power? If yes, to what extent can the State interfere with this private aspect of human life? Lastly, and as applied to the situation at hand, do the ordinances prohibiting home births constitute a valid exercise of police power?

A. The Ordinances Violate the Right to Reproductive Self-Determination

An analysis of reproductive rights in Chapters III and IV established that all matters concerning one's reproduction are not a proper subject of *coercive measures*, even those enacted in the exercise of police power. A violation of the principle of non-coercion in reproductive rights constitutes a violation of human rights.

1. Principle of Non-Coercion is at the Core of Reproductive Self-Determination

The RH Law reaffirms that reproductive self-determination is not simply a negative right; it is not merely a matter of privacy and liberty that requires non-interference by the State. Rather, reproductive rights are human rights which are demandable against the State and which the State has the obligation to respect.[544]

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542. Diya Uberoi & Maria de Bruyn, *Human Rights Versus Legal Control Over Women's Reproductive Self-Determination*, HEALTH & HUM. RTS., Volume No. 15, Issue No. 1, at 161 (citing Miguel Kottow, *Colpo di Chiesa in Cile*, AGENDA COSCIONI, June 2008).

543. Uberoi & de Bruyn, *supra* note 542, at 161.

544. *See* The Responsible Parenthood and Reproductive Health Act of 2012, § 2. It states —

> The State recognizes and guarantees the human rights of all persons including ... the right to choose and make decisions for themselves in accordance with their religious convictions, ethics, cultural beliefs, and the demands of responsible parenthood
>
> ...
>
> Moreover, the State recognizes and guarantees the promotion of gender equality, gender equity, women empowerment and dignity as a health and human rights concern and as a social responsibility. The advancement and protection of women's human rights shall be central to the efforts of the State to address reproductive health care.

The principle of non-coercion is enshrined in the RH Law, which provides that individuals have the right to make decisions concerning reproduction "free of discrimination, coercion[,] and violence,"[545] and that "[*t*]*he right to make free and informed decisions, which is central to the exercise of any right, shall not be subjected to* any form of coercion and must be fully guaranteed by the State[.]"[546]

Thus, the enactment of the RH Law has dispelled any doubt that an individual cannot be coerced into matters as private as reproductive health. The scope of reproductive health rights as defined in the RH Law is all-encompassing, in that it covers "all matters relating to the reproductive system and to its functions and processes"[547] — pregnancy, childbirth, family planning, education and counseling, child health and nutrition, sexually transmitted diseases, men's and children's reproductive health, and mental health.[548] The only aspects of reproduction which are not included in reproductive rights are abortion and access to abortifacients.[549] As discussed, Congress adopted the broader definition of reproductive rights and reproductive self-determination which is not limited to the right to plan one's family but also includes the right to autonomy. Thus, the proscription against coercion necessarily includes childbirth and its circumstances, as childbirth is one of the main facets of reproduction.

Further, even in the absence of and prior to the enactment of the RH Law, the right to reproductive self-determination has been protected as a human right under the Constitution,[550] the UDHR,[551] ICCPR,[552] the

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Id. paras. 1 & 3.

545. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

546. *Id*. § 3 (a) (emphasis supplied).

547. *Id*. § 4 (p).

548. *Id*. § 4 (q) & CONG. REC., Vol. 2-39a, at 66, 15th Cong., 3d Reg. Sess. (Dec. 12, 2012).

549. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

550. PHIL. CONST. art. III, §1 & § 5. *See also Morfe*, 22 SCRA at 442 (1968). The Court asserts that the right to privacy "is the beginning of all freedom" and "deserves constitutional protection on itself." *Morfe*, 22 SCRA at 442 (citing Public Utilities Commission v. Pollak, 343 U.S. 451, 467 (1952) (J. Douglas, dissenting opinion)).

551. UDHR, supra note 149, art. 12. The provision states —

> No one shall be subjected to arbitrary interference with his privacy, family, home[,] or correspondence, nor to attacks upon his [honor] and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Id.

ICESCR,[553] and the CEDAW,[554] as discussed in Chapters III and IV.[555] This proposition was recognized by Congress as the enactment of the RH Law was prompted by the need to comply with the State's obligations under these international human rights documents and to further protect an individual's constitutional rights to privacy and liberty in the context of reproduction.[556] In fact, prior to the enactment of the RH Law, the Supreme Court has recognized the doctrine of informed consent, that is, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[557] While primarily applicable to cases involving medical procedures, the doctrine of informed consent springs from the right to self-determination. As explained by Justice Estela M. Perlas-Bernabe in *Imbong*, "[t]he right to individual choice is the main thrust of the doctrine of personal autonomy and self-determination which provides that '... every individual [has the right] to the possession and control of his or her own person, free from all restraint or interference of others.'"[558] Thus, the RH Law did not create new rights; rather, the RH Law merely provided measures to protect rights which were previously recognized in human rights documents.

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552. ICCPR, supra note 154, art. 17. The article provides —

> (1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home[,] or correspondence, nor to unlawful attacks on his [honor] and reputation.
> (2) Everyone has the right to the protection of the law against such interference or attacks.

Id.

553. ICESCR, *supra* note 155, art. 12 & ICESCR General Comment No. 14, *supra* note 84, ¶ 8. The General Comment states that the right to health includes "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference." ICESCR General Comment No. 14, *supra* note 156, ¶ 8.

554. CEDAW, *supra* note 133, arts. 1-5; 10 (e); 11, ¶ 1 (f); 12; 14, ¶ 2 (b); 15; & 16.

555. *See* ICPD Program of Action, *supra* note 93, ¶ 7.3.

556. S. JOURNAL Sess. No. 10, at 150-53, 15th Cong., 2d Reg. Sess. (Aug. 17, 2011).

557. Li v. Soliman, 651 SCRA 32, 56 (2011) (citing Schloendorff v. Society of New York Hospital, 105 N.E. 92, 93 (N.Y. 1914) (U.S.)).

558. *Imbong*, 721 SCRA at 728 (J. Perlas-Bernabe, concurring and dissenting opinion) (citing Conservatorship of Wendland v. Wendland, 26 Cal. 4th 519, 531 (2001) (citing Union Pacific Railway Co. v. Botsford, 141 U.S. 250, 251 (1891))).

The concept of coercion under the RH Law should be understood in its ordinary meaning.[559] The word "coercion" is defined as "to compel to an act or choice [or] to make someone do something by using force or threats."[560] The ordinances in question do not merely prohibit women from giving birth at home but also coerce them into giving birth at a health facility by penalizing the mothers, their relatives, or any birth attendant for attending a home birth. Thus, the ordinances violate the principle of non-coercion under the right to reproductive self-determination.

2. Police Power Deemed Circumscribed by the Principle of Autonomy and Non-Coercion

The passage of the RH Law was prompted by LGU ordinances that violate reproductive rights.[561] The law was enacted precisely to eliminate the biases of LGUs in reproductive health measures as a result of disaggregated data on maternal mortality rates and infant mortality rates; informed choice through education was made the decisive factor for which reproductive health services a person shall avail of.[562] Further, the concurring and dissenting opinion of Justice Bienvenido L. Reyes in *Imbong* said that "personal autonomy, i.e.[,] to decide on matters affecting his/her reproductive health" is the spirit of the RH Law.[563] This implies that despite the pervasive nature of police power, the autonomy of a person over one's own reproductive health decisions should still be protected as reproductive self-determination has attained the status of a human right recognized under Philippine law. LGUs cannot violate the same rights which they seek to protect. Thus, the police power of LGUs must be deemed circumscribed by the principle of non-coercion provided under the RH Law.

3. The Concept of Adversarial Pregnancy Which Justifies Curtailment of the Right to Reproductive Self-Determination Does Not Apply

As discussed in Chapter III, the right to reproductive self-determination cannot be circumscribed by mere invocation of the State's interest in protecting the life of the unborn. The ordinances cite Article II, Section 12

559. *See* Manila Prince Hotel v. Government Service Insurance System, 267 SCRA 408, 437 (1997).

560. Coerce, Merriam-Webster Online Dictionary, https://www.merriam-webster.com/dictionary/coerce (last accessed Nov. 30, 2018).

561. S. JOURNAL No. 42, at 810, 15th Cong., 2d Reg. Sess. (Dec. 13, 2011).

562. *Id.* at 805-06 & Senate Economic Planning Office, Promoting Reproductive Health: A Unified Strategy to Achieve the MDGs (A 2009 Policy Brief)) at 6, *available at* http://www.senate.gov.ph/publications/PB%202009-03%20-%20Promoting%20Reproductive%20Health.pdf (last accessed Nov. 30, 2018).

563. *Imbong*, 721 SCRA at 707 (J. Reyes, concurring and dissenting opinion).

of the 1987 Constitution as the legal basis for their enactment. Article II, Section 12 provides that the State "shall equally protect the life of the mother and the life of the unborn from conception."[564] However, the deliberations of the Constitutional Commission reveal that the protection afforded to the life of the unborn was not intended to justify intrusion into the privacy and liberty of mothers.[565] The provision was merely intended to limit the power of Congress in the enactment of pro-abortion laws and the "protection" contemplated under the article refers to protection against any *deliberate attempt* on the life of the child from the moment of conception.[566] Thus, the constitutional provision only contemplates cases where there is a *direct intent* to harm the life of the unborn because the pregnancy is unwanted; the provision does not contemplate cases where the pregnancy is wanted and the mother intends to carry her unborn to term.[567] In the latter situation, the interest of the State and the mother are the same — that of protecting the life of the unborn. Thus, the compelling state interest sufficient to overcome the mother's autonomy should be limited to the abortion context.

Further, as discussed in Chapter III, coercive measures against pregnant women to protect the unborn were a result of a misapplication of the compelling state interest in the life of the unborn outside the abortion context. In cases where the mother's autonomy was infringed by the State, courts adopted the adversarial notion of pregnancy which was conceptualized in *Roe*.[568] The adversarial notion of pregnancy presupposes that because the mother intends to end the life of the unborn, the mother is considered as a legal adversary to her own fetus and State interference is necessary to protect the life of the unborn.[569] However, the adversarial notion of pregnancy does not apply to wanted pregnancies. In fact, Philippine law does not treat mothers and their children as legal adversaries. Rather, Philippine law recognizes that the mother is in the best position to protect her own child.[570] This presumption was also the basis of Article 213

564. PHIL. CONST. art. II, § 12.

565. IV RECORD OF THE 1986 CONSTITUTIONAL COMMISSION, NO. 85, at 724 (1986).

566. IV RECORD, 1986 CONST. COMM., NO. 84, at 683.

567. IV RECORD, 1986 CONST. COMM., NO. 85, at 699 (1986).

568. *Roe*, 410 U.S..

569. Kitchen, *supra* note 232 at 208.

570. *See, e.g.*, *De Los Santos*, 295 SCRA at 603; *Luna*, 137 SCRA at 20; *dela Cruz*, 573 SCRA at 721 (2008), *Mariano*, 124 SCRA at 805; *Villahermosa*, 80 Phil. at 548; *Inocencio*, 229 SCRA at 519; People v. Tipay, 329 SCRA 53, 73 (2000); *Villorente*, 210 SCRA at 660; & *Tapucar*, 293 SCRA at 336.

of the Family Code, also known as the tender-age presumption.[571] In *Imbong*, the Supreme Court acknowledged that "[t]he mother is never pitted against the child because both their lives are equally valuable."[572] As in custody cases, the presumption can only be overcome upon proof of neglect, abandonment, drug addiction, maltreatment, affliction with a communicable disease, immorality, insanity, or other similar causes.[573]

As it is the declared policy of the State that "[t]he advancement and protection of women's human rights shall be central to the efforts of the State to address reproductive health care[,]"[574] maternal health measures that seek to protect the child must likewise protect the mother's reproductive rights. Informed consent through education and without coercion must be the guiding principle of maternal health measures.[575]

4. The Right to Reproductive Self-Determination Does Not Preclude Regulation of Childbirth

The right to reproductive self-determination is violated by measures which are coercive or discriminatory. However, protection of such right does not preclude regulation of childbirth, provided that the measures respect women's autonomy and right to health, as will be discussed in the latter part of this Chapter.

5. Summary

Applying the principles discussed above, it is the Author's position that in the exercise of the right to reproductive self-determination, mothers can refuse to give birth in a health facility, and mothers have the right to insist on a home birth without the interference of the State. The United Nations Special Rapporteur for Health opined that legal restrictions on a woman's reproductive self-determination "[intervene with] human dignity ... which is [essential] to the realization of all human rights."[576] Allowing government

571. FAMILY CODE, art. 213, para. 2. It provides that "[n]o child under seven years of age shall be separated from the mother, unless the court finds compelling reasons to order otherwise." *Id*.

572. *Imbong*, 721 SCRA at 346.

573. *Pablo-Gualberto*, 461 SCRA at 476.

574. The Responsible Parenthood and Reproductive Health Act of 2012, § 2, para. 3.

575. *Id*. § 3 (a).

576. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable*

interference in reproductive rights would set a dangerous precedent. If the State can dictate where a woman should give birth on health justifications, coercion would easily escalate into a wholesale control of a mother's life — what she should consume, what her daily rituals should be, and what reproductive health measures she should undergo to protect the life of the infant.[577] Such coercive interference is proscribed by international human rights instruments and by the RH Law, as discussed in Chapter III.

B. The Ordinances are Contrary to the Principles of the CEDAW

As discussed in Chapter IV, the CEDAW mandates that healthcare laws and policies must be consistent with the rights of women to autonomy, privacy, confidentiality, informed consent, and choice.[578]

Therefore, the ordinances are contrary to the principles of the CEDAW and are discriminatory against women for two reasons: (1) the ordinances adopt the protectionist approach; and (2) the ordinances constitute gender-based discrimination.

First, the ordinances prohibiting home births adopt the protectionist approach, as they prohibit women from choosing an activity which is perceived to be dangerous to pregnant women or to their unborn children. The ordinances deprive women of control and autonomy over their own reproductive health. In effect, the State substitutes its will for that of the pregnant woman by dictating which healthcare option the pregnant woman must choose and punishing those which do not choose such option. Further, the right to informed consent is violated as a healthcare option is imposed upon women without their involvement. To be consistent with the provisions of the CEDAW, childbirth laws must not only respect the autonomy of pregnant women but must also consider the political, social, economic, and cultural reasons underlying the decision to choose home births and address such issues.

Second, deprivation of the right to reproductive self-determination based on one's pregnant status can be considered as gender-based discrimination. "Childbirth is not a gender-neutral issue."[579] The existence of laws curtailing a pregnant woman's freedom to make decisions with regard to her own body and her own health springs from the gender

Standard of Physical and Mental Health, ¶ 15, 66th Session of the General Assembly, U.N. Doc. A/66/254 (Aug. 3, 2011).

577. *See* Claire Andre & Manuel Velasquez, *Forcing Pregnant Women to Do as They're Told: Maternal vs. Fetal Rights*, 1 ETHICS, Winter 1988. *See also* Spence, *supra* note 541, at 75-77.

578. CEDAW Report, *supra* note 311, at ch. 1, ¶ 31.

579. van Leeuwen, *supra* note 337, at 206.

stereotype of the "good mother" — one who is willing to sacrifice the exercise of her rights for the benefit of the safety of her unborn.[580] Despite the applicability of the doctrine of informed consent in this jurisdiction, informed consent is disregarded in the context of pregnancy. Men and other non-pregnant women do not have healthcare options predetermined for them by the State for the sake of someone else.[581] Thus, pregnant women are deprived of their autonomy over their own health on the sole basis of being pregnant because the State glorifies the role of women in procreation. The "good mother" gender stereotype reinforces the aforementioned concept of adversarial pregnancy; the concept of adversarial pregnancy justifies state interference, while the "good mother" gender stereotype expands the scope of interference to include those which may pose geographical, financial, or legal restraints to pregnant women — all of which are by themselves considered as pregnancy risks.[582] As a result, pregnant women are relegated as second-class citizens with less rights than other individuals.

Further, the principle of non-discrimination under the ICESCR includes discrimination as to the *means and entitlements* for procurement of health services based on any of the prohibited grounds.[583] Sex as a prohibited ground for discrimination under the ICESCR has evolved to include "gender stereotypes, prejudices[,] and expected roles."[584] The provisions of the ordinances clearly discriminate as to the *means* of procuring health services — pregnant women, unlike all other individuals, can only seek medical assistance in health facilities and any medical professional, no matter how qualified, is prohibited from assisting the former at home even in life-threatening cases where medical assistance may be required. The infringement of rights on the basis of any prohibited ground, such as sex, where there is no comparable similar situation, as in the case of a woman who is pregnant, constitutes direct discrimination and violates the principle of non-discrimination under the ICESCR.[585]

C. The Ordinances Violate the Right to Life, Privacy, Liberty, and Health

Reproductive rights embrace human rights recognized under other international instruments, such as the right to life, privacy, liberty, and

580. *Id.* at 207.

581. Shirley Jones, *Ethico-legal Issues in Home Birth*, RCM MIDWIVES, Volume No. 6, Issue No. 3, at 127.

582. *See* ICESCR General Comment No. 14, *supra* note 156, ¶ 21.

583. *Id.* ¶ 18.

584. ICESCR General Comment No. 20, *supra* note 299.

585. *Id.* ¶ 10 (a).

health.[586] Considering the interdependence and indivisibility of human rights, a violation of the right to reproductive self-determination results in a violation of the right to life, privacy, liberty and health.

Specifically, ordinances that penalize health professionals, TBAs, and the pregnant woman's relatives from assisting the mother with her childbirth at home even in life-threatening and emergency cases[587] violate the right to life of the mother and of the child. Even the Philippine Midwifery Act's provision on illegal practice of midwifery does not apply in emergency cases.[588] In *Imbong*, the Supreme Court held that denying a service in life-threatening and emergency cases unnecessarily places the life of the mother in grave danger and amounts to a violation of the right to life.[589] The Court emphasized that "no person should be denied the appropriate medical care urgently needed to preserve the primordial right, that is, the right to life."[590]

Further, a violation of the right to reproductive self-determination results in a violation of the right to health, as the latter right includes "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference."[591]

D. The Ordinances Violate the Right to Culturally Sensitive Health Care and the Right to Religious Freedom

As discussed in Chapter I, several ordinances prohibiting home births affect women from IP communities. The DOH, NCIP, and DILG recognize that home births are a cultural and religious event to these IP communities.[592]

586. World Conference of the International Women's Year, Mexico City, Mexico, June 19-July 2, 1975, *Conference Report*, part 1, ch. I, ¶¶ 11 & 12, U.N. Doc. E/CONF.66/34.

587. Class A (Ordinances which absolutely prohibit home births and which impose penalties on the pregnant woman, her relatives, SBA, or TBA) and D (Ordinances which absolutely prohibit home births and which impose penalties on traditional birth attendants) ordinances. Class A ordinances are those of Magallanes (Sorsogon), Quezon City, Catbalogan (Samar), Pola (Oriental Mindoro), Tacurong (Sultan Kudarat), Pres. Carlos P. Garcia (Bohol), Naujan (Oriental Mindoro), Roxas (Oriental Mindoro), Iloilo City, Dasmariñas (Cavite), and Kananga (Leyte). Class D ordinances are those of Clarin (Bohol) and Cagayan de Oro City.

588. Philippine Midwifery Act of 1992, § 23.

589. *Imbong*, 721 SCRA at 345-46.

590. *Id.* at 353-54.

591. ICESCR General Comment No. 14, *supra* note 156, ¶ 8.

592. DOH-NCIP-DILG Joint Memorandum Circular No. 2013-01, part VII (G) (3). *See also* National Commission on Indigenous Peoples, Knowledge, Attitudes, Practices, Health Seeking Behaviour and Health Service Needs of

The State must therefore recognize the distinct views and traditions of IPs concerning reproductive health and eliminate *all forms of coercive and discriminatory practices*.[593] The requirement of culture-sensitivity and respect for one's religion in healthcare is embodied in the ICESCR,[594] RH Law,[595] and The Magna Carta of Women.[596]

Indigenous Cultural Communities/Indigenous Peoples with Regard to Maternal, Neonatal, Child Health and Nutrition, *supra* note 66, at 39 & Asian Development Bank, Culture-Sensitive Maternal and Newborn Care Program: Experience with the Mangyans of Oriental Mindoro at 11-20, *available at* https://www.adb.org/sites/default/files/project-document/79327/37402-012-tacr-07.pdf (last accessed Nov. 30, 2018).

593. ICPD Program of Action, *supra* note 93, ¶ 6.25 (emphasis supplied).

594. ICESCR General Comment No. 14, *supra* note 156, ¶¶ 12, 27, & 34. These provisions state,

> The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State [P]arty: (a) *Availability* ... (b) *Accessibility* ... (c) *Acceptability* ... (d) *Quality*.
>
> ...
>
> [I]ndigenous peoples have the right to *specific measures* to improve their access to health services and care. These health services should be culturally appropriate, *taking into account traditional preventive care, healing practices*[,] *and medicines*.
>
> ...
>
> [O]bligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices, and medicines.

Id. (emphases supplied).

595. The Responsible Parenthood and Reproductive Health Act of 2012, § 2, para. 1. It provides that,

> The State recognizes and guarantees the human rights of all persons including their right to equality and nondiscrimination of these rights, the right to sustainable human development, the right to health which includes reproductive health, the right to education and information, and the right to choose and make decisions for themselves in accordance with their *religious convictions*, ethics, *cultural beliefs*, and the demands of responsible parenthood.

Id. (emphases supplied).

596. The Magna Carta of Women. The law provides, thus —

> Section 17. *Women's Right to Health*. [—] (a) Comprehensive Health Services. [—] The State shall, at all times, provide for a comprehensive, *culture-sensitive*, and gender-responsive health services

"Cultural-sensitivity [of] health care" means that "policymakers and health workers acknowledge and respect cultural diversity among the populace."[597] A requirement for a culturally-sensitive health service is the adherence to the LEARN method of culture-sensitivity.[598] The LEARN method requires LGUs to "*accept the difference in perception*"[599] of IPs and to "negotiate for a *mutually acceptable compromise*."[600] Thus, culture sensitivity requires negotiation, and coercive measures enacted in the exercise of police power violate the right of IPs to culturally-sensitive health services. Further, while the States are obliged to shield women from the impact of "harmful traditional cultural practices and norms,"[601] such as female genital mutilation, the previous Chapters have established that home births *per se* are not harmful to the mother or the child.

The free exercise of religion is likewise a constitutionally guaranteed right.[602] The State adheres to the doctrine of benevolent neutrality, which enables individuals whose religious beliefs are burdened to claim an

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> and programs covering all stages of a woman's life cycle which addresses the major causes of women's mortality and morbidity: *Provided*, That in the provision for comprehensive health services, *due respect shall be accorded to women's religious convictions*, the rights of the spouses to found a family in accordance with their religious convictions, and the demands of responsible parenthood, and the right of women to protection from hazardous drugs, devices, interventions, and substances.

Id. ch. IV, § 17 (emphases supplied). Section 28 states, thus —

> Section 28. *Recognition and Preservation of Cultural Identity and Integrity*. — The State shall recognize and respect the rights of Moro and indigenous women to practice, promote, protect, and preserve their own culture, traditions, and institutions and to consider these rights in the formulation and implementation of national policies and programs. To this end, t*he State shall adopt measures in consultation with the sectors concerned* to protect their rights to their indigenous knowledge systems and practices, traditional livelihood, and other manifestations of their cultures and ways of life: *Provided*, That these cultural systems and practices are not discriminatory to women.

Id. ch. V, § 28 (emphasis supplied).

597. DOH-NCIP-DILG Joint Memorandum Circular No. 2013-01, part V, ¶ 12.

598. *Id.* part VII (G), ¶ 3 & part VII (B), ¶ 2.5.

599. *Id.* part VII (B), ¶ 2.5 (emphasis supplied).

600. *Id.* (emphasis supplied).

601. ICESCR General Comment No. 14, *supra* note 156, ¶ 21.

602. PHIL. CONST. art. III, § 5.

exception from the application of a facially neutral law.[603] When an individual claims an exemption from a general law, the compelling state interest test coupled with the least restrictive means test will be applied.[604] The threshold for a compelling state interest is very high; it is not enough that the interest is important and embodied as policies underlying some of our laws.[605] "Only the gravest abuses, endangering paramount interests,"[606] give occasion for permissible limitation.[607] Further, the State must show that granting exemptions would undermine the law's objectives.[608]

Religious exemption on matters relating to reproduction can be seen in various provisions of the RH Law. In *Imbong*, the Supreme Court struck down as unconstitutional the provisions that did not provide for religious exemption,[609] as one of the policies of the law is to allow individuals "to choose and make decisions for themselves in accordance with their religious convictions, ethics, cultural beliefs, and the demands of responsible parenthood."[610]

Similar to the rationale for the enactment of the ordinances, the Solicitor General argued in *Imbong* that the high mortality rate is a compelling state interest that would justify curtailment of religious freedom.[611] However, the Supreme Court held that aside from not supporting the assertion, the World Health Organization provided that the maternal mortality rate has dropped from 1990 to 2008, although the RH Law was not yet enacted at that time.[612] Further, the Court said that even granting that there exists a compelling state interest, religious freedom cannot be curtailed as this right, alongside informed choice, is one of the basic principles of reproductive rights — "[g]ranting that there are still deficiencies and flaws in the delivery of social healthcare programs for Filipino women, they could not be solved by a measure that puts an unwarrantable stranglehold on religious beliefs in

603. *Escritor*, 492 SCRA at 42.

604. *Id.* at 29 (citing *Escritor*, 408 SCRA at 141).

605. *Escritor*, 492 SCRA at 84.

606. *Id.*

607. *Id.*

608. *Id.* at 85 (citing *Escritor*, 408 SCRA at 126-28).

609. *Imbong*, 721 SCRA at 335.

610. The Responsible Parenthood and Reproductive Health Act of 2012, § 2, para. 1.

611. *Imbong*, 721 SCRA at 344.

612. *Id.* at 345 (citing Steven Ertelt, Philippines Sees Maternal Mortality Decline Without Abortion, *available at* http://www.lifenews.com/2011/09/01/philippines-sees-maternal-mortality-decline-without-abortion (last accessed Nov. 30, 2018)).

exchange for blind conformity."[613] Such ruling is consistent with the spirit of the RH Law, i.e., "freedom of choice through informed consent."[614] Freedom of choice necessarily "prohibits any degree of compulsion or burden, whether direct or indirect, in the practice of one's religion."[615]

Thus, considering the pronouncement of the Supreme Court in *Imbong* and the principles embodied in the RH Law, measures which have an effect on an individual's exercise of reproductive self-determination must allow room for religious exemption. As discussed in the previous subchapter on adversarial pregnancy, the same rule should apply even if the State has an interest in the life of the child.

Notably, permissible accommodation on legislations which seek to protect the health of the child is not new in this jurisdiction. The Newborn Screening Act of 2004[616] provides religious exemption, provided that the parents or guardians acknowledge in writing that refusing testing "places their newborn at risk for undiagnosed heritable conditions."[617] The Universal Newborn Hearing Screening and Intervention Act of 2009[618] likewise gives parents the right to refuse testing based on religious and/or cultural beliefs provided that parents acknowledge in writing that they have been informed of this responsibility and the "risks of undiagnosed congenital hearing loss in case of failure to administer hearing loss screening on their newborn."[619]

Thus, even granting that the State has a compelling interest in reducing maternal mortality, the doctrine of benevolent neutrality operates to justify an exemption from the operation of the law. Further, even if the State has a compelling interest in enacting the measures, the means adopted by the LGUs are not the least intrusive means to pursue the state interest, as will be discussed in the latter part of this chapter.

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613. *Imbong*, 721 SCRA at 345.

614. *Id.* at 336 (citing *Escritor*, 408 SCRA 134).

615. *Id.*

616. An Act Promulgating a Comprehensive Policy and a National System for Ensuring Newborn Screening [Newborn Screening Act of 2004], Republic Act No. 9288 (2004).

617. *Id.* § 7.

618. An Act Establishing a Universal Newborn Hearing Screening Program for the Prevention, Early Diagnosis and Intervention of Hearing Loss [Universal Newborn Hearing Screening and Intervention Act of 2009], Republic Act No. 9709 (2009).

619. *Id.* § 7.

E. The Ordinances Violate Substantive Due Process

Even granting that reproductive self-determination may be curtailed, the curtailment must be justified under current standards of law. The ordinances do not constitute a valid exercise of police power for failing to meet the jurisprudential tests:

1. Means Used Must Not Be Unduly Oppressive Upon Individuals

An ordinance is considered oppressive if the law or ordinance subjects individuals to fees, charges, or amounts to a deprivation of property.[620] This jurisprudential test is particularly important in the situation at hand because financial inaccessibility of health services is one of the main reasons why Filipinos choose to give birth at home.[621]

The ordinances in question are oppressive because pregnant women, whether PhilHealth members or not, are coerced to give birth in a health facility which imposes various charges for availing the services of the facility. The MNCHN MOP authorizes LGUs to impose user fees as part of cost-recovery schemes.[622] Consequently, the ordinances which prohibit home births contain provisions setting out fees which a pregnant woman must pay before she can give birth at the health facility. While the imposition of fees is authorized by the MNCHN MOP, the document does not authorize LGUs to *coerce* their constituents into availing health services which would subject them to fees.

The scenario above is analogous to the decision of the Supreme Court in *Lucena Grand Central Terminal, Inc. v. JAC Liner, Inc.*[623] In *Lucena Grand Terminal, Inc.*, an ordinance of Lucena City prohibited the operation of bus and jeepney terminals in the city to ease traffic congestion, establishing therefore a central terminal which bus and jeepney operators were required to use.[624] The Supreme Court held that the ordinance is oppressive "since the *compulsory use* of the terminal operated by petitioner would subject the users thereof to fees, rentals[,] and charges."[625] However, mere imposition of fees for use of government facilities or services does not constitute

620. Subong, *supra* note 453, at 223.

621. Philippine Statistics Authority, National Demographic and Health Survey 2013 at 107, *available at* https://dhsprogram.com/pubs/pdf/FR294/FR294.pdf (last accessed Nov. 30, 2018).

622. *See* MNCHN Strategy Manual of Operations, ch. 7.2.3 (2) (b).

623. Lucena Grand Central Terminal, Inc. v. JAC Liner, Inc., 452 SCRA 174 (2005).

624. *Id.* at 180.

625. *Id.* at 188 (emphasis supplied).

oppression. [626] The means used are deemed *unduly* oppressive if the government measure imposes fees which constituents would not have paid had the government adopted less intrusive means, as in *Lucena Grand Central Terminal, Inc.*[627] In the same vein, the ordinances in question must be deemed unduly oppressive as the compulsory use of the birth facilities would subject those who are required to avail of services to fees and charges and the means adopted by LGUs is not the least intrusive means, as will be discussed below.

2. Must Not Be Partial or Discriminatory

The ordinances are discriminatory for their all-encompassing nature and for their failure to consider pregnant women from GIDAs and IP communities as a special class. The Magna Carta of Women and the ICESCR consider IPs as a vulnerable and marginalized sector which deserves special protection.[628] Further, health laws have consistently treated individuals from GIDAs as a special class. The RH Law mandates that "people in geographically isolated or highly populated and depressed areas shall have the same level of access [to health care] and shall not be neglected by providing *other means* such as *home visits or mobile health care clinics* as needed[.]"[629] The Indigenous Peoples' Rights Act also recognizes that IPs have the right to "*special measures*" in health care and particular attention must be given to indigenous women.[630] The DOH, NCIP, and DILG issued a circular in 2013 recognizing that IPs and individuals from GIDAs have different health care needs and special consideration must be given to the fact that the GIDA population has little to no means of transportation and resources and it is the responsibility of LGUs to provide special means to reach these populations.[631] The requirement of adopting special measures to

626. *See, e.g.*, Ferrer, Jr. v. Bautista, 760 SCRA 652 (2015) (where the Court held in general that the collection of fee for garbage disposal is not *per se* oppressive, but it is oppressive if it is applied discriminatorily).

627. *Lucena Grand Central Terminal, Inc.*, 452 SCRA at 188.

628. The Magna Carta of Women, ch. II, § 4 (d) (7) & ICESCR General Comment No. 20, *supra* note 299, ¶¶ 11 & 18.

629. The Responsible Parenthood and Reproductive Health Act of 2012, § 6 (emphases supplied).

630. The Indigenous Peoples' Rights Act of 1997, ch. V, § 25 (emphasis supplied).

631. DOH-NCIP-DILG Joint Memorandum Circular No. 2013-01, part VII (E) (3).

eliminate the discriminatory effect of laws is embodied in the principle of non-discrimination under the ICESCR.[632]

By not allowing special provisions to these vulnerable sectors, the ordinances are discriminatory in operation. The Supreme Court has ruled that while a law may appear to be fair on its face, the law may still be adjudged unconstitutional because of their *discriminatory effect in operation* when it is oppressive to the minority and others are disproportionately disadvantaged by the law.[633] Such discrimination is considered as substantive or *de facto* discrimination, wherein certain groups are prejudiced by laws which are general in application.[634] As discussed in the previous Chapters, geographical inaccessibility is a main barrier to facility-based births and IP women had to endure travelling for hours to days just to get to the designated birth facility.[635] The reports of women dying while on their way to the health facilities[636] is a result of the discriminatory operation of the ordinances, which do not consider the distance or terrain a woman must endure to get to the health facility. Other ordinances permit home births upon proof that the woman is located in an isolated area.[637] However, most ordinances do not contain this exception.

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632. ICESCR General Comment No. 20, *supra* note 299, ¶ 9 & ICESCR General Comment No. 14, *supra* note 156, ¶¶ 19 & 27.

633. People v. Vera, 65 Phil. 56, 128 (1937) (citing General Oil Co.v. Crain, 209 U.S. 211, 227-228 (1908) & State v. Clement Nat. Bank, 78 A. 933, 952 (Vt. 1911) (U.S.)); People v. Dela Piedra, 350 SCRA 163, 181 (2001) (citing American Motorists Ins. Co. v. Starnes, 425 U.S. 637, 645 (1976)); & *Escritor*, 492 SCRA at 89.

634. ICESCR General Comment No. 20, *supra* note 299, ¶ 8 (b).

635. A Resolution Directing the House Committee on Health and Committee on Women and Gender Equality to Conduct an Investigation in Aid of Legislation on the Policy of the Department of Health Prohibiting Childbirth Deliveries Assisted by Traditional Birth Attendants (TBA) Dubbed as the "No Home-Birthing Policy" and the Subsequent Issuance of Municipal and City Ordinances of Local Government Units in Compliance with the Said Policy, and Recommend Measures that Would Truly Address the High Maternal and Infant Mortality Rates in the Country Without Violating the Rights of Mothers, H. Res. No. 1531, paras. 13 & 16, 16th Cong., 2d Reg. Sess. (2014).

636. *Id.* para. 18.

637. *See* Marikina City Ordinance No. 031-2012; Homebirth Regulation Ordinance; Oton Municipal Ordinance No. 2012-244; Socorro Municipal Ordinance No. 12-2012; Plaridel Municipal Ordinance No. 10-2014; & Iloilo Municipal Ordinance No. 2011-004.

The CEDAW provides that the State has the obligation to "[e]liminate discrimination against women in the field of health care."[638] Women from rural areas must not be discriminated against by ensuring that such women "have access to adequate health care facilities."[639] The RH Law likewise reiterates the principle of non-discrimination against women, explicitly providing that the State has the duty to "eradicate discriminatory practices, laws[,] and policies that infringe on a person's exercise of reproductive health rights."[640] Therefore, childbirth regulations must not be discriminatory in operation by providing other means of accessing health services to those situated in GIDAs and IP communities. The same conclusion applies even if there are severe resource constraints, as the principle of non-discrimination under the right to health is of immediate effect;[641] General Comment No. 3 of the ICESCR provides that despite severe resource constraints, "vulnerable members of society *can and indeed must be protected* by the adoption of relatively low-cost targeted [programs]."[642] The provisions on providing other means of delivering health services under the laws discussed above are likewise *unqualified* and under no circumstance inapplicable in case of resource constraints; therefore, the State has the duty to adopt special measures to eliminate discrimination in healthcare despite resource constraints.

3. Must Be General and Consistent with Public Policy

Public policy refers to the policies of the State as expressed in the Constitution, statutes, and judicial decisions.[643] The Magna Carta of Women expresses the policy of the State of women empowerment, specifically the observance of human rights and the participation of individuals in "decision-making processes that affect their lives and well-being."[644] The RH Law declares as a policy that individuals have "the right to choose and make decisions for themselves in accordance with their religious convictions,

638. CEDAW, *supra* note 133, art. 12, ¶ 1.

639. *Id.* art. 14 (2) (b).

640. The Responsible Parenthood and Reproductive Health Act of 2012, § 2, para. 6.

641. U.N. Committee on Economic, Social and Cultural Rights, *General Comment No. 3 (1990) The Nature of States Parties' Obligations (Art. 2, para. 1 of the Covenant)*, U.N. Doc. E/1991/23, ¶ 1 (Dec. 14, 1990) [hereinafter ICESCR General Comment No. 3].

642. *Id.* ¶ 12 (emphasis supplied).

643. Avon Cosmetics, Incorporated v. Luna, 511 SCRA 376, 392 (2006) (citing Ferrazini v. Gsell, 34 Phil. 697, 712 (1916)).

644. The Magna Carta of Women, ch. I, § 3, para. 5.

ethics, cultural beliefs, and the demands of responsible parenthood"[645] and that "[t]he advancement and protection of women's human rights shall be central to the efforts of the State to address reproductive health care."[646] Thus, coercive health measures which violate women's rights, specifically the rights mentioned above, are contrary to public policy.

4. Overbreadth Analysis

An ordinance is considered unreasonable and therefore suffering from overbreadth if "the means used for attaining the purpose sought 'go beyond what is reasonably necessary.'"[647] To determine whether the means used is the least intrusive of the rights mentioned above, a scrutiny of the purposes sought by the ordinances is called for. An analysis of the whereas clauses reveal that the objectives of the ordinances have two facets: first, the prohibition of childbirth assistance by traditional birth attendants;[648] and

645. The Responsible Parenthood and Reproductive Health Act of 2012, § 2, para. 1.

646. *Id.* para. 3.

647. Subong, *supra* note 453, at 223.

648. Municipal Birth Attendance and Safe Motherhood and Child Health Care Ordinance of 2011, whereas cl., para. 4; Quezon City Ordinance No. 2171-2012, whereas cl., para. 6; Maternal and Child Health Code of the City of Catbalogan, whereas cl.; Pola Homebirth Prohibition Ordinance, whereas cl.; City Ordinance of Facility-Based Deliveries of All Pregnant Women of the City of Tacurong, whereas cl., para. 2; Pres. Carlos P. Garcia Municipal Ordinance No. 12-233, whereas cl.; Naujan Comprehensive Child Delivery Ordinance of 2014, whereas cl.; Clarin Safe Motherhood Ordinance; & Safe Motherhood Ordinance of Cagayan de Oro, whereas cl., para. 3.

The municipal ordinance of Magallanes, Sorsogon says that "WHEREAS, in the province of Sorsogon including the Municipality of Magallanes, traditional birth attendants or so-called Hilots play a substantial role in birth attendance, the subsequent and delicate post-natal maternal and child-care especially in far flung barangays thus putting at risk pregnant mothers and their newborn babies." Municipal Birth Attendance and Safe Motherhood and Child Health Care Ordinance of 2011, whereas cl., para. 4.

The city ordinance of Quezon City says — "there is a need to regulate when expectant mothers opted to seek the services of traditional birth attendants called '*hilot*' and/or '*comadrona*.'" Quezon City Ordinance No. 2171-2012, whereas cl., para. 6.

The city ordinance of Catbalogan, Samar states that "40% of the total deliveries are assisted by hilots contributing to an MRR of 4 and an IMR of 24 in 2009." Maternal and Child Health Code of the City of Catbalogan, whereas cl.

The ordinance of Pola, Oriental Mindoro states that "WHEREAS, current health data from the DOH show that there are four types of risks that increase

second, the prevention of maternal deaths through emergency obstetric care.[649]

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the number of maternal and neonatal deaths in the country, one of which is the risk delivering without being attended to by skilled birth attendants, namely, skilled midwives, nurses and doctors." Pola Homebirth Prohibition Ordinance, whereas cl.

According to the ordinance of Tacurong, Sultan Kudarat: "one (1) maternal deaths and seven (7) stillbirths recorded were being attended by traditional birth attendants such as hilot and non[-hilot]." City Ordinance of Facility-Based Deliveries of All Pregnant Women of the City of Tacurong, whereas cl., para. 2.

The municipal ordinance of Pres. Carlos P. Garcia states that "all of these problems are preventable and can be addressed through adequate medical care, such as, the presence of skilled birth attendants." Pres. Carlos P. Garcia Municipal Ordinance No. 12-233, whereas cl.

The ordinance of Naujan, Oriental Mindoro states that "WHEREAS, health data from the DOH show that one of the risks that increases the number of maternal and neonatal deaths in the country, is the risk of delivering without being attended to by skilled birth attendants, like skilled midwives, nurses and physicians." Naujan Comprehensive Child Delivery Ordinance of 2014, whereas cl.

The ordinance of Clarin, Bohol states that "Not all obstetrical complications are predictable or avoidable but can be managed if identified early. Thus, there is a need to focus on perinatal and post-partum stages to be assisted by skilled birth attendant and that includes Physicians, Nurses and Midwifes only." Clarin Safe Motherhood Ordinance

The ordinance of Cagayan de Oro states —

> [T]wo indicators are proposed for monitoring progress towards the maternal health goal namely, the maternal mortality ratio and the proportion of deliveries with a skilled health care provider. The need for access to skilled health care for pregnancy, birth and the postnatal period has been central to World Health Organization's Making Pregnancy Safer initiative.

Safe Motherhood Ordinance of Cagayan de Oro, whereas cl., para. 3.

649. Quezon City Ordinance No. 2171-2012, whereas cl., para. 1; Pres. Carlos P. Garcia Municipal Ordinance No. 12-233, whereas cl.; Pola Homebirth Prohibition Ordinance; Homebirth Regulation Ordinance, whereas cl., para. 9.

The Quezon City ordinance says that "[t]hese problems can be prevented and can be addressed through adequate medical care such as the presence of skilled birth attendants, emergency ·obstetric care, when necessary, and access to family planning services." Quezon City Ordinance No. 2171-2012, whereas cl., para. 1.

The municipal ordinance of Pres. Carlos P. Garcia says that "all of these problems are preventable and can be addressed through adequate medical care,

With regard to the first objective, the prohibition on the illegal practice of midwifery by traditional birth attendants is already covered by the Philippine Midwifery Act of 1992. Said law imposes penalties on persons who practice midwifery without a license from the Board of Midwifery.[650] With regard to the second objective, the provision of basic emergency obstetric health care need not be provided in a health facility and can be delivered at home. Emergency obstetric care is defined under the RH Law as follows —

> *Basic Emergency Obstetric and Newborn Care* (*BEMONC*) refers to lifesaving services for emergency maternal and newborn conditions/complications being provided by a health facility *or professional* to include the following services: administration of parenteral oxytocic drugs, administration of dose of parenteral anticonvulsants, administration of parenteral antibiotics, administration of maternal steroids for preterm labor, performance of assisted vaginal deliveries, removal of retained placental products, and manual removal of placenta. It also includes neonatal interventions which include at the minimum: newborn resuscitation, provision of warmth, and referral, blood transfusion where possible.[651]

These services do not require a health facility and can be administered at home by a midwife or any skilled health professional. While emergency obstetric care (EmOC) is essential to reduce maternal mortality, "EmOC should not be confused with institutional delivery."[652] In fact, the RH Law amended the Midwifery Act of 1992 to accommodate situations where

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such as, the presence of skilled birth attendants, emergency obstetric and newborn care (EmONC)." Pres. Carlos P. Garcia Municipal Ordinance No. 12-233, whereas cl.

The ordinances of Pola, Oriental Mindoro and Roxas, Oriental Mindoro state that "one of which is the risk delivering without being attended to by skilled birth attendants, namely, skilled midwives, nurses and doctors in a BEmONC facility or any other equally capable health care facility." Pola Homebirth Prohibition Ordinance & Roxas Homebirth Prohibition Ordinance

The ordinance of Bacolod City states that "WHEREAS, risk of maternal and neonatal deaths for a given population group is magnified with the risk of delivering without being attended to by skilled birth attendants and of not having access to emergency obstetric and neonatal care services." Homebirth Regulation Ordinance, whereas cl., para. 9.

650. *See* Philippine Midwifery Act of 1992, §§ 23 & 27.

651. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (c) (emphasis supplied).

652. Suellen Miller, et al., *Quality of Care in Institutionalized Deliveries: The Paradox of the Dominican Republic*, 82 INT. J. GYNECOL. OBSTET. 89, 101-02 (2003).

childbirth at a health facility is not possible.[653] The RH Law expanded the scope of practice of midwives by allowing them to administer life-saving drugs which address the major causes of maternal and neonatal mortality.[654] The LGUs are required to ensure that all midwives assigned in the Rural Health Units be certified as qualified to administer these life-saving drugs.[655]

Further, in as early as 2010, the Department of Health issued an administrative order[656] acknowledging that maternal and neonatal deaths can be prevented by mere administration of drugs.[657] The administrative order authorized midwives to administer life-saving drugs to address the major causes of maternal and neonatal mortality.[658] It recognized that a great number of births in the country occur at home and that life-saving drugs are locally available, but midwives are not authorized to administer them whenever and wherever they are needed, especially in "hard-to-reach areas among the 42,000 villages where lives of mothers and newborns are at stake in the absence of doctors or referral facilities."[659] The World Health Organization recognizes that maternal and neonatal deaths can be prevented "if those mothers and children could only access a basic set of medicines and health supplies."[660]

The above situation is analogous to the circumstances in *White Light Corporation v. City of Manila*.[661] In *White Light Corporation*, the Supreme Court struck down as unconstitutional an ordinance of the City of Manila which prohibited short-time and wash rates in hotels, motels, and other

653. S. JOURNAL SESS. No. 48, at 915-16, 15th Cong., 2d Reg. Sess. (Jan. 31, 2012) & S. JOURNAL SESS. No. 54, at 1021-22, 15th Cong., 2d Reg. Sess. (Mar. 6, 2012).

654. The Responsible Parenthood and Reproductive Health Act of 2012, § 5, para. 2.

655. Department of Health, Rules and Regulations Implementing the Responsible Parenthood and Reproductive Health Act of 2012, Republic Act No. 10354, ch. 2, rule 4, § 4.13 (2013).

656. Department of Health, Administration of Life-saving Drugs and Medicine by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality, Administrative Order No. 2010-0014 [A.O. No. 2010-0014] (May 14, 2010).

657. *Id.* part I, para. 5.

658. *Id.* part VI, para. 1.

659. *Id.* part I, para 8.

660. World Health Organization, UN Commission on Life-Saving Commodities for Women and Children, *available at* http://www.who.int/reproductivehealth/news/un_commission/en (last accessed Nov. 30, 2018).

661. White Light Corporation v. City of Manila, 576 SCRA 416 (2009).

establishments in Manila to deter illicit use of these establishments.[662] The Court ruled that the ordinance constituted an unjustifiable intrusion into the right to liberty of the establishments' customers as *less intrusive measures, such as strict enforcement of laws* on prostitution and drug trafficking, can achieve the end sought to be attained.[663] The same analysis was adopted by the Supreme Court in *Imbong* when the Court struck down as unconstitutional provisions which required conscientious objectors to refer their patients.[664] The Court said that an assertion that the act of referral is merely momentary does not suffice to prove that the least intrusive means was adopted by the State, as there are existing laws, such as the Contraceptive Act, the Population Act, and the Magna Carta of Women, which provide measures protecting the right to health.[665] The analysis adopted in *White Light* and *Imbong* prove that convenience and efficiency in attaining the State's goals do not justify excessive State interference. The existence of other measures which do not infringe rights and which address the sought objectives negates the adoption of the least intrusive means. In such case, the police power measure should be deemed suffering from overbreadth.

Similarly, the current legal framework to address maternal mortality does not necessitate violation of various human rights. The goals of the ordinances can be addressed through less restrictive means, such as by enforcing the Philippine Midwifery Act of 2002 and by adhering to the provisions of the RH Law and Administrative Order No. 2010-0014 in administration of lifesaving drugs. The Supreme Court has ruled in several cases that adopting prohibitive measures, instead of imposing reasonable regulations, constitutes a "sweeping exercise" of police power and does not satisfy the reasonableness requirement.[666]

While public health goals may justify interference by the State to a certain extent, imposing punitive measures for childbirth-related acts does not further public health goals and, to the contrary, undermines them.[667] These laws are disproportionate to the ends sought to be achieved and are considered ineffective deterrents.[668] Thus, the means used by the LGUs

662. *Id.* at 425.

663. *Id.* at 443.

664. *Imbong*, 721 SCRA at 335.

665. *Id.* at 343.

666. *See, e.g.*, *De la Cruz*, 123 SCRA 569; *Laguio, Jr.*, 455 SCRA 308; *White Light Corporation*, 576 SCRA 416; *Lucena Grand Terminal, Inc.*, 452 SCRA at 189; *Lupangco*, 160 SCRA 848.

667. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 576, ¶ 42.

668. *Id.*

violate the concept of proportionality provided under the ICESCR[669] and are suffering from overbreadth.

a. No Reasonable Relation Between Maternal Mortality Reduction and the Means Employed

The two-pronged purpose of the ordinances mentioned above was a result of the desire to reduce maternal and neonatal mortality rates. As discussed in Chapter II, there is no reasonable relationship between increase in facility-based births and decrease in maternal and neonatal mortality rates.[670] Maternal mortality rates continue to increase despite the increase in facility-based births.[671] Likewise, the neonatal mortality rate has remained relatively stagnant notwithstanding the continuous increase in facility-based births.[672] Further, the case studies presented in Chapter VI showed that home birth models can reduce maternal mortality even in developing countries, such as Sri Lanka, Ethiopia, and Bangladesh.

While said outcomes do not warrant the proposition that facility-based births have no role whatsoever in the reduction of maternal and neonatal mortality rates, said outcomes negate the conclusion that high home birth rates *per se* increase maternal and neonatal mortality rates. As discussed in the previous Chapters, the major causes of maternal and neonatal mortality are not attributable to the *place of birth* but to the *quality of care* received by the pregnant woman during childbirth.[673] Such role of a skilled birth attendance in the reduction of maternal and neonatal mortality rates was recognized in

669. The concept of proportionality is also a requirement for valid state action encroaching on rights recognized under the ICESCR. Proportionality means that "the least restrictive alternative must be adopted where several types of limitation are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review." ICESCR General Comment No. 14, *supra* note 156, ¶ 29.

670. *See* Ank de Jonge, et al., *Perinatal Mortality and Morbidity in a Nationwide Cohort of 529 688 Low-Risk Planned Home and Hospital Births*, 116 (9) BR. J. OBSTET. & GYNAEC. 1177, 1179 (2009).

671. National Statistics Office, 2011 Family Health Survey, *available at* https://www.scribd.com/doc/98939199/Maternal-and-Child-Health-Family-Health-Survey-for-2011 (last accessed Nov. 30, 2018).

672. *Id.*

673. *See* REDUCING MATERNAL MORTALITY: LEARNING FROM BOLIVIA, CHINA, EGYPT, HONDURAS, INDONESIA, JAMAICA, AND ZIMBABWE 1-2 (Marjorie A. Koblinsky ed., 2003).

the MNCHN MOP[674] and served as the basis for enacting Section 5 of the RH Law.[675]

F. Permissible Regulation

As discussed in the first part of this analysis, reproductive self-determination does not preclude regulation of the circumstances surrounding childbirth, provided that the measures are not coercive and/or discriminatory; this pertains to the negative aspect of human rights, non-interference with individual liberty.[676] In fulfilling the right to health and with regard to social entitlement, the second aspect of human rights, the State may adopt such measures to the end that only quality health care shall be delivered to the public.[677] The following are circumstances surrounding childbirth which the State may regulate in the exercise of police power.

1. Birth Attendance

The regulation of a profession is a proper subject of the police power of the State.[678] Licensure requirements and other regulatory measures are imposed on individuals seeking to be certified as health professionals, with the goal of protecting patients or clients from incapacity and incompetency of these prospective professionals and as a shield against fraud.[679] The State exercised this police power by enacting Republic Act 2644, the old midwifery law, which was then revised by Republic Act 7392, the Philippine Midwifery Act of 1992. Thus, at present, TBAs are not legally authorized to assist with childbirths. A home birth model should therefore be consistent with the provisions of the Philippine Midwifery Act; only licensed midwives and other skilled health professionals can assist with home births.

674. MNCHN Strategy Manual of Operations, ch. 2.3.1 (3) (citing Oona M.R. Campbell, et al., *Strategies for Reducing Maternal Mortality: Getting on with What Works*, 368 LANCET 1284, 1284-99 (2006)).

675. S. JOURNAL No. 48, at 915-16, 15th Cong., 2d Reg. Sess. (Jan. 31, 2012).

676. *See* ICESCR General Comment No. 14, *supra* note 156, ¶¶ 34 & 35 & DIXON-MUELLER, *supra* note 124, 4-5.

677. *See* ICESCR General Comment No. 14, *supra* note 156, ¶ 36 & *Ventura*, 4 SCRA at 213.

678. *Id.*

679. *Id.*

Nevertheless, the provisions of the Philippine Midwifery Act do not preclude task shifting. Task shifting was authorized by the Department of Health through a circular issued in 1994 which ordered the training of TBAs.[680] However, said move by the DOH is an example of task shifting carried out in the absence of legal mechanisms which suspend the provisions on illegal practice of midwifery.

The United Nations and the World Health Organization urges States to adopt legislation which protects the practice of health workers while regulating task shifting practice.[681] The RH Law is an example of legislation which protects health workers tapped for task shifting.[682] Thus, a health legislation aiming to increase the accessibility of healthcare should therefore contain provisions which accommodate task shifting. The proposed measure in this Note shall contain provisions enabling Barangay Health Workers and TBAs to be certified as skilled birth attendants, as in the case of Ethiopia and Bangladesh.

2. Mandatory Childbirth Education

In *Imbong*, the Supreme Court held that a provision requiring would-be spouses to attend a seminar on parenthood, family planning, breastfeeding, and infant nutrition constitutes a reasonable exercise of police power as there is no violation of the right to liberty, privacy, and religious freedom.[683] The Court held that those who receive the information are *not compelled to accept* such information and are free to reject the information they find unacceptable.[684] Thus, the Court differentiated between *passive acts* (receipt of information) and *active acts* (compulsion to accept and act on the information).[685] Requiring passive acts without compulsion to do active acts does not constitute infringement of the right to religious freedom, privacy, and liberty.[686]

680. Dept. Circ. No. 69-A, s. 1994.

681. World Health Organization, Task Shifting to Tackle Health Worker Shortages at 7, *available at* http://www.who.int/healthsystems/task_shifting_booklet.pdf (last accessed Nov. 30, 2018).

682. *See* The Responsible Parenthood and Reproductive Health Act of 2012, § 5, para. 2.

683. *Imbong*, 721 SCRA at 347.

684. *Id.*

685. *Id.*

686. *Id.* at 342.

The Magna Carta of Women provides that the State has the obligation to "provide women in all sectors with appropriate, timely, complete, and accurate information and education" on maternal health in government education and training programs.[687] Applying the ruling in *Imbong*, pregnant women can then be required to receive information on the advantages and disadvantages of home births and facility-based births as such does not violate their right to reproductive self-determination and their religious freedom. This requirement is consistent with the right to health as "information to enable a person to make informed decisions is essential in the protection and maintenance of ones' health."[688]

3. Least Intrusive Curtailment of Religious Freedom

In *Imbong*, the Supreme Court held that "only the prevention of an immediate and grave danger to the security and welfare of the community"[689] can satisfy the compelling state interest requirement for curtailment of religious freedom,[690] such as in "life-threatening cases that require the performance of emergency procedures."[691] Even if such immediate and grave danger exists, the regulation must be narrowly tailored such that the least intrusive means to achieve the state objective is adopted.[692]

A measure regulating IP's religious practices in home births should therefore satisfy two requirements: (1) immediate and grave danger to the life or health of the mother and/or of the child; and (2) the least intrusive means to protect the life of the mother and/or the child is adopted. Thus, the proposed measure which would affect IPs with religious childbirth practices shall limit State intrusion in the aspect of childbirth assistance. Only skilled birth attendants shall be allowed to assist with childbirths. However, IP traditions surrounding childbirth, such as home births, shall be allowed. Further, the proposed measure shall provide a community-based midwifery program as a form of task shifting so that *babaylans* in IP communities can be licensed as skilled birth attendants and skillfully assist with childbirths even in far-flung communities.

687. The Magna Carta of Women, ch. IV, § 17 (b).

688. *Imbong*, 721 SCRA at 353.

689. *Id.* at 341.

690. *Id.*

691. *Id.* at 345.

692. *Id.* at 342 (citing *Escritor*, 492 SCRA at 33).

IX. CONCLUSION AND RECOMMENDATION

A. The Unconstitutionality and the Human Rights Implications of the Ordinances

The issues surrounding home birth involve both liberty and social justice — liberty, as a matter of reproductive self-determination and as a civil and political right, and social justice as a matter of economic and social right.

With regard to the first point, under the right to reproductive self-determination, individuals have the right to make decisions concerning reproduction "free of discrimination, coercion and violence,"[693] and "[t]he right to make free and informed decisions, which is central to the exercise of any right, shall not be subjected to *any form of coercion* and must be fully guaranteed by the State."[694] Therefore, maternal health outcomes must be sought by means of empowerment through education and informed consent, consistent with the spirit of the RH Law. Mere invocation of the State's interest in the life of the unborn is not sufficient to overcome the right to reproductive self-determination as this Note has proved that the concept of adversarial pregnancy is limited to the abortion context and does not apply in wanted pregnancies. The ordinances likewise violate the right to life by penalizing home birth assistance even in life-threatening and emergency cases, in consonance with the pronouncement in *Imbong v. Ochoa, Jr.*[695] Further, the ordinances violate the right to culturally-sensitive health care and the right to religious freedom of IP women.

With regard to the second point, the ordinances do not meet the substantive due process requirements established in Philippine jurisprudence. The ordinances are unduly oppressive, discriminatory, and inconsistent with public policy. These also suffer from overbreadth. The ordinances failed the strict scrutiny test to the extent that the means used are not the least intrusive of private rights and there is no reasonable relation between the purpose of the police power measure and the means employed. Home births *per se* do not result in maternal and neonatal mortality. The studies discussed in this Note show that in both developed and developing countries, maternal and neonatal mortality can be reduced following home birth models. Further, maternal mortality in the Philippines continues to increase despite the increase in facility-based births. As emphasized in the RH Law and in the MNCHN MOP, skilled birth attendance is the key factor in reducing maternal and neonatal mortality.

693. The Responsible Parenthood and Reproductive Health Act of 2012, § 4 (s).

694. *Id.* § 3 (a) (emphasis supplied).

695. *Imbong*, 721 SCRA at 353-54.

Therefore, the ordinances prohibiting home births violate human rights and do not meet the jurisprudential requisites for a valid exercise of police power.

B. The Ordinances vis-à-vis the State's Maternal Health Obligations

While police power is pervasive in nature, its exercise cannot violate the same rights it seeks to protect — the right to health. The right to health includes "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference."[696] The obligation to respect under the right to health requires the State to refrain from direct or indirect interference with the right to health and to refrain from coercive healthcare measures, except on *an exceptional basis* "for the treatment of mental illness or the prevention and control of communicable diseases."[697] Clearly, pregnancy cannot be considered as within the purview of the abovementioned cases where coercive measures are justified.

Further, the obligation to respect the right to health mandates the State to refrain from *limiting access* to reproductive health services and from "preventing people's participation in health-related matters."[698] Coercive measures in health services are necessarily limiting and non-participatory. Health-related regulations aiming to fulfill human rights can in fact violate human rights when they *prohibit, criminalize, or hinder access* to health services as the State "coercively substitutes its will for that of the individual,"[699] thereby violating the right of the individual to autonomy and dignity.[700] Thus, such measures contradict the State's public health justification in enacting the prohibition.[701]

C. The Need to Amend the Responsible Parenthood and Reproductive Health Act of 2012

696. ICESCR General Comment No. 14, *supra* note 156, ¶ 8.

697. *Id.* ¶ 34.

698. *Id.*

699. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 576, ¶ 12.

700. *Id.* ¶¶ 12 & 13 & Uberoi & de Bruyn, *supra* note 542.

701. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* note 576, ¶ 18.

Failure to address maternal mortality is considered to be "one of the greatest social injustices of our times."[702] Thus, there is a need to adopt a legal framework which addresses the major causes of maternal mortality while, at the same time, respecting and protecting the human rights of pregnant women.

The concept of reproductive justice presupposes that the fulfillment of an individual's reproductive rights is contingent upon the fulfillment of the State's health obligations. Thus, non-interference with the right to reproductive self-determination is not sufficient to fulfill such right and the right to health in general. As previously discussed, the issues surrounding home births do not merely involve civil and political rights, but also economic and cultural rights. Therefore, the exercise of reproductive rights requires an enabling legal and institutional environment where human rights serve as the framework for health measures. As discussed in the case studies, the childbirth policies of other jurisdictions put great emphasis on a woman's autonomy on matters concerning her own childbirth. Further, even in developing countries, childbirth regulations focus on the accessibility and quality of health care, rather than on the reduction of maternal and neonatal mortality rates.

Notably, the RH Law has provisions that are consistent with a measure regulating home births: (1) Section 2 on the duty of the State to protect and promote the right to health of mothers, the centrality of women's human rights in the reproductive health efforts of the State, and universal access to reproductive health services;[703] (2) Section 3 on the right to reproductive self-determination,[704] the primacy of maternal health,[705] the treatment of pregnancy-related complications in a "humane, nonjudgmental[,] and compassionate manner,"[706] and the adequate and effective allocation of resources;[707] (3) Section 5 on the hiring of an adequate number of skilled health professionals for maternal health care, the duty to provide accessible services to those in geographically isolated or depressed areas, and the power

702. Report of the Office of the U.N. High Commissioner for Human Rights, *supra* note 339, ¶ 17 (citing R.J. Cook, et. al, Advancing Safe Motherhood through Human Rights (Report by the WHO Department of Reproductive Health and Research) at 5, *available at* http://whqlibdoc.who.int/hq/2001/WHO_RHR_01.5.pdf?ua=1 (last accessed Nov. 30, 2018)).

703. The Responsible Parenthood and Reproductive Health Act of 2012, § 2.

704. *Id.* § 3 (a).

705. *Id.* § 3 (c).

706. *Id.* § 3 (j).

707. *Id.* § 3 (n).

of midwives to administer life-saving drugs;[708] and (4) Section 6 on the duty of LGUs to provide other means of delivering health services, such as mobile health clinics and home visits, to those situated in GIDAs.[709]

However, the current provisions of the RH Law are insufficient to safeguard the rights of pregnant women. According to the Supreme Court, while the RH Law contains special provisions on maternal health, the bulk of the RH Law refers to family planning.[710] Despite the ultimate goal of improving maternal and newborn health, the law failed to exhaust the various aspects of reproductive rights in the context of childbirth. The Magna Carta of Women also has a provision on culture sensitivity of maternal healthcare.[711] However, the provisions of the Magna Carta of Women are likewise insufficient to protect the rights of pregnant women.[712] The lack of specific reproductive health guidelines in the Magna Carta of Women has left LGUs with unbridled discretion in the interpretation and implementation of maternal health measures.[713] Such insufficiency was deemed a discriminatory act against women by the drafters of the RH Law.[714] The RH Law was therefore intended to be a special law on all aspects of reproductive health, setting forth specific guidelines on general entitlements provided under the Magna Carta of Women.[715]

Considering the foregoing, the proposed amendments will amend the RH Law by setting standards in the regulation of childbirths so as to protect women's reproductive rights in the community level. The amendments to the RH Law will focus on health empowerment, informed choice, accessibility, and community-based care, in accordance with the AAAQ standards under the right to health.

D. Features of the Amendments

1. Establishment of a Strong Home Birth System

The proposed amendments will neither encourage nor discourage home births. The amendments shall merely put in place safety guidelines to protect the life of the mother and of the unborn, whether childbirth occurs at home

708. *Id.* § 5, para. 2.

709. The Responsible Parenthood and Reproductive Health Act of 2012, § 6.

710. *Imbong*, 721 SCRA at 287.

711. *See* The Magna Carta of Women, ch. IV, § 17.

712. S. JOURNAL No. 42, at 807, 15th Cong., 2d Reg. Sess. (Dec. 13, 2011).

713. *Id.*

714. *Id.*

715. S. JOURNAL No. 21, at 337, 15th Cong., 2d Reg. Sess. (Sep. 20, 2011).

or at a health facility. The Department of Health shall be tasked to develop safety guidelines specifically addressing home birth issues. These guidelines include eligibility for home births, qualifications of health care professionals, and risk management strategies. The issuance of specific guidelines on home births is necessary because at present, only facility-based births are covered by DOH guidelines, leaving home births unregulated and riskier. Further, the amendments will prohibit any public officer or health care service provider from depriving women of a choice between alternatives, such as between facility-based births and home births, whether by way of policy, legislation, or fund allocation. Such prohibition is necessary to protect the reproductive rights of pregnant women and preclude any form of coercion.

Also, the multitude of barriers in accessing health facilities inevitably results in an abandonment of those who cannot, by choice or circumstance, give birth at health facilities. Thus, fulfilling the right to health of mothers necessitates a decentralization of healthcare — from facilities down to the communities. A common theme in health reforms of countries which have reduced maternal and neonatal mortality rates is the improvement of home birth conditions by providing skilled birth assistance and maternity care services at home.[716] Only when governments have established strong home-based health care systems did they shift to facility-based births.[717] The amendments shall be patterned after the health reforms of developing countries which have successfully reduced maternal and neonatal mortality following home birth models.

2. Women's Reproductive Rights in Childbirth

The proposed amendments shall expressly recognize reproductive rights in childbirth as an essential aspect of social justice and provide the scope of reproductive rights in the context of childbirth. As previously discussed, while the main goal of the RH Law is the reduction of maternal and neonatal mortality, maternal health provisions were overshadowed by family planning provisions, leaving LGUs with unbridled discretion in enacting maternal health measures which violate human rights. The express declaration of women's reproductive rights in childbirth shall ensure that LGUs will adopt health measures consistent with the reproductive and constitutional rights of pregnant women. The reproductive rights of pregnant women shall be set forth as a component of the guiding principles for implementation.

716. *See* REDUCING MATERNAL MORTALITY: LEARNING FROM BOLIVIA, CHINA, EGYPT, HONDURAS, INDONESIA, JAMAICA, AND ZIMBABWE, *supra* note 673, at 25.

717. *Id.*

Further, a provision shall expressly recognize the autonomy of pregnant women to make healthcare decisions and their right to receive evidence-based information on childbirth methods to arrive at an informed choice between alternatives.

3. Mandatory Childbirth Education and Securing Informed Consent

The previous Chapter has established that health education, i.e. passive measures, do not infringe constitutional rights and may be required by the State, provided that individuals are not forced to act on the information received. Information on matters relating to one's childbirth is necessary for the fulfillment of the right to health in general and of the right to reproductive self-determination in particular. Thus, the amendments will require the DOH and the LGUs to enact measures for mandatory childbirth education wherein pregnant women will be informed of the benefits and risks of various childbirth options, such as home births versus facility-based births. The accuracy and scientific basis of the information shall be assured by the DOH.

Corollary to the requirement of education is informed consent. Informed consent is said to be the "bridge between evidence-based care and human rights in childbirth" — information referring to the evidence and consent referring to human rights.[718] The requirement of informed consent precludes the use of coercion in maternal health measures. Thus, the amendments seek to empower women to make informed healthcare decisions by setting out the specific responsibilities of healthcare providers in securing informed consent.

Further, the provision on informed consent requires public healthcare professionals to determine barriers in choosing the recommended healthcare measures. LGUs are tasked to encourage women to choose such recommended measures by removing barriers to healthcare. Measures to improve health-seeking behavior and service utilization are likewise provided.

4. Regulation of Childbirth Assistance

The most important facet of childbirth laws is skilled birth attendance. A strong home birth system will only fulfill the right to health if individuals can be assured of quality care. Thus, the amendments complement the current provisions of the RH Law, endeavoring the hiring of a sufficient number of skilled health professionals, by mandating that LGUs must

718. Hermine Hayes-Klein, Informed Consent in Childbirth, *available at* http://www.humanrightsinchildbirth.org/blog/2014/3/7/informed-consent-in-childbirth (last accessed Nov. 30, 2018).

develop measures to ensure that all childbirths, whether at home or at a facility, are assisted by skilled health professionals. Such requirement is important because under the RH Law, only skilled health professionals can administer life-saving drugs. Sufficient legroom is provided for IPs with recognized religious leaders who also serve as TBAs; the religious leaders can coordinate with the skilled health professional for arrangements on culturally sensitive childbirth assistance. However, the skilled health professional shall be the main attendant and the religious leader shall have a supportive role. Such regulation satisfies the benevolent-strict scrutiny test as the limitation on religious beliefs is narrowly tailored — only in the aspect of childbirth assistance. The provision would likewise provide an exception in emergency situations, such as in unexpected labor and in the absence of skilled health professionals, wherein community-based midwives who have completed a special curriculum on community-based midwifery may assist with childbirths.

5. Special Provisions for IPs' Childbirth Traditions and Cultural Sensitivity in Healthcare

The proposed amendments integrate culture sensitivity in healthcare, presently found in the Magna Carta of Women, into the RH Law. Such integration is necessary because culture plays an important role in reproductive health decisions, as provided in the RH Law. The amendments will therefore set standards to be observed by healthcare providers in delivering health services to IPs. The LEARN method of cultural sensitivity was included in the amendments to preclude coercion and imposition by LGUs. Further, a specific provision for respecting IP traditions surrounding childbirth was included. The DOH, in coordination with the NCIP, is tasked to determine the extent by which childbirth rituals may be harmful to the mother or to the child and to discourage such rituals by following the LEARN method.

6. Provisions for Task Shifting

The amendments seek to incorporate task shifting provisions for three reasons: (1) to provide legal protection to workers tapped for task shifting; (2) to answer the unmet need for health human resource; and (3) as a step to progressively realize the fulfillment of the right to health. As previously discussed, the DOH has been employing *de facto* task shifting because of the need to expand the country's human resources in healthcare, while maintaining the prohibition on unlicensed practice of midwifery. The lack of human resources in healthcare does not justify abandonment of those who cannot give birth at health facilities.[719] The obligation of the State to take

719. ICESCR General Comment No. 3, *supra* note 641, ¶ 12.

steps to fully realize the right to health is of immediate effect.[720] Hence, the provisions for task shifting is a deliberate and targeted step towards decentralizing the delivery of health services, making healthcare more accessible and acceptable.

The proposed amendment seeks to establish a special community-based midwifery program where health workers, such as BHWs and TBAs, can be licensed and certified as community-based midwives. The RH Law amends the Philippine Midwifery Act of 1992.[721] Thus, task shifting provisions in the RH Law shall likewise amend the definition of midwives and practice of midwifery in the Philippine Midwifery Act of 1992.

7. Removal of Barriers to Healthcare

Considering the multitude of barriers which prevent pregnant women from accessing facility-based care, a rights-based approach to maternal health calls for measures which do not penalize women for failure to access health services but, instead, remove barriers to healthcare. Specifically, the amendments seek to uphold non-discrimination, physical, economic, and information accessibility of healthcare as essential elements of the right to health.[722] As with health reforms in other countries, accessibility and quality of health services shall be the main thrust of the amendments; the reduction of maternal and neonatal rates will only be treated as the ultimate goal. The amendments will therefore include provisions on availability of life-saving drugs and identification of barriers and measures to eliminate barriers to healthcare.[723]

8. No Encroachment on the Autonomy of LGUs

Providing specific reproductive health guidelines at the local government level does not intrude upon the powers devolved to LGUs under Section 17 of the Local Government Code. Section 17 vested upon the LGUs the duties and functions of delivering basic services and facilities.[724] In *Imbong v. Ochoa*, the Court ruled that the exception provided in paragraph (c) of Section 17 applies in the case of the RH Law — "unless an LGU is particularly designated as the implementing agency, it has no power over a

720. *Id.* ¶ 2.

721. The Responsible Parenthood and Reproductive Health Act of 2012, § 29.

722. ICESCR General Comment No. 14, *supra* note 156, ¶ 12 (b).

723. *Id.* ¶ 12 (a). Life-saving drugs are considered as essential medicines by the World Health Organization. General Comment No. 14 of the ICESCR provides that an essential element of the right to health is the availability of life-saving drugs. *Id.*

724. LOCAL GOV'T CODE, ch. II, § 17.

program for which funding has been provided by the national government under the annual general appropriations act, even if the program involves the delivery of basic services within the jurisdiction of the LGU."[725] The provisions of the RH Law on maternal health provide that it is the national government which shall provide funding for its implementation.[726] The Court further went on to say that "[l]ocal autonomy is not absolute. The national government still has the say when it comes to national priority programs which the local government is called upon to implement like the RH Law."[727] The Department of Health is the implementing agency for the provisions of the RH Law.[728] Therefore, the exception to the exception under Section 17 (c) of the Local Government Code does not apply.

725. *Imbong*, 721 SCRA at 370 (citing Pimentel, Jr. v. Ochoa, 676 SCRA 551, 559-60 (2012)).

726. *See* The Responsible Parenthood and Reproductive Health Act of 2012, §§ 5, 6 & 16.

727. *Imbong*, 721 SCRA at 370-71.

728. The Responsible Parenthood and Reproductive Health Act, § 19 (a).