

RESEARCH BRIEF

Ban on Home Birth and Pursuit of Safety in Delivery

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Individuals pursue different ends through different means, many of which may be collectively considered reasonable. Sometimes, however, individuals may need help to achieve their goals. At those times, the society, most notably the government, should be there to assist them. But, because personalized information on individuals' varied ends and varied means are costly to obtain and likely to be imperfect when obtained, the society, particularly the government, should, from a capability perspective, which is a normative framework used to evaluate how social arrangements are expanding people's freedom to live the lives they have reason to value (Robeyns, 2005, p. 94), target for people to have the freedom to pursue and live the lives they would like to lead (Sen, 1999).

Individuals are, however, subject to bounded rationality. With limited information, limited cognitive ability, and limited time to process information, they may make decisions that are, upon further consideration, not in their best interests. Society may thus provide facilities for development, but individuals, being less than fully rational, may fail to take advantage of these opportunities (Kahneman, 2011; Thaler & Sunstein, 2009).

Paternalism, or the policy of interference by someone, often the government, in the affairs of another, often the public, for the latter's benefit, seems apt in leading individuals to behave rationally. However, paternalists themselves are individuals subject to bounded rationality. They may, as such, hold inaccurate views about other individuals' goals and how those are best achieved. Thus, despite its intentions, paternalism may leave individuals vulnerable to the paternalist's mistakes.

Further, a lot depends on the accountability relationship in which the government is situated. Paternalism may take place in environments that allow paternalists to compel individuals to behave in ways that are apt in the paternalists' view regardless of the individuals' own views. It therefore leaves the individuals vulnerable not only to the paternalists' incompetence but also to their abuse as the latter may oblige the individuals to conduct themselves in certain ways to promote other interests that may run against their own. Therefore, although paternalism is, by definition, intended to prevent individuals from tripping over their own feet, so to speak, it may, in practice, put them at risk of tripping over the paternalists' feet (Easterly, 2006).

This paper touches on the issue of the suitability of strict paternalism (i.e., a type of paternalism where the paternalized may not opt out) as a development strategy by reporting on a paternalistic policy implemented to improve safety in delivery in Almeria, Philippines: ban on home birth. In implementing the ban, the local government makes two claims: (i) safety in delivery must be pursued; and (ii) the best way to promote it is through facility-based delivery. Hardly anyone will argue against the first claim, but, noting that some women may have reasons to disagree with the second one, the local government based the ban on two further claims: (i) those reasons matter less than safety in delivery; and (ii) women are better off compelled having facility-based delivery regardless of the reasons they may have against it. We examine the appropriateness of this policy by asking three questions: (i) If safety in delivery is a common goal, why do some women pursue it differently? (ii) In light of these reasons, what are the likely harms of the ban on home birth? and (iii) How should alternatives be designed to prevent these harms?

Ban on Home Birth in Almeria, Philippines

Almeria is a poor municipality in the province of Biliran, an island in central Philippines. Until 2005, seven out of 10 normal births in the province took place at home and were assisted by non-professional attendants. In the same year, the rate of maternal mortality in the province was 289 per 100,000 live births while that of infant mortality was 17 per 1,000 live births (Department of Health, 2005, p. 23).

In line with the Philippine Government's commitment to reduce maternal and infant mortalities to 52 per 100,000 live births and 19 per 1,000 live births respectively by 2015, the province of Biliran was, in 2006, selected to benefit from a number of interventions to improve both the provision and consumption of institutional maternal and child care. To improve the supply of institutional care, the Department of Health (DOH), in collaboration with the local government and local health units, with support from foreign donors, initiated the development of facilities capable of Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric

and Newborn Care (CEmONC), trained professional and non-professional maternal and child care providers, and developed local health systems. To match the increase in supply of institutional care with an increase in demand, the local government and local health units promoted the use of health services and facilities in the province. More importantly, later during the year, the Philippine Health Insurance Corporation (PhilHealth) accredited Almeria's rural health unit (RHU), which allowed PhilHealth members as well as the dependents of members to avail of maternity and newborn care services at the RHU at a substantially-reduced rates (Department of Health, Biliran Provincial Government, Ifugao Provincial Government, & Japan International Cooperation Agency, 2010, p. 17).

To further boost the demand for institutional maternal and child care, the Municipality of Almeria issued, in 2007, a resolution with the following provisions:

“Hilots (traditional birth attendants) whether trained or untrained are hereby prohibited from performing live birth deliveries at home. Failure to follow will be meted with the following penalties:

1. First offense – reprimand
2. Second offense – fine of P500.00 or rendition of community work for 8 hours a day for 2 days at the discretion of the court
3. Third offense – fine of P1,000.00 or imprisonment for 3 days at court discretion

Likewise, pregnant women delivering at home shall also be fined with the following penalties:

1. An amount of P1,200.00 shall be collected for those first deliveries made outside the maternity clinic
2. Subsequent deliveries outside the designated maternity lying in shall be fined an amount of P700.00.” (Resolution No. 15, S-2007, 2007, pp. 3-4)

Not long after the interventions, including the ban, were put in place, Biliran saw notable reductions in cases of traditional birthing and rate of maternal mortality as indicated in Table 1.

Table 1
Birth Arrangement and Maternal and Infant Mortalities in 2006, 2009, and 2012

| Results Indicators | 2006 | 2009 | 2012 |
|---------------------------------------|------|------|------|
| Output | | | |
| Delivery at home (%) | 67 | 6 | 4 |
| Attendance by a non-professional (%) | 76 | 5 | 3 |
| Outcome | | | |
| Maternal mortality (per 100,000 l.b.) | 289 | 155 | 51 |
| Infant mortality (per 1,000 l.b.) | 17 | 17 | 20 |

Source: Department of Health, 2006, 2009, and 2012.

Proponents readily attributed the sudden transition to institutional birthing arrangements and the reduction in maternal mortality to the interventions, including the ban. Almeria's resolution banning home birth is the first ban on home birth in the country. Along with the news of its apparent success, the policy of banning home birth quickly spread to other villages and municipalities within the province of Biliran, and even to some villages, municipalities, and cities in northern Philippines (e.g., Barangay San Marcos, Municipality of Alfonso Lista, Quezon City). This is despite the facts that the extent of the change attributable to the ban, if any, can only be determined through a rigorous impact evaluation, and that, thus far, none has been conducted.

However, aside from the question of effectiveness, another important question with regard to the ban is: If safety in delivery was a goal shared by women and the proponents of the ban, then why had some women pursued it differently? In other words, if the proponents of the ban saw home birth as unsafe, why had some women, who supposedly also aim for safe delivery, gone for home birth?

Pursuit of Safety in Delivery

Women who decide to have home birth cite either or both reasons: (i) facility-based delivery is not an option for them; or/and (ii) they do not perceive facility-based delivery as an option that is superior to home birth.

Home birth was a popular option among women in Almeria because many of them faced financial and accessibility constraints that rendered facility-based delivery not a real option. The 2013 Philippine National Demographic and Health Survey (NDHS) reported that

two of the top three reasons cited by women (i.e., age 15-49 who had a live birth outside a health facility in the five years preceding the survey) for not delivering in a health facility were: (i) it "costs too much"; and (ii) the facility was "too far" or there was "no transportation" (Philippine Statistics Authority and ICF International, 2014, p. 108). These findings at the national level were confirmed by the local government officials and health workers to be true in the municipality before the interventions were implemented. Facility-based delivery for first-time mothers, for instance, costs 1,650 pesos for women without health care coverage, while the minimum wage in the locality is only 250 pesos. Health facilities were also, prior to the interventions in Almeria, few and far between based on interviews with the Mayor and local health workers in June 2013.

These constraints are not unique to the Philippines. In Bangladesh, for example, it was found that:

"A significant constraint for women [in deciding where to give birth], most of whom were poor, was the lack of financial resources to access Bangladesh Rural Advancement Committee Health Center." (Afsana & Rashid, 2001, p. 81)

Likewise, in Western China, "difficulty in travel to hospitals" and "cost of hospital delivery" were identified as among the barriers to hospital delivery (Gyaltsen, Gyal, Gipson, Kyi, & Pebley, 2014, p. 164).

Despite having access to health facilities and having enough money to pay for institutional care, some women in Almeria still opted for home birth because of the absence, in their view, of a clear case for facility-based delivery. The 2013 Philippine NDHS reported that aside from financial and accessibility

constraints, women cited “not necessary” as one of the top three reasons for not delivering in a health facility (Philippine Statistics Authority and ICF International, 2014, p. 108). Related to this finding at the national level, local government officials and health workers in Almeria shared that the confidence some women had in home birth would have delayed the transition to institutional birthing in the municipality had home birth not been banned there and in other municipalities in the province. Some women, they said, who had already tried home birth and did not have much difficulty during delivery had developed a sense of assurance that they can deliver their next child at home with as little difficulty as they previously had. They cited as an example a woman who found it hard to appreciate the additional value of a facility-based delivery for her sixth child after having safely delivered five children through home birth and not getting any indications that her sixth pregnancy was high risk. As home used to be the default place of delivery before health facilities became widespread, confidence in home birth among many women is neither surprising nor uncommon. In Bangladesh, it was found that:

Most women and their families were reluctant to spend money on something that was perceived to be a natural event that can be practised at home at negligible expense. (Afsana & Rashid, 2001, p. 81)

For pregnancies that are not considered high risk, scholars considered access to emergency obstetric care, not facility-based delivery per se, as crucial for safe delivery. As Berer (2007) notes, “[t]here is no longer any disagreement that good nutrition and effective treatment during pregnancy for chronic conditions such as anaemia, diabetes, HIV, TB, and malaria; delivery with a skilled attendant; and access to timely obstetric care, when required, are the best way to avoid unnecessary deaths and morbidity in women and newborns” (p. 6).

For one thing, some women found facility-based delivery wanting in terms of privacy. The 2013 Philippine NDHS reported that some women who opted out of facility-based delivery had done so because they “don’t trust [the] facility” or they perceive the quality of its services as “poor” (Philippine

Statistics Authority & ICF International, 2014, p. 108). In Almeria, the local government officials and health workers shared that some women are uncomfortable with the extent of exposure they get when giving birth at a facility. Many women, for example, prefer to keep their private parts from public view, and therefore feel more secured having their lower extremities covered with a blanket during birth and not being surrounded by many unfamiliar faces during labour. But, while traditional birth attendants had no problems working with blankets, and women had greater control over who were at home while they were giving birth, institutional care was less sympathetic to women’s need for privacy. Professional birth attendants found a blanket an unnecessary interference to their facilitation, and interns at the facility often appear during delivery without permission from women. Accounts of similar and related experiences can also be found in other countries. In Bangladesh:

privacy was not well maintained due to a lack of cultural understanding and dismissive attitudes towards poor women... They [women] admitted to feeling uncomfortable lying undressed on the labour table in front of unfamiliar faces. (Afsana & Rashid, 2001, p. 83)

Similar concerns about neglect of privacy in hospital practice were raised by women in Nicaragua (Kvernflaten, 2013, p. 35).

For another, some women found institutional care less considerate and even humiliating. Local government officials and health workers in Almeria acknowledged that some women received “scolding” from professional birth attendants, while the traditional birth attendants, in contrast to the professional birth attendants, went the extra mile to make women feel understood and cared for. The same scenario was found in Benin, Bangladesh, Uganda, and Nicaragua. In Benin:

many [women] complained about not being able to ask questions or get any explanations, being mistreated and humiliated by health personnel and described the anguish they felt in the face of medical procedures they did not understand. (Grossman-Kendall, Filippi, De Koninck, & Kanhonou, 2001, p. 90)

In Bangladesh:

women and their families were not always clearly informed of the reasons for physical examinations, why medication was required, the progress of labour, the condition of the baby, the baby's sex, whether the delivery would require surgical intervention [...] As a result, they were left worrying and anxious about many things and at worst were made to feel like passive objects. (Afsana & Rashid, 2001, p. 82)

In Uganda:

women found it impossible to express and communicate their pains to the health workers or receive an appropriate sympathetic response. (Kyomuhendo, 2003, p. 22)

In Nicaragua:

[w]omen and their families were often dissatisfied with the care received. Their complaints focused on poor treatment, long waiting lines and unpleasant personnel. (Kvernflaten, 2013, p. 37)

Women and the proponents of the ban on home birth assume different roles in society; although they share the goal of safety in delivery, they define the concept differently. For the proponents of the ban, safety in delivery is basically reduction in, if not elimination of, maternal and infant mortalities and morbidities. This is because these are the measures by which their performances as local government officials and professional health workers are being assessed. Women, who themselves give birth, and find themselves in a vulnerable position while doing so, on the other hand, adopt a broader definition of safety in delivery. To them, it is the condition where the mother and the infant emerge from delivery alive and well, but also where the mother's needs for financial security, privacy, good relationship, and respect throughout the whole birthing process are met. Safety in delivery is, therefore, broadly conceived by women as having protection not only from threats to life and health, but also from threats to privacy, dignity, and economic

security. This broader definition of safety in delivery makes home birth, in some cases, a more suitable option for women.

Likely Harms of the Ban on Home Birth

As women consider financial security, privacy, good relationship, and respect throughout the whole birthing process as important elements of safety that are inextricable to their birthing experience, and home birth, as they find it, sometimes provides these better than institutional birth does, the ban on home birth could actually be harming rather than helping women's development.

Human development is basically the accumulation of human value. The ban on home birth could be harming women's human development by discounting the human value that they already have, by restricting the ways by which they can acquire human value, and by limiting the kinds of human value that they can acquire.

First, the ban on home birth could be harming women's human development by discounting the human value that they already have. Except in cases of severe intellectual disability, the ability to know is considered inherent in adults in most, if not all, societies. By disregarding the birth plans that women may have carefully formed for themselves, and limiting the latitude they may exercise in forming their future birth plans, the ban on home birth could be harming women by withholding the credibility that they are entitled to as adults. When their knowledge is denied and their capacity as a knower is deprecated, women may suffer insult in the short term and stunted self-development in the long term (Code, 2008, para. 2). Some scholars consider this wrong, and call it testimonial injustice (Fricker, 2007). Ill persons or patients in a healthcare setting, some scholars noted, are particularly vulnerable to this kind of epistemic injustice as they are, in their state of illness or in their role as patients, often readily thought of as "cognitively unreliable" or "emotionally unstable" and thereby undeserving of credibility due to normal adults (Carel & Kidd, 2014, pp. 530-531).

The experience of Ara Chawdhury, a woman who had home water birth in Biliran in 2013 when the ban

on home birth was already province-wide, illustrates how the ban on home birth could cause women to suffer testimonial injustice (Chawdhury, 2013):

[...] My mother's house is almost entirely made of Nipa, so I could hear every painful thing my mother's siblings were saying about my refusal to go with the ambulance, which had already left.

They ranted about how stubborn I was, how correct I thought I was for refusing professional help, etc etc. The people making these statements weren't part of my birth plan nor were they briefed about water birth [...]

As much as I know they were only looking out for me and my baby's well being, I resent that they wouldn't respect my birthing decisions enough to leave me to it. You'd think they'd at least understand that I was prepared for this and had done my research. And if there was going to be any authority over how this baby was going to come out of me, it was going to be me. (paras. 6, 7, 9)

Second, the ban on home birth could be harming women's human development by restricting the ways by which they can acquire human value. Having control over important matters in one's life is valuable in and of itself. Living is not just relishing achievements and bemoaning failures. The process that precedes those achievements and failures (e.g., thinking, deciding, and taking action) is also constituent of living that people value, particularly when they feel strongly about their goals and they have formed preferences for pursuing them. Because giving birth is often an anticipated event in a woman's life, the ban on home birth could be forcing some women, especially those who have devised personal birth plans that may involve home birth, to relinquish control over their birth arrangements even when they would have wanted more influence over this momentous event in their lives.

Third, the ban on home birth could be harming women's human development by limiting the kinds of human value that they can acquire. Except for those who intend to abort their pregnancy, women normally aim for safe delivery. However, they may want this in

conjunction with the other considerations that they may have. They may, for example, want to deliver their baby safely in a private setting, assisted by a caring birth attendant, at an affordable cost; birthing aspirations that are not beyond the pale. As facility-based delivery sometimes falls short of women's requirements, and home birth, in some cases, cater to women's needs better than facility-based delivery does, the ban on home birth could be harming women by forcing on them a quality of care that is below their standards.

Reducing maternal mortality was surely an important societal goal, and not an easy accomplishment. The local government officials and health workers must have done some things right to have made it happen. Whether the ban on home birth was one of them is something that only a rigorous impact evaluation can confirm. But, regardless of its contribution, if any, to the reduction in maternal mortality, the ban, through the assumptions on which it is based and the mode by which it operates, could be posing harm on women's human development. The next question then is how alternatives should be designed to prevent these harms.

Alternatives to the Ban on Home Birth

To begin with, the proponents of the ban on home birth should try to promote safety in delivery in its broader sense. This means improving the accessibility and affordability of institutional care, and accommodating women's other birthing considerations, including those that concern respect and privacy (Grossman-Kendall et al., 2001, p. 96; Gaitonde, 2012, p. 122). When institutional care reaches a state where it is able to satisfy these requirements, women will have fewer reasons not to seek institutional care once reached by standard promotions. In Lao PDR, for example, despite the general notion that cultural practices are hard to change, women are gradually abandoning the cultural practice of forest-based delivery in favor of home-based and facility-based deliveries, which have been demonstrated as far safer and more convenient alternatives (Alvesson, Lindelow, Khanthaphat, & Laflamme, 2013, p. 203).

From a capability perspective, freedom is best promoted by more freedom, not less. In this view, a suitable alternative would be one that enhances, not

replaces, women's decision-making. *Burod-tabang-burod* or (pregnant-helping-pregnant) is one of the promotional strategies, which the local health officials in Almeria started employing around the same time that the ban on home birth was implemented, to help expectant mothers learn about the value of accessing appropriate health services from their fellow pregnant women and also post-partum women. Their testimonies carry the credibility of someone who is going through the same experience or who has gone through it and succeeded. They therefore offer women access to lived experiences from which they can learn and re-assess the birthing arrangements before them.

Well-designed information and education campaigns are effectively employed by parties who aim to elicit certain behaviors from their target audience, but who do not possess police power to enforce those behaviors. This mode works for businesses and non-government advocates. If the institutional care that the government offers meets women's standards and is better than other alternatives, there is no reason why the same mode would not work for the government. It does not guarantee total switch to institutional care, but it guarantees procedural requirements that uphold women's dignity and leaves them with greater freedom to pursue their respective birthing aspirations more effectively.

Conclusion

Whether home birth is better than facility-based delivery or the other way around depends very much on context, which varies widely from place to place and even from woman to woman. These contextual variations show that giving birth is not merely a matter of survival; but, broadly viewed, is a matter of security that encompasses the safety of the infant and the mother, the dignity of the mother, and the stability of the household's economic resources. For this reason, it makes more sense to count not how many women had facility-based delivery, but how many women had the real opportunity to have a secured birthing experience, and work towards increasing the latter rather than the former.

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