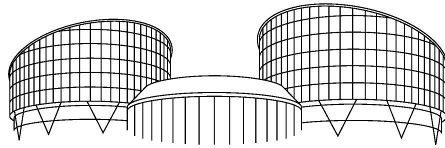

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

GRAND CHAMBER

CASE OF DUBSKÁ AND KREJZOVÁ v. THE CZECH REPUBLIC

(Applications nos. 28859/11 and 28473/12)

JUDGMENT

STRASBOURG

15 November 2016

This judgment is final. It may be subject to editorial revision.

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

In the case of Dubská and Krejzová v. the Czech Republic,

The European Court of Human Rights, sitting as a Grand Chamber composed of:

Guido Raimondi, *President,*
András Sajó,
Işıl Karakaş,
Luis López Guerra,
Mirjana Lazarova Trajkovska,
George Nicolaou,
Kristina Pardalos,
Julia Laffranque,
Helen Keller,
Helena Jäderblom,
Aleš Pejchal,
Valeriu Griţco,
Faris Vehabović,
Dmitry Dedov,
Egidijus Kūris,
Jon Fridrik Kjølbro,
Síofra O'Leary, *judges,*
and Johan Callewaert, *Deputy Grand Chamber Registrar,*

Having deliberated in private on 2 December 2015 and on 15 September 2016,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case originated in two applications (nos. 28859/11 and 28473/12) against the Czech Republic lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by two Czech nationals, Ms Šárka Dubská and Ms Alexandra Krejzová ("the applicants"), on 4 May 2011 and 7 May 2012 respectively.

2. The applicants were represented by Mr D. Záhumenský, a lawyer with the human rights organisation Liga lidských práv, and Mr R. Hořejší, a lawyer practising in Prague. The Czech Government ("the Government") were represented by their Agent, Mr V.A. Schorm, of the Ministry of Justice.

3. The applicants alleged that Czech law did not allow health professionals to attend home births, in violation of Article 8 of the Convention.

4. On 11 December 2014, following a hearing on admissibility and the merits (Rule 54 § 3), a Chamber of the Fifth Section, composed of Mark Villiger, President, Angelika Nußberger, Boštjan M. Zupančič, Ganna Yudkivska, André Potocki, Paul Lemmens and Aleš Pejchal, judges, and also of Claudia Westerdiek, Section Registrar, delivered a judgment in which it held, by six votes to one, that there had been no violation of Article 8 of the Convention. The concurring opinions of Judges Villiger and Yudkivska and the dissenting opinion of Judge Lemmens were annexed to the judgment. On 10 March 2015 the applicants requested the referral of the case to the Grand Chamber in accordance with Article 43 of the Convention. On 1 June 2015 the panel of the Grand Chamber granted that request.

5. The composition of the Grand Chamber was determined according to the provisions of Article 26 §§ 4 and 5 of the Convention and Rule 24 of the Rules of Court.

6. The applicants and the Government each filed further written observations (Rule 59 § 1) on the merits. The parties replied in writing to each other's observations. In addition, third-party comments were received from the Government of the Slovak Republic, the Government of the Republic of Croatia, the Royal College of Midwives (United Kingdom), the International Study Group of the World Association of Perinatal Medicine, the Czech Union of Midwives (UNIPA – *Unie porodních asistentek*) and Ms Anna Šabatová, Public Defender of Rights (*Veřejná ochránkyně práv*), all of whom had been given leave by the President to intervene in the written procedure (Article 36 § 2 of the Convention and Rule 44 § 3). The parties replied to those comments (Rule 44 § 6).

7. A hearing took place in public in the Human Rights Building, Strasbourg, on 2 December 2015 (Rule 59 § 3).

There appeared before the Court:

(a) *for the Government*
Mr V.A. SCHORM, *Agent*,
Mr O. HLINOMAZ, Office of the Government Agent, Ministry of Justice,
Ms J. MARTINKOVÁ, Office of the Government Agent, Ministry of Justice,
Ms D. KOPKOVÁ, Ministry of Health,
Mr J. FEYEREISL, Head of the Institute for the Care of Mother and Child, President of the Czech Gynaecological and Obstetrical Society,
Mr P. VELEBIL, Head of the Perinatal Centre of the Institute for the Care of Mother and Child, Scientific Secretary of the Czech Gynaecological and Obstetrical Society, *Advisers*;

(b) *for the applicant Ms Dubská*
Ms Z. CANDIGLIOTA, *Counsel*,
Ms P. JANSSEN, Professor, Maternal Child Health, School of Population and Public Health, University of British Columbia, Associate Member, Department of Family Practice, Obstetrics and Gynaecology and School of Nursing, University of British Columbia,
Ms S. SLÁDEKOVÁ, *Advisers;*

(c) *for the applicant Ms Krejzová*
Mr R. HOŘEJŠÍ, *Counsel*,
Ms A. HOŘEJŠÍ,
Ms M. PAVLÍKOVÁ, *Advisers*.

The applicant Ms Krejzová was also present.

The Court heard addresses by Ms Candigliota, Mr Hořejší, Mr Schorm and Mr Velebil, and also replies by Ms Janssen to questions put by Judges.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

8. The applicants were born in 1985 and 1980 and live in Jilemnice and Prague respectively.

A. Application lodged by Ms Šárka Dubská

9. The applicant gave birth to her first child in hospital in 2007 without any complications. According to her, during the birth the medical personnel present were urging her to agree to undergo various kinds of medical intervention even though she had expressly stated her wish not to be subjected to any unnecessary medical treatment. She was also forced to give birth in a position she did not find comfortable. She wanted to leave the hospital a few hours after the birth as both she and the baby were healthy, but a doctor ordered her to stay in the hospital. She therefore did not leave until the next day, when she presented a letter from her paediatrician, who confirmed that the applicant would take care of the child.

10. In 2010 the applicant became pregnant for the second time with an expected delivery date in the middle of May 2011. The pregnancy was free from complications and the medical examinations and tests did not indicate any problems. Since she considered that giving birth in a hospital had been stressful for her, the applicant decided to give birth at home and searched for a midwife to assist at the birth. However, she was unable to find any midwife who was willing to assist her with a home birth.

11. On 5 April 2011 she wrote to her health-insurance company and to the Liberec Regional Office (*krajský úřad*) asking for help in finding a midwife.

12. On 7 April 2011 the health-insurance company replied that Czech legislation did not provide for the possibility of a public health-insurance company covering costs arising from home births and that it therefore had no contracts with any health professionals providing such services. Moreover, prevailing expert medical opinion did not approve of home births.

13. In a letter of 13 April 2011 the Regional Office added that the midwives listed in its register of health professionals were, in any event, only allowed by law to attend births at premises possessing the technical equipment required by Decree no. 221/2010 and not in a private home.

14. Not having found any health professional to assist her, the applicant gave birth to her son alone at home on 11 May 2011.

15. On 1 July 2011 she lodged a constitutional appeal (*ústavní stížnost*), complaining that she had been denied the possibility of giving birth at home with the assistance of a health professional, in violation of her right to respect for her private life.

16. On 28 February 2012 the Constitutional Court (*Ústavní soud*) dismissed the appeal, holding that it would be contrary to the principle of subsidiarity for it to decide on the merits of the case, because the applicant had not exhausted all the available remedies, which included an action for protection of personal rights under the Civil Code and an application for judicial review under Article 82 of the Code of Judicial Administrative

Procedure. It nevertheless expressed its doubts as to the compliance of Czech legislation with Article 8 of the Convention and asked the relevant parties to initiate a serious and well-informed debate about new legislation. Nine out of the fourteen judges attached separate opinions to the decision, in which they disagreed with the reasoning behind it. Most of them considered that the Constitutional Court should have dismissed the appeal as an *actio popularis* and should have refrained from expressing any views on the constitutionality of the legislation concerning home births.

B. Application lodged by Ms Alexandra Krejzová

17. The applicant is the mother of two children who were born at home in 2008 and 2010 with the assistance of a midwife. The midwives attended the births without any authorisation from the State.

18. According to the applicant, before deciding to give birth at home, she had visited several hospitals, which had all refused her requests to deliver the baby without any medical intervention that was not strictly necessary. They had also refused to agree to her wish for uninterrupted contact with the baby from the moment of birth, as the regular practice was to take the child away from the mother immediately after the birth to be weighed and measured and for further medical observation for a period of two hours.

19. At the time of lodging the present application, the applicant was pregnant again, with an expected delivery in the middle of May 2012. The pregnancy was free from complications and she again wished to give birth at home with the assistance of a midwife. However, she was unable to find a midwife willing to assist because of the risk of a heavy fine if medical services were provided without authorisation. The applicant asked various authorities to help to find a solution.

20. In a letter of 18 November 2011 the Ministry of Health replied that it did not provide medical services to individual patients and that the applicant should make enquiries to the City of Prague (*Město Praha*), which, acting as a regional office, registered and issued licences to health professionals.

21. On 29 November 2011 the applicant's health-insurance company informed her that the attendance of a health professional at a home birth was not covered by public insurance.

22. On 13 December 2011 the City of Prague informed the applicant that no midwife registered in Prague was authorised to assist with home births.

23. On 7 May 2012 the applicant gave birth to a child in a maternity hospital in Vrchlabí, 140 km away from Prague. She had chosen that hospital because of its reputation for respecting the wishes of mothers during delivery. Nevertheless, according to her, not all her wishes had been respected. Despite the fact that both she and the child had been healthy and that no complications had occurred during the birth, the applicant had had to

stay in the hospital for seventy-two hours. The newborn baby had been separated from her after the birth, and before leaving the maternity hospital the remains of the child's umbilical cord had been cut off despite her wishes to the contrary.

II. GENERAL INFORMATION PERTAINING TO HOME BIRTHS IN THE CZECH REPUBLIC

A. Guidelines issued and action taken by the Ministry of Health

24. In its bulletin no. 2/2007 of February 2007 the Ministry of Health published practice guidelines, which stated:

> "Conducting a delivery in the Czech Republic is regarded as a health-care service that is provided only in a health-care institution. Each health-care institution must fulfil the statutory requirements ... and the requirements laid down by the relevant secondary legislation."

25. On 20 March 2012 the Ministry of Health set up an expert committee on obstetrics with the objective of studying the issue of home births. There were representatives of care recipients, midwives, physicians' associations, the Ministry of Health, the Government's Commissioner for Human Rights and public health-insurance companies. The representatives of the physicians' associations boycotted the meetings, declaring that the current state of affairs was satisfactory and that, in their view, there was no need to change anything. Subsequently, the Minister of Health removed the representatives of care recipients, midwives and the Government's Commissioner for Human Rights, with the argument that only by changing the committee's composition in this way it would be possible for it to agree on certain conclusions.

26. On 18 January 2013 the Governmental Council for Equal Opportunities for Women and Men (*Rada vlády pro rovné příležitosti žen a mužů*), an advisory body to the Government, recommended the prevention of further discrimination against women in the enjoyment of their right to a free choice of the method and circumstances of giving birth and the place of delivery. It also recommended the prevention of discrimination against midwives by permitting them to practise their profession fully through their inclusion in the public health-insurance system. The Council also referred to the recommendations of the Committee on the Elimination of Discrimination against Women, which monitors implementation of the Convention on the Elimination of All Forms of Discrimination against Women, to support its position that women should have a choice of where to give birth.

27. In its bulletin no. 8/2013 published on 9 December 2013, which replaced the previous practice guidelines of 2007, the Ministry of Health

described the procedure for providers of health-care services when discharging newborns into their own social environment. It stated that the recommendation of specialists was that a newborn should be discharged from the maternity hospital no sooner than seventy-two hours after birth. The new procedure allows for the discharge of the newborn from the maternity hospital less than seventy-two hours after the birth at the request of the newborn's legal representative, provided that the latter:

> "(a) has submitted a written withdrawal of his or her agreement to the provision of medical services to the newborn, or a written statement declaring his or her disagreement with the provision of the medical services, or, alternatively, such agreement or disagreement has been entered in the newborn's medical documentation ...;
>
> (b) has been demonstrably and duly informed about the possible consequences following the discharge of the newborn before seventy-two hours have elapsed since the birth ...;
>
> (c) has been duly informed that – in the interests of the subsequent healthy development of the newborn – the Czech specialist medical associations recommend:
>
> 1. that a clinical examination be conducted within twenty-four hours of the discharge of the newborn ...;
>
> 2. that a blood sample be taken within forty-eight to seventy-two hours following the birth for the purposes of screening for hereditary metabolic malfunctions ..."

B. Data on perinatal mortality

28. According to estimated data provided by the World Health Organisation for 2004, the Czech Republic was among the countries with the lowest perinatal mortality rate, which is defined as the number of stillbirths and deaths in the first week of life. The rate for the Czech Republic was 0.4%. In other European countries the figures ranged from 0.5% in Sweden and Italy to 4.7% in Azerbaijan. In most European countries the figures were below 1%. According to their 2006 report, perinatal mortality is an important indicator of maternal care and maternal health and nutrition; it also reflects the quality of available obstetric and paediatric care, comparing different countries. The report recommended that, if possible, all foetuses and infants weighing at least 500 g at birth, whether alive or dead, should be included in the statistics. The reported data regarding stillbirths were not adjusted to this effect in the study.

29. According to the European Perinatal Health Report on the health and care of pregnant women and babies in Europe in 2010, issued in 2013 within the framework of the activities of the Euro-Peristat Project, the Czech Republic was among the countries with the lowest mortality rate for newborns in the first twenty-seven days of their life. The rate was 0.17%. The data for other countries included in the report, mostly European Union member States, ranged from 0.12% for Iceland to 0.55% for Romania.

C. Criminal proceedings against midwives

30. It appears that no midwives have been prosecuted in the Czech Republic for attending home births *per se*. Several have been prosecuted, however, for alleged malpractice in connection with a delivery at home. The applicants referred to the cases of Ms Š. and Ms K., who are both well-known promoters of natural deliveries without any unnecessary medical intervention and who used to regularly conduct home deliveries.

31. On 27 March 2013 the Prague 6 District Court (*obvodní soud*) found Ms Š. guilty of negligently causing the death of a baby who was stillborn. She was sentenced to two years' imprisonment, suspended for five years, and prohibited from practising the occupation of midwife for three years. The culpability of Ms Š. was based on the fact that she had not strongly advised the mother to contact a medical facility when consulted by telephone during a labour that was already ongoing at home. She had thus given flawed advice to the mother-to-be without actually examining her. The conviction was upheld on appeal by the Prague Municipal Court (*městský soud*) on 29 May 2013, although the sentence was changed to fifteen months' imprisonment, suspended for thirty months, and two years' prohibition on practising as a midwife.

32. On 29 April 2014 the Supreme Court (*Nejvyšší soud*) quashed the judgments of the lower courts. Ms Š. was eventually acquitted by the District Court on 23 May 2016. It appears that the proceedings are currently pending before the appellate court.

33. On 21 September 2011 the Prague 3 District Court found Ms K. guilty of negligently causing bodily harm to a baby whose home birth she had attended and who had stopped breathing during the delivery. The baby died several days later. Ms K. was sentenced to two years' imprisonment, suspended for five years, prohibited from practising as a midwife for five years, and ordered to pay 2,700,000 Czech korunas (CZK) (equivalent to 105,000 euros (EUR)) by way of reimbursement of the costs incurred by the insurance company in treating the child until the latter's death. According to the court, the malpractice on the part of Ms K. consisted in the fact that she had not followed the standard procedures for deliveries as laid down by the Czech Medical Association (*Česká lékařská komora*) and her conduct had thus been *non lege artis*. The criminal complaint was not lodged by the parents but by a hospital.

34. On 24 July 2013 the Constitutional Court quashed all the judgments in the case against Ms K., finding that there had been a violation of her right to a fair trial. It held that the conclusions of the ordinary courts as to Ms K.'s guilt had been too subjective and were not supported by the evidence beyond all reasonable doubt, thereby violating the principle of the presumption of innocence. It stated in particular that the courts had uncritically relied on an expert opinion which they had failed to subject to

thorough scrutiny. It held that – on the basis of the expert opinion – the courts had applied very strict liability to the conduct of Ms K. in a situation where it had not been clear how she could have prevented the baby's death. Moreover, it had been established that she had tried to help the baby and had called an ambulance immediately after establishing that the baby had hypoxia. To foresee every possible complication during delivery and be able to react to it immediately, as was required of Ms K., would ultimately lead *de facto* to an absolute prohibition of home births. In that context the Constitutional Court noted:

> "... 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 parents 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."

III. RELEVANT DOMESTIC LAW

A. People's Health Care Act

35. Under section 12a(1) of the People's Health Care Act (no. 20/1966 – *zákon o péči o zdraví lidu*), which remained in force until 31 March 2012, an institution which provided health care had to be equipped with appropriate human, material and technical resources depending on the nature and extent of health care it provided. Under section 12a(2) of the Act, the Ministry of Health was to specify, by means of a decree, the requirements for material, human and technical resources in health-care institutions.

36. Section 18(1) of the Act specified that outpatient care, which also included the visiting service, was provided by a general practitioner and other specialists in consulting rooms or in associated outpatient institutions.

B. Health Care in Private Health-Care Institutions Act

37. Section 4(1) of the Health Care in Private Health-Care Institutions Act (no. 160/1992 – *zákon o zdravotní péči v nestátních zdravotnických zařízeních*), which was in force until 31 March 2012, required private institutions to be equipped with appropriate human, material and technical resources for the type and extent of health care they provided.

38. Under section 4(2)(b), the Ministry of Health was empowered to adopt a decree to specify the requirements for technical and material equipment in private health-care institutions.

39. By virtue of section 5(2)(a), a private institution could provide health care as specified in the decision on registration.

40. Under section 14, a person breaching the Act could be fined, but the amount of the fine was not specified.

C. Paramedical Professions Act

41. Under section 6(3) of the Paramedical Professions Act (no. 96/2004 – *zákon o nelékařských zdravotnických povoláních*), which entered into force on 1 April 2004, the duties involved in practising the profession of midwife include, *inter alia*, physiological deliveries and provision of care for newborns.

D. Decree no. 424/2004 of the Ministry of Health

42. The Decree of the Ministry of Health on Activities of Medical Staff and Other Specialists (*vyhláška, kterou se stanoví činnosti zdravotnických pracovníků a jiných odborných pracovníků*), which entered into force on 20 July 2004 and remained valid until 13 March 2011, set out the duties of health professions and other professionals. Under section 5(1)(f), midwives could carry out certain activities without professional supervision, including physiological deliveries in emergency situations, together with episiotomy if necessary.

E. Decree no. 221/2010 of the Ministry of Health

43. The Decree of the Ministry of Health on Requirements for Material and Technical Equipment in Health-Care Institutions (*vyhláška o požadavcích na věcné a technické vybavení zdravotnických zařízení*), which entered into force on 1 September 2010 and remained valid until 31 March 2012, provided for the possibility of midwives performing deliveries but only in specially equipped rooms, measuring at least 15 square metres, containing the following essential items: (a) a birthing bed for a delivery room or other appropriate device for carrying out a physiological delivery; (b) an examination light; (c) a sterile clamp or rubber band for the umbilical cord; (d) sterile scissors; (e) an EFM (electronic foetal monitoring) device; (f) a pulse oximeter; (g) a suction unit; (h) a laryngoscope and instruments to secure the airways; (i) a bed for women after the birth; (j) a suitable space and surface for treating the newborn; (k) scales for weighing the newborn; (l) an instrument to measure the newborn's length; and (m) a source of medical oxygen. Moreover, a room for care of a woman and her newborn after the birth, measuring at least 8 square metres, and a shower had to be made available.

44. Such rooms had to be located so as to allow a birth by Caesarean section or an operation to terminate birth to be carried out in a health-care institution providing in-patient care and complying with the requirements set out in the Decree, within fifteen minutes from the discovery of complications.

45. Moreover, the Decree entitled midwives to set up a "contact workplace", which had to be equipped with: (a) suitable furniture for the work of a midwife; and (b) a mobile phone.

46. Midwives were also required to have a visiting bag containing: (a) a device for detection of foetal sounds; (b) disposable equipment for examining pregnant women; (c) a sphygmomanometer; (d) a stethoscope; (e) a medical thermometer; and (f) first-aid equipment, including a device for cardio-pulmonary resuscitation.

47. Section 2 of the Decree required health-care institutions existing at the date of the Decree's entry into force to comply with the requirements for material and technical equipment laid down in the Decree within twelve months from its entry into force.

The period of twelve months was extended to twenty-eight months by Decree no. 234/2011, which entered into force on 31 August 2011.

F. Medical Services Act

48. The Medical Services Act (no. 372/2011 – *zákon o zdravotních službách*) entered into force on 1 April 2012. It replaced the People's Health Care Act (see paragraphs 35-36 above), the Health Care in Private Health-Care Institutions Act (see paragraphs 37-40 above) and the Decree on Requirements for Material and Technical Equipment in Health-Care Institutions (see paragraphs 43-47 above).

49. In accordance with section 2(2)(a), "health services" means the provision of health care under the Act by health professionals, and also activities carried out by other professionals if these activities are directly connected with the provision of health care.

50. In accordance with section 2(4)(a)(4) of the Act, "health care" means a set of activities and measures carried out in relation to individuals, for purposes including that of assistance during delivery.

51. In accordance with section 4(1), a "health-care institution" means premises intended for the provision of health services.

52. Under section 10 of the Act, the provision of health care in a patient's own social environment, including home care, may involve only such procedures as are not subject to conditions regarding the technical and material equipment necessary for their performance in health-care institutions.

53. Under section 11(5), health services can be provided only in the health-care institutions specified in the licence for the provision of health

services, except for health services which are provided in a patient's own social environment. In those cases, providers of health-care services must have their own contact home-care workplace.

54. Pursuant to section 11(6), a health-care institution must possess technical and material equipment for the provision of health services. The technical and material equipment in health-care institutions must correspond to their specialisation and the type and form of health care they provide. Requirements for the minimum technical and material equipment are to be laid down in an implementing decree.

55. Section 114 provides that a person providing a health-care service without an appropriate licence can be fined up to CZK 1,000,000 (EUR 37,000).

G. Explanatory Report on the Medical Services Act

56. The Explanatory Report on the Medical Services Act reads as follows, in so far as relevant:

> "The ... legislation ... belong[s] to a group of laws and regulations governing the legal conditions for fulfilling everyone's constitutional right to the protection of health and the constitutional right of citizens to free medical care within the meaning of Article 31 of the Charter of Fundamental Rights and Freedoms and the right to the protection of human dignity, the right to private and family life and physical integrity ...
>
> The Act ... defines professional health care ... The State must regulate [such] health care ...; the State is obliged to ensure the availability of health-care services and also their adequate quality and safety. This requirement is satisfied by the condition that professional health care can only be provided by a provider of health-care services ...
>
> The ... Act will be one of the pieces of legislation creating the conditions for the performance of the Czech Republic's obligations in the field of health protection and the provision of health-care services, as deriving from ... the International Covenant on Economic, Social and Cultural Rights ... and the European Charter ... The Act also takes into consideration the Convention on the Rights of the Child. ...
>
> As regards the provision of health-care services, the patient is an equal partner with the provider and with the medical staff and has the right to give or to refuse to give consent to the health-care services offered, on the basis of information and advice on such services duly given by the provider or a person the provider has designated for that purpose ...
>
> Providing patients with health services in their own social environment is often more efficient and appropriate. The patient's own social environment does not necessarily mean only his or her home but can also mean another alternative environment, such as social care homes or children's homes. ... The health-care services provided in the patient's own social environment can be divided into home-care services and outpatient health-care services. Home-care services have a significant effect on planned systemic changes in the health-care system, by... improving patients' lives and prolonging their stay in their home environment. ...

> One of the patient's fundamental rights is the right to free choice with regard to providers of health-care services. ... The Act will provide patients with the right to all information about their condition and about the health-care services to be provided to them. ...
>
> As part of care for their own health, individuals are able to make use of other activities based on their own choices; these activities include support for health and other activities in the field of 'self-treatment' ... The Act does not prevent these activities; it simply does not define them as being part of professional health care and health-care services, the quality of which is guaranteed by the State. The main reason is that it is not feasible to assess the quality of such care objectively and therefore it is not possible to guarantee its safety or efficiency. Therefore, health-care services can only be provided on the basis of the Medical Services Act."

H. Decree of the Ministry of Health no. 92/2012

57. The Decree on Requirements for Minimum Technical and Material Equipment at Health-Care Institutions and Contact Home Care Workplaces (*vyhláška o požadavcích na minimální technické a věcné vybavení zdravotnických zařízení a kontaktních pracovišť domácí péče*) entered into force on 1 April 2012. It replaced the Decree on Requirements for Material and Technical Equipment in Health-Care Institutions (see paragraphs 43-47 above).

58. The Decree provides, *inter alia*, for the possibility of midwives performing deliveries in delivery rooms specially equipped for that purpose. The equipment requirements are the same as those specified in Decree no. 221/2010. However, the Decree includes a new requirement: if a Caesarean section or an operation to terminate birth cannot be performed in a medical institution providing inpatient care within fifteen minutes from the discovery of birth complications, it is necessary to set up a delivery room complying with the requirements indicated in the Decree. Moreover, a midwife's workplace must also be equipped in accordance with the Decree.

59. As regards "contact workplaces" for the provision of nursing care in relation to gynaecology and birth assistance, the Decree requires such workplaces to contain: (a) suitable furniture for the work of a midwife; (b) a filing cupboard if medical records are not kept exclusively in electronic form; (c) a connection to a public mobile telephone network; (d) a device for detection of foetal sounds; (e) disposable equipment for examining pregnant women; (f) a sphygmomanometer; (g) a stethoscope; (h) a medical thermometer; (i) first-aid equipment, including a device for cardio-pulmonary resuscitation; and (j) a box for transporting biological material. The contact workplace must have a surface area of at least 10 sq. m and sanitary facilities for employees.

60. Health-care institutions and contact home-care workplaces existing at the date of the entry into force and satisfying the requirements of the

previous Decree had to comply with the requirements laid down in the new Decree within a period of between nine and twelve months.

I. Decree of the Ministry of Health no. 99/2012

61. The Decree on Minimum Personnel Requirements for the Provision of Health-care Services (*vyhláška o požadavcích na minimální personální zabezpečení zdravotních služeb*) entered into force on 1 April 2012. The chapter entitled "Personnel Requirements for Provision of Home Care" indicates that nursing care in gynaecology and birth assistance is to be provided by a midwife qualified to practise her profession independently and a midwife with a special qualification competent to practise her profession independently if activities specified in another legal provision are to be carried out (midwife for intensive care; midwife for intensive care in neonatology; or midwife for community care).

IV. RELEVANT INTERNATIONAL MATERIAL

A. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine)

62. The relevant provisions of the Convention on Human Rights and Biomedicine read as follows:

Article 5 - General rule

"An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time."

Article 6 - Protection of persons not able to consent

"... an intervention may only be carried out on a person who does not have the capacity to consent, for his or her direct benefit.

Where, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. ..."

Article 8 - Emergency situation

"When because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned."

63. Moreover, the explanatory report on the Convention on Human Rights and Biomedicine states in paragraph 34 that "the word 'intervention' is understood in its widest sense, as in Article 4 – that is to say, it covers all medical acts, in particular interventions performed for the purpose of preventive care, diagnosis, treatment, rehabilitation or research".

B. Convention on the Rights of the Child

64. The relevant provisions of the Convention on the Rights of the Child read as follows:

Article 3

"1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures. ..."

Article 5

"States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention."

Article 6

"1. States Parties recognise that every child has the inherent right to life.

2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

..."

Article 18

"1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern. ..."

Article 24

"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

...

(d) To ensure appropriate pre-natal and post-natal health care for mothers; ...”

C. Convention on the Elimination of All Forms of Discrimination against Women

65. The Committee on the Elimination of Discrimination against Women recommended in its Concluding Observations on the Czech Republic of 22 October 2010 (CEDAW/C/CZE/CO/5), under the heading “Health” in particular:

“36. While acknowledging the need to ensure maximum safety for mothers and newborns during childbirth, as well as the State party’s low perinatal mortality rate, the Committee takes note of reports of interference with women’s reproductive health choices in hospitals, including the routine application of medical interventions, reportedly often without the woman’s free, prior and informed consent or any medical indication, a rapid increase in the caesarean section rate, separation of newborns from their mothers for up to several hours without health-related reasons, refusal to release the mother and child from hospital before 72 hours after childbirth, and patronizing attitudes of doctors which impede the exercise by mothers of their freedom of choice. It also notes reports about women’s limited options for delivering their babies outside hospitals.

37. The Committee recommends that the State party consider accelerating the adoption of a law on patients’ rights, including women’s reproductive rights; adopt a protocol of normal birth care ensuring respect for patients’ rights and avoiding unnecessary medical interventions; ensure that all interventions are performed only with the woman’s free, prior and informed consent; monitor the quality of care in maternity hospitals; provide mandatory training for all health professionals on patients’ rights and related ethical standards; continue raising patients’ awareness of their rights, including by disseminating information; and consider taking steps to make midwife-assisted childbirth outside hospitals a safe and affordable option for women.”

66. In its Concluding Observations on the Czech Republic of 14 March 2016 (CEDAW/C/CZE/CO/6), the Committee recommended the following:

“4. The Committee welcomes the progress achieved since the consideration in 2010 of the State party’s fifth periodic report (CEDAW/C/CZE/CO/5) in undertaking legislative reforms, including the adoption of:

(a) The adoption of the Act No. 372/2011 Coll., on health services and the terms and conditions for the providing of such services (The Act on Healthcare Services), as amended by Act No. 167/2012 Coll.; ...

...

30. The Committee welcomes the low rates of perinatal mortality in the State party. However, it is concerned about continued reports on the conditions for childbirth and

obstetric services in the State party unduly curtailing women's reproductive health choices, including:

(a) Unnecessary separation of newborns from their mothers without medical grounds;

(b) Disproportionate limitations on home childbirths;

(c) Frequent use of episiotomy without medical need and in contravention of the mother's preference to abstain from them; and

(d) Undue restrictions on the use of midwives in lieu of physicians/gynecologists in situations where such use does not pose a health risk.

31. The Committee reiterates its previous recommendation that the State party accelerate the adoption of a law on patients' rights, including women's reproductive rights. In doing so, the State party should:

(a) Adopt clear guidelines for ensuring that the separation of newborns from their mothers is subject to the requirement of medical necessity;

(b) Establish a prenatal care system that allows for the effective assessment of the suitability of home childbirths and the option for it where appropriate;

(c) In light of its recent adoption of Act No. 372/2011 Coll., on health services and the terms and conditions for the providing of such services, ensure its effective implementation in compliance with the Convention, including by: Adopting and enforcing a protocol of normal birth care ensuring respect for patients' rights and avoiding unnecessary medical interventions; and ensuring that all interventions are performed only with the woman's free, prior and informed consent; monitoring the quality of care in maternity hospitals; providing mandatory training for all health professionals on patients' rights and related ethical standards; continue raising patients' awareness of their rights, including by disseminating information; and

(d) Undertake measures, including legislation, to make midwife-assisted childbirth outside hospitals a safe and affordable option for women."

V. COMPARATIVE-LAW MATERIAL

67. From the information available to the Court, it would appear that planned home births are provided for in domestic law and regulated in twenty member States of the Council of Europe (Austria, Belgium, Denmark, Estonia, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Luxembourg, the Netherlands, Poland, Sweden, Switzerland, "the former Yugoslav Republic of Macedonia" and the United Kingdom). In these countries, the right to a home birth is never absolute and is always dependent on certain medical conditions being satisfied. Moreover, national health insurance covers home birth in only fifteen of these countries.

68. It would also appear that home births are unregulated or under-regulated in twenty-three member States (Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Croatia, Finland, Georgia, Lithuania, Malta, the Republic of Moldova, Monaco, Montenegro, Portugal, Romania,

Russia, San Marino, Serbia, Slovakia, Slovenia, Spain, Turkey and Ukraine). It would appear that in some of these countries, private home births do take place but in a legal vacuum and without national health cover. Moreover, no legislation has been found which prohibits the assistance of midwives at home births. In a very small number of the member States surveyed, disciplinary or criminal sanctions are possible, but appear to be rarely imposed.

THE LAW

ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

69. The applicants complained that Czech law did not allow health professionals to assist them with giving birth at home, in violation of the right to private life as provided for in Article 8 of the Convention, which reads:

> "1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

70. The Government contested that argument.

A. The Chamber judgment

71. In its judgment of 11 December 2014, the Chamber held that there had been no violation of Article 8 of the Convention. It concluded that giving birth was a particularly intimate aspect of a mother's private life encompassing issues of physical and psychological integrity, medical intervention, reproductive health and the protection of health-related information. Decisions regarding the circumstances of giving birth, including the choice of the place of birth, therefore fell within the scope of the mother's private life for the purposes of Article 8 of the Convention. The Chamber considered it appropriate to analyse the applicants' complaints as concerning negative obligations: the fact that it had been impossible for the applicants to be assisted by midwives when giving birth at home amounted to an interference with their right to respect for their private life.

72. The interference was in accordance with the law since, although the legislation was not entirely clear, the applicants had nevertheless been able

to foresee with a degree that was reasonable in the circumstances that the assistance of a health professional at a home birth was not permitted by law. The interference had served a legitimate aim as it had been designed to protect the health and safety of both the newborn child and, at least indirectly, the mother.

73. As to whether the interference had been necessary in a democratic society, the Chamber held that the respondent State was entitled to a wide margin of appreciation on account of the need for an assessment by the national authorities of expert and scientific data concerning the relative risks of hospital and home births, the need for strong State involvement because of newborn children's vulnerability and dependence on others, the lack of any clear common ground among the member States on the question of home births and, lastly, general social and economic policy considerations, such as the allocation of resources to set up an adequate emergency system for home births.

74. The Chamber held that while the situation in question had a serious impact on the applicants' freedom of choice, the Government had focused primarily on the legitimate aim of protecting the best interests of the child. Depending on their nature and seriousness, the child's interests could override those of the parent, who was not entitled under Article 8 of the Convention to take measures that would harm the child's health and development. While there was generally no conflict of interest between mother and child, certain choices as to the place, circumstances or method of delivery could give rise to an increased risk to the health and safety of the newborn child, as the figures for perinatal and neonatal deaths attested.

75. Although the majority of the research studies available to the Chamber on the safety of home births indicated that there was no increased risk compared to hospital births, this was true only if certain conditions were fulfilled, namely that the birth was low-risk, attended by a qualified midwife and close to a hospital in the event of an emergency. Thus, situations such as in the Czech Republic, where health professionals were not allowed to assist mothers giving birth at home and where there was no special emergency aid available, actually increased the risk to the life and health of mother and newborn. At the same time, however, the Government had argued that the risk for newborn children was higher in the case of home births and it was true that even where a pregnancy seemed to be without complications, unexpected difficulties requiring specialised medical intervention could arise during delivery. In these circumstances, the Chamber held that the mothers concerned, including the applicants, could not be said to have had to bear a disproportionate and excessive burden, and that accordingly, in adopting and applying the policy relating to home births, the Czech authorities had not exceeded the wide margin of appreciation afforded to them or upset the requisite fair balance between the competing interests.

76. The Chamber lastly noted that notwithstanding this finding, the authorities should keep the relevant provisions under constant review, taking into account medical, scientific and legal developments.

B. The parties' submissions to the Grand Chamber

1. The applicants

(a) Negative or positive obligations

(i) The applicant Ms Dubská

77. The applicant maintained that the present case concerned the protection of both women and their children's health, which was seriously undermined when the State allowed women to give birth at home but adopted regulations that made it impossible for them to receive assistance from a midwife. Relying on the Chamber judgment, the applicant submitted that the State had interfered with her private life. Although the case could be analysed through the lens of both positive and negative obligations, she considered it appropriate to assess the case primarily in terms of the negative obligation, since the fact that midwives were prohibited from assisting pregnant women with home births could be viewed as an interference with her right to respect for her private life. In other words, as a direct result of the State's policies the applicant had been unable to obtain the assistance of a midwife when giving birth.

(ii) The applicant Ms Krejzová

78. The applicant stated that her inability to effectively opt for any alternative model of childbirth and the requirement for her to surrender to the obstetric model of birth care in hospital – causing her to experience obstetric violence – represented a serious breach of her right to decide on the circumstances in which to give birth, and interference with her right to physical and psychological integrity under Article 8 of the Convention. Although she believed that the circumstances of her case called for an assessment primarily in terms of the Government's positive obligations, the applicant intended to apply a holistic approach to the assessment of whether the damage sustained by her was justifiable in the light of the relevant principles of the Convention, bearing in mind that the underlying principles of legality, legitimacy and proportionality were inherent in both the positive and negative obligations of the State.

(b) Lawfulness

(i) The applicant Ms Dubská

79. The applicant maintained that the Czech legal system allowed for an interpretation to the effect that the assistance of a health-care professional at a home birth was permitted. Since there was a legal framework which regulated the duties of midwives, women's right to self-determination and informed consent and the institution of in-home care – which also included assistance of health-care professionals with a home birth – it could be said that there was a minimum legal and institutional environment that allowed women to choose their place of birth. The applicant stated that recognising the possibility of choosing home birth did not require any detailed and explicit regulations or any enhancement of the existing emergency services. Furthermore, emergency services were already available to any women in the Czech Republic, regardless of where they chose to give birth and whether a health-care professional was present during the delivery or not.

80. The applicant maintained that while legislation on home birth provided for the right of patients to decide and guaranteed that they could opt for home birth as a lawful alternative, this legislation, or at least its interpretation, was not clear or certain concerning the possibility of midwife services at home.

81. Decree no. 221/2010 had entered into force on 1 September 2010, making no changes to the regulation of home births, and not imposing a ban on the provision of assistance during a home birth. The Decree identified three possible workplaces for midwives: a workplace where childbirth was allowed; a workplace where physiological childbirth was not allowed; and a midwife's office for in-home care. It did not actually forbid midwives to perform home births, so it was unclear whether a midwife who had an office for in-home care could or could not provide assistance with home births outside her workplace. The applicant added in that connection that section 18(1) of the People's Health Act permitted in-home care as part of health care. The Decree failed to regulate midwifery in a detailed manner. The applicant argued that even a midwife who had a registered workplace where childbirth was not allowed could offer assistance with a hospital birth and accompany a woman to hospital, despite not being employed by the hospital in question, provided that she concluded a special contract with it. The Decree had been in force only until 31 March 2012, and therefore had been unable to change the ambiguous situation which had existed before its adoption. Indeed, under section 2(1), health-care facilities already in operation had been given a twelve-month interim period to comply with the requirements of the Decree. The applicant noted in that connection that at the time when she had given birth, the Decree had been in force for only eight months and the existing health-care facilities – including midwives,

who faced an unclear and unforeseeable registration process – had been under no obligation to comply with it.

82. Referring to the Court's judgment in *Gillan and Quinton v. the United Kingdom* (no. 4158/05, § 77, ECHR 2010 (extracts)), the applicant stressed that the legislation in place had not set any limits for decisions of the Ministry of Health regarding the conditions under which midwives could work in the Czech Republic. Furthermore, in the absence of any direct regulation of home births, no clear or transparent rules had been set for regional offices when determining which midwives could be granted a licence and the scope of such a licence.

83. It was only after the applicant had given birth that the Medical Services Act (no. 372/2011) had been passed and had entered into force (on 1 April 2012), together with Decree no. 92/2012. The applicant stated that the contents and principles of the legal regulations remained unchanged. Indeed, the Medical Services Act provided for in-home care as one of the forms of health care, one of its variants being nursing care (section 10). The applicant stated that the definition of nursing care clearly included health care provided during pregnancy and childbirth (section 5(2)(g)). Furthermore, the Decree set down the requirements for technical equipment for midwives providing in-home care (Appendix no. 9). However, the Act contained a new provision enshrining the right of patients to receive health services in the least restrictive environment possible, provided that the quality and safety of such services was ensured as well (section 28(3)(k)). The applicant emphasised that neither the Act nor the Decree contained any restrictions preventing midwives from providing health services during home births in the form of in-home care. However, the legislation was interpreted by the Government and other public authorities in such a way that midwives were not allowed to provide assistance at home births, and this had a clear chilling effect on midwives, who were unwilling to provide such assistance. The applicant contended that the legislation was not accessible and foreseeable in its application as different interpretations were possible. She therefore disputed the Chamber's conclusion that she could have reasonably foreseen that the assistance of a medical professional at a home birth was not allowed by law.

(ii) The applicant Ms Krejzová

84. The applicant agreed with the Government that Czech law had not allowed assisted home births at the time of her delivery in May 2012. However, she pointed out that during most of her pregnancy she had been bound by the pre-April 2012 legislation. The applicant reiterated in that connection that prior to 1 April 2012, there had been no statutory restriction on midwives providing health care during home births. In order to provide care, a midwife needed, *inter alia*, an "operational" licence authorising her to be regarded as a non-governmental medical facility. After the adoption of

Decree no. 221/2010, which required midwives to have equivalent human, material and technical resources to those available in a delivery room in maternity hospitals, no midwife had been granted such a licence. However, although it had imposed extensive requirements on midwives in terms of equipment, the Decree had not automatically terminated the operational licences already issued. As a result, while they were still bound by the availability of compulsory equipment, there were midwives who theoretically could carry on their activities in line with the previous regulations, or rather the previous legal vacuum. As a result, pregnant women lacked legal certainty as to whether they could enjoy the assistance of a midwife during a home birth, and similarly midwives lacked the same certainty as to whether they could legally provide such assistance. Such a situation contravened the notions of foreseeability and absence of arbitrariness.

85. As to the legislation introduced in 2012, namely Decree no. 92/2012, which in general imposed similarly extensive requirements on midwives in terms of human, material and technical resources, the applicant submitted that it infringed the compulsory procedure for the adoption of secondary legislation by the Ministry of Health. Ministries were obliged to ensure that a regulatory impact assessment was carried out in respect of new regulations. However, such assessments had not been performed, let alone published, by the commencement of the process for the adoption of Decree no. 221/2010 and Decree no. 92/2012, with the result that there had been no effective public scrutiny of the exercise of the legislative power delegated to the Ministry of Health.

(c) Legitimate aim

(i) The applicant Ms Dubská

86. The applicant maintained that the Chamber had been incorrect in accepting the purported legitimate aim relied on by the Government. In her submission, the policy pursued by the State did not have the effect of protecting the health and life of women and their children, but instead exacerbated threats to their health and life. There was no logical connection between the declared legitimate aim of protecting the life and health of women and children on the one hand, and the interference with the right to protection of private life consisting in preventing the provision of health care during home births on the other hand. Instead, the prohibition on providing skilled care exposed women to increased risks to their health and life.

(ii) The applicant Ms Krejzová

87. The applicant stated that in the present case, there was no legitimate aim which could have been pursued by preventing her from enjoying midwife-based care.

88. The principle of legitimacy inherently required that the aim pursued should be specific. This necessitated detailed knowledge on the State's part of the specific matter to be regulated and of any deficiencies or room for improvement. The applicant pointed out that the necessity of detailed knowledge came to the fore when taking into account the complex matter at issue in the present case, which required an assessment by medical experts and scientific data concerning the relative risks of hospital and home births. Since the Government had introduced specific legislation entirely denying women the possibility of assistance from midwives at planned births outside hospital, it was reasonable to expect that such a measure should be based on sufficient expert analysis and scientific data justifying it, in order to meet the criterion of legitimacy.

89. Indeed, until Czech women had been denied the right to decide on the circumstances of delivery in 2010 and 2012, it had been legally possible for them since 1992 to enjoy the assistance of a midwife during a home birth. The Government had thus had two decades to procure scientific data concerning out-of-hospital midwifery care and to carry out a comprehensive analysis of such care. However, they had never even claimed to have performed such a background analysis. Therefore, when denying women in 2010 and 2012 the right to decide on the circumstances in which they gave birth, the Government had not actually known what specific negative aspects and risks relating to assisted home births were to be eliminated by the legislation in question and what specific positive aim was to be achieved.

(d) Necessity in a democratic society

(i) The applicant Ms Dubská

90. The applicant submitted that the present case was to be distinguished from the cases of *Stübing v. Germany* (no. 43547/08, 12 April 2012) and *A, B and C v. Ireland* ([GC], no. 25579/05, ECHR 2010), both of which had been referred to by the Chamber. The Court had found that both cases concerned issues of a "moral" nature and that *A, B and C v. Ireland* involved issues of particular "sensitivity" in the country concerned, and this had led it to allow a wide margin of appreciation despite the existence of common ground or consensus among member States.

91. The applicant submitted that the present case did not concern moral or sensitive questions and that the Czech Republic had not suggested that any such matters were at issue, or that the aim or interest pursued by the State's interference with the applicant's rights under Article 8 was the

protection of public morals. Moreover, the Chamber had incorrectly found that there was no clear common ground regarding skilled attendants at home births. In fact, sixteen out of thirty-two Council of Europe member States expressly allowed skilled attendants at a home birth under certain conditions, in five countries this was not expressly regulated but accepted in practice, and in two States legislation allowing home birth was being considered. The applicant was of the opinion that there was significant common ground among member States regarding the best way of safeguarding the interests of women wishing to give birth at home by allowing midwives to provide skilled assistance to them.

92. The applicant further stated that the penalising approach adopted by the Czech Republic might affect women's enjoyment of other fundamental rights, such as the right to life and health. By making birth at home less safe for women, the State might put these other rights at risk. As a result, the margin of appreciation should be narrow. The applicant added that the consensus among member States was supported by international expert opinion on the issues of maternal health and the importance of skilled attendants at birth. She referred in this connection to opinions of the World Health Organisation.

93. The applicant noted that the Chamber's admission that the conditions in most Czech hospitals were questionable, as far as respecting the mother's choices was concerned, was in fact a very euphemistic way of describing treatment which often attained the level of inhuman and degrading treatment prohibited by Article 3 of the Convention. In her submission, hospital births in the Czech Republic were associated with a high risk of procedures that did not respect women's choices and often were even detrimental to their health or the health of the newborn child. In addition, the national courts had repeatedly failed to afford protection where the rights of women had been violated in Czech maternity hospitals. This represented a type of violence which, in the Czech context, was completely ignored and downplayed.

94. The applicant further pointed out that the State policy of preventing midwives or other skilled birth attendants from assisting women during home births was inconsistent with international standards regarding the elimination of preventable maternal and child mortality and morbidity. In addition, without providing any specifics, the applicant claimed that the situation in the Czech Republic was at odds with the obligations of the State under European Union law.

(ii) The applicant Ms Krejzová

95. The applicant stated that the right of women to choose the circumstances in which to give birth involved the general notion of choice, which comprised quantitative and qualitative components, both of them to be satisfied concurrently.

96. It had been undisputed between the parties that the Medical Services Act and Decree no. 92/2012 prohibited the provision of midwife-based care at any births outside hospitals and that if the applicant intended to enjoy any assistance from qualified medical personnel, she had to give birth in hospital. Hence, the Czech childbirth set-up was a single-option one, being inherently incompatible with the notion of women's choice of the circumstances in which to give birth.

97. The applicant further stated that matters relating to pregnancy and delivery and the extent of women's freedom in this regard also raised significant gender issues. Women's reproductive rights stood for an inherently feminine area which had been oppressed by men, *inter alia* through the relocation and transformation of childbirth by the medical profession, thus weakening women's natural responsibilities. This relocation had brought a new notion of hierarchy into the field of pregnancy and childbirth, such a notion being at odds with midwife-based care arising from a holistic, feminine approach to childbirth. In the masculine-driven field of biomedical obstetrics, a woman's body forfeited its fundamental privacy and became vulnerable when faced with a male medical expert acting as a sort of public authority.

98. The applicant reiterated that pregnancy and childbirth represented the most intimate aspects of a woman's life, while the intimacy of the delicate act of childbirth inherently involved exposure of the woman's body and her deepest emotions to other people. The right to self-determination included the freedom to decide whether to expose one's body at all, and to what extent, to specific third parties. However, women giving birth could not *ipso facto* enjoy the same extent of control over their bodies in this regard, since they were compelled to share their most intimate sphere with third parties during childbirth. Taking into account the inherent limitations on a woman's right to self-determination in this context, mechanisms compensating for such limitations were required. The right of women to decide on the circumstances in which to give birth was one of the most significant mechanisms of this kind. The applicant therefore asserted that her right to decide on the circumstances of delivery, as a mechanism compensating for her limited freedom of self-determination, did not in principle allow for further limitations deriving from the Government's margin of appreciation, which, for this reason also, had to be a narrow one.

99. Regarding the issue of European consensus in this matter, the applicant noted that out of thirty-three States Parties to the Convention, only four of them, including the Czech Republic, made assisted birth outside hospitals illegal and subject to sanctions in respect of medical professionals. Just as the existence of a European consensus narrowed the Government's margin of appreciation in terms of a quantitative argument, the concept of the Convention as a living instrument further narrowed the Government's margin of appreciation on qualitative grounds. In the applicant's

submission, the margin of appreciation was all the narrower when common values of member States were identified not only under the Convention, but also in other international instruments, regardless of whether they were binding or whether most States Parties to the Convention had ratified them, and also in the light of the general practice, moral climate and conduct observed in the member States.

100. The applicant further maintained that the monopolisation of hospital care did not represent any safety benefit for newborns but actually increased the risks for the mother, including the risk of obstetric violence, and that home births did not have any adverse impact on perinatal mortality.

101. In respect of the fair balance to be struck between the competing private and public interests, since a home birth was safer for low-risk expectant mothers than a hospital birth, as it did not involve any invasive, routine and harmful procedures, the public interest in the health and safety of expectant mothers could not be considered to be the interest outweighing the applicant's private right. Moreover, the newborn's health and safety was not the public interest at stake either. It had actually been proved that both medical childbirth in hospital and assisted home births provided a similar level of safety and health for the newborn child. Therefore, since in terms of safety the obstetric mode of childbirth did not achieve better results than assisted home births, this interest likewise could not represent a valid public interest that could outweigh the applicant's right to choose the circumstances in which to give birth.

102. In the applicant's submission, there were other reasons supporting a conclusion that there had been a lack of proportionality and of a fair balance between competing interests, such as the requirement to submit to undesired medical treatment, the adverse effects of the Government's measures on childbirths outside hospital and the Government's breach of their obligations under international treaties.

2. The Government

103. At the outset, the Government informed the Court about recent developments concerning the issues of obstetrics, midwifery and related women's rights. They stated that in 2014 a new governmental expert committee had been set up involving experts from various relevant fields, including representatives of care recipients, midwives' associations, physicians' associations, the Ministry of Health, public health-insurance companies and lawyers. The committee focused on the complex situation in the Czech obstetric and midwife-based system of care, including issues relating to respect for women's rights and wishes, such as the right to choose from among various circumstances in which to give birth. It was intended to serve as an expert body with the possibility of issuing recommendations, including of a legislative nature, to the Government

through the Governmental Council for Equal Opportunities for Women and Men.

104. The Government further stated that in 2015 the Czech Gynaecological and Obstetrical Society had issued an official statement in which it had identified the leading principles in obstetric care in the Czech Republic: the provision of such care by both physicians and midwives in adequately equipped premises only and in close proximity to a higher level of health care; close cooperation between physicians and midwives in the area of obstetric care; a common practice of midwife-led deliveries in cases of physiological pregnancies; the provision of care according to regularly updated guidelines reflecting current scientific and international trends; and adherence to the rights of patients to respectful care, privacy and autonomy.

105. They also referred to several scientific papers which had been published in the *American Journal of Obstetrics and Gynecology* since 2013, based on new research on the safety of birth in relation to various birth settings and birth attendants. According to the research findings, home births were strongly associated with worse outcomes than births in adequately equipped health-care facilities, regardless of the presence of a birth attendant. Therefore, home birth did not meet current standards for patient safety in obstetrics, as it entailed an unnecessary, preventable and irremediable increased risk of harm for pregnant, foetal and neonatal patients.

(a) Negative or positive obligations

106. The Government argued that the case should be examined exclusively from the perspective of positive obligations. They observed that the law in force did not prohibit childbearing women from giving birth at their private home, and that no sanctions were imposed by the authorities in such cases. Accordingly, in the Government's view, the core question in the present case was whether the State should broaden the current scope of health care provided to women giving birth in the Czech Republic. The provision of health care in general was an area where regulation was the default, so that the State could guarantee a certain quality and standard for both private and public health care. In order to "allow" the assistance of health professionals at home births, the Government would have to put in place a considerable legislative and administrative framework, in addition to other facilities, including a change to the system of emergency care.

107. Alternatively, the Government suggested that the Court leave open the question whether the State's positive or negative obligations were at issue, referring in particular to the case of *Hristozov and Others v. Bulgaria* (nos. 47039/11 and 358/12, ECHR 2012 (extracts)).

108. Should the Court, however, decide to examine the present case from the perspective of negative obligations, the Government submitted that there had been no interference with the applicants' right to respect for their

private life: the law in force did not prohibit childbearing women from giving birth at their private homes and the authorities did not punish them for doing so.

(b) Lawfulness

109. The Government submitted that the provisions of the Medical Services Act clearly established that the assistance of a health professional at a delivery constituted health care that could be provided only in a health-care facility meeting clearly defined minimum requirements set out in the implementing decree. There were explicit exceptions to the rule that health care must be provided in adequately equipped health-care facilities in places specified in the licence. These exceptions included health care provided in the patient's own social environment (for example, private homes) and emergency health care. The Government emphasised that assistance at a planned delivery did not fall under any of these exceptions. In particular, it did not fall under health care provided in the patient's own social environment as defined in section 10 of the Medical Services Act, since this provision explicitly specified that where health care was provided in the patient's own social environment, only those medical procedures were allowed which were not subject to requirements concerning the technical and material equipment necessary for their performance in health-care facilities. However, assistance at delivery was subject to such requirements.

110. Therefore, the regional authorities could not and would not issue a licence for the provision of health-care services to a midwife in a field entitling her to provide such services at home births. Without a licence, a health-care provider was not allowed to provide health-care services.

111. The Government further submitted that the relevant legal framework ensured legal certainty and foreseeability as it laid down unambiguous and precise requirements that had to be fulfilled when assisting at any planned delivery, regardless of whether such assistance was provided by a midwife or a doctor. Contrary to the Hungarian law which had been criticised by the Court for its lack of foreseeability in the case of *Ternovszky v. Hungary* (no. 67545/09, 14 December 2010), the Czech legislation provided that health professionals, including midwives, could assist at deliveries only in adequately equipped premises with clearly defined requirements that had to be fulfilled for the provision of such health care.

(c) Legitimate aim

112. The Government argued that the policy in issue was designed to protect the health and safety of the newborn child during and after delivery and, at least indirectly, that of the mother. These interests echoed the general legitimate aims of the protection of health and the protection of the rights of others.

(d) Necessity in a democratic society

113. The Government emphasised that, in order to safeguard the public interest in the protection of health and life, one of the primary tasks of the State was to ensure and maintain a certain standard and quality of health care, regardless of whether it was provided on a public or private basis. The State should not therefore be forced to allow a form of health care which they did not consider safe.

114. The Government further observed that the applicable domestic legislation aimed to ensure that health care was provided in "safe places of delivery" – that is, in adequately equipped premises close to a higher level of health care – in order to minimise the risks to the health and life of the newborn or that of the mother when sudden complications occurred. Lowering these medical standards could increase the risks associated with the provision of health care throughout the childbirth process and decrease the level and quality of such care.

115. In the Government's submission, tensions between the applicants' claims and the obligations under the right to life and health supported the Government's view that the right to respect for private life could not be so extensively interpreted as to require the State to put in place a framework allowing for the provision of health care during home birth when the authorities, in cooperation with experts in the fields of obstetrics and midwifery, had determined that the most suitable State policy, reflecting the strong above-mentioned public interest, was to provide free, accessible care for birthing in places with adequate medical equipment and the ability to respond quickly to emergencies. The mere assistance of a midwife at a home birth was insufficient. If sudden complications occurred, the newborn could be the subject of risks which were, however, avoidable. Health professionals, including midwives, could not deal effectively with such complications in private homes, since the premises would not be adequately equipped for that purpose and often were not in close proximity to a higher level of health care. In other words, in cases of planned births in private homes, health care would not be provided in a safe place for delivery.

116. The Government further submitted that the legislation under review required health professionals to conduct planned deliveries only in adequately equipped premises and in close proximity to a higher level of health care. Such requirements could not be regarded as measures specifically preventing midwives from assisting at home births, but as the minimum necessary standards for providing health care at any planned delivery. The minimum requirements in question were not excessive, effectively serving the aim of minimising the risks of acute complications by detecting them in a timely manner and securing a quick solution.

117. Referring to several examples of good practice, the Government further disagreed with the Chamber's conclusion that the conditions in most local hospitals were questionable, as far as respecting the choices of mothers

was concerned. They argued that due weight had been given to the privacy interests involved and that the Czech birth policy had been crafted in an effort to ensure an appropriate balance, taking into account the interests of both the child and the mother. They observed that there was a clear and proven trend in Czech maternity hospitals towards fulfilling childbearing women's rights, including the right to choose from among a wide range of circumstances in which to give birth.

118. The Government drew the Court's attention to the 2013 European Perinatal Health Report, according to which the Czech Republic had the lowest foetal mortality rate and also, together with Iceland and Cyprus, the lowest early neonatal mortality rate in Europe (see paragraph 29 above). They noted that those objectively exceptional results were primarily caused by the sophisticated system of high-level obstetric care and the legislation in force, ensuring that such health care (namely assistance with deliveries) could only be provided in adequately equipped premises. The Government underlined in this connection that such care was available free of charge to all childbearing women.

119. Overall, the Government expressed their strong conviction that on account of the very nature of the issue at stake, involving complex matters of health-care policy, including expert and scientific considerations and other general economic policy considerations, the State had a broad margin of appreciation, which it had not overstepped in this case.

120. In addition, the Government disputed the third-party observations of certain interveners. In respect of those submitted by the Public Defender of Rights, the Government maintained that they did not represent a reliable source of information for the purposes of the present case, having regard, in particular, to the fact that they referred to a few sparse complaints of alleged mistreatment of women in Czech maternity hospitals – representing a negligible fraction of all instances of childbirth taking place in the country – which the Public Defender herself had not yet fully examined and determined.

121. They also disputed part of the information included in the observations of the Czech Union of Midwives (*Unie porodních asistentek* – UNIPA).

122. Finally, regarding the Royal College of Midwives, which advocated a system like the one existing in the United Kingdom, the Government stated that there were several cultures and health-care systems with considerable differences in Europe, some of which showed more satisfactory results than the United Kingdom. In the Government's submission, the third-party intervener had omitted to mention that the Czech Republic had one of the lowest perinatal mortality rates in Europe and that the corresponding results in the United Kingdom were far worse. The British health-care system did not lead to better objective results. It was the

Government's view that the Court should not rule on the various practical arrangements available for the organisation of health-care systems.

3. *Third-party observations*

(a) The Government of the Republic of Croatia

123. The Croatian Government noted that their country had similar legislative arrangements regarding home birth to those in force in the Czech Republic.

124. In their submission, planned home delivery, in the light of all the scientific findings known to them, still represented a less safe option compared to full hospital delivery. They note that the Commission for Perinatal Medicine of the Ministry of Health of the Republic of Croatia is of the view that the hospitals are the safest venues for performing deliveries, giving both to a mother and a new-born the best guarantees for the preservation of their health and life. As such, the question whether the State should allow its medical staff to participate in such deliveries fell within its own margin of appreciation, meaning that each Contracting Party should be absolutely free to decide on its own, on the basis of its own assessment of numerous factors which needed to be considered, whether to provide this alternative to its citizens or not. The Croatian Government asserted that the Contracting Parties should not be compelled to make provision for home delivery, and that the spirit of the Convention did not require that legislative measures or practices to that effect should be implemented in every Contracting Party. That, however, did not mean that a Contracting Party should entirely disregard the fact that a substantial number of women did not feel comfortable in a hospital environment, and that certain adverse effects in relation to delivery could be linked to that particular feeling of discomfort and fear.

125. However, the Croatian Government did not think that the solution to this problem lay in making compulsory provision for assisted home delivery. A compromise could be found in the implementation of measures aimed at providing a higher level of hospital comfort. Ensuring a home-like hospital environment, the possibility of the partner or close relatives being present during the delivery, rooming-in, respect for pregnant women's wishes prior to and during labour as regards the choice of available medical procedures, and alternative positions for women during labour were all possible ways of providing the best of both worlds.

126. The Croatian Government submitted that respect for women's wishes regarding the above-mentioned aspects, in the context of Article 8 of the Convention, undoubtedly fell well within the ambit of the Convention; assisted home births, however, did not.

(b) The Government of the Slovak Republic

127. The Slovak Government fully supported the Chamber's finding of no violation of Article 8 of the Convention in the present case. At the same time, they submitted that it would be more appropriate to examine the case from the perspective of the State's positive rather than negative obligations.

128. Referring to Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, Article 24 of the Convention on the Rights of the Child and paragraphs 15, 90 and 94 of General Comment no. 15 (2013) on the latter Convention, the Slovak Government observed that States had a strong positive obligation to regulate and organise their system for the provision of health care in relation to births. This included the provision of adequate education for all health-care providers and other persons involved, supervision and enforcement of compliance with existing medical, material and human rights and other relevant standards and, within this context, the operation of a system for continuous monitoring and review of those standards. The aim should nonetheless be to ensure the protection and enjoyment of the right to life and health of the woman, as well as the child.

129. The Slovak Government were aware both of the State's positive obligation to protect the life and health of the child and to provide the child with the highest attainable standard of health care, and of the associated responsibilities. In their view, it might not be possible to fulfil that obligation in the case of home births. Under the Slovakian legal regulations, health-care providers were obliged to have access to the material and technical equipment laid down in the relevant rules. Qualified midwives were entitled to assist individually in health-care institutions only in the case of a physiological delivery during which an episiotomy was required. Home births brought about risks for the mother and child which were not offset by the basic facilities available at home.

130. The Slovak Government noted that since the rate of births outside health-care institutions in the Slovak Republic amounted to 0.36% (198 births) according to the most recent data (from 2013), it was not possible to make a statistical assessment of the degree of safety of this mode of delivery. Statistics from western European countries where home birth was allowed showed that a significant proportion of such births required transport to hospital – for example, in Germany in 2013, up to 11.3% of home births had required a transfer to hospital during delivery and in 0.1% of cases the baby had been born during the transfer.

131. Moreover, most births did not proceed according to plan, and there could be unforeseeable circumstances and the possibility of an acute threat to the mother and baby's health and life. It was impossible to foresee whether a pregnancy would end with a physiological birth or would require rapid intervention or emergency surgery. Birth was in all cases a dynamic

process which could become complicated at any stage, with a direct threat to the life of the foetus and obviously the woman in labour. None of these complications could be resolved at home, as was attested by births with lasting consequences, either for the child or for the mother. Problems such as acute hypoxia for the child, or embolism or bleeding for the mother, could not be handled outside health-care institutions. A further trend that had been overlooked was the constantly increasing age of mothers and the complications associated with this. According to statistics issued by the National Centre for Health Information, in the Slovak Republic in 2013 6,292 newborns had required health care in specialist neonatal institutions; in other words, approximately one in every eight to nine newborn children had required specialist intensive health care.

132. Regarding the State's wide margin of appreciation in the present field, the Slovak Government acknowledged that a humanised approach was preferable during birth and in the event of any changes in the circumstances of a birth, but emphasised that this was only possible in health-care institutions. It was inevitable to stress the need for protection of children's rights, their chance to live and their right to health, all of which were diminished during birth outside a health-care institution. The majority of women opting for delivery in a domestic environment referred to the need for intimacy, the opportunity to select the method and position of delivery and to decline particular types of medical intervention during childbirth, the need for the presence of a person close to them, and the importance of not being separated from the child. The Slovak Government noted in this connection that the United Nations Committee for the Rights of the Child required States to support the Mother and Baby Friendly Hospital Initiative (MBFHI), whereby the WHO and UNICEF had set down the criteria for maternity and neonatal units of health-care institutions. While cooperating with the above-mentioned organisations, the Slovak Republic had since 1996 implemented quality projects for perinatal care, including support for physiological birth, a behavioural approach to nursing for newborns and mothers, support for breastfeeding, and emphasis on the inseparability of the mother/child bond. Each health-care provider should be responsible for ensuring the highest standard of humanisation of birth. Some providers had rebuilt health-care institutions in order to offer alternative methods of giving birth, for example the vertical birth position or water birth; to tailor birth arrangements to the mother's request; and to provide separate rooms allowing the husband or other family members to be present during the birth and throughout the stay in the institution. Immediate contact between the mother and the newborn after delivery should be ensured in each delivery room and was a precondition for the MBFHI. From the point of view of breastfeeding support, the MBFHI was considered in the European Union to constitute a model of best practice as regards care for the mother and the newborn after delivery. Among other things, it required the newborn child,

once dried, to be placed on the mother's body within half an hour after delivery, and the newborn and mother to be given the opportunity to be together for breastfeeding "upon request".

133. The Slovak Government submitted that this approach to births, which was similar to that adopted in the Czech Republic, was in line with the idea of respect and active support for women's rights in connection with births. At the same time, they fully acknowledged the rights of the child deriving from international instruments, with a view to striking a balance between the interests of the mother and her child and the interest of society in preserving their health and well-being.

(c) The Royal College of Midwives

134. The Royal College of Midwives stated that it was the United Kingdom's only professional organisation and trade union led by midwives for midwives. Its objects were to promote and advance the art and science of midwifery and to promote the effectiveness and protect the interests of its members.

135. It had maintained a consistent position on the safety of home birth, which it considered a safe choice for women with uncomplicated pregnancies.

136. Under the current government policy, all hospitals in the United Kingdom were expected to make home birth an option, and women were entitled to self-refer to home birth services in their area. In interpreting the common law, the national courts had shifted their approach to clinical negligence to emphasise that women were responsible for making decisions about the maternity care that they received. The national midwifery regulator, the Nursing and Midwifery Council, had recognised that women could not be forced to give birth in hospital against their wishes. It had therefore been accepted that midwives had a professional duty of care to attend women who were giving birth outside hospital.

137. Home births were not expressly regulated by national law: midwives' capacity to provide care to women at home was an implied part of their general competence and any care they provided, regardless of the setting in which they provided it, was subject to scrutiny by the professional regulator and the general law. Rules governing the specific practicalities of home births were laid down by the appropriate regulatory body and the midwife's employer.

138. The Royal College of Midwives submitted that the following consequences arose from prohibiting midwifery assistance at home birth: (i) giving birth at home without any trained assistance would give rise to risks for the health of women and babies should complications occur; (ii) as there was no regulation of the qualifications and competence of home birth attendants, women might be assisted by an untrained birth attendant who was not subject to any regulatory control; (iii) there would be a disincentive

to transfer to hospital if complications arose during birth because the midwife or other attendant might be reported to the authorities; (iv) transfer to hospital in an emergency would be hindered by lack of proper referral procedures and record-keeping and the hospital would have no record of the woman's obstetric history, the progress of labour or the nature of any complication; and (v) giving birth at home would become stigmatised and hospital staff would often treat women who transferred from home with suspicion and disrespect and might delay urgent care.

(d) The International Study Group of the World Association of Perinatal Medicine

139. The World Association of Perinatal Medicine and the International Academy of Perinatal Medicine included in their membership scientific and clinical leaders in the medical care of pregnant women, foetal and neonatal patients. The International Study Group had begun its scientific work on planned home birth in 2013.

140. It stated that according to the results of its studies, planned home birth involved unnecessary, preventable increased risks to the newborn and the mother. A pregnant woman who continued her pregnancy to term freely assumed ethical obligations towards her foetus and soon-to-be-born child to select a site for delivery that was not unnecessarily risky. Her autonomy was therefore justifiably constrained by such ethical obligations.

141. In respect of the finding set out in the joint statement by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives to the effect that planned home birth was a "safe option for many women", the third-party intervener argued that this conclusion did not withstand close scrutiny for planned home birth without immediate access to hospital-based care. Such settings were unavoidably at risk for transport to hospital. Moreover, the perinatal mortality rate had been reported to be more than eight times higher when transport from home to an obstetric unit had been used. The unavoidable delay involved in even the best transport systems from home to hospital and even from labour and delivery to the operating room resulted in increased risks of mortality and morbidity for both the newborn and the mother.

142. The International Study Group mentioned the long tradition in the Netherlands of optimally organised home birth, with well-trained midwives and a transport system with short distances to hospitals. Nonetheless, 49% of primiparous and 17% of multiparous women were transported during labour. The most frequent indications were the need for pain relief and prolonged labour.

143. Planned home birth often did not satisfy its *raison d'être*, namely improved patient satisfaction. Professional responsibility required hospital physicians and midwives to take measures to improve patient satisfaction, by creating home birth-like environments that were appropriately staffed not

only to ensure patient safety, which was the paramount professional responsibility, but also to ensure patient satisfaction. A pregnant woman did indeed have the right to decide and control what happened to her body during pregnancy and delivery. However, a more clinically appropriate view was that the physician or midwife had an independent obligation, as a matter of professional integrity, to protect pregnant, foetal and neonatal patients. Their role was to identify and present medically reasonable alternatives for the management of pregnancy, in other words clinical management for which there was an evidence base of net clinical benefit.

144. The patient had the right to select from among the medically reasonable alternatives. If she rejected them all and also remained a patient, then her refusal was not a simple exercise of a negative right to non-interference. Her refusal was more complex, being coupled with a positive right to the services of clinicians and the resources of health-care organisations and society. Insistence on implementing the unconstrained rights of pregnant women to control the birth location was an ethical error and therefore had no place in professional perinatal medicine.

145. In conclusion, planned home birth was not consistent with professional integrity because its increased risks were preventable by planned hospital birth. Pregnant women did not have absolute freedom to control the place of assisted birth because they had an ethical obligation towards the soon-to-be-born child to protect the child's health-related interests. This obligation could not be fulfilled by planned home birth but could be fulfilled by planned hospital birth. The precautionary principle justified reducing risks for the vulnerable when the burdens of doing so were minimal. Planned hospital birth protected foetal and neonatal patients from the risks of planned home birth, from which risks they could not protect themselves. The burdens on pregnant women of planned hospital birth were minimal. Planned home birth was therefore not compatible with the precautionary principle.

(e) The Czech Union of Midwives (*Unie porodních asistentek* – UNIPA)

146. UNIPA stated that it was a professional organisation associating independent midwives.

147. At the outset, it described the professional organisations for midwives in the Czech Republic. Apart from UNIPA, which united midwives and midwifery university students across the Czech Republic, there was the Czech Confederation of Midwives (*Česká konfederace porodních asistentek* – ČKPA), which grouped midwives into particular clusters according to region. These two organisations cooperated closely in order to develop and promote midwifery in the Czech Republic as a viable model of maternity health care. There was also the Czech Association of Midwives (*Česká společnost porodních asistentek* – ČSPA), an organisation

that had been established in 2014 and brought together other medical and paramedical professionals.

148. UNIPA submitted that the provision of midwife-based care had been expressly banned by law in relation to home births and that such care was also banned at midwives' offices and in birth centres owing to the excessive technical requirements imposed by secondary legislation. As a result of the State's approach and hospitals' practice, midwives could not legally assist at childbirth outside hospitals. Moreover, as the State allowed only for the obstetric model of care, a midwife wishing to provide assistance at childbirth had to do so in a hospital in accordance with that model, subject to obstetric rules, with the need for prior instructions from a physician and under supervision. In such cases, the midwife also needed to be in an employment relationship with the hospital. Such a set-up inherently prevented midwives from providing midwife-based care and performing the statutory duties of a midwife.

149. UNIPA observed that out of 6,000 qualified and licensed midwives in the country, none had been awarded a technical licence authorising them to perform the full range of a midwife's duties, including assistance at childbirth. Consequently, no midwives had been licensed by the State to carry out childbirth-related duties independently and without prior instructions from a physician. In addition, although from a purely legal and technical standpoint the existence of birth centres was not currently restricted, the extensive requirements in terms of technical, material and human resources effectively eliminated this option. There had in fact been one attempt to register a birth centre in Brno, but although it had been intended to be located in close proximity to a local hospital, the response of the relevant public authority had been negative.

150. Owing to the monopoly enjoyed by physicians in the field of maternity health care, the health-care system entirely failed to distinguish between primary and secondary care for mother and child. The failure to distinguish between these levels of care necessarily led to the provision of a standardised form of care for all mothers, without reflecting their particular different needs. As a result, the system failed to distinguish between spontaneous low-risk mothers whose deliveries were reasonably anticipated to be free of complications, and mothers whose pregnancies indicated the existence of pathological conditions.

151. UNIPA next drew the Court's attention to the absence of any national professional standards of care in midwifery, a fact that, in particular, exposed midwives to higher risks in terms of their professional liability, in both civil and criminal matters. Referring to two examples of criminal proceedings against midwives, it maintained that although they had been found innocent, their reputation, as well as that of midwifery, had suffered irreparable damage.

152. The third-party intervener lastly contended that no viable statistical data had been collected by the State as regards practices in specific hospitals and births outside medical facilities. In the intervener's opinion, this limited the choice available for prospective mothers as regards the place of childbirth. Moreover, there were no comprehensive methods for informing prospective mothers about the health care provided by public authorities in connection with childbirth. Women were therefore not aware of their various options during pregnancy and childbirth. Such information was only accessible in pre-childbirth courses that were subject to a fee.

(f) The Public Defender of Rights (*Veřejná ochránkyně práv*)

153. The Public Defender of Rights (Ombudsman) stated that her role was mainly to protect persons from conduct that was either unlawful or in any way improper, and from inactivity on the part of the authorities and other public bodies (in other words, to scrutinise and inspect public administration). At the same time, the Public Defender acted as the national equality body (the national body for equal treatment and protection from discrimination) by virtue of the relevant European Union directives (no. 2000/43/EC of 29 June 2000, implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, and no. 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation). The Public Defender also conducted systematic visits of places where persons were restricted in their freedoms (by virtue of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) and monitored forced returns or expulsions of aliens under Directive no. 2008/115/EC of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

154. The Public Defender submitted to the Court an overview of cases referred to her, without providing any statistical data.

155. The first category of complaints concerned procedures during labour and childbirth in a medical facility, which the women in question had described as lacking in dignity and privacy. More specifically, some women had complained of certain types of intervention being performed without their consent, the obligation to pay a fee for the presence of their own doula, overcrowding in the delivery room and failure to respect their wishes regarding the opportunity to eat and drink, to move around or to opt for specific birthing positions either on or off the bed. Certain complaints also concerned the continuous monitoring of the unborn child, the mother's separation from the child immediately after the birth or in the forty-eight hours following the birth, and the failure to comply with a birth plan submitted by the mother.

156. The second category of complaints examined by the Public Defender concerned the impossibility of delivery outside a medical facility with professional assistance, and the ambiguity of the legal regulations governing home births.

157. The first complaint on that account had been received by the Public Defender in 2003. The woman concerned had complained that it was impossible to deliver a baby outside a medical facility with the assistance of a midwife and that the midwife's services were not reimbursed by the public health-insurance fund. The outcome of that complaint was not stated. The Public Defender noted that even though Czech law did not expressly prohibit delivery outside a medical facility, this possibility was virtually excluded by Decree no. 92/2012 of the Ministry of Health. She emphasised that the legal requirements for minimum equipment in medical facilities and home-care centres could not, in principle, be complied with in a home-delivery environment or in any other environment. She observed that delivery rooms meeting the conditions set out by the legislation were thus located exclusively in health-care facilities. The Public Defender pointed out in this connection that some mothers-to-be would have found it sufficient if the delivery in the medical facility had been performed by their "own" midwife. However, the medical facilities only allowed deliveries to be performed by midwives with whom they had concluded an agreement, and such agreements often proved impossible to obtain.

158. The third category of complaints to the Public Defender concerned administrative difficulties faced by the parents of a child born outside a health-care facility. In many cases it had been difficult to obtain a birth certificate or parental allowance.

159. Lastly, the Public Defender noted that there had been some complaints from midwives concerning the legal regulations which in practice had made it impossible to assist with and conduct a delivery outside a medical facility.

C. The Court's assessment

1. Applicability of Article 8 of the Convention

160. In the instant case the applicants formulated their complaint under Article 8 of the Convention and the Government did not dispute the applicability of that provision in the proceedings before the Grand Chamber.

161. The Court notes that the applicants sought to be assisted by a midwife during a home birth. The issue arising in the present case is therefore whether the right to determine the circumstances in which to give birth falls within the scope of Article 8 (see also paragraph 74 of the Chamber judgment).

162. The Grand Chamber confirms that the concept of "private life" is a broad one (see paragraph 73 of the Chamber judgment). It reiterates in this connection that in the case of *Odièvre v. France* [GC], no. 42326/98, § 29, ECHR 2003-III) the Court held that "birth, and in particular the circumstances in which a child is born, forms part of a child's, and subsequently the adult's, private life guaranteed by Article 8 of the Convention". Moreover, in the case of *Ternovszky*, cited above, § 22, it held that "the circumstances of giving birth incontestably form part of one's private life for the purposes of this provision".

163. The Court finds that while Article 8 cannot be interpreted as conferring a right to give birth at home as such, the fact that it is impossible in practice for women to be assisted when giving birth in their private home comes within the scope of their right to respect for their private life and accordingly of Article 8. Indeed, giving birth is a unique and delicate moment in a woman's life. It encompasses issues of physical and moral integrity, medical care, reproductive health and the protection of health-related information. These issues, including the choice of the place of birth, are therefore fundamentally linked to the woman's private life and fall within the scope of that concept for the purposes of Article 8 of the Convention.

2. Whether the case should be examined from the standpoint of the State's negative or positive obligations

164. The parties disagree on whether the case should be examined in terms of an interference with the applicants' rights under Article 8 of the Convention or from the angle of positive obligations on the State to protect the applicants' rights. The central issue in this case may indeed be seen as either a curtailment of the applicants' right to choose the circumstances of giving birth, to be analysed as an interference with their right to respect for their private life, or as a failure on the part of the State to provide an appropriate regulatory framework securing the rights of persons in the applicants' situation, to be analysed in terms of the State's positive duty to ensure respect for their private life (see, *mutatis mutandis*, *Hristozov and Others*, cited above, § 117).

165. Having regard to the nature and content of the applicants' complaints, the Grand Chamber considers it appropriate, as the Chamber did, to approach the present case as one involving an interference with the applicants' right to avail themselves of the assistance of midwives when giving birth at home, owing to the threat of sanctions for midwives, who in practice were prevented from assisting the applicants by the operation of the law. In any event, as the Court has already held, the applicable principles regarding justification under Article 8 § 2 are broadly similar regardless of analytical approaches adopted (see *S.H. and Others v. Austria* [GC], no. 57813/00, § 88, ECHR 2011, with further references).

166. To determine whether this interference entailed a violation of Article 8 of the Convention, the Court must examine whether it was justified under the second paragraph of that Article, that is, whether the interference was "in accordance with the law" and "necessary in a democratic society" for the pursuit of one of the "legitimate aims" specified in Article 8.

3. Was the interference "in accordance with the law"?

167. The Court reiterates that an impugned interference must have some basis in domestic law, which law must be adequately accessible and be formulated with sufficient precision to enable the citizen to regulate his or her conduct, he or she being able – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail (see *A, B and C v. Ireland*, cited above, § 220, with further references).

168. In the present case it was undisputed between the parties that the domestic legal provisions providing the legal basis for the impugned interference were accessible to the applicants. The Court sees no reason to disagree with the parties on this.

169. In respect of their foreseeability, the Court first notes that giving birth at home is not as such prohibited by the Czech legal system. It further observes that the Health Care in Private Health-Care Institutions Act, which was in force when Ms Dubská gave birth to her second child in April 2011, regulated private health-care institutions and provided for sanctions for any such health-care providers who breached the Act, while not specifying the amount of the fine which could be imposed. The Act empowered the Ministry of Health to lay down technical and material requirements for equipment in health-care institutions. This was done by means of Decree no. 221/2010, which entered into force on 1 September 2010 and set out detailed conditions to be complied with in order to practise the profession of midwife independently, identifying, *inter alia*, three possible categories of workplaces for midwives: workplaces where delivery was not allowed, workplaces where delivery was allowed, and contact workplaces which had to be equipped with the furniture appropriate for a midwife and a mobile phone. The decree also defined the content of a midwife's bag (see paragraphs 43-46 above). At the same time, the Paramedical Professions Act, which was in force at the time of both applicants' deliveries and is still in force, laid down the requirements for the independent practice of the profession of midwife, empowering the Ministry of Health to define the activities of midwives. This was done by means of Decree no. 424/2004, later superseded by Decree no. 55/2011, both of which stated that midwives could carry out activities on their own, such as performing physiological deliveries, including episiotomy if needed.

170. The Medical Services Act entered into force shortly before Ms Krejzová gave birth to her third child in May 2012. It repealed both the Health Care in Private Health-Care Institutions Act and Decree no. 221/2010. It specified that a person could provide health-care services only if in possession of the appropriate licence, except in special situations. The health-care institutions referred to in the licence had to be adequately equipped in respect of the services provided, as specified in a decree to be issued by the Ministry of Health. A person who provided health care otherwise than in accordance with the Act could be fined for breaching the Act which also defined a number of concrete sanctions. The essential equipment which had to be available to midwives in the places where they were to assist with deliveries was described in detail in Decree no. 92/2012, which indicated, *inter alia*, three different categories of workplaces for midwives, namely: workplaces where delivery was not allowed, workplaces where delivery was allowed, and contact workplaces for nursing care relating to gynaecology and childbirth (see also paragraph 82 of the Chamber judgment).

171. The Court accepts that while there might have been doubts about the clarity of certain legislative provisions in force at the relevant time, the applicants were nevertheless able – if need be with appropriate advice – to foresee to a degree that was reasonable in the circumstances that their private homes were unable to satisfy the requirements relating to the equipment listed successively in both the above-mentioned instruments of secondary legislation and that, as a consequence, the provisions in question did not permit a health professional to assist with a planned home birth.

Consequently, the impugned interference was in accordance with the law.

4. Did the interference pursue a legitimate aim?

172. The Court considers, contrary to the applicants, that there are no grounds for doubting that the Czech State's policy of encouraging hospital births, as reflected in the relevant national legislation, was designed to protect the health and safety of the mother and the child during and after delivery.

173. It may accordingly be said that the interference in the present case served the legitimate aim of the protection of health and of the rights of others within the meaning of Article 8 § 2 of the Convention.

5. Was the interference necessary in a democratic society?

174. An interference will be considered "necessary in a democratic society" for the achievement of a legitimate aim if it answers a "pressing social need" and, in particular, if it is proportionate to the legitimate aim pursued and if the reasons adduced by the national authorities to justify it

are “relevant and sufficient” (see, *mutatis mutandis*, *Fernández Martinez v. Spain* [GC], no. 56030/07, § 124, ECHR 2014 (extracts)).

175. In this connection, the Court reiterates the fundamentally subsidiary role of the Convention system and recognises that the national authorities have direct democratic legitimation in so far as the protection of human rights is concerned. Moreover, by reason of their direct and continuous contact with the vital forces of their countries, they are in principle better placed than an international court to evaluate local needs and conditions (see, e.g., *Maurice v. France* [GC], no. 11810/03, § 117, with further references, ECHR 2005-IX).

176. It is therefore primarily the responsibility of the national authorities to make the initial assessment as to where the fair balance lies in assessing the need for an interference in the public interest with individuals’ rights under Article 8 of the Convention. Accordingly, in adopting legislation intended to strike a balance between competing interests, States must in principle be allowed to determine the means which they consider to be best suited to achieving the aim of reconciling those interests (see *Odièvre*, cited above, § 49; *Van Der Heijden v. the Netherlands* [GC], no. 42857/05, § 56, 3 April 2012).

177. While it is for the national authorities to make the initial assessment, the final evaluation as to whether an interference in a particular case is “necessary”, as that term is to be understood within the meaning of Article 8 of the Convention, remains subject to review by the Court (see *S. and Marper v. the United Kingdom* [GC], nos. 30562/04 and 30566/04, § 101, ECHR 2008; *Van Der Heijden,* cited above, § 57).

178. A certain margin of appreciation is, in principle, afforded to domestic authorities as regards that assessment; its breadth depends on a number of factors dictated by the particular case. The margin will tend to be relatively narrow where the right at stake is crucial to the individual’s effective enjoyment of intimate or key rights. Where a particularly important facet of an individual’s existence or identity is at stake, the margin allowed to the State will also be restricted. Where there is no consensus within the member States of the Council of Europe, either as to the relative importance of the interest at stake or as to the best means of protecting it, particularly where the case raises sensitive moral or ethical issues, the margin will be wider (see *Van der Heijden*, cited above, §§ 55-60 with further references, and also *Parrillo v. Italy* [GC], no. 46470/11, § 169, with further references, ECHR 2015).

179. A wide margin is usually allowed to the State under the Convention when it comes to general measures of economic or social strategy. Because of their direct knowledge of their society and its needs, the national authorities are in principle better placed than the international judge to appreciate what is in the public interest on social or economic grounds, and the Court will generally respect the legislature’s policy choice unless it is

"manifestly without reasonable foundation" (see *Stec and Others v. the United Kingdom* [GC], nos. 65731/01 and 65900/01, § 52 with further references, ECHR 2006-VI; *Shelley v. the United Kingdom* (dec.), no. 23800/06; 4 January 2008; and *Hristozov*, cited above, § 119).

180. In the case at hand, the Court has to establish whether the fact that it was impossible in practice for the applicants to be assisted by a health professional during a home birth struck a fair balance between, on the one hand, the applicants' right to respect for their private life under Article 8 and, on the other, the interest of the State in protecting the health and safety of the child during and after delivery and that of the mother (see paragraph 174 above): in other words, whether or not the respondent State, by introducing legislation that did not allow in practice for such assistance, overstepped the margin of appreciation afforded to it.

181. The Government maintained that the State's margin of appreciation in the present case was wide. The applicants argued that a penalising approach to home births might affect women's right to life and health and that, by making home birth less safe for women, the State might be putting these rights at risk. Moreover, according to the applicants, the right of women to decide on the circumstances in which to give birth, as a mechanism compensating for their limited freedom of self-determination at that moment, did not in principle allow for any further limitations, on account of the Government's margin of appreciation, which was necessarily narrow in this area. The applicants further maintained that there was a consensus among member States in respect of home births, which was supported by international expert opinion on the issues of maternal health and the importance of skilled attendants at birth. The existence of this European consensus should, in their view, lead to the Government's margin of appreciation being narrowed.

182. While the question of home birth does not as such raise acutely sensitive moral and ethical issues (see, by contrast, *A, B and C v. Ireland*, cited above), it can be said to touch upon an important public interest in the area of public health. Moreover, the responsibility of the State in this field necessarily implies a broader boundary for the State's power to lay down rules for the functioning of the health-care system, incorporating both State and private health-care institutions. In this context the Court notes that the present case involves a complex matter of health-care policy requiring an assessment by the national authorities of expert and scientific data concerning the risks of hospital and home births. In addition, general social and economic policy considerations come into play, including the allocation of financial means, since budgetary resources may need to be shifted from the general system of maternity hospitals to the provision of a framework for home births (see, *mutatis mutandis*, *Maurice*, cited above, § 84, with further references, and *Stec and Others*, cited above, § 52).

183. Moreover, contrary to the applicants' submissions, the Court finds that among the member States of the Council of Europe there is no consensus capable of narrowing the State's margin of appreciation, in favour of allowing home births. In particular, the Court notes that planned home births are provided for in domestic law and regulated in twenty member States, but the right to choose this mode of delivery is never absolute and is always dependent on certain medical conditions being satisfied. In addition, national health insurance covers home birth in only fifteen of these countries. The Court further notes that home births are unregulated or under-regulated in twenty-three other countries. In some of these countries private home births do take place, but in a legal vacuum and without national health cover. Moreover, no legislation has been found which explicitly prohibits the assistance of midwives at home births. In a very small number of the member States surveyed, disciplinary or criminal sanctions are possible, but appear to be rarely imposed.

184. In the light of these considerations, the Court takes the view that the margin of appreciation to be afforded to the national authorities in the present case must be a wide one, while not being unlimited. The Court must indeed supervise whether, having regard to that margin of appreciation, the interference constitutes a proportionate balancing of the competing interests involved (see *A, B and C v. Ireland*, cited above, § 238, with a further reference). In cases arising from individual applications the Court's task is not to review the relevant legislation or practice in the abstract; it must as far as possible confine itself, without overlooking the general context, to examining the issues raised by the case before it (see *S.H. and Others v. Austria*, cited above, §§ 91-92, with further references). Consequently, the Court's task is not to substitute its own view for that of the competent national authorities in determining the most appropriate policy for regulating matters regarding the circumstances of giving birth. Instead, it must decide on the compatibility with Article 8 of the State's interference in the present case on the basis of the fair-balance test described above.

185. The applicants in the present case both expressed their wish to give birth in their private home with the assistance of a midwife. The Court accepts that as a consequence of the operation of the legislative provisions in force at the relevant time, they were put in a situation which had a serious impact on their freedom of choice: they were required, if they wished to give birth at home, to do so without the assistance of a midwife and, therefore, with the attendant risks that this posed to themselves and their newborns, or to give birth at hospital (see also paragraphs 93 and 95 of the Chamber judgment). The Court notes in this connection that while there is generally no conflict of interest between the mother and her child, certain choices made by the mother as to the place, circumstances or method of delivery may be seen to give rise to an increased risk to the health and safety of newborns, whose mortality rate, as shown in figures for perinatal

and neonatal deaths, is not negligible, despite all the advances in medical care (see also paragraph 94 of the Chamber judgment).

186. In this respect, the Court notes the Government's argument, supported by the Government of the Republic of Croatia and the Government of the Slovak Republic, that the risk for mothers and newborns (see paragraphs 124 and 131 above) is higher in the case of home births than in the case of births in maternity hospitals which are fully staffed and adequately equipped from a technical and material perspective, and that even if a pregnancy proceeds without any complications and can therefore be considered a "low-risk" pregnancy, unexpected difficulties can arise during the delivery which would require immediate specialist medical intervention, such as a Caesarean section or special neonatal assistance. Moreover, a maternity hospital can provide all the necessary urgent medical care, whereas this would not be possible in the case of a home birth, even with a midwife attending (see also paragraph 97 of the Chamber judgment). It is to be noted in this connection that the Czech Republic has not set up a system of specialist emergency assistance for cases of home births. Contrary to the applicants' argument (see paragraph 79 above), the lack of such a system would be likely to increase the potential risks for women giving birth at home and their babies.

187. It also transpires from the material before the Court that in States where home births are allowed, certain preconditions must be fulfilled: the pregnancy must be "low risk", a qualified midwife must be present at the birth to detect any complications and transfer the woman in labour to hospital if necessary, and such a transfer must be secured in a very short period of time (see also paragraph 96 of the Chamber judgment). Accordingly, as the applicants contended, a home birth without the assistance of medical professionals may increase the risk to the life and health of both the mother and the newborn child.

188. The Court notes that the applicants could have opted, as the Government also indicated, to give birth in one of the local maternity hospitals, where their wishes would in principle have been satisfied. However, according to the applicants' submissions based on their own experience (see paragraphs 9 and 23 above), in a number of those hospitals the conditions in which pregnant women are admitted and provided with medical treatment and medication would appear to be questionable, and in several local hospitals the wishes of mothers-to-be do not seem to be fully respected (see also paragraph 95 of the Chamber judgment). These remarks would seem to be confirmed in substance by the Committee on the Elimination of Discrimination against Women, in its Concluding Observations on the Czech Republic issued on 22 October 2010, which expressed concern regarding the conditions for child birth and obstetric services in the Czech Republic and made a number of recommendations to

the Government in this area (see paragraph 65 above; and also paragraphs 56 and 95 of the Chamber judgment).

189. In the Court's opinion, these concerns cannot be disregarded when assessing whether the authorities struck a fair balance between the competing interests. At the same time, the Court acknowledges that since 2014 the Government have taken some initiatives with a view to improving the situation, notably by establishing a new governmental expert committee on the issue of obstetrics, midwifery, and related women's rights. The Court also takes note of the recent statement the Czech Gynaecological and Obstetrical Society, issued in August 2015 (see paragraphs 103-104 above). Against this background, the Court finds it appropriate to invite the Czech authorities to make further progress by keeping the relevant legal provisions under constant review, so as to ensure that they reflect medical and scientific developments whilst fully respecting women's rights in the field of reproductive health, notably by ensuring adequate conditions for both patients and medical staff in maternity hospitals across the country.

190. In conclusion, having regard to the State's margin of appreciation (see paragraph 184 above), the Court is of the view that the interference with the applicants' right to respect for their private life was not disproportionate.

191. Accordingly, there has been no violation of Article 8 of the Convention.

FOR THESE REASONS, THE COURT,

Holds, by twelve votes to five, that there has been no violation of Article 8 of the Convention.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 15 November 2016.

Johan Callewaert — Deputy to the Registrar

Guido Raimondi — President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the joint dissenting opinion of Judges Sajó, Karakaş, Nicolaou, Laffranque and Keller is annexed to this judgment.

G.R.
J.C.

DISSENTING OPINION OF JUDGES SAJÓ, KARAKAŞ, NICOLAOU, LAFFRANQUE AND KELLER

I. Introduction

1. To our regret, we are unable to share the view of the majority of the Grand Chamber that there has been no violation of Article 8 of the Convention in the present case. In our opinion, the relevant Czech legislation renders home births *de facto* impossible given that it creates excessively rigid requirements regarding the equipment needed for a birth, which can only be met in hospitals. This constitutes an interference with mothers' freedom of choice that is not proportionate in a democratic society. The system is also detrimental to the health of mothers and their newborns, as it deprives them of the possibility of receiving the indispensable assistance of a midwife during home births.

2. The majority correctly recognised that choosing the circumstances of how one gives birth falls within the scope of Article 8 of the Convention. We also share our colleagues' view that the Czech law in its current wording constitutes an interference with the applicants' right to benefit from the assistance of midwives when giving birth at home. Despite some hesitations, we can accept that this interference was in accordance with the law and, in theory, pursued a legitimate aim. However, we come to a different conclusion from the majority as regards the proportionality test.

3. We will begin by examining the general Convention framework that applies to a multipolar human rights context (II.). We will then analyse the Court's previous case-law on home births (III.) and point out some particularities concerning obstetric services in the Czech Republic (IV.) and the risk involved in home births (V.). We will subsequently turn to the majority's main arguments in finding no violation of Article 8 (VI.). Applying the relevant general principles in the applicants' concrete circumstances (VII.) leads us to the conclusion (VIII.) that the interference concerned was disproportionate.

II. General Convention framework

4. In the present case we are confronted with a clear example of a multipolar human rights situation: different rights are at stake here, namely expectant mothers' freedom to choose how they wish to give birth (which is covered by Article 8 of the Convention), on the one hand, and the mothers' and newborns' right to life under Article 2 of the Convention, on the other. The State has an obligation to provide the necessary framework to guarantee both aspects, that is, to respect the mothers' choice *and* to protect the mothers' and children's right to life as well.

5. The majority correctly state that the question of home births touches upon an important public interest in the area of public health (see paragraph 182 of the judgment). The challenge is to strike a fair balance between the applicants' right to respect for their private life and the interest of the State in protecting the health and safety of newborns and of their mothers (see paragraph 180). In the case of competing Convention rights, the case-law of the Court explicitly recognises that the member States usually enjoy a certain margin of appreciation (see *Odièvre v. France* [GC], no. 42326/98, §§ 40–49, ECHR 2003-III, and *Dickson v. the United Kingdom* [GC], no. 44362/04, §§ 77–85, ECHR 2007-V).

6. This margin of appreciation is also applicable, in particular, to the legislature. However, domestic legislation is not beyond the scrutiny of the Court, as the Convention imposes boundaries on the legal framework set by the State. The existence of a margin of appreciation should not be equated with any kind of "*carte blanche*" in favour of the national legislature. Otherwise, the rights guaranteed by the Convention would be devoid of any substance. In deciding any case under Article 8 of the Convention, a number of factors must be taken into account in order to determine the breadth of the margin of appreciation to be enjoyed by the State. Where a particularly important facet of an individual's existence or identity is at stake, the margin granted to the State will normally be restricted. Where, however, there is no consensus within the member States of the Council of Europe, either as to the relative importance of the interest at stake or as to the best means of protecting it, particularly where the case raises sensitive moral or ethical issues, the margin will be wider (see *S.H. and Others v. Austria* [GC], no. 57813/00, § 94, ECHR 2011).

7. We note, firstly, that the decision regarding how an expectant mother wishes to give birth constitutes *a core issue* under Article 8 of the Convention. Childbirth represents one of the most intimate aspects of a woman's life. In this regard we agree with the majority, who describe birth as a unique and delicate moment in a woman's life (see paragraph 163 of the judgment). Secondly, we would like to underscore that there is generally no conflict of interest between the mother and her child (see paragraph 185). In other words, under ordinary circumstances we trust that a mother will choose the best option for the birth of her child, taking into account her own health and the health of her baby. Thirdly, the Court must always submit absolute prohibitions or blanket bans to the closest scrutiny. In *Costa and Pavan v. Italy* (no. 54270/10, § 68, 28 August 2012), concerning the Italian ban on the use of preimplantation genetic diagnosis (PGD), the Court reiterated that it had the power to examine the compatibility with the Convention of domestic measures even in areas in which the State enjoyed a wide margin of appreciation. In that case, the Court came to the conclusion that the measures taken had not been proportionate given that, although the applicants could opt for a termination of pregnancy on medical grounds,

they did not have access to PGD (ibid., §§ 69–70). In other words, the Court has to be convinced that the national legislature has taken the different issues at stake into account (see *S.H. and Others v. Austria*, cited above, § 117) and that the final legislative framework does not lead to a paradoxical result.

8. Since any pregnant women wishing to give birth at home in the Czech Republic in general, as in the case of the applicants, are forced to do so without any medical personnel present, the legal framework – which thus creates a *de facto* ban on home births – leads to a paradoxical und counterproductive outcome in practice in that the mother and child are put at risk if the mother chooses to give birth at home (this has ultimately also been acknowledged by the majority: see the last sentence of paragraph 187 of the judgment).

III. Ternovszky v. Hungary

9. In *Ternovszky v. Hungary* (no. 67545/09, § 22, 14 December 2010) the Court stated for the first time that "the circumstances of giving birth incontestably form part of one's private life". The Court then declared that "where choices related to the exercise of a right to respect for private life occur in a legally regulated area, the State should provide adequate legal protection to the right in the regulatory scheme ... It is true that, in this regard, the State has a wide margin of appreciation; however, the regulation should *ensure a proper balance between societal interests and the right at stake*. In the context of home birth, regarded as a matter of personal choice of the mother, this implies that *the mother is entitled to a legal and institutional environment that enables her choice*, except where other rights render necessary the restriction thereof" (ibid., § 24, emphasis added).

10. We do not contest that the right to choose a home birth is never absolute. All countries examined in the Court's comparative-law research (see paragraphs 67-68 of the judgment) specify some additional preconditions. However, it is not compatible with the Convention if midwives or health professionals run the risk of prosecution for assisting at a home birth in a manner consistent with the *arte legis*. The Court held in *Ternovszky* that there had been a violation of Article 8 of the Convention in this context. Consequently, a real choice for a home birth must exist; if not, Article 8 of the Convention will *per se* be violated.

11. The legal framework in the two countries is slightly different. In the Czech Republic, no provision penalising midwives exists. However, the equipment required in the Medical Services Act and Decree no. 92/2012 makes it impossible for mothers to have a midwife assist them during a home birth. The law in the two countries – despite a different set of rules – renders assisted home births impossible in the case of Hungary and unsafe in the case of the Czech Republic. The parents concerned thus do not enjoy

a real choice in the latter State, either, since a home birth without a midwife incontestably puts the lives of mother and child at risk. Czech law therefore prevents *de facto* home births and has a chilling effect on mothers wishing to give birth at home.

12. Furthermore, some countries have, inspired by the relevant international documents and the Court's case-law, recently changed their legislation in order to respect the right to choose the circumstances and place of delivery (for example, Estonia in 2014, which based its regulation on the WHO's definition of a normal birth). The judgment in the present case, by watering down the principles developed in *Ternovszky*, may be adding a confusing signal to this trend. This is in conflict with the majority's own views as expressed in paragraph 189 of the judgment, where the Court invites the Czech authorities to make further progress by keeping the relevant legal provisions under constant review so as to ensure that they reflect medical and scientific developments.

IV. Specificities of obstetric services in the Czech Republic

13. Before examining the Court's reasoning more thoroughly, we would like to analyse the broader context of the issue at hand. Two aspects are important: the widespread dissatisfaction with the failure to respect women's choices during childbirth in Czech hospitals and the economic dimension of the obstetric services provided.

14. Several complaints against the Czech Republic have been received by the Committee on the Elimination of Discrimination against Women about unnecessary medical intervention performed without women's prior, informed and free consent, especially during birth. The Committee has recommended that women should have a choice of where to give birth and, in its observations on the Czech Republic of 14 March 2016 (CEDAW/C/CZE/CO/6), explicitly mentioned the disproportionate limitations on home births, as well as undue restrictions on the use of midwives in lieu of physicians in situations where such use did not pose a health risk (see p. 9 of the Committee's observations, § 30).

15. Patronising attitudes among health personnel should not be taken lightly, as they may constitute a violation of an individual's right to self-determination under the Convention.[1] The Court has, in the past, explicitly

[1] See, to similar effect, Lord Kerr and Lord Reed (with whom Lord Neuberger, Lord Clarke, Lord Wilson and Lord Hodge agreed) in *Montgomery (Appellant) v Lanarkshire Health Board (Respondent)* (Scotland) [2015] UKSC 11 (11 March 2015), paragraph 81: "The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based upon medical paternalism. They also point away from a model based upon a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and

recognised the duty to involve individuals in decisions relating to their medical treatment (see *Glass v. United Kingdom*, no. 61827/00, §§ 70–83, ECHR 2004-II, and *Tysiąc v. Poland*, no. 5410/03, §§ 114–130, ECHR 2007-I).

16. In this connection, worrying signs can already be found in the case-law of the Court as far as developments in the Czech Republic are concerned. For example, the Court found a violation of Article 8 in a case which concerned a court-ordered interim measure requiring the return to hospital of a newborn baby and the mother, who had just given birth and had immediately gone home, and the lack of any remedy by which to complain about that interim measure (see *Hanzelkovi v. the Czech Republic*, no. 43643/10, 11 December 2014). The Court held, in particular, that the taking into care of a newborn baby at birth was an extremely harsh measure and that there usually had to be compelling reasons for a baby to be removed from the care of the mother against the latter's will.

17. By indirectly preventing midwives from assisting during home births by law – via the excessively rigorous requirements placed on the available equipment – the State health sector and hospitals are awarded a *de facto* monopoly position in this field. If such a State monopoly goes hand in hand with a severe restriction of a core Article 8 right, it deserves thorough scrutiny by the Court. This is due to the fact that, in the creation of the State's legislative framework, economic interests might have played a more decisive role than the protection of the newborn child.

18. The Committee on the Elimination of Discrimination against Women invited the Czech Republic to become active on the legislative level in order to make midwife-assisted childbirth outside hospitals a safe and affordable option for women (CEDAW/C/CZE/CO/6, p. 9, § 31). As will be explored below, less intrusive measures than those currently imposed by the domestic legislative framework are certainly available in this regard without sacrificing the interest of the State in protecting mothers and their newborn children.

V. Risks associated with home births

19. With regard to the risks associated with home births, the public-health argument put forward by the Government is not, contrary to the opinion of the majority (see paragraph 186 of the judgment), convincing in itself.

20. As pointed out by the Royal College of Midwives, giving birth at home *without* the help of a midwife raises the risks for mother and child,

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then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices."

and women might be hesitant to be transferred to hospital if complications arise during an unassisted home birth, owing to the stigmatisation faced by those who choose to give birth in this way (see paragraph 138 of the judgment).

21. What is more, the statistical data provided by the Czech Government allow for a different argument if compared with the information available regarding other countries. Even though the Czech Republic has one of the lowest perinatal mortality rates, at 0.17% for newborns in the first twenty-seven days, this rate is lower or only insignificantly higher in a number of countries which allow home births.[2] For example, the rate is 0.16% in Sweden and 0.12% in Iceland, where planned and assisted home deliveries take place.

22. Furthermore, the Court did not consider the international trends towards assisted home births and the efforts made to regulate midwifery. A report issued by the WHO as far back as 1996 (WHO/FRH/MSM/96.24) stated:

> "The Netherlands is a developed country with an official home birth system. The incidence of home deliveries differs considerably between regions, and even between large cities. A study of perinatal mortality showed no correlation between regional hospitalisation at delivery and regional perinatal mortality (Treffers and Laan 1986). A study conducted in the province of Gelderland, compared the 'obstetric result' of home births and hospital births. The results suggested that for primiparous women with a low-risk pregnancy a home birth was as safe as a hospital birth. For low-risk multiparous women the result of a home birth was significantly better than the result of a hospital birth (Wiegers et al 1996). There was no evidence that this system of care for pregnant women can be improved by increasing medicalization of birth (Buitendijk 1993)." (p. 12)"

23. In its report on "Legislation and Regulation of Midwifery – Making Safe Motherhood Possible", issued in 2011, the WHO even stated that "there is now strong evidence that underpins the recent recommendation that all women should have a skilled attendant during pregnancy, childbirth ..., in order to advance the goal of making pregnancy safer" (p. 7).

24. For all these reasons, we are of the opinion that an informed, healthy mother-to-be who is carrying a low-risk pregnancy can reasonably opt for a home birth assisted by a midwife and that this choice is not associated with an excessive risk, either for the mother or for the baby.

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[2] See Annex C2, "Neonatal Mortality Rate for annual deaths [numbers and rates per 1000 live births]" of the *European Perinatal Health Report: The Health and Care of Pregnant Women and Babies in Europe in 2010,* May 2013.

VI. Margin of appreciation and consensus on *non-prohibition* of home births

25. Turning now to the Court's line of argument, we would like to address the margin of appreciation available to the State in this particular case (see paragraphs 178 et seq. of the judgment). While we concur with the majority of the Court that according to the case-law, the margin of appreciation afforded to the national authorities should be a wide one, we come to this conclusion through slightly different reasoning, which leads us to reach the conclusion that the interference at issue is unnecessary in a democratic society.

26. As mentioned above (see paragraph 5), States will usually enjoy a wide margin of appreciation where competing private and public interests or several Convention rights are concerned. As this is the case here, it is – contrary to the majority's approach – thus not necessary to determine whether there is a consensus between the member States regarding home births in order to establish the width of the State's margin of appreciation.

27. Where States have a broad margin of appreciation under Article 8 of the Convention, an interference with the rights enshrined in that provision can only be justified if "relevant and sufficient reasons" are present (see *Zaieţ v. Romania*, no. 44958/05, § 50, 24 March 2015; *Hanzelkovi*, cited above, § 72; *Winterstein and Others v. France*, no. 27013/07, §§ 75-76, 17 October 2013; and *S. and Marper v. the United Kingdom* [GC], nos. 30562/04 and 30566/04, § 101, ECHR 2008-V). In its examination of a case, the Court therefore has to accord due weight to the interests of the individual (see *Hatton and Others v. the United Kingdom* [GC], no. 36022/97, § 99, ECHR 2003-VIII). In our opinion, the Court did not proceed carefully enough in this regard in the present case (see below, paragraphs 29 et seq.).

28. Even assuming that the Court was called upon in the present case to examine whether a State consensus exists as regards home births, we disagree with the majority's approach to this question. When nearly 50% of the member States provide for and regulate home births (twenty out of the forty-three member States surveyed) and home births are unregulated or under-regulated in twenty-three member States, but no legislation prohibits the assistance of midwives at home births in any of these forty-three States (see paragraph 68 of the judgment), then there is a *consensus in favour of not prohibiting home births* among the member States.

29. Turning to the proportionality of a *de facto* ban on home births, we share the position of the Czech Constitutional Court that

> "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 parents 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.” (decision no. I. ÚS 4457/12, cited in paragraph 34 of the judgment)

30. Thus, despite the wide margin of appreciation available to the State, a legislative framework providing for only one option for giving birth, namely in hospital, cannot be viewed as proportionate and constitutes, in our view, an unnecessary interference with women’s rights under Article 8 of the Convention by the State. In addition, we note – as the majority refused to recognise – that, until the present date, no birth centres have been established in the Czech Republic owing to the extensive requirements imposed on such centres in terms of technical, material and human resources (see paragraph 149 of the judgment).

VII. The circumstances of Ms Dubská’s and Ms Krejzová’s cases

31. We turn now to the specific circumstances concerning the two applicants in this case. Having suffered an unpleasant experience during her first delivery in hospital, Ms Dubská decided to give birth to her second child at home, alone. Her second pregnancy, until she delivered her son in May 2011, was free of any complications (see paragraph 10 of the judgment). Nonetheless, she was unable to find a midwife to assist her.

32. Ms Krejzová gave birth to her first two children at home in 2008 and 2010, with the assistance of a midwife. However, the midwife attended the births without any authorisation from the State. When Ms Krejzová became pregnant again in 2011, she was unable to find a midwife willing to assist her because of the risk of a heavy fine (see paragraph 19 of the judgment). The national authorities contacted were unwilling to provide a solution. She was therefore obliged to give birth in hospital. These two examples are a perfect illustration of the chilling effect on home births provoked by the Czech legislation.

33. In both cases, no risks or complications associated with the applicants’ pregnancies demanded that they should give birth in hospital. While it might be true that even “low-risk” pregnancies may be faced with unexpected difficulties during delivery, the Government’s argument, as summarised in paragraph 186 of the judgment, cannot by itself justify an absolute *de facto* ban in such circumstances. The argument itself is questionable given that the perinatal mortality rate in countries where home births with the assistance of a midwife are permitted is sometimes even lower or only insignificantly higher than the Czech rate (see above, paragraph 21). Moreover, the Czech Constitutional Court has itself stated that there is a certain degree of acceptable risk in these matters (see above, paragraph 29).

34. We therefore argue that, as far as “low-risk” pregnancies are concerned, it is possible and reasonable to allow parents to choose the

circumstances of the birth while protecting the interests of the child as covered by Article 2 of the Convention at the same time. However, this requires the State to ensure that midwives can assist during delivery, or at least means that it should not prevent them from doing so.

VIII. Conclusions

35. To conclude, we consider the single-option birth model envisaged by the Czech legislation at issue, which leaves expectant mothers little choice but to give birth in hospital, to be *per se* problematic as regards Article 8 of the Convention. To prevent midwives from assisting the two applicants in giving birth in their homes – what is more, in circumstances concerning low-risk pregnancies in women who were not first-time mothers – was, in our view, not justified in a democratic society by any convincing public-health argument.

36. For future cases, we can only underscore the Court's invitation to the Czech legislature, namely "to make further progress by keeping the relevant legal provisions under constant review, so as to ensure that they reflect medical and scientific developments *whilst fully respecting women's rights* in the field of reproductive health, notably by ensuring adequate conditions for both patients and medical staff in maternity hospitals across the country" (see the last sentence of paragraph 189, emphasis added).