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4 November 2015

Applicant: Šárka Dubská, born on xxxxxxxxxxx 1985
residing at xxxxxxxxxxxxxxxxxxxxxxxxxxx Jilemnice

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and

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Written observations to the third-party submissions

Dubská and Krejzová v. the Czech Republic

Application no. 28859/11 and 28473/12

The Royal College of Midwives (RCM)

The Royal College of Midwives (RCM) pointed out the fact that the autonomy of midwifes is critical to ensuring respect for women´s right to make their own decision about childbirth. It also added that **the failure by the Czech Republic** to safeguard midwives´professional autonomy and permit home birth **threatens to harm women and their babies**.

We identify with this attitude and, as a proof that it is true in the context of the Czech practices, we attach a statement by the Czech midwife xxxxxxxxxxxxxxxxxxxxxxxxxxxxx (see Appendix No. 2). The authorities obstruct her to provide care by threatening her with liquidating fines, despite the fact that she is properly authorized to provide home care (see Appendix No. 3). But even when she accompanied women to give birth in a hospital and provided them with birth care based on a contract with the hospital, she faced problems. Her experience implies that even in the hospital which is renowned for its accommodating approach (the hospital in Vyškov), **a midwife cannot independently provide healthy and safe care to women there – the doctors force her to participate in harmful procedures to women and children and disturb the physiological birth-giving process without the woman's informed consent**. If the midwifes refuses that practices, she faces very unpleasant conflicts with the staff and bullying.

The RCM further points out that **although home birth is not expressly regulated by legislation in the UK, it is permitted on the basis of general legislation stipulating the competencies of midwives and women's rights for an informed choice as well as professional standards**. Formally speaking, **this situation is very similar to the one in the Czech Republic**, where there is also this general legislation, even including an expressly stipulated right for healthcare in the least restrictive environment (Section 28(3k) of Healthcare Services Act No. 372/2011 Coll.) and a home care option (Section 10 thereof). Furthermore, the Czech Confederation of Midwives has drawn up professional standards for midwives working in community care in 2007, which include care during home birth.[1] **The difference is thus only in the rejecting and repressive approach of the Czech state and all of its authorities** (with certain exceptions, such as the Office of the Public Defender of Rights, which, however, has no powers on its own).

The RCM's attitude is thus in accordance with the analysis by Oxford Pro Bono Publico[2] (see Appendix No. 8), which concludes that home birth are permitted only implicitly not only in England and Wales, but also in Italy, France or Sweden. It was therefore confirmed that the comparative document, on which the formed fifth section was based (see Section 59 of the judgement on the merits delivered by a Chamber), was incorrect. Subsequently countries were artificially divided into two groups: countries that expressly permit home births and countries that do not expressly regulate this matter. **It is substantial in this case to divide countries as follows:**

1) **countries that tolerate the provision of care during home births** (this option can have many forms – from not obstructing the provision of care to supporting such care during home births and reimbursing it from public health insurance schemes);

[1] Standards for midwives working in community care, 2010. Available for download here: http://www.ckpa.cz/praxe-pa.html.
[2] The Legal Regulation of Home Birth in the Domestic Jurisdictions of the Council of Europe. Research prepared for the League of Human Rights, the Czech Republic, February 2015.

2) **countries that actively obstruct the provision of care by repressive measures**, such as criminalization or threats of liquidating fines to be paid by midwives.

The conclusion from this division of countries is a clearly predominant tolerance for home birth and the resulting consequences that the state should not enjoy a margin of appreciation.

New York-Presbyterian Weill Cornell Medical Center

The document submitted on behalf of the New York-Presbyterian Weill Cornell Medical Center consists of two parts – the first part contains the results of scientific studies on planned home births in the US and the second part contains the results of ethical studies on planned home births.

It needs to be stated at the very beginning, that Mr Chervenak, the author of the statement, is an ideological opponent of home births, against which he has repeatedly fought to such extent that his activities are called "a home birth crusade".[3] His arguments are highly one-sided and intentionally distort scientific data to the detriment of planned home births and to the benefit of births in hospitals managed by doctors. He is not an independent researcher, but a gynaecologist-obstetrician in charge of a maternity ward with an excessive rate of obstetric interventions (32.7% of caesarean sections in 2012,[4] which considerably exceeds the 10-15% considered legitimate by the WHO[5]) , who is thus in a conflict of interest –he tends to defend his practice based on birth interventions.

The researcher Patricia Janssen responds to the statement in her expert's statement submitted on behalf of both complainants (see Appendix No. 1); she explains, among other things, what are the assumptions of valid methodologies for studying home birth, inform the Court about research in the safety of home births and mention the costs related to home births and related ethical issues.

As far as ethical issues related to home birth are concerned, which Mr Chervenak mentions in his statement, the Court may see that they are apparently one-sided; in his statement, he completely omitted the FIGO's statement on planned home births (see Footnote No. 13) and the **FIGO's publication of 2012,[6] which directly focuses on ethical issues in obstetrics** and which makes the following recommendations:

1. ***Where women have a choice to give birth in a healthcare facility or at home, healthcare providers should respect their right to prefer home birth. As with the choice of any patient, the patient should be informed about its risks and alternatives, and their implications. For instance, patients should be made aware that those at high risk of birth***

[3] See Cheyney M1, Burcher P, Vedam S. A crusade against home birth. Birth. 2014 Mar;41(1):1-4.
[4] See Reduction of caesarean delivery rates after implementation of a comprehensive patient safety program. Grunebaum A, Dudenhausen J, Chervenak FA, Skupski D. J Perinat Med. 2013 Jan;41(1):51-5.
The abstract is available here: http://www.ncbi.nlm.nih.gov/pubmed/23072842.
[5] See the WHO Statement on Caesarean Section Rates, which is available here:
http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1.
[6] ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY by the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health OCTOBER 2012. Available at:
https://www.glowm.com/pdf/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf.

complications may not feel ill or show signs of distress, so that planning home birth should be carefully assessed.

2. *Preparation for home birth should be as comprehensive as the circumstances allow, with clear and adequate contingency plans for transportation where feasible to a referral centre where properly trained and equipped services are accessible. A clean delivery kit as recommended by WHO should be made available.*

3. *Where the services of qualified obstetrician-gynecologists are not regularly available or requested, practitioners should collaborate to prepare midwives, nurses and/or other female caregivers, to support women approaching and in labour with their trained skills, emotional support and physical comfort, to reduce women's anxiety. This should extend to preparation for labour, labour itself and postpartum care of the mother and newborn(s) (see recommendations on TaskShifting in Obstetric Care).*

4. ***Where laws prohibit or prevent practitioners from providing assistance to women who propose home birth, practitioners and their professional societies should urge and collaborate in law reform to advance women's human rights of choice, and to assure women of the best professional advice and care in making their decisions.***

Governments of the Slovak Republic and Republic of Croatia

Alongside with the Czech government and governments of other countries – Slovakia and Croatia, where the healthcare system and approach to patients is influenced by their recent totalitarian history, they share the same attitude:

- they consider home birth an option that is less safe than home birth in hospital and mention unexpected complications that can occur during birth;

- they refer to their obligation to protect lives and health and ensure the highest attainable standard of health;

- they highlight the excellent results of their obstetric system in the field of perinatal mortality.

The governments intentionally build on **a wrong assumption:** by obstructing healthcare services during home births, women will choose hospitals, where they and their babies will receive health care; the state will thus fulfil its obligation to protect their lives and health.

The actual situation, however, is that **a certain part of women will plan their birth at home regardless of state policy or the ideas of physicians, as it happened with the applicant Šárka Dubská**. After all, in none of these countries, likewise in the Czech Republic, laws do not prohibit this practice to women. What the governments do not specify, however, is the manner how they fulfil their obligation to protect lives and health of women and children in such instances. **It is obvious that their policy is heading towards refusing healthcare services during home births and the punishing women for their choice, i.e. not towards the protection of lives and health of mothers and children, but on the contrary, putting them at risk.**

As far as the alleged hazard of home births and the safety of hospital births is concerned, none of the governmental statements suggest that they would gather data in this matter, which would provide reliable grounds for this assertion. The governments also do not gather data on the occurrence of complications or mortality related to home births, do not compare them with comparable hospital births or do not monitor whether hospital care conforms to evidence-based medicine. The governments presented no proof that home births would be more dangerous than hospital births, except for references to studies with the wrong methodology (see the expert statement – Appendix No. 1)

Where governments present certain data, they are totally irrelevant. For example, the fact that *„in Slovak Republic 6292 newborns required provision of health care in specialized neonatological institutions"* (see Section 17 of the Slovak government's statement) can be a proof of something completely different than the hazard of home births. Either they might have been premature newborns where home birth would not be an option anyway, or contrary may be true and the data may point out to a low-quality care in Slovak hospitals which causes harm to both mothers and newborns, or a useless overuse of intensive newborn care due to higher reimbursements from health insurance company.

The Slovak government also mentioned essential elements of the right to health – availability, accessibility, acceptability and quality, without mentioning how these elements are implemented in practice of Slovak hospital. For example, **according to High Commissioner for Human Rights,[7] the element of acceptability includes respect for inter alia the culture of individuals, minorities, peoples and communities**. It is evident that a large part of women chooses home birth just right for the missing element of acceptability (and also quality) of care provided in hospitals in countries such as Slovakia, Croatia and Czech Republic.

Croatian arguments on the need of investments

Although Croatia argues that its territory consists of rural areas, islands and mountains terrain which is difficult to access, it is clear that even on that kind of territory a woman may choose to give birth at home, which is always safer when a healthcare professional is present than without a healthcare professional. The Croatian government argues that the provision of care would require huge investments of capital, but it is not clear what the government deduced such necessity from. Moreover, the governmental statement raises a question how the government currently ensures emergency care of patients on the less accessible territory – it looks as if it needed to implement this services in relation to home births now. We can assume that in the case of a heart attack or injury, **there already is a working system of emergency care that can be used by anybody, without any discrimination, so expectant mothers can currently use it regardless of whether they planned to give birth at home or in a maternity hospital**. If women are allowed to give birth at home with the assistance of a midwife, it would be more likely that the emergency service will be call on time, should the need of transfer to hospital arise.

The available international data indicate that emergency medical services are used by only about 3 – 5 % of women who have decided to give birth outside the healthcare facility, which in the conditions of the Czech Republic represents no more than 50 women a year. Emergency services in

[7] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Available at: http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf.

the Czech Republic annually provides treatment for over 900.000 people, and about 9 % of the pregnant women use the services for non-emergency transport to give birth to the hospital and not for the purpose for which the emergency service has been established – to rescue life or health.[8] It is therefore apparent that women who choose their home as a place for giving birth to their child are no burden to the existing system of emergency medical services. On the contrary, this system is overused by pregnant women, who want to give birth at a hospital.

The applicant´s primary aim is that her right for arranging the provision of service - assistance during home birth - with a qualified midwife that conforms to the requirements of Council Directive 80/155/EEC and subsequent Council Directive 2005/36/EC, both concerning the recognition of professional qualifications, **be respected**. In these proceedings, the applicant claims neither state investments nor the financing of midwife care from public budgets, as the Croatian government implies. The contrary is true – if midwife-assisted home births were permitted, research shows and Patricia Janssen explains in her expert statement that it would save resources in public budgets (see Appendix No.).

The observance of international obligations

It needs to be emphasized that EU legislation establishes a right for free motion of services and cross-border provision of services. In the case of healthcare, it is enough that healthcare professionals are properly authorized in their home country. In the country across the border, they do not apply for another authorization, just announce the conduct of service. Therefore, the Czech Republic, Slovakia and Croatia now cannot prevent, for example, Austrian midwives to arrive to provide their clients with care during home birth on the territories of the countries. That would breach EU laws; **it is unacceptable that EU countries attempt, through proceedings before the European Court for Human Rights, to waive their obligation to implement** (formally as well as practically) **EU legislation**, including the obligation to permit midwives to apply all of their competencies independently, without a physician's supervision, and women to use this care.

As far as Croatia and its international obligations in the field of women's health protection are concerned, it also needs to be mentioned that the **Committee on the Elimination of Discrimination against Women** (CEDAW) and its recent Concluding observations on the combined fourth and fifth periodic reports of Croatia of 24th July 2015 state the following:

„The Committee notes with concern (…) the lack of oversight procedures and mechanisms for ensuring adequate standards of care in deliveries and protection of women's rights during delivery as well as their autonomy and the lack of options for child births outside of hospitals."

„The Committee urges the State party to (…) ensure adequate safeguards to ensure that medical procedures for childbirth are subject to objective assessments of necessity and conducted with adequate standards of care and respect for women's autonomy and the requirements for informed consent; and, introduce options for home births for women who wish to choose such contexts for childbirth."

[8] See M. Pavlíková – The transfer is not a sign of failure, but the functionality of the system, 13 Sept 2014 (Transfer není známka selhání, ale funkčnosti systému). Available in Czech here: http://www.biostatisticka.cz/transfer-neni-znamka-selhani-ale-funkcnosti-systemu.

Again, it is true also in this case that Croatia attempts, through proceedings before the European Court for Human Rights, to defend breaching its international obligations.

Situation in Slovakia

As far as situation in Slovakia is concerned, recently published independent documents describe a completely different situation in the field of obstetrics in Slovakia than the one presented by the Slovak government.

In particular, it is necessary to mention **current Joint submission of international and Slovak NGOs prepared for the Committee on the Elimination of Discrimination Against Women**,[9] which the following section on the topic of Ill-treatment of women during facility-based childbirth. It points to the **massive violations of women's rights in Slovak maternity hospitals, including serious findings regarding increasing of the maternal mortality, which currently is one of the highest among the member states of the European Union**:

„The majority of childbirth in Slovakia takes place in hospitals and is conducted by doctors, with the assistance of midwives. This is because of various factors including the fact that the law does not recognize the possibility for midwives to work independently outside of hospital settings, limiting women's choices as to where to give birth.

The government does not monitor and collect data related to the treatment of women, or respect for their rights, in childbirth, and it has not adopted any policies on this matter.[68] Since 2013, Citizen, Democracy and Accountability and Women's Circles have conducted monitoring and research activities (hereinafter "research") concerning the treatment of women in maternity hospitals, with a primary focus on vaginal childbirth.[69] The research findings have been documented in a recently published report[70] (English summary attached) and they reveal very concerning violations of women's rights in the provision of obstetric care in Slovak health care facilities.

The practices identified by the research include: spatial arrangements and behavior of hospital staff that heavily impede women's privacy, intimacy and confidentiality of care; [71] regular verbal humiliation, ridiculing, harassment;[72] significant failures by medical staff to provide women with adequate information before, during and after childbirth and to guarantee their right to full and informed decisionmaking without coercion and other abuses of power; [73] practices preventing women from moving freely and choosing the birthing position;[74] practices that prevent women from eating and drinking during delivery;[75] the routine performance of medically unnecessary interventions (such as forced shaving of pubic hair, the application of oxytocin, or episiotomy), very often without women's consent, and sometimes also against their will;[76] the exertion of extreme physical pressure by healthcare personnel on women's abdomens during the pushing stage (known also as the Kristeller Maneuver); [77] suturing birth injuries without, or with insufficient, anesthesia;[78] separating new born babies from women against their will and without medical reasons, especially during the very first hours following birth.[79] These practices, which often contradict scientific evidence and international standards of care, [80] point to serious violations of women's human rights during childbirth in Slovakia including the right to

[9] Joint submission by the Center for Reproductive Rights, Občan, demokracia a zodpovednosť (Citizen, Democracy and Accountability), Ženské kruhy (Women's Circles), and TransFúzia (TransFusion), November 2015. Available (including footnotes) at: http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/SVK/INT_CEDAW_NGO_SVK_21974_E.pdf

freedom from cruel, inhuman or degrading treatment and the rights to privacy, highest attainable standard of health and personal integrity. Not only may women suffer physical and mental trauma and harm as a result of such practices but their autonomy and decision-making capacity is heavily undermined.

The research has also revealed that health professionals often disrespect, or misunderstand, the concept of free and informed decision-making. All of the women interviewed during the research were asked to sign informed consent forms upon arriving in maternity hospitals without being provided with information necessary to enable them understand what they were consenting to. The research demonstrates that many health professionals perceive informed consent to be a mere formality – a requirement simply to obtain a written signature that covers any intervention a health professional may decide to perform. In addition, some obstetricians misinterpret legislation that allows them to perform interventions without prior informed consent in cases of emergency, in which case although informed consent cannot be obtained in advance it can be assumed, [81] *and they erroneously treat childbirth as healthcare intervention that generally does not require prior free and informed consent.* [82] *The research has also revealed that pregnant women often face substantial difficulties in obtaining information about healthcare facilities in Slovakia.* [83] *This prevents women from freely choosing a provider and enables hospitals to retain a monopoly and exercise considerable power over women in childbirth.*

The research findings on suturing of birth injuries are particularly disturbing. Many women reported that this procedure was extremely painful for them, for many it was the worst and most painful part of the birth.[84] *The suturing was painful for 59% of women who responded to our internet survey on suturing experiences. 15% described it as "slightly painful", 21% as "painful", and 23% as "extremely painful."* [85] *In 14% of births that were followed by suturing no anesthesia was applied. Of the women who experienced suturing as painful, 28% verbalized that the suturing was painful, 25% moaned, cried or screamed of pain, 40% could not lay still because of the pain (moving up their pelvis/buttocks), and as many as 27% neither complained nor showed any sign of pain (multiple answers were possible).* [86] *Of those who complained, only 28% received additional anesthesia. This percentage was even lower when women were only showing signs of pain without making verbal complaints. These findings point to, inter alia, systemic deficiencies in knowledge and skills on the part of medical practitioners with regard to their ability to perform this intervention properly,* [87] *as well as to the normalization of this particular form of illtreatment. In addition, some women feel compelled, against their wishes, to remain in hospital following childbirth for a number of days (usually 3 to 5). Although there is no legal obligation per se that requires a woman to stay in hospital for a certain amount of time following childbirth, Slovak legislation does contain certain provisions that in fact often compel women to remain in hospital until they are allowed to leave.*[88] *Moreover, the lack of provision of post-natal care in the home after birth is an additional factor that may compel women to stay in hospital for a number of days after giving birth.*

Furthermore, although maternal mortality in Slovakia decreased significantly at the end of the 20th century, it has significantly risen in the last 10 years, as reported by leading Slovak experts in obstetrics and gynecology. The maternal mortality ratio in the Slovak Republic in 2007-2009 was 17.3 per 100 000 live births. This is one of the highest ratios among EU countries. [89]

Recommendations

- *Take a series of effective measures to ensure that the human rights of women giving birth in Slovakia are respected and protected. These should include adequate training of current and future obstetricians and midwives, both on international medical standards and on human rights.*

- *Establish effective mechanisms, including those operating on an ex-officio basis, to monitor and oversee respect for women's rights in childbirth."*

The research mentioned in the Joint submission included also a request for information directed to the Slovak Ministry of Health. From the response of the Ministry (see page 28 of the Appendix No. 6) following is apparent:

1. The Slovak government has no strategic materials concerning national health policy in the field of obstetrics and a care for women and children.

2. Slovak Ministry of Health did not conduct nor coordinate any research in the field of obstetric care.

3. In connection with the provision of maternity care, Slovak Ministry of Health does not monitor either of following:

    - method of providing information to women
    - obtaining informed consent
    - standardized internal procedures of medical facilities
    - method of guaranteeing privacy during childbirth
    - the possibility of the presence of family members during childbirth
    - the possibility of women to move freely during labor
    - the possibility of women to choose a position during labor, other than in the birting chair
    - the possibility of women to take fluids and food during labor
    - the possibility of the direct and uninterrupted contact between the mother and the child
    - using the method of pushing on the belly of women in labor (so called Kristeller expression)
    - rate of episiotomies conducted
    - cases of maternal mortality and the extent and circumstances in individual hospitals
    - obtaining feedback from women regarding healthcare and so on.

With regard particularly to the last of the points – the fact that the Slovak government admits that it does not monitor practically anything related to childbirth and the right of mother and their children, it is difficult to understand on the basis of what the government formulated its statement, especially the part regarding humanization of Slovak obstetric system as well as the part regarding respecting of the rights of women and children.

Survey conducted in Slovak maternity hospitals over the years 2010-2014 (see Appendix No. 7)[10] showed the complete failure of the program "Baby Friendly Hospital" in Slovakia. This program should support breastfeeding, which would be based on the standards arising from the evidence-based medicine. Results of the analysis showed that breastfeeding support is inadequate, regardless of whether the hospital was awarded title "Baby Friendly Hospital". For example, contact between the mother and her child is essential for support of breastfeeding, however, the contact was not made possible after the birth in more than 80% of women. After leaving the hospital, more than 70% of mothers were not informed about where to seek advice concerning breast-feeding.

It is clear from the above that treatment of women in maternity hospitals in Slovakia is comparable to treatment in maternity hospitals in the Czech Republic, which has been documented in the earlier court proceedings by dozens of statements of Czech women who have described their experiences from Czech maternity hospitals describing massive violations of their rights.

In conclusion, it should be pointed out that **the Slovak government does not understand the link between obstetric care and human rights of women, as it is clear from the fact that the most basic rights of women in labor, such as choice of the position, acceptance of birth plans upon mother request or possibility of presence of husband and family members during birth, are perceived as "alternative methods"** (see para. 19 of the statement of the Slovak government).

Public Defender of Rights and UNIPA

Czech Public defender of Rights as well as the Union of Midwives (Unie porodních asistentek) have explained **what difficulties and repression do women**, who decides to give birth at home with the assistance of midwife, **and midwives**, who would like to provide such care, **face**.

Beyond what they have stated, it is necessary to point to the latest developments in preventing the establishment of the first birth centre in the Czech Republic which would be led by midwives and which, according to the researches, is the safest option for low-risk women.[11] **It is apparent that the Court´s call in this case** (see para. 100 of the judgment on the merits delivered by a Chamber) **for the states authorities to „keep the relevant provisions under constant review, reflecting medical, scientific and legal developments" did not bring any results.**

Establishment of the birth centre – in the word of the law called "workplace of midwife, where physiological births are conducted" – is allowed by the decree of the Ministry of Health on technical equipment at healthcare institutions (No. 92/2012 Coll.). Although the legislation includes certain conditions which are difficult to fulfil, and which moreover allow various interpretations, the **Ministry of Health now brought an official interpretation, according to which the establishment of such a place is practically impossible.**

One of the conditions set in the decree is that is it necessary to "ensure conducting of the birth by caesarean section or operation aimed at ending the birth in a medical facility within 15 minutes

[10] An Analysis of Breastfeeding Support in Maternity Hospitals in Slovakia, 2010- 2014.

[11] "Perinatal and maternal outcomes by planned place of birth for healthy women with low- risk pregnancies: the Birthplace in England national prospective cohort study", BMJ, 2011;343:d7400; Available at: http://www.bmj.com/content/343/bmj.d7400.

from the detection of complication during birth". This period can be interpreted in different ways. In the case of emergency, law guarantees transportation period for 20 minutes, so it could be possible to interpret the 15 minutes period as a period for transport counted from the location of the birthing house to the hospital, where it is possible to perform a caesarean section.

With regard to legal uncertainty as to how the provision will be interpreted, the midwives from Olomouc requested the Ministry of Health for the interpretation. When applying for an authorization to provide health services, midwives need to have a particular place assured, where the care will be provided and thus they need to rent or buy a property in advance, which naturally, requires huge investments. Before applying for an authorization, the midwives thus must have a certain assurance that their application will be accepted and they will be able to start a business.

However, in its opinion of 29 October 2015 (see Appendix No. 9) the Ministry of Health stated that **the 15 minutes period does not cover only the transport time between the workplace of the midwife and the hospital, but it also covers preparing of the woman for the transport, transport of the birthing woman within the hospital, where the caesarean section will be performed and moreover it cover the actual performance of the caesarean section.**

In essence, the Ministry has chosen such a formalistic interpretation, which in practice does not leave any time left for the actual transport of the woman. The interpretation leads to a conclusion, that the birthing house can only be located in the hospital; otherwise it will not fulfil the requirements of the Ministry. With regard to the negative attitude of the Czech hospitals, which have no interest in creation of the competitive workplace within their own premises, the independent workplace of midwives cannot actually be established despite the fact that Czech women are interested in such a service and that this service is the safest option for low-risk women.

Withdrawal of the FIGO's request for intervention

In conclusion, we would like to comment on the non-standard action by the International Federation of Gynecology and Obstetrics (FIGO), which withdrew its request to intervene in this case.

Together with the International Confederation of Midwifes (ICM), FIGO initially requested permission to intervene in the case. The Court accepted the request, which act is not automatic; it expresses a trust on the part of the Court and it is an honour for the requestor being able to submit their statement to the Court. Therefore we consider it non-standard that, after the request was accepted, it was suddenly withdrawn without any explanation.

We have several reasons to believe that it was an internal intervention by the Czech Gynaecological and Obstetrical Society (ČGPS), which is the only member of FIGO representing the Czech Republic; ČGPS does not want any changes in the Czech system of obstetrics; on the contrary, it benefits from the monopolistic position of hospitals as the only providers of care during birth and private gynaecologist as the only providers of complex care during pregnancy.

The ČGPS's board includes Jaroslav Feyereisl (ČGPS's chairman) and Petr Velebil (ČGPS's scientific secretary), who represented the Czech government as consultants during negotiations of the former fifth section concerning this case raised by the complainants. It is thus clear that there is an

institutional link between this professional society and the state. Moreover, these experts intentionally provided distorted and manipulative information to the Court; the Court took it for experts' statements and believed them (see Section 97 of the judgement and CONCURRING OPINION OF JUDGE VILLIGER); this was mentioned in the statement by the Royal College of Midwives (Section 15 of the statement). On the contrary, other important information, e. g. concerning danger to women's lives in relation to high maternal mortality, were concealed by them before the Court.[12]

ČGPS's members intentionally breach FIGO standards based on scientific knowledge. Besides the non-tolerating approach towards midwife-assisted home births, which FIGO together with ICM considers safe[13] and which ČGPS considers a non lege artis healthcare[14], we can, for example, mention the birth position on the back to which women in Czech maternity hospitals are normally forced and manipulated by the staff, despite the fact that FIGO considers this practice harmful and typical of low-resource countries (see Appendix No. 5)[15]. FIGO standards applicable to Informed Consent (see Appendix No. 4) are commonly breached in Czech maternity hospitals, too. Although FIGO standards include to allow every woman her "to be accompanied by her choice of a supportive person (husband, friend, mother, relative, TBA)", the Podolí Hospital, where Mr Feyereisl and Mr Velebil work, charges the highest fees for father or other person's presence during birth,

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[12] Mr. Velebil unilaterally emphasized low infant mortality rate in the Czech Republic without this data being in fact related to quality of care. At home, however, this expert speaks differently. His presentation "Maternal mortality in the Czech Republic" has been published and it points to the problem of relatively high maternal mortality within developed European countries, insufficient statistical monitoring of these deaths and the impossibility to take any remedial measures nationwide.
See P. Velebil – „Maternal mortality in the Czech Republic" (Mateřská úmrtnost v České republice), 2010. Available in Czech:
http://lekari.porodnice.cz/ici_files/kriticke-stavy/prednasky_final_2010/03_Materska_mortalita_v_CR_2008_Velebil.pdf

[13] FIGO and ICM reacted to criminalization of midwifery in Eastern Europe and in 2012 issued a press release pointing out the safety of home births assisted by midwives and call for respect for women's freedom of choice
"There is strong evidence that out of hospital birth supported by a registered midwife is safe, and a preferred experience for many mothers. Women should not be denied this choice because of the lack of an adequate and enabling regulatory framework that makes it possible for midwives to practice their profession in any place that women choose to give birth."
Media release „ICM and FIGO call for the European Union to honour its commitment to fundamental human rights for women and to halt, in the European countries where it exists, the criminalisation of midwifery.", 8 March 2012. Available here:
http://www.internationalmidwives.org/assets/uploads/documents/ICM%20Newsletters/ICM%20spring%20newsletter.pdf

[14] See „Professional Statement of the Committee of the Czech Gynaecological and Obstetrical Society ČLS JEP and the Committee of the Perinatal Medicine Division of the Czech Gynaecological and Obstetrical Society ČLS JEP on Home Births" of 2008 (but already published in previous years). Available here:
http://www.perinatologie.cz/dokumenty/doc/doporucene-postupy/CG_Supplementum%20final.pdf.

[15] FIGO GUIDELINES: Management of the second stage of labor:
„Unfortunately, inappropriate medical and midwifery teaching and habit have meant that many women are made to deliver lying flat on their backs with their feet in stirrups (Fig. 3). This position reduces uteroplacental blood flow, can contribute to fetal distress, and provides no mechanical advantage to enhance descent."
„Unfortunately, in many hospitals in low-resource countries, lying supine while in labor has become the norm—a tendency exacerbated by a lack of available cushions or the use of nonflexible delivery beds where the upper part cannot be elevated—and the use of stirrups is common."

amounting to approx. EUR 55 per one person[16]; these fees actually hinder the presence of those people.

In August 2014, the media broadly covered the intention of Bohuslav Svoboda, a Czech politician, a member of the parliament, a gynaecologist-obstetrician and a former head of the Gynaecological-Obstetrician Clinics of the 3rd Faculty of Medicine of the Charles University, to prohibit home births by law; in his opinion, the deliveries should occur only in hospital because of the interest of the newborns.[17] With regard to these totally unprecedented efforts, which have no parallels worldwide, I as a lawyer of the Human Rights League contacted FIGO (because of their accommodating approach to home births), explained the situation and asked it to issue an official statement on this intention.

Hamid Rushwan, Chief Executive of FIGO, sent the following response (see Appendix No. 10):

"Whilst FIGO considers the sexual and reproductive rights of women to be of great importance and a fundamental element in the various charitable activities that it undertakes, I regret to advise you that it is not possible for the organisation to become involved in this issue at the present time. For your information, any activity undertaken by FIGO must be done through and with the support of its member society in the relevant country. I would suggest therefore that you should contact our member society - the Czech Gynaecological and Obstetrical Society - the contact details for which are…"

„Should FIGO receive an approach from a senior official of the member society with a request for assistance on this issue as a result of your contacting the society then, naturally, it would be possible for the FIGO Officers to consider what would be the most appropriate course of action for the organisation to take in respect of this matter."

Based on this information, it is clear that it is ČGPS as a FIGO member that can obstruct the issuance of the FIGO's statement on the bad situation in the Czech obstetrics. In our opinion, what happened was that although FIGO originally intended to make a statement on this case and its statement (with regard to its previous statement on home births) would be probably in favour of the complainants, the gynaecologists-obstetricians from ČGPS had to block the issuance of FIGO's statement through an internal procedure. With regard to the circumstances, we can hardly imagine other explanation; however, we will let the Court to make its own opinion on the ČGPS's influence, based on the information available.

Zuzana Candigliota

on behalf of Šárka Dubská

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[16] See the hospital's pricelist available here: https://www.upmd.cz/?page_id=648.
[17] See e. g. the article "Former Mayor Svoboda Wants a Ban on Home Births", available here: http://www.tyden.cz/rubriky/zdravi/exprimator-svoboda-chce-zakazat-domaci-porody_315489.html; The article "Svoboda from ODS Declared War on Home Births" is available here: http://www.novinky.cz/domaci/345159-svoboda-z-ods-vytahl-do-boje-proti-porodum-doma.html; The articles "Parents Cannot Deprive Newborns of Their Chances. Svoboda Is Preparing Ban on Home Births" is available here: http://domaci.eurozpravy.cz/politika/100177-rodic-nesmi-brat-novorozenci-sanci-svoboda-chysta-zakaz-domacich-porodu.

List of appendices:

1. Expert's statement of Patricia Janssen, researcher
2. Statement of the Czech midwife xxxxxxxxxxxxxxxxxxxxxxxxxxxx
3. xxxxxxxxxxxxxxxxxxxxxxxxxxxxx´s authorization for the provision of healthcare services in the home environment of women
4. FIGO guidelines regarding informed consent
5. FIGO guidelines Management of the second stage of labor
6. Summary of "Women – Mothers – Bodies. Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia"
7. An Analysis of Breastfeeding Support in Maternity Hospitals in Slovakia
8. A research "The Legal Regulation of Home Birth in the Domestic Jurisdictions of the Council of Europe", Oxford Pro Bono Publico.
9. Statement of the Ministry of Health dated 29 October 2015
10. E-mail from FIGO dated 21 August 2014