European Court of Human Rights
Attn: Mr Johan Callewaert
Deputy Grand Chamber Registrar
Council of Europe
67075 Strasbourg
France

Dubská and Krejzová v the Czech Republic (case no. 28859/11 and 28473/12)

Written submissions by UNIPA - Unie porodních asistentek

I. INTRODUCTION

These written comments are submitted by UNIPA - Unie porodních asistentek ("UNIPA")[1] pursuant to the permission granted by the President of the Chamber in accordance with Rule 44 § 2 of the Rules of Court[2] and they focus on factual and legal situation of mothers, children and medical caregivers, particularly midwives, in relation to childbirth in the Czech Republic. These comments are particularly focused on the regulatory framework and public authorities' practices that causes midwifery in the Czech Republic to be a non-systematic option of care provision for mothers, effectively preventing midwives to provide their care and petrifying the monopoly of the obstetric model of care.

UNIPA is a professional organization associating independent midwives, i.e. those medical care givers who intend to provide their care in the full extent of their statutory competences and who are fully qualified for the provision of this care as required both by the national and European laws. UNIPA coins the only professional standards in midwifery in the Czech Republic, adhering to the standards published by WHO and ICM, and raises public awareness regarding adverse situation in childbirth in the Czech Republic. Under these standards, midwife's care is non-invasive based on a personal relationship with a mother and detailed knowledge of her needs.

II. POSITION OF MIDWIVES IN THE CZECH REPUBLIC

Definition in the system

Under both the Czech[3] and European legislation[4], a midwife is understood to be a medical professional who is qualified to carry out her occupation independently, i.e. without a prior indication and without a supervision of a physician. Midwife's care represents a complex care of mother and child during maternity from the commencement of pregnancy, via childbirth to the end of puerperium, irrespective of the place of childbirth. Statutory competences of a midwife include an independent assistance at childbirth and identification of any pathologies during her entire care and transfer of the mother and child to the secondary care level, i.e. to a physician if necessary. The ultimate aim of statutory definition of a midwife is to procure a continuous care during maternity. Such care, which is provided by a single qualified provider procures better knowledge of the mother, her anamnesis and

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1 Czech Union of Midwives;

2 Pursuant to a letter dated 24 September 2015 issued by the Deputy Grand Chamber Registrar, Mr Johan Callewaert;

3 Act no. 96/2004 Coll., on Non-medical Professionals and related decrees;

4 E.g. Council Directive 80/155/EEC and subsequent Council Directive 2005/36/EC, both concerning recognition of professional qualifications;

needs by the care giver, and, hence, allowing to reflect the mother's and child's needs, including identification of necessity of transferring mother and child to superior level of care anytime during the pregnancy, delivery and puerperium. Such setup of medical care has been identified by numerous international researches as the gentlest model of health care in early maternity equally respectful to women's and children's and procuring the best level of security[5].

Professional organizations of midwives

Traditionally, there have been three professional organizations associating midwives in the Czech Republic. Apart from UNIPA, which unites midwives and midwifery university students globally in the Czech Republic, there currently is Česká konfederace porodních asistentek[6] (ČKPA), which unite midwives into particular clusters according to particular regions. Historically, although not an association *per se*, there was a gynaecologic and midwifery section attached to Česká associace sester[7] (ČAS), an association merely associating nurses at hospitals' gynaecologic departments. However, this association has not been active for some time.

UNIPA and ČKPA closely cooperate in order to develop and promote midwifery in the Czech Republic as a viable model of health care in maternity. In a long term, they take part in legislation process by means of providing comments to drafts of primary legislation, albeit without any success, they prepare qualitative professional standards for midwifery, raise public and expert awareness as well as they organize education programs for midwives etc.

For sake of completeness, there also is Česká společnost porodních asistentek[8] (ČSPA), an organization that was established quite recently, at the outset of 2014. However, despite its name, this society does not primarily focus on midwifery as it unites other medical and paramedical professionals; it is, therefore, impossible to guess the proportion of midwives and other medical professionals among the members of this society. More importantly, according to the ČSPA's articles of association, this society does not support statutory competences of independent midwives and rather claim allegiance to nursing care, i.e. care under a supervision and indication of a physician. This association also commits to provide care under the recommendations of Česká gynekologicko-porodnická společnost[9][10], which contravene not only the statutory specification of a midwife and

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[5] Hatem M, Sandall J, Devane D, Soltani H, Gates S: **Midwife-led versus other models of care for childbearing women.** Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD004667; Janssen PA, Saxell L, Page LA, Klein MC, Liston RM, Lee SK.: **Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician.** CMAJ. 2009 Sep 15;181(6-7):377-83. Epub 2009 Aug 31; Birthplace in England Collaborative Group: **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; O. Olsen, M.D. Jewell, **"Planned hospital birth versus planned home birth"**, Cochrane Database of Systematic Reviews 2012 Sep 12;9:CD000352; A. de Jonge, B.Y. van der Goes, A.C. Ravelli, M.P. Amelink-Verburg, B.W. Mol, J.G. Nijhuis, J. Bennebroek Gravenhorst, S.E. Buitendijk, **"Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital births"**, An International Journal of Obstetrics & Gynaecology 2009 Aug;116(9):1177-84; U. Ackermann-Liebrich, T. Voegeli, K. Günter-Witt, I. Kunz, M. Züllig, C. Schindler, M. Maurer, **"Home versus hospital deliveries: follow up study of matched pairs for procedures and outcome,"** BMJ, 1996 Nov 23;313(7068):1313-8; Janssen PA, Mitton C, Aghajanian J (2015) **Costs of Planned Home vs. Hospital Birth in British Columbia Attended by Registered Midwives and Physicians.** PLoS ONE 10(7): e0133524. doi: 10.1371/journal.pone.0133524;

[6] Czech Confederation of Midwives;

[7] Czech Association of Nurses;

[8] Czech Society of Midwives;

[9] Czech Society for Gynaecology and Obstetrics;

[10] [Online] available at http://www.porodniasistentky.info;

claims any and all assisted childbirths outside medical facilities represent *non lege artis* care, but also is incompatible with internationally acknowledged standards of, and recent development in, childbirth care. Therefore, this society can hardly be considered to be an organization established to protect and promote rights of midwives, mothers and children. In addition, there is a clear personal connection between certain leading obstetricians and the high representatives of this society[11]. This casts additional doubts about the actual purpose of this society.

Historic excurse

Since 1992[12] until 2012, midwives were able to provide women with early maternity care including assistance at birth, irrespective of its place. However, until 2010, there was no legislation that would specify either standards of care provided by midwives or that would specify their mandatory equipment. Albeit partly in legislative vacuum, midwives were able to exercise their competences without any major difficulties or controversies. On the contrary, in late nineties, a joint midwife-obstetrician project called Centrum aktivního porodu (Centre for Active Childbirth) was successfully run within the Bulovka Hospital in Prague. The statutory status of midwives materially improved in 2004 in relation to the Czech Republic's accession to the European Union, whereby the State transposed European legislation defining competences of a midwife. In general, these competences included all care in early maternity including controls during pregnancy, assistance at spontaneous childbirth irrespective of its place, identification of pathologies, and post-childbirth care in puerperium; these competences have not been restricted until today.

Since 1992 until today, midwives needed two licences in order to provide their health care, i.e. a registration certifying a qualification for the exercise of the midwife profession and a technical registration certifying that a midwife may operate a non-governmental medical facility. Since the qualification registration must be issued by the respective public authority exclusively upon meeting statutory qualification criteria such as education and/or practice period, the latter technical registration is not claim-based and has become the tool of the State to restrict, and ultimately eliminate, provision of midwife-based care.

The statutory anchoring of midwives' competences and an increasing reputation of midwife-based care in the public led, after the accession to the European Union, to an increased demand of midwife-based care among prospective mothers. However, such increased demand revealed that in the application level the pre-dominantly obstetric system of childbirth care was not prepared to incorporate midwives. This led to establishment of a broad front of obstetric experts, backed up by conduct of public authorities and particularly by the Ministry of Health, calling for restoration of the obstetric model of childbirth as the exclusive one and for marginalizing of the midwife-based care.

This obstetric campaign supported by the State included, over the time: the effort of the Ministry of Health to derive possible criminal liability of mothers opting for home delivery; adopting authoritative interpretation of the Act on Non-medical Professionals eliminating midwives to assist at births without prior indication of a physician; administrative practices of public authorities obstructing midwives in the process of obtaining the technical license, refusing provision of this licence or even arbitrarily limiting the extent of licenses ex officio. Ultimately, the process of re-monopolization of the obstetric model of care was crowned by adoption of secondary legislation by the Ministry of Health in 2010

[11] Mr Antonín Pařízek is a leading obstetrician and one of high representatives of the U Apolináře Maternity Hospital know for his antipathy to midwifery. His wife, Ms Petra Pařízková, counts to the high represenatives of the said society;

[12] By adopting Act no. 160/1992 Coll., on Non-state Medical Facilities;

exposing midwives to technical, material and personal requirements that were clearly impossible to be met and that in fact corresponded to the equipment in hospitals. Ultimately, in 2012 the State adopted Act on Medical Services that does not allow midwives to assist at planned home births and related secondary legislation that in fact eliminates provision of such assistance in birth centres.

Current position

As mentioned above, the current adverse position of midwives in the Czech Republic is determined predominantly by two aspects. First, the provision of the midwife-based care is expressly banned in relation to home births by law, such care is in fact banned in relation to midwives' office and in birth centres due to unreasonably excessive technical requirements imposed by secondary legislation. Second, the midwife-based care at childbirth cannot be provided by midwives in hospitals due to absence of hospitals that would allow midwives to accompany woman in labour into the hospital and to assist at the childbirth independently without supervision of a physician.

As a result of the State's approach and hospitals' practice, legally midwives cannot assist at childbirth outside hospitals; they theoretically may provide their assistance in hospitals which refuse such care; actually they cannot provide their assistance at childbirth at all. Such a situation represents a failure of the State to organize health care in childbirth in a systematic and transparent way, allowing midwives to form a viable part of the system and allowing a clear distinction among primary, secondary and tertiary care, including a clear interface of respective responsibilities.

Current situation is flanked by an actual impossibility of midwives to provide their care on one hand and on the other hand by vague and unclear borders of their competences and liabilities, assessment of which has already proved to be prone to arbitrariness by the conduct of Czech public authorities. This position is fairly frustrating to midwives, whose aim is only to provide standardized care under internationally recognized standards. Midwives face uncertainty, stress, are either ignored or threatened by public authorities and face attempts for criminalization of their activities. Such situation has serious impact not only on midwives themselves, but also on their marital, parental and family relationships.

Independent midwife v. hospital midwife

Quite frequently, one may notice an argument under which there actually is a midwifery care procured by midwives within hospitals; this argument is commonly used by public authorities, too. This argument is, however far from the truth. Care provided by midwives is not, naturally, limited to out-of-hospital area. On the contrary, in general there are both midwives who wish to provide their care within hospitals, further there are midwives who provide continuous care to mothers and who only attend to hospital when assisting the mother at the childbirth on an *ad hoc* basis and there are midwives who provide care and assistance to mothers without visiting hospital at birth at all. What is common to all of these midwives is first that they work as independent professionals within the full extent of their statutory competences, without any a priori supervision and they bear respective responsibility therefor and second that their care is based on midwifery standards of care.

As mentioned above, the State allows only for the obstetric model of care. Therefore, should a midwife like to provide assistance at childbirth, she may do so in a hospital within the obstetric model of care, under obstetrician rules, with the need of prior physician's indication and under supervision. In addition, such a midwife needs to be in an employment relationship with the hospital, which, similarly to any employment relationships, is based on subordination principle. Consequently, such a setup inherently disallows midwives to provide midwife-based care and to exercise statutory competences of

a midwife. With all due respect, hospital midwives are rather qualified nurses and assistants to physicians and their care, irrespective how qualified it may be, is merely nursing care. That is to add that hospital in Vyškov in Southern Moravia represents a partial exemption from the above, as it allows on one hand that mother is accompanied by an external midwife, but on the other hand, the midwife needs to surrender to the obstetric rules based on an ad-hoc employment contract constituting the need of prior physician's indication and supervision.

Outline facts. No midwives, no birth centres

As at today, there are approximately six thousand midwives in the Czech Republic who dispose of the said qualification license and who are qualified to provide midwife-based care. That said, there is no midwife that has been provided with the technical license in the full extent of midwives' competences including assistance at a childbirth. Consequently, there is no midwife licensed by the State to carry out its competences in childbirth independently and without a prior indication of a physician. That is to say that midwives may provide their care during pregnancy, but due to the insufficient interconnection with the obstetric system of care. In practice this means that this care is to be paid in full by mothers outside the system of public health insurance, including the payment for a subsequent expert care where a mother is referred to by a midwife (unlike if mother was referred similarly by a physician), term of delivery determined by a midwife is not recognized by public authorities for the purposes of mother's maternal leave, birth certificates issued by midwives have been regularly not recognized by register of births etc..

In addition, although purely legally and technically an existence of birth centres in the Czech Republic is not currently restricted, the extensive technical, material and personal requirements effectively eliminate this option. UNIPA adds that there has been only a single attempt to register a birth centre in the Czech Republic in Brno. Although the birth centre was supposed to be located , in a close vicinity to a local hospital, the approach of the relevant public authority was negative.

III. SYSTEM OF CHILDBIRTH CARE IN THE CZECH REPUBLIC

As an immanent feature of the system of childbirth care in the Czech Republic and as a heritage of the development after the World War II, the system of childbirth care is built upon an exclusive care provided by physicians during women's pregnancy and labour. This system is based on a network of gynaecologists who provide health care during pregnancy and a network of maternity hospitals allowing exclusively obstetricians to provide care in labour and exclusively neonatologists to provide care to child once the umbilical cord is cut. Such a system counts with at least two changes of the care giver and, in addition, evince the lack of understanding of a mother and child as a single unit. This is to contract the midwifery approach under which a midwife takes care of mother and child as a single unit throughout pregnancy, delivery and puerperium irrespective of the place of childbirth. Several international studies show unequivocal positives of this approach[13][14]

Medicalization of childbirth in Czech Republic and hegemony of medical profession over childbirth/delivery has serious impact on the local practice. The hospital routine causes iatrogenic effects, rivalry among the potential "bearers of the good news" and fear for secure jobs form one of the

[13] McLachlan HL, Forster DA, Davey MA, Farrell T, Gold L, Biro MA, Albers L, Flood M, Oats J, Waldenström U. *BJOG* 2012 Nov;119(12):1483-92: *Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial*;

[14] Tracy SK, Hartz DL, Tracy MB, Allen J, Forti A, Hall B, White J, Lainchbury A, Stapleton H, Beckmann M, Bisits A, Homer C, Fourcur M, Welsh A, Kildea S. Lancet 2013 Nov 23;382(9906):1723-32: *Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial*;

core impediments for adequate recognition of other involved professions in the process, such as midwifes. All these circumstances limit the availability of choice of place of birth and care provision in labour for birthing women.

The second stumbling element is the gendered character of the professions. Despite feminisation of the health care system, the medical profession keeps its prestige on structurally masculine attributes: rationality, action, intervention, objectivity, emotional neutrality, universality, technological advancements etc., whereas midwifery as well as the recipients of care represent a feminine opposite: affectivity, assistance, patience or passivity, partiality, conservative use of practical knowledge limiting biomedical interventions etc. Symbolically, these two collectives of actors acquire a respective symbolic gender with all the stereotypes and prejudices culturally and historically allocated to them. It is important to note that the Czech Republic and its society, even professional bodies, lack reflection on these issues and respective power imbalance. Cultivation of political correctness and practical fulfilment of formal requirement for gender equality are needed to bring recognition of legitimacy of the issues at stake. These are plurality of personal choices of treatment in case of birthing women, or autonomy of the professional performance in case of midwifery profession. Needless to say, as a recent research inquiry into the obstetrical profession[15] indicates, there is heterogeneity within the medical professional group itself regarding practices in hospital childbirth. Rigidities and obstacles laid to promoters of change in hospital practice by the few professional exponents represent the hegemonic, most powerful and visible segment of Czech obstetrics, impeding systematic change even from within.

Thanks to the monopoly of the physicians' health care in maternity, it is of no surprise that the health care system entirely fails to distinguish between the primary and secondary care of mother and child. Such distinguishing is, however, crucial not only for choosing an appropriate approach to respective mother and child and crucial for respecting the their catalogue of rights, but also for determining the ideal provider of care according to the mothers' and children's needs. A failure to distinguish between the particular levels of care necessarily leads to a standardization of care and to the application of a standardized care universally on all mothers without reflecting their particular different needs.

As a result, the system fails to distinguish between spontaneous low-risks mothers, whose deliveries are reasonably anticipated to be free of complications, and mothers whose pregnancies indicate an existence of pathologies. Instead of providing spontaneous, low-risk mothers with an adequate care in line with best practices for spontaneous childbirths (i.e. a care corresponding to the primary care), spontaneous mothers are, along with high-risk mothers treated as potential emergencies within the secondary care. Such application of incorrect type of care equally results in an excessive application of interventions and medications in the case of spontaneous mothers, where such medications and interventions are not needed and are unjustifiable, and equally to worse possibilities for procuring the relevant care to those mothers whose conditions it indeed require. In order to illustrate the above, a notion of cascade of complication has developed. Such a notion implies that an unjustifiable intervention into labour represents an interference with natural processes; such

[15] Šmídová in *Games of Life* (2015). E.g. Šmídová, Iva, Eva Šlesingerová and Lenka Slepičková. (2015). *Games of Life. Czech Reproductive Biomedicine. Sociological Perspectives*. Brno: Masarykova univerzita - munipress. munipress.muni.cz/book/id_550: Gender inequality impacts hierarchy of power within the physicians, too. See for example Šmídová, Iva (2015). Invisible Lady Doctors and Bald Femininity: Professional Conference in Czech Reproductive Medicine. *Visual studies: Encounter Imagination. Social Studies/Sociální studia* 12(1): 31 - 52. http://socstudia.fss.muni.cz/sites/default/files/03_Invisible_Lady_Doctors_and_Bald_Femininity_Iva_Smidova.pdf

interference leads to other complications necessitating subsequent further compensatory measures. This sequence of initial interventions and caused consequences requiring other interventions may be repeated several times, ending, as the case may be, with a caesarean section or an surgery vaginal delivery (use of forceps or vacuum-extraction including genital cut-in).

That said, physicians can hardly be blamed for this situation as they are educated to deal with pathologies in order to provide a qualified secondary care, but are not educated within the education system to deal with natural processes that evince lack of pathologies not necessitating for their attendance. On the contrary, the responsibility for the lack of division between care givers within the primary and secondary base lies with competent public authorities including the Ministry of Health.

Although midwives have formed a part of the Czech childbirth system, irrespective of their (im)possibility to provide their services, for nearly twenty years, they have never become incorporated into the health care system and merely have been an appendix thereto. Apart from the system being de facto secondary-care system, the main reason may be seen in lack of authoritative guidelines and rules regulating cooperation between particular providers of primary care and secondary care and particularly processes relating to transferring mother to the higher level of care by public authorities. Up to date, the Ministry of Health has never prepared any guidelines or policies regulating the above. Such passivity of public authorities that constitutes unclear specification of rights and obligations of care givers leads to creation of friction points between particular providers of health care, ultimately endangering the final users of the health care, i.e. mothers and children. In addition, individual regional authorities in the Czech Republic are not interested in establishing a community care provided by midwives and such a care is missing in their health care policy. From experience, even when regional authorities are pro-actively approached by midwives, including UNIPA, with a request for cooperation, there is no reply from the regional authorities.

IV. RESTRICTION OF MIDWIFE-BASED CARE IN PRACTICE

Limitations by public authorities' conduct

Irrespective of particular legislation in force, midwives have been in a long term subject to various restrictions and arbitrariness by the respective public authorities. The public authorities have broadly been withholding and refusing issuing the technical license to midwives, hence, disallowing them to provide their care. Apart from formalistic reasons the regional authorities typically restricted the permitted competences by assistance at childbirth, some midwives were forced to sign a side declaration committing to refrain from attending a home birth[16]. There have also been cases in which authorities arbitrarily and without any formal petition to do so restricted midwives' competences[17]. Even after the adoption of legislation in fact eliminating assistance of a midwife at a planned home birth in 2010 and 2012 respectively, there were several attempts to obtain respective registrations by midwife (e.g. Kristina Neubertová Zemánková, Marie Vnoučková, Ladka Ryšavá and Jitka Pokorná), which were not successful.

Albeit some of these above mentioned cases of arbitrary decision making by public authorities were challenged in appeal procedures and related judicial review, the courts refused to provide midwives with any protection of their rights. Not to mention, despite that the Court Chamber's

[16] E.g. registration process of Milena Dvořáková;

[17] E.g. Ivana Königsmarková's permitted competences were restricted by the regional authority in Prague in relation to her request of to change her registered place of business;

decision in the case at hand has not yet become final, Czech courts already rely on the argument that monopolizing childbirth care in hospital does not contravene Article 8 of the Convention[18]

Limitations by lack of the state-procured standards

Another substantial hindrance disallowing a smooth performance of midwife-based care is lack of professional standards of care in midwifery. Albeit the State explicitly acknowledged midwives to form a valid part of the health care system in childbirth, public authorities have never cooperated with midwives and their professional organisations in setting up professional standards. On the contrary, instead of doing so, public authorities keep undermining midwives' position by repeatedly publicly expressed opinions on allegedly higher risks at births outside hospitals and exclusivity of lex artis procedures in hospitals . Since any professional cannot duly carry out his/her occupation without a prior defining respective standards of the respective profession, this lack of public authorities' activity forced midwives' associations (UNIPA and ČKA) to span it by claiming allegiance to international standards of WHO and ICM. That said, such measure could not have been generally binding and was merely intended as a temporary measure until public authorities indicate the applicable standards. This has not happened until now and midwives are forced to provide their services relying in good faith on standards that are, on one hand, internationally recognized, but confirmation of which has not occurred on the national level.

The lack of professional standards sanctified by public authorities also exposes midwives to greater risk in terms of their professional liability, both in civil and criminal areas. Any civil litigation or criminal investigation that deal with midwife's professional liability will sooner or later have to decide whether applicable standards of care (*lex artis*) were adhered to or not and such expert question will be passed to an expert. Since there are no applicable midwifery standards and since there are no state-approved experts in the field of midwifery, an obstetrician expert applying obstetrics standards will be appointed, finding *non lege artis* conduct of the midwife. Exactly this process has already been experienced in the criminal proceedings held against two leading representatives of midwives in the Czech Republic, Ivana Königsmarková and Zuzana Štromerová. Albeit they both have been, ultimately, found innocent, their reputation as well as midwifery's reputation suffered incurable damage. The lack of applicable standards, hence, extend the liability of midwives' liability, both in civil and criminal field. Eventually, midwives find themselves in a situation in which the ultimate assessment of their civil or criminal liability is in hands of their professional opponents.

Limitations by the State's failure to procure statistic data in obstetrics

Situation in Czech health care system in childbirth is further complicated by lack of solid statistic data. Although the State has established its Agency for Medical Information[19], professionals and expert public lack substantial amount of information that would help focusing on those aspects of health care provision that evince certain insufficiencies and remedying them. However, this lack is of special importance in relation to prospective mothers, who do not receive any information on their options during maternity. They do not dispose of information on particular models of care and their features and do not even dispose of documents that would enable them to compare conduct and practices in various care givers within the same model of care.

For instance, a prospective mother, who intends to deliver in a hospital is in no position to find out particular practices in hospitals of her interest in order to determine in which hospital to deliver; the

[18] Decision of the Constitutional Court under ref. no. II. ÚS 391/14;

[19] Ústav zdravotnických informací a statistiky (ÚZIS);

only information she may obtain, subject to exercising rather substantial effort are only anonymized information that cannot be attributed to particular hospitals. Not only that these information are not publicly available, but the respective public authorities refuse to provide these specific information contrary to the law[20]. In the end of the day, a prospective mother lacks background information on specific care, practices and conduct in particular hospital, which disallows her to choose the hospital providing care closest to her wishes and needs. The notion of choice made without relevant information may easily be replaced with notion of random choice.

In addition to the unavailability of statistic data on practices in specific hospitals, the State has also been failing to carry out a systematic collection of data concerning childbirths outside medical facilities. The State consequently has no information on how many home births there are, what is their stratifications etc. Even during the era prior to the elimination of midwives' assistance at home births, no such data was systematically collected.

Furthermore, there is no complex method of informing prospective mothers on the health care provided in childbirth by public authorities, unlike many countries to the Convention. Therefore, women are not aware of their respective options during pregnancy and childbirth, their pros and cons; women may get these relevant information only in pre-childbirth courses that are subject to fees. In this relation, raising the public awareness has always been one of UNIPA's priorities, de facto standing in for the State.

V. SUMMARY

The position of Czech midwives currently is unsustainable. Although they are recognized by the law, the legal system restricts execution of their competences. Midwives are banned from assisting mothers at planned home births by virtue of law, they are in fact banned from assisting at births in their consultancy room and from establishing a birth centre due to excessive technical requirements that may be satisfied only in hospitals. Last but not the least, midwives cannot provide their care by means of accompanying mothers to hospitals since the hospitals refuse mothers to bring in their own midwife. The State's approach is far beyond what it calls a status of non-encouragement. To the contrary, the conduct of the State and public authorities directly and indirectly discourage midwives from carrying on their profession and women from enjoying their care. That said, UNIPA has always been, and still is, ready to cooperate with any and all public authorities and other providers of health care in childbirth in order to set up a functional model of health care that will be transparent for mothers allowing them a qualified and informed choice regarding the type of care mothers will deem to suit them the best.

The deep-established obstetric model of childbirth care which is still not prepared for interaction, cooperation and, ultimately competing with in terms of procuring wellbeing of mothers and children, the midwifery model of maternity care. Petrification of the current hegemony of the obstetric model of health care with all benefits this hegemony brings to those participating on it, which is supported by the State and its bodies, is characteristic to the current situation. Midwives lack any support from the public authorities, suffer from the State's passivity in terms of procuring solid statistic data that would allow the expert and layman public a better insight into the system of childbirth health care.

Albeit being far from commenting on the factual and legal circumstances of the present case, UNIPA believes that a decision in the case at hand will have a great impact on women's reproduction

[20] [ŽÁDOSTI NA ÚZIS O DATA, VIZ LIGOVÉ PODÁNÍ + DALŠÍ]

rights in the Czech Republic as well as on all persons and entities providing care to them. The outcome of the case at hand may only lead either to liberalization of the adverse situation in the Czech Republic allowing women to exercise their reproduction rights widening their options in maternity or may petrify the current monopoly of the obstetrician system, the entire elimination of women's choice in terms of circumstances of their childbirth. A petrification which, unless theoretically changed by an enlightened legislator, will be impossible to be overridden.

In Prague on October 12th, 2015

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