



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

FORMER FIFTH SECTION

CASE OF DUBSKÁ AND KREJZOVÁ v. THE CZECH REPUBLIC

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

JUDGMENT

STRASBOURG

11 December 2014

**THIS CASE WAS REFERRED TO THE GRAND CHAMBER
WHICH DELIVERED JUDGMENT IN THE CASE ON
15/11/2016**

This judgment may be subject to editorial revision.

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

The European Court of Human Rights (Former Fifth Section), sitting as a Chamber composed of:

Mark Villiger, *President*,
Angelika Nußberger,
Boštjan M. Zupančič,
Ganna Yudkivska,
André Potocki,
Paul Lemmens,
Aleš Pejchal, *judges*,

and Claudia Westerdiek, *Section Registrar*,

Having deliberated in private on 10 September 2013 and 7 October 2014,
Delivers the following judgment, which was adopted on the latter 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 (“the first applicant”) and Ms Alexandra Krejzová (“the second applicant”), on 4 May 2011 and 7 May 2012 respectively.

2. The first applicant was represented by Mr D. Zahumenský, a lawyer with the human rights organisation Liga lidských práv in Brno, and the second applicant by Mr R. Hořejší, a lawyer practising in Prague. The Czech Government (“the Government”) were represented by their Agent, Mr Vít A. Schorm, of the Ministry of Justice.

3. The applicants alleged that Czech law forbade health professionals to attend home births, in violation of Article 8 of the Convention.

4. On 3 September 2012 the applications were communicated to the Government.

5. A hearing took place in public in the Human Rights Building, Strasbourg, on 10 September 2013 (Rule 59 § 3 of the Rules of Court).

There appeared before the Court:

(a) *for the Government*

Mr Vít A. SCHORM,
Ms D. KOPKOVÁ,
Ms I. KÖHLEROVÁ,
Mr O. HLINOMAZ,
Ms T. JANČÁRKOVÁ,
Mr J. FEYEREISL,

Agent,

Mr P. VELEBIL,

Advisers;

(b) *for the first applicant*

Mr D. ZAHUMENSKÝ,
Ms Z. CANDIGLIOTA,

*Counsel,
Adviser;*

(c) *for the second applicant*

Mr R. HOŘEJŠÍ,
Ms A. HOŘEJŠÍ,
Ms M. PAVLÍKOVÁ,

*Counsel,
Advisers.*

The Court heard addresses by Mr Schorm, Mr Velebil, Mr Zahumenský, Mr Hořejší, Ms Pavlíková and their answers in reply to questions put by the Court.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

6. The first applicant, Ms Šárka Dubská, was born in 1985 and lives in Jilemnice. The second applicant, Ms Alexandra Krejzová, was born in 1980 and lives in Prague.

A. Application lodged by Ms Šárka Dubská

7. The first 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 wish. 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 she would take the child into her care.

8. 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.

9. 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.

10. On 7 April 2011 the health-insurance company replied that Czech legislation did not provide for the possibility that a public health-insurance company might cover 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.

11. 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.

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

13. On 1 July 2011 she lodged a constitutional appeal (*ústavní stížnost*) claiming 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.

14. 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 section 82 of the Code of Judicial Administrative Procedure. It nevertheless expressed its doubts as to the compliance of the 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 to the decision their separate opinions, 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

15. The second 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.

16. 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 required by the situation. 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 lasting for two hours.

17. 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 willing midwife because of the risk of a heavy fine if medical services were provided without authorisation. The applicant asked various authorities to help find a solution to her situation.

18. 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 with the City of Prague (*Město Praha*) which, acting as a regional office, registered and issued authorisations to health professionals.

19. 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.

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

21. 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.

C. General information pertaining to home births in the Czech Republic

1. Guidelines issued and published by the Ministry of Health

22. In its bulletin no. 2/2007 of February 2007 the Ministry of Health published a practice guideline which stated:

“Conducting a delivery in the Czech Republic is regarded as a healthcare provision that is provided only in a healthcare institution. Each healthcare institution must fulfil the statutory requirements ... and the requirements laid down by the relevant secondary legislation.”

23. The Czech Medical Chamber (*Česká lékařská komora*) considers a home birth to be a procedure *non lege artis* because of the dangers associated therewith.

24. Almost all births in the Czech Republic currently take place in hospital, with only about 0.2% to 0.3% of births happening at home.

25. In reaction to what has been perceived as an attempt to criminalise midwifery in some central and eastern European countries – in particular in Hungary – the President of the International Confederation of Midwives and the President of the International Federation of Gynecology and Obstetrics issued a joint statement on 6 March 2012 in which they declared: “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 regulatory framework that makes it possible for midwives to practice their profession in any place that women choose to give birth.”

26. 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 would it be possible for it to agree on certain conclusions.

27. 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 in full 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 (see paragraph 56 below), 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.

28. In its bulletin no. 8/2013 published on 9 December 2013, which replaced the previous practice guideline of 2007 (see paragraph 22 above), the Ministry of Health described the procedure for providers of healthcare 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 ...”

In the event that the newborn is hospitalised without the agreement of the legal representative in order to be given medical treatment necessary to save the child's life or to prevent serious damage to the child's health, the hospital should proceed in accordance with sections 38 and 40 of the Medical Services Act (Law no. 372/2011). This practice guideline came into force on 1 January 2014.

2. Data on perinatal mortality

29. According to estimated data provided by the World Health Organisation in a 2000 report, 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 5.8% in Azerbaijan. In most European countries the figures were below 1%. According to the 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 500g 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.

30. 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 amongst the countries with the lowest mortality rate amongst newborns in the first twenty-seven days of their life. The rate was 0.17%. The data for other included countries, mostly European Union (EU) member States, ranged from 0.12% for Iceland to 0.55% for Romania. However, if only statistics relating to babies born after twenty-four weeks of pregnancy were taken into account, the Czech Republic, with a rate of 0.16%, moved closer to the average of 0.2%. The report noted that the wide variation in gestational age-specific neonatal mortality rates at twenty-two to twenty-three weeks suggested that not all births and deaths very early in the neonatal period were systematically included. Consequently, the report considered the data including only babies born after twenty-four weeks of gestation more reliable.

31. The applicants pointed out that the above sets of data were not easily comparable across countries owing to the different definitions used. The majority of European countries set a weight limit of 500 g for counting live births and stillborn children. In the Czech Republic, however, the practice until April 2012 had been that a birth was registered for statistical purposes only if the child weighed at least 1,000 g.

3. Conditions in Czech hospitals

32. The Government stated that Czech maternity hospitals offered high-quality services during delivery that fully respected the rights and wishes of mothers. For their part, the applicants submitted testimonies from numerous mothers who had given birth in maternity hospitals during recent years and who pointed to practices that were – in their view – unacceptable, including the following: medical intervention during delivery without the consent of the mothers and sometimes against their explicitly expressed will, such as artificial rupture of membranes; episiotomy; intravenous infusion of medication for the mother; performing the Kristeller manoeuvre (pushing with the fist or forearm the top of the uterus coinciding with a contraction and pushing by the mother during the second stage of labour); performing Caesarean section without sufficient medical justification; using techniques and medication to speed up the delivery; separation of mothers from their babies for several hours after delivery, ignoring the mother's wishes to have immediate contact with the baby after delivery; routinely placing healthy babies in incubators; administering treatment to babies against the express wishes of the mother; and forcing the mother and baby to stay in hospital for seventy-two hours after delivery even when they were both healthy. There had also been complaints of arrogant, intimidating, disrespectful and patronising behaviour on the part of the hospital staff and of a lack of privacy.

4. Criminal proceedings against midwives

33. It appears that no midwife has been prosecuted in the Czech Republic for attending home births *per se*. Several of them have been prosecuted for alleged malpractice in connection with a delivery at home, however. 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.

34. 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 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. An appeal on points of law is pending.

35. 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. She 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 Chamber (*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.

36. On 24 July 2013 the Constitutional Court quashed all the judgments in the case against Ms K. on account of a violation of her right to a fair trial. It considered the conclusions of the ordinary courts as to Ms K.'s guilt to have been too subjective and not supported by the evidence beyond any 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.”

II. RELEVANT DOMESTIC LAW

A. Medical Care Act (no. 160/1992) (in force until 31 March 2012)

37. Under section 5 of this Act, a person could provide medical care only if in possession of the appropriate licence, the conditions of which included having appropriate technical equipment on the premises where such services were being provided as specified in a decree issued by the Ministry of Health. Under section 14, a person providing medical care could be fined for violating this Act. The amount of the fine was not specified.

B. Medical Services Act (no. 372/2011) (entry into force on 1 April 2012)

38. Under section 11(5) of this Act, healthcare services can be provided only in healthcare institutions in places specified in the licence as providing healthcare services. Under section 4(1), a healthcare institution means premises intended for the provision of healthcare services. Under section 11(6), a healthcare institution must possess technical and material equipment for the provision of healthcare services. The technical and material equipment in such healthcare institutions must correspond to the specialisation, type and form of healthcare provided by the institutions. Requirements for the minimum standard of technical and material equipment must be set down in an implementing decree.

39. Under section 28(1), healthcare services can be provided to patients only with their free and informed consent. Under section 28(3), when receiving healthcare services, the patient has the right to respect for privacy in the provision of those healthcare services in accordance with the nature of the services being provided; the right to choose a provider who is authorised to provide healthcare services meeting the patient’s health needs, and to choose a healthcare institution; the right to the presence of a close friend or relative or other person specified by the patient; and the right to the

provision of healthcare services in the least restrictive environment while ensuring the quality and safety of the healthcare services provided.

40. Under section 114, a person providing a healthcare service without an appropriate licence can be fined up to CZK 1,000,000 (approximately EUR 40,000).

C. Decree no. 221/2010 of the Ministry of Health on technical equipment at healthcare institutions (in force from 1 September 2010 to 31 March 2012)

41. This decree envisaged the possibility of midwives conducting deliveries in rooms specially equipped for that purpose. Midwives had to have the following essential equipment in such a room: a birthing bed for a delivery room or other appropriate device for carrying out a physiological delivery, an examination light, a sterile clamp or rubber band for the umbilical cord, sterile scissors, EFM (electronic foetal monitoring), a pulse oximeter, a suction unit, a laryngoscope and instruments to secure the airways, a suitable space and surface for treating newborns, scales for newborns, an instrument to measure the newborn's length, and a source of medical oxygen. Furthermore, such a place had to be a maximum of fifteen minutes' drive from a hospital that could perform a birth by Caesarean section. The decree did not provide for the possibility of health professionals attending home births.

D. Decree no. 92/2012 of the Ministry of Health on technical equipment at healthcare institutions (entry into force on 1 April 2012)

42. This decree provides for the possibility of midwives conducting deliveries in delivery rooms specially equipped for that purpose. The equipment requirements are the same as those specified in Decree no. 221/2010. The decree does not provide for the possibility of health professionals attending home births.

E. Paramedical Professions Act (no. 96/2004)

43. Under section 6 of this Act, the practice of the profession of midwife includes conducting physiological deliveries and providing care for newborns.

F. Emergency Medical Services Act (no. 374/2011)

44. This Act regulates the emergency ambulance service. Under section 5(2), the service must be organised in such a way that an ambulance must be able to reach any location within twenty minutes of the request.

III. RELEVANT INTERNATIONAL LAW

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)

45. The relevant provisions of this Convention are the following:

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.”

46. The explanatory report on the Convention 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. International Covenant on Economic, Social and Cultural Rights

47. Under Article 12 of the Covenant, the States Parties recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the Covenant to achieve the full realisation of this right include those necessary

for the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child.

48. In General Comment no. 14 on the right to the highest attainable standard of health, published on 11 August 2000 (E/C.12/2000/4), the Committee on Economic, Social and Cultural Rights stated, *inter alia*, the following:

“1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. ...

8. ... The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. ...

14. ‘The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child’ (article 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”

49. The Committee also stated that the right to health, like other social rights, included the following interrelated and essential elements: availability (meaning that properly functioning public health and healthcare facilities, goods, services and programmes have to be available in sufficient quantity within the State party), accessibility (meaning that healthcare facilities, goods and services have to be accessible to everyone), acceptability (meaning that all healthcare facilities, goods and services must be respectful of medical ethics and culturally appropriate) and quality (meaning that healthcare facilities, goods and services must also be scientifically and medically appropriate and of good quality).

50. Furthermore, the Committee noted that the obligation to fulfil the right to health included “dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services ... [and] supporting people in making informed choices about their health.”

51. The Committee also noted that every State had a margin of discretion in assessing which measures were most suitable to meet its specific circumstances.

C. Convention on the Rights of the Child

52. The relevant provisions of this Convention are the following:

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 recognized in the present Convention.”

Article 6

“1. States Parties recognize 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; ...”

53. In General Comment no. 7 on implementing child rights in early childhood, published on 20 September 2006 (CRC/C/GC/7/Rev.1), the Committee on the Rights of the Child stated, in particular, the following:

“4. ... In its consideration of rights in early childhood, the Committee wishes to include all young children: at birth and throughout infancy; ...

10. Right to life, survival and development. Article 6 refers to the child's inherent right to life and States parties' obligation to ensure, to the maximum extent possible, the survival and development of the child. States parties are urged to take all possible measures to improve perinatal care for mothers and babies, reduce infant and child mortality, and create conditions that promote the well-being of all young children during this critical phase of their lives. ... Ensuring survival and physical health are priorities, but States parties are reminded that article 6 encompasses all aspects of development, and that a young child's health and psychosocial well-being are in many respects interdependent. Both may be put at risk by adverse living conditions, neglect, insensitive or abusive treatment and restricted opportunities for realizing human potential. ... The Committee reminds States parties (and others concerned) that the right to survival and development can only be implemented in a holistic manner, through the enforcement of all the other provisions of the Convention, including rights to health, adequate nutrition, social security, an adequate standard of living, a healthy and safe environment, education and play (arts. 24, 27, 28, 29 and 31), as well as through respect for the responsibilities of parents and the provision of assistance and quality services (arts. 5 and 18). ...

13. Best interests of the child. Article 3 sets out the principle that the best interests of the child are a primary consideration in all actions concerning children. By virtue of their relative immaturity, young children are reliant on responsible authorities to assess and represent their rights and best interests in relation to decisions and actions that affect their well-being, while taking account of their views and evolving capacities. The principle of best interests appears repeatedly within the Convention (including in articles 9, 18, 20 and 21, which are most relevant to early childhood). The principle of best interests applies to all actions concerning children and requires active measures to protect their rights and promote their survival, growth, and well-being, as well as measures to support and assist parents and others who have day-to-day responsibility for realizing children's rights ...

15. A crucial role for parents and other primary caregivers. Under normal circumstances, a young child's parents play a crucial role in the achievement of their rights, along with other members of family, extended family or community, including legal guardians, as appropriate. This is fully recognized within the Convention (especially article 5), along with the obligation on States parties to provide assistance, including quality childcare services (especially article 18). ...

18. Respecting parental roles. Article 18 of the Convention reaffirms that parents or legal guardians have the primary responsibility for promoting children's development and well-being, with the child's best interests as their basic concern (arts. 18.1 and 27.2). States parties should respect the primacy of parents, mothers and fathers. ...

27. Health-care provision. States parties should ensure that all children have access to the highest attainable standard of health care and nutrition during their early years, in order to reduce infant mortality and enable children to enjoy a healthy start in life (art. 24). In particular:

...

(b) States parties have a responsibility to implement children's right to health by encouraging education in child health and development, including about the advantages of breastfeeding, nutrition, hygiene and sanitation. Priority should also be given to the provision of appropriate prenatal and post-natal health care for mothers and infants in order to foster healthy family-child relationships, especially between a child and his or her mother. ..."

54. In General Comment no. 15 on the right of the child to the enjoyment of the highest attainable standard of health, published on 17 April 2013 (CRC/C/GC/15), the Committee on the Rights of the Child stated, *inter alia*, the following:

“33. States have an obligation to reduce child mortality. The Committee urges particular attention to neonatal mortality, which constitutes an increasing proportion of under-5 mortality. Additionally, States parties should also address adolescent morbidity and mortality, which is generally under-prioritized.

34. Interventions should include attention to still births, pre-term birth complications, birth asphyxia, low birth weight, mother-to-child transmission of HIV and other sexually transmitted infections, neonatal infections, pneumonia, diarrhoea, measles, under- and malnutrition, malaria, accidents, violence, suicide and adolescent maternal morbidity and mortality. Strengthening health systems to provide such interventions to all children in the context of the continuum of care for reproductive, maternal, newborn and children’s health, including screening for birth defects, safe delivery services and care for the newborn are recommended. Maternal and perinatal mortality audits should be conducted regularly for the purposes of prevention and accountability.

...

51. The Committee notes that preventable maternal mortality and morbidity constitute grave violations of the human rights of women and girls and pose serious threats to their own and their children’s right to health. Pregnancy and child birth are natural processes, with known health risks that are susceptible to both prevention and therapeutic responses, if identified early. Risk situations can occur during pregnancy, delivery and the ante- and postnatal periods and have both short- and long-term impact on the health and well-being of both mother and child.

52. The Committee encourages States to adopt child-sensitive health approaches throughout different periods of childhood such as (a) the baby-friendly hospital initiative which protects, promotes and supports rooming-in and breastfeeding; (b) child-friendly health policies focused on training health workers to provide quality services in a way that minimizes the fear, anxiety and suffering of children and their families; ...

54. ... Maternal and newborn care following delivery should ensure no unnecessary separation of the mother from her child.”

55. In General Comment no. 14 on the right of the child to have his or her best interests taken as a primary consideration, published on 29 May 2013 (CRC/C/GC/14), the Committee on the Rights of the Child stated, *inter alia*, the following:

“32. The concept of the child’s best interests is complex and its content must be determined on a case-by-case basis. It is through the interpretation and implementation of article 3, paragraph 1, in line with the other provisions of the Convention, that the legislator, judge, administrative, social or educational authority will be able to clarify the concept and make concrete use thereof. Accordingly, the concept of the child’s best interests is flexible and adaptable. It should be adjusted and defined on an individual basis, according to the specific situation of the child or children concerned, taking into consideration their personal context, situation and needs. For individual decisions, the child’s best interests must be assessed and

determined in light of the specific circumstances of the particular child. For collective decisions – such as by the legislator –, the best interests of children in general must be assessed and determined in light of the circumstances of the particular group and/or children in general. In both cases, assessment and determination should be carried out with full respect for the rights contained in the Convention and its Optional Protocols.

33. The child's best interests shall be applied to all matters concerning the child or children, and taken into account to resolve any possible conflicts among the rights enshrined in the Convention or other human rights treaties. Attention must be placed on identifying possible solutions which are in the child's best interests. This implies that States are under the obligation to clarify the best interests of all children, including those in vulnerable situations, when adopting implementation measures.

...

39. However, since article 3, paragraph 1, covers a wide range of situations, the Committee recognizes the need for a degree of flexibility in its application. The best interests of the child – once assessed and determined – might conflict with other interests or rights (e.g. of other children, the public, parents, etc.). Potential conflicts between the best interests of a child, considered individually, and those of a group of children or children in general have to be resolved on a case-by-case basis, carefully balancing the interests of all parties and finding a suitable compromise. The same must be done if the rights of other persons are in conflict with the child's best interests. If harmonization is not possible, authorities and decision-makers will have to analyse and weigh the rights of all those concerned, bearing in mind that the right of the child to have his or her best interests taken as a primary consideration means that the child's interests have high priority and not just one of several considerations. Therefore, a larger weight must be attached to what serves the child best."

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

56. 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."

E. World Health Organisation

57. In 1996 a group of experts under the auspices of the World Health Organisation adopted a document called "Care in normal birth: a practical guide" (WHO/FRH/MSM/96.24). The document presented universal guidelines for the routine care of women during uncomplicated labour and childbirth. The report was in response to the proliferation of practices designed to start, augment, accelerate, regulate or monitor the physiological process of labour in industrialised and developing countries alike. After establishing a working definition of "normal birth", the report aimed to identify the commonest practices used during labour and attempted to establish some norms of good practice for the conduct of non-complicated labour and delivery. Amongst other things, the report stated:

"With the global phenomenon of increasing urbanisation many more women are delivering in obstetric facilities, whether they are having normal or complicated births. There is a temptation to treat all births routinely with the same high level of intervention required by those who experience complications. This, unfortunately, has a wide range of negative effects, some of them with serious implications. They range from the sheer cost of time, training and equipment demanded by many of the methods used, to the fact that many women may be deterred from seeking the care they need because they are concerned about the high level of intervention. Women and their babies can be harmed by unnecessary practices. ...

In some developed countries birth centres in and outside hospitals have been established where low-risk women can give birth in a home-like atmosphere, under primary care, usually attended by midwives. In most such centres electronic fetal monitoring and augmentation of labour are not used and there is a minimum use of analgesics. ... Experiments with midwife-managed care in hospitals in Britain, Australia and Sweden showed that women's satisfaction with such care was much higher than with standard care. The number of interventions was generally lower, especially obstetric analgesia, induction and augmentation of labour. The obstetric outcome did not significantly differ from consultant-led care, though in some trials perinatal mortality tended to be slightly higher in the midwife-led models of care ...

In a number of developed countries dissatisfaction with hospital care led small groups of women and caregivers to the practice of home birth in an alternative setting, often more or less in confrontation with the official system of care. Statistical data about these home births are scarce. In an Australian study data were collected which suggested that the selection of low-risk pregnancies was only moderately successful. In planned home deliveries the number of transfers to hospital and the rate of obstetric interventions was low. Perinatal mortality and neonatal morbidity figures were also relatively low, but data about preventable factors were not provided ...

So where then should a woman give birth? It is safe to say that a woman should give birth in a place she feels is safe, and at the most peripheral level at which appropriate

care is feasible and safe ... For a low-risk pregnant woman this can be at home, at a small maternity clinic or birth centre in town or perhaps at the maternity unit of a larger hospital. However, it must be a place where all the attention and care are focused on her needs and safety, as close to home and her own culture as possible. If birth does take place at home or in a small peripheral birth centre, contingency plans for access to a properly-staffed referral centre should form part of the antenatal preparations.

...

In conclusion, normal birth, provided it is low-risk, only needs close observation by a trained and skilled birth attendant in order to detect early signs of complications. It needs no intervention but encouragement, support and a little tender loving care. General guidelines can be given as to what needs to be in place to protect and sustain normal birth. However, each country willing to invest in these services needs to adapt these guidelines to its own specific situation and the needs of the women as well as to ensure that the basics are in place in order to adequately serve women at low, medium and high risk and those who develop complications.”

58. The report also contains guidelines concerning the tasks of the caregiver during normal birth and what action he or she should take during the birth. One of the main tasks is referral to a higher level of care if risk factors become apparent or complications develop that justify such referral, assuming that the referral can be carried out easily.

IV. LAW AND PRACTICE IN COUNCIL OF EUROPE MEMBER STATES

59. On the basis of the comparative material available to the Court covering thirty-two member States, the following practices may be observed.

60. Sixteen member States expressly allow home birth under certain conditions (Austria, Belgium, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Liechtenstein, Luxembourg, the Netherlands, Poland, Sweden, Switzerland and the United Kingdom).

61. In sixteen member States the issue of home birth is not expressly regulated by law (Albania, Bosnia and Herzegovina, Croatia, Estonia, Finland, Georgia, Lithuania, Malta, Montenegro, Romania, Russia, Slovenia, Spain, the former Yugoslav Republic of Macedonia, Turkey and Ukraine). In practice, the approach to home deliveries with the assistance of a health professional differs in these countries. In some of them midwives attend home births and this practice is tolerated (for example, Estonia, Finland, Malta, Spain and Turkey). In some countries, such as Estonia and Slovenia, legislation is being considered to regulate professional assistance at planned home births. Only in a handful of States can a health professional face a sanction for the simple fact of having assisted with a planned home birth (Croatia, Lithuania and Ukraine).

V. SUMMARY OF RELEVANT INTERNATIONAL EXPERT RESEARCH STUDIES ON SAFETY OF HOME BIRTHS SUBMITTED TO THE COURT BY THE PARTIES

62. Research conducted in the United States and published in 2010 concluded that planned home births were associated with fewer maternal interventions including epidural analgesia, electronic foetal heart rate monitoring, episiotomy, and operative delivery. The women giving birth in this manner were less likely to experience lacerations, haemorrhage and infections. Neonatal outcomes of planned home births revealed less frequent prematurity and low birth weight, and less need for assisted newborn ventilation. Although planned home and hospital births exhibited similar perinatal mortality rates, planned home births were associated with significantly elevated neonatal mortality rates.¹ However, several scientific articles criticised this study for serious deficiencies in methodology.² Another study conducted on United States data from 2008 concluded that the risk of lower 5-minute Apgar score and neonatal seizure was higher for planned home births.³

63. Research conducted in Canada and published in 2009 found that a planned home birth attended by a registered midwife was associated with very low and comparable rates of perinatal death and reduced rates of obstetric interventions and other adverse perinatal outcomes compared with planned hospital birth attended by a midwife or a doctor.⁴

64. Another research study published in 2012 concluded that there was no strong evidence from randomised trials to favour either planned hospital birth or planned home birth for low-risk pregnant women. However, the trials showed that women living in areas where they were not well informed about home birth might welcome ethically well-designed trials that would ensure an informed choice.⁵ A study comparing midwife-led care with

1 J.R. Wax, F.L. Lucas, M. Lamont et al., “Maternal and newborn outcomes in planned home birth vs planned hospital births: a meta-analysis”, *American Journal of Obstetrics & Gynecology*, 2010;203:243.e1-8.

2 Carl A. Michal, Patricia A. Janssen, Saraswathi Vedam, Eileen K. Hutton and Ank de Jonge, “Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong”, <http://www.medscape.com/viewarticle/739987>; Gill Gyte, Mary Newburn and Alison Macfarlane, “Critique of a meta-analysis by Wax and colleagues which has claimed that there is a three-times greater risk of neonatal death among babies without congenital anomalies planned to be born at home”, National Childbirth Trust. <http://fr.scribd.com/doc/34065092/Critique-of-a-meta-analysis-by-Wax>

3 Yvonne W. Cheng, Jonathan Snowden and Aaron Caughey, “Neonatal Outcomes Associated with Intended Place of Birth: Birth Centers and Home Birth Compared to Hospitals”, *American Journal of Obstetrics & Gynecology*, Supplement at 42, January 2012.

4 P.A. Janssen, L. Saxell, L.A. Page, M.C. Klein, R.M. Liston, S.K. Lee, “Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician”, *Canadian Medical Association Journal*, 2009 Sep 15;181(6-7):377-83.

models of medical-led care and shared care – which included 11 trials, involving 12,276 women – concluded that midwife-led care was associated with several benefits for mothers and babies, and had no identified adverse effects, taking into account data on foetal loss and neonatal death.⁶

65. Research conducted in the Netherlands and published in 2009 concluded that planning a home birth did not increase the risks of perinatal mortality or severe perinatal morbidity among low-risk women, provided that the maternity care system facilitated this choice by making available both well-trained midwives and a good transportation and referral system.⁷ On the other hand, another Dutch study published in 2010 concluded that infants of low-risk pregnant women who started labour in primary care had a higher risk of delivery-related perinatal death than did infants of high-risk pregnant women who started labour in secondary care. Of major concern was the fact that the highest mortality was among the infants of women who were referred from primary care to secondary care during labour because of an apparent complication.⁸

66. Research conducted in Switzerland and published in 1996 concluded that healthy low-risk women who wished to deliver at home experienced no increased risk either to themselves or to their babies.⁹

67. Research conducted in the United Kingdom and published in 2011 found that for healthy women with low-risk pregnancies, the incidence of adverse perinatal outcomes was low in all birth settings. For healthy multiparous women with a low-risk pregnancy, there were no differences in adverse perinatal outcomes between planned births at home or in a midwifery unit compared with planned births in an obstetric unit. For healthy nulliparous women with a low-risk pregnancy, the risk of an adverse perinatal outcome seemed to be higher for planned births at home, and the intrapartum transfer rate was high in all settings other than an obstetric unit.¹⁰ Another study based on data from England and Wales between 1994

5 O. Olsen, M.D. Jewell, “Planned hospital birth versus planned home birth”, *Cochrane Database of Systematic Reviews* 2012 Sep 12;9:CD000352.

6 M. Hatem, J. Sandall, D. Devane, H. Soltani, S. Gates, “Midwife-led versus other models of care for childbearing women”, *Cochrane Database of Systematic Reviews* 2008, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub2.

7 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.

8 Annemieke C.C. Evers, Hens A. A. Brouwers, Chantal W. P. M. Hukkelhoven, Peter G. J. Nikkels, Janine Boon, Anneke van Egmond-Linden, Jacqueline Hillegersberg, Yvette S. Snuif, Sietske Sterken-Hooisma, Hein W. Bruinse, Anneke Kwee, “Perinatal mortality and severe morbidity in low and high risk term pregnancies in the Netherlands: prospective cohort study”, *BMJ* 2010;341:c5639 doi:10.1136/bmj.c5639.

9 U. Ackermann-Lieblich, 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.

and 2003 concluded that women who booked for home births and had their babies at home seemed to have a generally low perinatal mortality rate during labour and delivery. However, women who had booked for a home birth, but later needed to transfer their care for a hospital birth, appeared to have the highest risk of perinatal mortality rate in the study period.¹¹

THE LAW

I. JOINDER OF THE APPLICATIONS

68. The Court notes that the subject matter of applications nos. 28859/11 and 28473/12 is similar. In accordance with Rule 42 of the Rules of Court, it is therefore appropriate to join the cases.

II. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

69. The applicants complained that Czech law forbade a health professional to assist with a home birth, 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. Admissibility

71. The Government submitted that the case was incompatible *ratione materiae* with the Convention, since the obligations to respect the individual circumstances of giving birth and the private life of the mother had to be distinguished from the obligation to establish a framework to allow assistance at a home birth.

10 “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

11 R. Mori, M. Dougherty, M. Whittle, “An estimation of intrapartum-related perinatal mortality rates for booked home births in England and Wales between 1994 and 2003”, *BJOG* 2008;115:554–559.

72. The applicants, referring to the Court's judgment in *Ternovszky v. Hungary* (no. 67545/09, 14 December 2010), argued that the complaint fell within the scope of Article 8 of the Convention. In their submission, a mother's choice of where to give birth belonged to the essence of self-determination and as such constituted part of private and family life.

73. The Court reiterates that the concept of "private life" is a broad term not susceptible to exhaustive definition. It embraces, *inter alia*, the right to personal autonomy and personal development (see *Pretty v. the United Kingdom*, no. 2346/02, § 61, ECHR 2002-III) and to physical and psychological integrity (see *Tysiāc v. Poland*, no. 5410/03, § 107, ECHR 2007-I; *A, B and C v. Ireland* [GC], no. 25579/05, § 214, ECHR 2010; and *Haas v. Switzerland*, no. 31322/07, § 50, ECHR 2011). It further covers issues such as the decision whether or not to have a child or to become genetic parents (see *Evans v. the United Kingdom* [GC], no. 6339/05, § 71, ECHR 2007-I), and the right of prisoners to procreate while in prison (see *Dickson v. the United Kingdom* [GC], no. 44362/04, § 66, ECHR 2007-V). Moreover, 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".

74. The Court points out that in the present case, the issue concerning the scope of Article 8 of the Convention is not, as argued by the Government, whether it covers the right to give birth at home with the assistance of a midwife, but rather whether the right to define the circumstances in which to give birth falls within the scope of this provision.

75. Relying on the above case-law, the Court considers that giving birth is a particularly intimate aspect of a mother's private life. It encompasses 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 fall within the scope of the mother's private life for the purposes of Article 8. The Court therefore dismisses the Government's objection.

76. The Court further finds that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention and no other ground for declaring it inadmissible has been established. It must therefore be declared admissible.

B. Merits

1. *Positive or negative obligations under Article 8 of the Convention*

77. The applicants submitted that there had been an interference with their rights guaranteed by Article 8 of the Convention. The Government disagreed.

78. While there are positive obligations inherent in effective respect for private life (see *A, B and C v. Ireland*, cited above, § 216), the Court considers it appropriate to analyse the applicants' complaints as concerning negative obligations, their core argument being that midwives were prohibited from assisting them at home births under the threat of a sanction, which disproportionately restricted the applicants' right to respect for their private life. Having regard to the broad concept of private life within the meaning of Article 8, including the right to personal autonomy and to physical and psychological integrity (see paragraph 73 above), the Court finds that the fact that it was 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.

2. *Was the interference "in accordance with the law"?*

79. In order for the "interference" established above not to infringe Article 8, it must first of all have been "in accordance with the law".

80. The Government maintained that Czech law was clear on the point that the assistance of a doctor or midwife at a birth constituted healthcare that could be provided only in a medical institution which had to meet clearly defined minimum requirements relating to the provision of material and technical equipment.

81. The applicants argued that their situation was comparable to that in the *Ternovszky* case (see paragraph 72 above), in which the Court had found a violation of Article 8 of the Convention. Moreover, at least until 1 April 2012, there had been no legal basis that would satisfy the requirement of foreseeability as the law did not regulate the possibility of giving birth at home.

82. The Court notes that, while giving birth at home is not as such prohibited by the Czech legal system, the Medical Services Act as in force at the relevant time specified that a person could provide medical care only if in possession of the appropriate licence, the conditions of which included a requirement that appropriate technical equipment as specified in a decree issued by the Ministry of Health was available on the premises where such services were to be provided. A person providing medical care otherwise than in accordance with the Act could be fined for violating the Act. It further notes that the relevant decree then in force specified the essential equipment which had to be available to midwives in any places where they

were to assist with deliveries. It is clear from the list of such equipment specified in the decree that private homes were unable to satisfy this requirement.

83. Nevertheless, while the Court accepts that there might be certain doubts concerning the clarity of the legislative provisions in force at the relevant time, it finds that the applicants were 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. Accordingly, it finds that the interference in question was “in accordance with the law” for the purpose of Article 8 § 2 of the Convention.

3. Did the interference pursue a legitimate aim?

84. The Government argued that the interference pursued the legitimate aims of protecting the health and the rights and freedoms of others, in particular the health and life of the mother and child during and after the birth.

85. The applicants disputed this assertion. They maintained that the aim was rather to actively prevent mothers-to-be from benefiting from healthcare provided by midwives, in order to protect the financial and power monopoly of the incumbent providers of institutional health care.

86. The Court considers that there exist no grounds for doubting that the policy in issue, as reflected in the decree of the Ministry of Health, was designed to protect the health and safety of the newborn during and after delivery and, at least indirectly, that of the mother. It may accordingly be said that it 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.

4. Was the interference “necessary in a democratic society”?

87. The Court must examine whether there existed a pressing social need for the interference in question and, in particular, whether it was proportionate to the legitimate aim pursued, regard being had to the fair balance which has to be struck between the relevant competing interests in respect of which the State enjoys a margin of appreciation (see *A, B and C v. Ireland*, cited above, § 229, with further references).

88. The Government maintained that the balance struck between the individual interests of mothers in choosing where to give birth and the interest of the State in protecting the health of mothers and their children lay within the State’s margin of appreciation. According to them, the results of the studies on the safety of home births and births in healthcare institutions were not unequivocal. They further stressed that the privacy of mothers was fully respected in hospitals, and that this weakened the importance of the interest at stake for the applicants’ private life from the point of view of

Article 8 of the Convention. Moreover, women were free to choose the hospital in which they wished to give birth.

89. The applicants argued that while home births were not forbidden *per se*, a mother who decided to give birth at home with the assistance of a midwife put the latter at risk of being criminally prosecuted and fined. As no midwife could obtain a licence to conduct home births, and any assistance provided without a licence was liable to heavy fines, mothers had no choice but to give birth in a hospital if they wished to be assisted by a medical professional.

90. The applicants accepted that women could not have a completely free choice as to the circumstances in which they gave birth and that any such choice had to be balanced against other interests, including the right to life and health of the newborn. While it was desirable that the State should set reasonable and adequate standards regarding a midwife's technical, material and personal equipment, the legal provisions excluded any possibility of assistance with home births since it was only hospitals that could satisfy those requirements. Expecting mothers were therefore deprived of any real possibility of opting to give birth at home.

91. Moreover, having decided to deliver at home, the applicants had suffered distress during their pregnancy as a result of the State's prohibition on any medical assistance, which could also have had a negative effect on their children. Lastly, they noted that home births were less expensive and that, therefore, the Government could not invoke any budgetary or economic factors to justify their approach.

92. The Court points out that a number of factors must be taken into account when determining the breadth of the margin of appreciation to be enjoyed by the State when deciding any case under Article 8 of the Convention. The margin will tend to be narrower where the right at stake is crucial to the individual's effective enjoyment of intimate or key rights (see *Connors v. the United Kingdom*, no. 66746/01, § 82, 27 May 2004, with further references). 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, the margin will be wider (see *A, B and C v. Ireland*, cited above, § 232, with further references, and *Stubing v. Germany*, no. 43547/08, § 60, 12 April 2012, with further references).

93. The Court observes that the present case involves a complex matter of healthcare policy requiring an assessment by the national authorities of expert and scientific data concerning the relative risks of hospital and home births. It notes in this connection that besides their physical vulnerability, newborns are fully dependent on decisions made by others, which justifies a strong involvement on the part of the State. Moreover, the issue of home births touches on areas where there is no clear common ground amongst the member States (see paragraphs 59-61 above) and involves general social

and economic policy considerations for the State, including the allocation of financial means, as setting up an adequate emergency system may involve shifting budgetary resources from the general system of maternity hospitals to a new security network for home births. In the light of these considerations, the Court is of the opinion that the margin of appreciation to be afforded to the respondent State must be a wide one.

94. In balancing the interests at stake, the Court notes that the Government focused primarily on the legitimate aim of protecting the best interests of the child, which – depending on their nature and seriousness – may override those of the parent, who cannot, in particular, be entitled under Article 8 to have measures taken that would harm the child’s health and development (see *Haase v. Germany*, no. 11057/02, § 93, ECHR 2004-III (extracts)). The Court considers 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 the newborns, whose mortality rate, as shown in figures for perinatal and neonatal deaths, is not negligible, despite all the advances in medical care.

95. The Court accepts that the situation in question had a serious impact on the freedom of choice of the applicants, who 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 to the newborns, or to give birth at hospital (see paragraph 93 above). The applicants were free to give birth in a hospital of their choice, where in theory their wishes relating to matters concerning the birth would be respected (see paragraph 39 above). However, the material before the Court suggests that the conditions in most local hospitals, in terms of respecting the choices of mothers, were questionable (see paragraphs 7, 16 and 21 above). In this context the Court notes that the Committee on the Elimination of Discrimination against Women recommended to the respondent State that it should ensure respect for patients’ rights, avoiding unnecessary medical interventions (see paragraph 56 above). Accordingly, the free choice of mothers as to the hospital in which to give birth did not weaken the applicants’ interest in having assisted home births.

96. The Court further observes, on the one hand, that the majority of the research studies presented to it do not suggest that there is an increased risk for home births compared to births in a hospital, but only if certain preconditions are fulfilled. First, home births would be acceptable only in the case of “low-risk” pregnancies. Second, a home birth has to be attended by a qualified midwife, who is able to detect any complications during a delivery and to refer a woman in labour to a hospital if necessary. Third, the transfer of mother and child to hospital should be secured within a very short period of time. Thus, a situation such as the one in the Czech Republic, where medical professionals are not allowed to assist mothers

who wish to give birth at home and where no specialised emergency aid is available, may be said to increase rather than reduce the risk to the life and health of the mother and newborn.

97. On the other hand, the Court, noting the Government's argument that the risk for newborns is higher in respect of home births than in respect of deliveries in fully staffed and equipped maternity hospitals, is aware that, even if a pregnancy seems to be without any particular complications, unexpected difficulties can arise during the delivery, such as an acute lack of oxygen supply to the foetus or profuse bleeding, or events which require specialised medical intervention, such as a Caesarean section or the need to put a newborn on neonatal assistance. Moreover, in the course of a hospital birth, the institution can immediately provide the necessary care or intervention, which is not true of a home birth, even one attended by a midwife. The time spent getting to a hospital should such complications occur could indeed give rise to increased risks to the life and health of the newborn or that of the mother (see paragraphs 65-67 above).

98. Therefore, in the light of these considerations, the Court concludes that the mothers concerned, including the applicants, did not have to bear a disproportionate and excessive burden.

99. Lastly, the Court must establish whether the national authorities, principally the Ministry of Health, when dealing with the policy concerning home births and, especially, when adopting and maintaining the relevant regulations (see paragraphs 22, 26-28 and 42-43 above), gave due weight to the competing interests and whether they carefully considered the possible alternatives and assessed the proportionality of their policy in respect of home births. The Court notes in this consideration that the material before it does not show that the Ministry of Health did originally carry out such an assessment. It further appears that the national authorities tried to initiate an open discussion, involving all relevant interest groups, on the issue of home births, but that this initiative eventually failed (see paragraph 26 above). A further assessment, by way of an *obiter dictum*, was made in July 2013 by the Constitutional Court, which held that a modern democratic State protected freedoms, including those that were accompanied by a certain degree of acceptable risk, and that the right of parents to a free choice of the place and mode of delivery was limited only by the interests of the safe delivery and health of the child; those interests could not, however, be interpreted as entailing an unambiguous preference for deliveries in hospital (see paragraph 36 above).

100. Finally, the Court finds it appropriate to add that the State authorities should keep the relevant provisions under constant review, reflecting medical, scientific and legal developments. Indeed, the Ministry of Health has recently re-examined its policy: since 1 January 2014, women with low-risk pregnancies have been able to choose whether they wish to remain in hospital for a period of seventy-two hours after delivery,

following the recommendation of medical specialists, or to give birth in hospital under the care of a midwife and leave the hospital twenty-four hours after the birth (see paragraph 28 above).

101. Having regard to all the circumstances of the case and bearing in mind that there is no European consensus in the matter, the Court finds that in adopting and applying the policy in force at the relevant time relating to home births, the authorities did not exceed the wide margin of appreciation afforded to them or upset the fair balance which is required to be struck between the competing interests. Accordingly, there has been no violation of Article 8 of the Convention.

FOR THESE REASONS, THE COURT

1. *Decides*, unanimously, to join the applications;
2. *Declares*, unanimously, the applications admissible;
3. *Holds*, by six votes to one, that there has been no violation of Article 8 of the Convention.

Done in English, and delivered at a public hearing at the Human Rights Building in Strasbourg on 11 December 2014.

Claudia Westerdiek
Registrar

Mark Villiger
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

- (a) Concurring opinion of Judge Villiger;
- (b) Concurring opinion of Judge Yudkivska;
- (c) Dissenting opinion of Judge Lemmens.

M.V.
C.W.

CONCURRING OPINION OF JUDGE VILLIGER

I agree with the reasoning of the judgment and its conclusions. However, I find it necessary to add the following remarks.

The Court is here confronted, not with a concrete complaint about a particular home birth, but with general and abstract legislation in the Czech Republic which effectively prohibits home births. As such, the Court is, exceptionally, exercising the role of a constitutional court examining legislation in the abstract.

In my opinion, this particular vantage point of the case calls for circumspection. The abstract examination of legislation must consider many, indeed countless possible situations and circumstances where the legislation may come to bear. This in itself calls for a large margin of appreciation of the respondent Government.

In addition, the Court is here called upon to examine health issues in a Contracting State, namely the dangers of home births for newborn babies. At the hearing before the Court on 10 September 2013, the respondent Government had among its advisers one of the leading obstetricians of the Czech Republic. He informed the Court that the country had one of the lowest (if not *the* lowest) mortality rates of newborn babies in Europe – due, *inter alia*, to the legislation which ensures that all babies are born in hospitals.

With such arguments put forward – and bearing its constitutional role in mind – it is particularly difficult for the Court to act as the highest supervisory medical body in Europe called upon to approve, or not to approve, the health system in a particular country.

This, too, calls for a large margin of appreciation of the respondent Government.

Having said that, it is clear that once the Court is confronted with an application concerning a particular case (and not undertaking an abstract examination), it will have to approach the case from a different vantage point, namely by concentrating on the specific circumstances of that case.

CONCURRING OPINION OF JUDGE YUDKIVSKA

I fully agree with the majority that Article 8 was not violated in the present case. Indeed, I have some doubts as to whether it is applicable in principle in the circumstances in issue.

It is true that Article 8 is “one of the most open-ended provisions of the Convention”, and its scope evolves naturally with developments in society. There are many events in our lives that form part of the notion of our “private life”. Still, Article 8 cannot be a non-exhaustive source of different rights deriving from the various aspects of this notion. This Court has held that Article 8 cannot be considered applicable each time an individual’s everyday life is disrupted, but only in the exceptional cases where the State’s failure to adopt measures interferes with that individual’s right to personal development and his or her right to establish and maintain relations with other human beings and the outside world (see *Zehnalová and Zehnal v. the Czech Republic* (dec.), no. 38621/97, ECHR 2002-V).

I see a clear distinction between the case-law cited in paragraph 73 of the judgment concerning fundamental spheres of personal autonomy and family such as the decision whether or not to become a parent, on the one hand, and the situation in the present case on the other. I also believe that “the circumstances in which a child is born” in the context of the identity of an abandoned child, as a pertinent aspect of her private life (see *Odièvre v. France* [GC], no. 42326/98, ECHR 2003-III, cited in the same paragraph), and the “circumstances” of delivery in the practical meaning of this word, cannot have a comparable level of importance. Whilst it is clear that childbirth itself forms part of a woman’s private life, I can hardly agree that all the particular aspects of giving birth engage the protection of the Convention. In this respect the case should also be distinguished from the recent case of *Konovalova v. Russia* (no. 37873/04, 9 October 2014), in which the uninvited presence of students during the applicant’s delivery amounted to interference with her private life, given that they “had access to the confidential medical information concerning the applicant’s condition”.

I understand perfectly that for many women home delivery is preferable because they find it far more comfortable psychologically. However, I believe that the Convention is aimed at safeguarding fundamental human rights, and Article 8 covers values that are essential to human dignity, personal autonomy, privacy and the ability to develop relationships with other people. It cannot be interpreted as requiring the State to guarantee the level of comfort an individual seeks, even at the crucial moment of giving birth. As Lord Bingham said, cited in *Gillan and Quinton v. the United Kingdom* (no. 4158/05, ECHR 2010), “It is true that ‘private life’ has been generously construed to embrace wide rights to personal autonomy. But it is clear Convention jurisprudence that intrusions must reach a certain level of seriousness to engage the operation of the Convention, which is, after all,

concerned with human rights and fundamental freedoms...”. A mere issue of a greater or lesser degree of psychological comfort does not, in my view, reach the required “level of seriousness”, and goes far beyond the original intentions of the drafters of the Convention to protect the private life of an individual against arbitrary interference by the public authorities.

Aside from these hesitations, I disagree with the majority’s conclusion in paragraph 78 that “the fact that it was 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” (emphasis added). To my mind, even assuming that Article 8 is applicable, we can only talk about positive obligations under this provision.

Indeed, as justification for its approach to the case from the standpoint of negative obligations, the majority reiterates the “core arguments [of the applicants] ... that midwives are prohibited from assisting them at home births under the threat of a sanction...”. However, while this can certainly be viewed as interference with midwives’ professional lives, it has nothing to do with the State’s negative obligations towards the applicants. Under Article 8 the authorities are obliged not to hinder the right claimed by the applicants to give birth at home, and the applicants are not forbidden to deliver at home – they would not be sanctioned for that. But they requested the provision of qualified medical assistance. In other words, they requested the State to organise the necessary facilities to enable them to give birth at home with minimal risk, that is, in conditions similar to those in maternity hospitals. Thus they criticised not an action but a lack of action where they were concerned, and the issue at stake clearly concerns positive obligations.

It is the long-standing and inevitable position of the Court that the boundaries between the State’s positive and negative obligations under Article 8 do not lend themselves to precise definition, and in both instances regard must be had to the fair balance to be struck between the competing interests. Still, whilst negative obligations prohibit interference with a right or interest unless the impugned interference is definitely justified, any positive obligation is less demanding. Thus, in order to secure a woman’s right to deliver in a preferable environment, a State is required to do only what can be reasonably expected in the circumstances, for instance to establish clear rules and define the conditions under which home delivery should be supported.

I appreciate the classic three-step proportionality test carefully applied by the majority in paragraphs 94-98 and the due respect accorded to the margin of appreciation of the State. Had the case been examined from the standpoint of positive obligations, the wide margin of appreciation would, however, immediately limit the scope of the State’s duty in this delicate bioethical sphere, since giving greater consideration to women’s choice to deliver at home would weaken the protection of the lives of mothers and babies in the specific socio-economic conditions of the Czech Republic.

DISSENTING OPINION OF JUDGE LEMMENS

1. To my regret, I am unable to agree with the majority that there has been no violation of Article 8 of the Convention. I will try to explain the reasons for my dissent.

2. First of all, I would prefer to have had the applicants' complaint examined from the point of view of the positive obligation on the State, not of its negative obligation.

Czech law does not prohibit mothers from giving birth at home. The Czech authorities do not apparently believe that such a drastic step should be taken. As I will try to explain below, this absence of a prohibition says something about the validity of the public-health reasons invoked to justify the present system.

At this point, I should like to point out that not only is there no prohibition imposed on mothers, but also that the applicants themselves do not complain about such a prohibition. They complain about the fact that Czech law forbids a health professional to assist with a home birth. As a result, the applicants argue that Czech law does not make it possible for them to have a safe birth at home. The question therefore is whether the State fails to protect their right to respect for their private life, understood as including the right to define the circumstances in which one gives birth (see paragraphs 74-75 of the judgment).

However, this point of disagreement is not of decisive importance. As the Court has repeatedly stated, "the boundaries between the State's positive and negative obligations under Article 8 do not lend themselves to precise definition. The applicable principles are nonetheless similar. In particular, in both instances regard must be had to the fair balance which has to be struck between the general interest and the interests of the individual; and in both contexts the State enjoys a certain margin of appreciation" (see, for a recent confirmation, *Fernández Martínez v. Spain* [GC], no. 56030/07, § 114, ECHR 2014 (extracts)).

3. Was a fair balance struck in the present case between the general interest and the interests of the applicants, taking into account the margin of appreciation enjoyed by the States in matters of public health?

According to the Government, the general interest pursued by the State lies in protecting the health of mothers and their children. However, as I noted above, the law does not prohibit mothers from giving birth in a place of their choice. It is therefore theoretically possible for mothers to give birth at home. Should they choose to do so, however, they are unable to obtain the assistance of a midwife. I cannot understand how such a system, taken as a whole, can be seen as compatible with the stated aim of protection of the health of the mothers and their children. Even the majority acknowledges that, on this point, there is something strange about the Czech system (see paragraph 96 of the judgment).

Without suggesting that health considerations are totally absent, I think that it is clear that other considerations also come into play. As in other countries, the issue of home births seems to be the object of a form of power struggle between doctors and midwives. Paragraph 26 of the judgment gives an idea of how this struggle is fought out. When the issue of home births came up for examination in 2012, the Ministry of Health set up an expert committee composed of representatives of care recipients, midwives, physicians' associations, the Ministry itself, the Commissioner for Human Rights and public health-insurance companies. However, the representatives of the physicians' associations boycotted the meeting, arguing that there was no need to change the existing legal framework. Subsequently, no doubt after some efficient lobbying, they managed to obtain from the Ministry that it removed from the committee the representatives of care recipients, midwives and the Commissioner for Human Rights, with the argument that only with the remaining composition would it be possible for the committee to agree on certain conclusions. I am not aware whether, once the committee had been cleansed, it was capable of making any suggestion at all.

Having regard to the foregoing, I believe that the public-health argument put forward by the Government should not be overestimated.

4. As far as the interests of the applicants are concerned, I fully agree with what is written in paragraph 95 of the judgment. The impugned legislation has a “serious impact on the freedom of choice of the applicants, who 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 to the newborns, or to give birth at a hospital”. While only relatively few mothers might prefer to give birth at home, I have no reason to doubt that for these women this is a very important matter of personal choice. To some extent this is also confirmed in the 2010 observations on the Czech Republic, adopted by the Committee on the Elimination of Discrimination against Women. That Committee took up the issue and recommended that the State “consider taking steps to make midwife-assisted childbirth outside hospitals a safe and affordable option for women” (see § 37 of the observations, quoted in paragraph 56 of the judgment).

5. It is of course true that delivery at home, even with the assistance of a midwife, would not be fully without risk. The majority rightly points out that there could be unexpected complications which would require a specialised medical intervention, and which could give rise to a life- or health-threatening delay before the mother could avail herself of the necessary care in a hospital (see paragraph 97 of the judgment).

However, with respect to this aspect of the issue, I think we should, in a spirit of subsidiarity, take due account of what the Czech Constitutional

Court held in its judgment of 24 July 2013 (see paragraph 36 of the judgment):

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

6. Having regard to all the above, I find that it has not been shown that the present situation in the Czech Republic strikes a fair balance between the competing interests at stake. I therefore find that there has been a violation of Article 8 of the Convention.