The Legal Regulation of Home Birth in the Domestic Jurisdictions of the Council of Europe

Research prepared for the League of Human Rights, the Czech Republic

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PART 1

EXECUTIVE SUMMARY

I. INTRODUCTION

1. This report is prepared by Oxford Pro Bono Publico (OPBP) for the League of Human Rights, the Czech Republic (LHR), to assist in the preparation of a referral request to the Grand Chamber of the European Court on Human Rights (ECtHR) with respect to the case of Dubská and Krejzová v. the Czech Republic, in which the LHR represents one of the applicants, Ms. Dubská.

2. The case arises from two applications of Czech women who were not allowed to give birth at home with the assistance of midwives. They complained to the Court that the Czech law prohibiting health professionals to assist at home birth violated their right to private life under Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR).

3. The ECtHR held that the impossibility to be assisted by midwives during home birth constituted an interference with the right of applicants to respect for their private lives. Nevertheless, after conducting a three-step balancing analysis of the permissibility of such interference pursuant to Article 8 (2) of the ECHR, the Court decided that there was no consensus among the member States on this complex matter of health care policy. Therefore, the Czech authorities did not exceed the wide margin of appreciation or strike an unfair balance between the competing interests of the mothers in choosing where to give birth and the State in protecting the health of mothers and children by adopting such a restrictive policy relating to home birth. Consequently, the Court decided that there was no violation of Article 8 of the ECHR.

1 Dubská and Krejzová v. the Czech Republic App nos 28859/11 and 28473/12 (ECtHR, 11 December 2014).
2 ibid [69].
3 ibid [78].
4 ibid [59]-[61], [93].
5 ibid [101].
4. This decision conflicts with the previous E CtHR decision in the case of Ternovszky v. Hungary,6 where the limitation of the applicant’s choice with regard to home birth was recognised as an unlawful restriction of the women’s right to private life.7

5. The Court in its decision in Dubská and Krejzová v. the Czech Republic largely relied on the absence of a European consensus regarding the regulation of the issue of home birth. In particular, the E CtHR analysed the comparative material covering thirty-two member States, which showed that sixteen member States expressly allowed home birth under certain conditions, and that the other half did not expressly regulate this matter.8 The full comparative analysis of the Court, however, has not been provided to the LHR.

6. The LHR’s goal in challenging the E CtHR decision is to argue that the Court was wrong to recognise the interference with women’s right to decide the birthplace of their children compatible with Article 8 (2) of the ECHR and to show that there is indeed a consensus among the member States of the Council of Europe permitting home birth with the assistance of health care professionals (midwives).

II. NATURE OF THE RESEARCH

7. To assist the LHR with its referral request to the Grand Chamber of the E CtHR in this case, particularly, with regard to the analysis of general trends in the legal regulation of home birth and midwifery services, OPBP has undertaken comparative research of eight domestic jurisdictions of the Council of Europe.

8. The countries selected for consideration are:
   
   I. England and Wales
   II. Germany
   III. Italy
   IV. France
   V. Sweden

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6 Ternovszky v. Hungary App no 67545/09 (E CtHR, 14 December 2010).
7 ibid [26]-[27].
8 Dubská (n 1) [59]-[61].
VI. Bosnia and Herzegovina
VII. Russian Federation
VIII. Hungary

9. The questions that the researchers have addressed are the following:

1. Is the issue of home birth regulated by law and how?

2. If the issue of home birth is not regulated expressly, is a ‘home health care’ generally regulated by law (including home care for the elderly, etc.) and how? Does this regulation prevent health care providers from provision of care at home birth? Does it exclude the possibility of home care during childbirth?

3. Where a health care professional can face sanctions for having assisted with planned home birth, how is a possibility of sanctions regulated and worded?

9. All the researchers have undertaken the research in answer to these three questions. However, in some jurisdictions, where home birth is allowed by law and health care professionals are not sanctioned for assisting in home birth and/or ‘home health care’ does not cover midwifery services, the researchers focused only on Question 1 (as Questions 2 and/or 3 were not applicable to their jurisdiction). Each report, nonetheless, provides a comprehensive analysis and helpful insights as to the regulation in every jurisdiction of the women’s right to physical autonomy, private life, and freedom to choose the place of birth of their children, including home birth assisted by health care professionals (midwives).

10. The reports have attempted to address relevant legislation and self-regulatory rules and standards of medical professionals, as well as, where applicable and possible, case law, actual practice and public debate regarding the possibility of women to have access to midwife-assisted home birth.

11. The report on Hungary differs from the others, as it aims, in response to the LHR’s request, to analyse the new legislation on home birth that was adopted after the above mentioned ECtHR decision in the case of Ternovszky v. Hungary.9

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9 Ternovszky (n 6).
III. SUMMARY CONCLUSIONS

12. This section is a summary of our main findings about the legal reality of home birth and midwifery services in respect of each of the three questions. In it, we seek to identify broad trends across the eight surveyed jurisdictions.

*Question 1: Is the issue of home birth regulated by law and how?*

13. In all researched jurisdictions the issue of home birth is not regulated expressly, neither specifically permitted nor prohibited, except Germany, where home birth with assistance of midwives has been explicitly allowed since 2012.

14. In England and Wales, Italy, France, Sweden, and Hungary home birth assisted by midwife is implicitly allowed. These provisions usually derive from the right to self-determination and private life.

15. On the other hand, in Bosnia and Herzegovina and the Russian Federation, midwives and health care professionals are effectively prohibited from assisting women during labour at home through licensing regulations and/or limitations on medical institutions and equipment necessary for provision of midwifery services. Additionally, in Bosnia and Herzegovina and the Russian Federation women encounter certain administrative difficulties with registration of their children, if labour took place outside the hospital.

16. It should be noted, however, that no jurisdiction that was analysed for the purposes of this report prohibits women from having home birth. If any, the restrictions concern exclusively the assistance of midwives and health care professionals.

17. In countries where midwife-assisted home birth is allowed, the law still imposes certain conditions on women that choose home as place for labour, including low-risk pregnancy, age, proximity to the hospital, etc. In some jurisdictions, including Italy, Sweden and France, lack of coverage by medical insurance seem to be one of additional obstacles that women come across when opting for childbirth at home.
**Question 2:** If the issue of home birth is not regulated expressly, is a ‘home health care’ generally regulated by law (including home care for the elderly, etc.) and how? Does this regulation prevent health care providers from provision of care at home birth? Does it exclude the possibility of home care during childbirth?

18. Even though home birth is not regulated expressly in seven out of eight jurisdictions examined in this report, it also does not appear to be specifically regulated in the provisions regarding home health care. For example, in Bosnia and Herzegovina home health care concerns exclusively people with permanent mental and physical disabilities or the elderly.

**Question 3:** How is a possibility of sanctions regulated and worded in the States, where a health care professional can face sanctions for having assisted with planned home birth?

19. Among the examined jurisdictions, Bosnia and Herzegovina and Russian Federation sanction health care professionals for assisting in planned home birth. In neither of these jurisdictions does the law expressly envisage sanctions for assisting home birth. Nonetheless, the provisions are formulated in a way that makes it impossible for midwives or health care professionals to assist in home birth without violating the law. This is achieved either with rules regarding the mandatory equipment for medical institutions or terms of possessing a medical license.
PART 2

COMPARATIVE REPORTS

I. ENGLAND AND WALES

A. Summary

20. Home birth is not unlawful in England and Wales. Midwifery services at home are provided free of charge to the patient,\textsuperscript{10} with an individual NHS Trust paying for the services.\textsuperscript{11} The availability of home birth is seen as an element of a woman’s free choice in Parliamentary debates and is a cornerstone of maternity services in England and Wales, although various practical obstacles have meant that the courts have not recognised this \textit{qua} legal right. Medical evidence suggests that home birth can even be safer than giving birth in a specialised hospital unit.

B. Legal Framework

Creation of National Health Service

21. Since 1948 there has been a National Health Service (NHS) in the United Kingdom. Section 1 of the Health and Social Care Act 2012, a statutory duty upon the Secretary of State to ‘continue the promotion in England of a comprehensive health service designed to secure improvement—(a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness.’ This obligation includes, per section 3(d) of the National Health Service Act 2006 for the arrangement of the provision of ‘services or facilities for the care of pregnant women.’ By section 1(4) of the same Act, these services must be provided for free at the point of treatment.

Regulation of Midwives

\textsuperscript{10} See s1(4) of the Health and Social Care Act 2012: ‘The services provided as part of the health service in England must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.’

22. Midwifery forms part of a state-sanctioned and largely self-regulated professional system. Specifically, the Nursing and Midwifery Order SI 2002/253 creates the Nursing and Midwifery Council (NMS) (Article 3). The Order further, in Article 41, creates the statutory Midwifery Committee.

23. The NMS has produced the NMS Rules and Standards (NMS Rules) and the non-binding Code of Practice (NMS Code of Practice). In addition, it produces various statements and guidelines about maternal health and midwifery practice.

Home Birth

24. There is no specific statutory basis for the right to have a home birth. However, such methods clearly fall within section 3(d) of the National Health Service Act under which the State is obligated to make provisions for the care of pregnant women. Moreover, section 296(4)(b) of the same Act refers to the obligation to contact the local Primary Care Trust imposed upon ‘any person in attendance upon the mother at the time of, or within six hours after, the birth’ in attendance upon refers to the activities of a midwife. This clearly, albeit impliedly, shows that there is no comparable statutory restriction on midwife-assisted home birth.

25. There is ample non-statutory evidence that midwife-assisted home birth takes place. Some examples may be given:

   a. On the official NHS website, it is stated that ‘In England, around one in every 50 babies is born at home. If you give birth at home, you'll be supported by a midwife who will be with you while you're in labour.’

   b. A Nursing and Midwife Council Circular March 2006 entitled ‘Midwives and Home Birth’ outlines professional duty of the midwife to support the woman and, significantly, the woman’s right to a choice for care including the place of birth.

   c. In 2004, in response to a question by Helen Clark in the House of Commons, Dr Ladyman stated that ‘[w]e expect the NHS to provide a range of maternity services that includes the provision of home births.

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15 HC Deb 13 September 2004 vol 424 c1469W.
d. ‘Community midwives can attend women who have chosen to deliver their baby at home, or they may accompany women to hospital to give birth.’

Specific Legal Provisions Regulating Home Birth

26. There is a criminal offence in the UK of ‘attending a woman in child birth while unqualified’ outside of cases with ‘sudden or urgent necessity.’ The last such prosecution was in 1980s, and is rare.

27. Beyond this, there is little regulation of home birth. The relevant principles of the UK approach can be distilled into the following three strands:

a. Legally, there is a strong emphasis on autonomy, leading to a light-touch regulatory approach to home birth (autonomy).

b. More generally, health services in the UK will actively respect the choices made by women in respect of the birth location (respect).

c. Finally, there is generally an encouraging attitude to home birth (encouragement).

These will be considered in the following section.

Legislative Interpretation of the Right to Home Birth

28. In addition, a number of governmental reports from the Department of Health consider that the choice of a home birth is a priority for maternity services in the UK. This list can be read in conjunction with the sources offered in [36]:

a. Department of Health, Delivering High Quality Midwifery Care: ‘The project’s vision for tomorrow’s midwives is that all pregnant women will be cared for by a midwife they can get to know and trust in or near their home.’

b. Health Care Commission, Toward Better Births: ‘The choice of home birth should be offered to all women.’

c. Maternity Matters 2007 Department of Health: ‘In 2005, the Government underlined the importance of providing high quality, safe and accessible

17 The Nursing and Midwifery Order 2001 (SI 2002/253), art 45.
maternity care through its commitment to offer all women and their partners, a wider choice of type and place of maternity care and birth. Building on this commitment, four national choice guarantees will be available for all women by the end of 2009 […] The national choice guarantees described in this document are: Choice of how to access maternity care; Choice of type of antenatal care; Choice of place of birth – Depending on their circumstances, women and their partners will be able to choose between three different options. These are:

i. a home birth
ii. birth in a local facility, including a hospital, under the care of a midwife
iii. birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option
iv. Choice of place of postnatal care.’ (emphasis supplied)

29. The legislature has clearly considered that home birth is a matter that touches upon the sphere of women’s autonomy. This can be seen in many instances of Parliamentary discussion:

a. ‘The Government want to ensure that, where it is clinically appropriate, if a woman wishes to have a home birth she should receive the appropriate support from the health service. At the end of the day, it must be the woman's choice.’ ²¹

b. ‘Being the key player in an essentially natural operation—child birth—is not the same as being ill. Yes, medical opinion and expertise have their place, but they should start from the position that this is a normal, joyful experience, where the woman is the person who is calling the shots.’ ²²

c. ‘We want to explore all the areas which we know are important to women: a safe birth which is as normal as possible; a choice of place of birth, with home birth as a realistic option.’ ²³

d. ‘I start with home births. They are not desired by all women, but a substantial number want home delivery …. The Association for Improvements in Maternity Services has reported many instances of women being pushed into hospital delivery, usually at a very late stage in pregnancy, because they are told that no midwife will be available to support a home delivery. Those women have been denied real choice and have lost control of their birth arrangements….We need more midwives if we are to improve the prospect of real choices being available to women—choices such as home births, but also births in other settings.’ ²⁴

²¹ HL Deb 15 January 2003 vol 643 col 296 (Lord Hunt of Kings Head).
²² HC Deb 11 February 1998 vol 306 col 325 (Patrick Nicholls).
²³ HL Deb 15 January 2003 vol 643 col 295 (Lord Hunt of Kings Head).
²⁴ ibid 291, 293 (Baroness Noakes).
Definition of Midwifery Services

30. The general definitions of midwifery services do not exclude the provision of labour services at home. For example, Article 42(2)(c) of Directive 2005/36/EC includes the duty of ‘caring for and assisting the mother during labour,’ without geographical restriction.

31. Most international organisations positively include the home within the definition of the profession.

   a. The International Confederation of Midwives, in a statement adopted the 15th June 2011, explains that ‘[a] midwife may practise in any setting including the home, community, hospitals, clinics or health units.’

   b. This statement has been adopted by

      i. the World Health Organisation,
      ii. the Midwives Alliance of North America and
      iii. the International Federation of Gynaecology and Obstetrics.

C. Overview of Case Law

Autonomy

32. Competent adults are free to make decisions about their health, even if this may harm them. An example would include that of a man who validly refused to have his gangrenous foot amputated. Mentally competent women would thus have the right to a totally non-assisted home birth, even in a situation where it would cause grave harm to herself or the resultant child. This has been applied in relation to childbirth where a woman refused a caesarean in spite of medical evidence that she and the baby could both die and there was a risk of the baby being born with severe brain damage.

33. Substantial authority can be found for this point:

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27 See Standards for Pre-registration Midwifery Education, 4.


30 Bridgit Dimond, Legal Aspects of Nursing (2008 Pearson Health): ‘If there is the refusal of consent, then the woman, if mentally competent, has the right to have a non-assisted home-birth.’

31 St George’s Healthcare Trust v S [1998] 3 All ER 673.
a. *MB Baroness Elizabeth Butler-Sloss:* 'The right to determine what shall be done with one’s own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self determination and individual autonomy are based.'

b. ‘A patient cannot be said to be lacking capacity just because their thinking appears bizarre and irrational even if a refusal is likely to cause serious harms to her baby or the patient herself.’

c. ‘If there is the refusal of consent, then the woman, if mentally competent, has the right to have a non-assisted home birth.’

d. ‘A midwife has no right to be at a baby’s birth if a woman chooses to exercise her autonomy by not contacting or engaging a midwife.’

e. ‘The right to determine allows patients to refuse treatment even if the outcome is harmful.’

34. This not only means that there is no statutory right to compel a mentally capacitated mother to go into hospital for the birth of a child whatever the clinical indicators, but also that the law will respect the decisions taken by a woman in respect of the location of her parturition.

Respect

35. The UK’s central commitment in maternity policy is that of women-centred care with a stress on autonomy. This puts maternal decision-making at the forefront and specifically includes ‘decisions on whether to have a home birth (including unassisted birth), assisted midwife-led birth, or a hospital birth and on whether or not to have an elective caesarean section.’

36. Scamell provides the following chronology as evidence of this:

a. ‘Changing Childbirth’ white paper in 1993 affirmed that women-centred is a core principle upon which all NHS maternity services should be delivered.

b. 2007 Maternity Matters: ‘women and their partners will be able to choose between three different options. These are: a homebirth; birth in a local facility, including a hospital, under the care of a midwife; birth in a hospital supported by a local maternity care

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33 C[25] of *Butterworth’s Health Services Law and Practice* (Bloom and Harris).
34 Bridgit Dimond *Legal Aspects of Nursing* (Pearson Education 2008).
35 Richard Griffith, and others *Law and professional issues in midwifery* (Learning Matters 2010), 84.
36 Richard Griffith and others *Law and Professional Issues in Nursing* (Learning Matters 2010), 95.
39 Ibid.
37. To this we may also add the following:
   
a. Nursing and Midwifery Council Circular: ‘Should a conflict arise between service provision and a woman’s choice for place of birth, a midwife has a duty of care to attend her … Women have the right to make their own decisions on these issues if they are competent to do so and midwives have a duty of care to respect a woman’s choice.’
   
b. National Midwifery Circular Annexe 2: ‘A woman can make the choice for a particular place of birth at any stage in pregnancy… Regardless of the setting, a midwife providing care to a woman, must take care to identify possible risk and pre plan to mitigate those risks through her approach to care.’
   
c. National Midwifery Council Conference Papers: ‘Implicit in the Government policy in all four constituent countries of the UK is the promotion of choice for women in relation to their pregnancy care and place of birth. This includes being offered the choice of planning a birth at home.’
   
d. The Consensus Statement of The Maternity Care Working Party, agreed by The Royal College of Midwives and The Royal College of Obstetricians and Gynaecologists. This Statement records that ‘there is a shared emphasis on offering pregnant women more choice, … there is also an explicit focus on facilitating normal birth and reducing interventions…For the majority of women, pregnancy and childbirth are normal life events requiring minimal intervention.’

Encouragement

38. In the UK healthy women are not encouraged, *per se*, to have a home birth. It is crystal clear that the final decision where to give birth is an individual choice. However, it is equally clear that the Nursing and Midwifery Council see no problem in a healthy woman giving birth at home, and, that, in some circumstances it may be positively advantageous.

41 Mandie Scamell, ‘She Can’t Come Here!’ Ethics and the Case of Birth Centre Admission Policy in the UK’ (2014) Journal of Medical Ethics 813.
44 NMC Council Papers provided to the Midwifery Committee, cited in Bridgit Dimmond *Legal Aspects of Midwifery* (Quay Books 2014).
39. Most recently, in December 2014, the National Institute for Health and Care Excellence, a statutory body set up in 1999 by SI 1999/220, issued guidance that midwives should explain to women that they ‘may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth.’

40. Given that the health justification weighed heavily in the court’s assessment of proportionality, it is useful to note the following UK official observations in this regard:

   a. In 1992, The House of Commons Maternity Care Select Committee concluded that ‘the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety.’

   b. The NHS official guidance states that ‘[g]iving birth is generally safe wherever you choose to have your baby….For women having their second or subsequent baby, a planned home birth is as safe as having your baby in hospital or a midwife-led unit.’

   c. Nursing and Midwifery Council: ‘home birth is at least as safe as hospital-based birth for healthy women with normal pregnancies.’

   d. ‘The available information on planning place of birth suggests that, among women who plan to give birth at home, there is a higher likelihood of a normal birth, with less intervention.’

   e. The National Institute for Health and Care Excellence guidance of December 2014 states that for low-risk women, ‘planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.’

   f. National Professor Mark Baker of NICE states: ‘Where and how a woman gives birth to her baby can be hugely important to her….there is no reason why women at low risk of complications during labour should

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48 NHS (n 13).
49 NMC (n 42).
50 National Midwifery Circular (n 43).
not have their baby in an environment in which they feel most comfortable.\textsuperscript{52}

g. The Royal College of Midwives director for midwifery Louise Silverton, said: ‘We agree that decisions about where to give birth should be based on the best possible evidence. The Birthplace Study showed that planned out of hospital births were, generally, as safe for the baby as those in hospital for low-risk women having their second or subsequent baby.’\textsuperscript{53}

h. National Perinatal Epidemiology Unit: ‘For healthy multiparous women with a low-risk pregnancy, there are no differences in adverse perinatal outcomes between planned births at home or in a midwifery unit compared with planned births in an obstetric unit.’\textsuperscript{54}

i. Nursing and Midwifery Council: ‘Research over the last couple of decades suggests that home birth is at least as safe as hospital-based birth for healthy women with normal pregnancies.’\textsuperscript{55}

\textbf{Circumstances Limiting Midwives in Attending Births Outside Hospitals}

41. There has been some mention in the literature about the availability of midwives limiting the election of home birth.\textsuperscript{56}

42. However, first, it is clear that, as per section 1(4) of the National Health Service Act 2006, that services provided under the NHS are free at the point of treatment. Second, the shortages of midwives is a wider problem in the provision of health services in the UK and not a legal problem or fetter to the exercise of choice. Third, it is clear that there are obligations upon midwives to contact their superiors and the local NHS trust in case they feel that they are unable to fully assist a woman give birth.\textsuperscript{57}

43. Taken together, this not only shows that the limits are of a non-legal nature, but that shortages of midwives are matter taken seriously. The presumption is that there should be a midwife to assist in giving birth.


\textsuperscript{55} NMC Circular 8–2006.

\textsuperscript{56} e.g. HC 464 – I House of Commons Health Committee Provision of Maternity Services Fourth Report of Session 2002–03Volume I [17], [176].

\textsuperscript{57} NMC (n 42).
Cases on Women’s Right to Home Birth

44. There have been no court cases and/or administrative decisions concerning women’s right to home birth, physical autonomy or private life. There have been a number of cases on the question of ‘forced caesareans.’ However, no court has ever considered the issue of whether there is a right to a home birth such that if the NHS refuses to provide a midwife, the mother would be free to pursue the NHS in damages.

45. There would be a number of legal impediments to recognising this right:

   a. Courts typically refrain from dictating how NHS trusts should distribute their resources, as they are policy-oriented and polycentric decisions that they are not always equipped to make.

   b. Short of an identifiable legal flaw in the decision-making process, the courts are unlikely to find that an individual refusal by the NHS was unlawful.

46. However, this only means that it is unlikely that a right to home birth can be established in the narrow sense of having a valid claim in damages against the NHS for failing to provide such services. It is nonetheless clear that the election of the location of where to give birth is regarded as an element of respect and autonomy (see above).

D. History of Regulation of Home Birth

47. As emerges from the above, the question of home birth was never regulated per se. Rather it was a) left to the representative bodies of midwives to promulgate Rules and Codes of Practice and b) statute law imposed an obligation upon the Secretary of State for the Home Department to make provision for such services.

48. The provision of midwives, for example, could be traced back to earlier versions of the 2006 Act, including:

   a. The National Health Service Act 1946, which requires the minister to provide all ‘reasonable requirements... and services,’ including the services of specialists ‘whether at a hospital.... Or, if necessary on medical grounds, at the home of the patient’ (s3 (1)(c)).

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58 Re DM [2014] EWHC 3119 (Fam); Mental Health Trust v DD [2014] EWCOP 11.
b. The National Health Service Act 1977, which requires the minister to provide the same ‘such other facilities for the care of expectant and nursing mothers’ (s31 (d)).

49. As to the more general history, we note that midwives were first subject to a Registration regime in 1902, which also set up a Central Midwives Board. It was this Board that was charged with making rules for regulating the practice of midwifery. Once again this demonstrates the self-regulated nature of the profession.\(^{61}\)

50. Similarly, in 1936, the Public Health Act imposed notification obligations upon ‘any person in attendance upon the mother’ who gave birth and upon the father ‘if he is actually residing on the premises where the birth takes place.’\(^{62}\) Once again, this points to the availability of midwifery services at the home.

51. The upshot of this analysis demonstrates that the issue of home birth has never properly been regarded as a medical service that needs to be regulated. It is rather the midwifery profession that must be licensed and conform to certain standards of conduct. This is undertaken by the now Nursing and Midwifery Council. The issue of home birth is rightly regarded as a choice personal to the woman in question, although it may be questioned whether the courts will recognise this right in the legal sense of awarding damages where a woman is denied a midwife for a home birth.

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\(^{62}\) Public Health Act 1936, s203(1).
II. GERMANY

A. Summary

52. The right to home birth is explicitly recognised by the German legislator since 30 October 2012. It is enshrined in paragraph 24f of Volume 5 of the German Social Code Book (Sozialgesetzbuch – SGB V). Women about to give birth have the right to be assisted by a midwife prior to, during, and after the birth process, regardless of where it takes place, according to paragraph 134a SBG V. The same provision regulates that the corresponding costs are borne by the health insurance company of the mother, including cases of home birth. Furthermore, the German Midwife Code (Hebammengesetz – HebG) regulates the training, license, and practice of midwives.

53. Although the number of home births per annum in Germany is low, there seems to be a firmly established and state-backed practice of out-of-hospital births, assisted mainly by freelance midwives. The legal and practical situation in Germany reflects the longstanding tradition in the country to recognise the right of the mother to freely choose where to give birth to her baby and to medically and financially assist the birth, regardless of whether it takes place in or outside of a hospital. This approach is backed both by the government’s and the people’s positive attitude towards home birth in accordance to the exercise of the mother’s fundamental right to privacy.

B. Legal Framework

54. The health insurance companies cover the provision of medical care and assistance, which includes childbirth. Health insurance, being part of the broader realm of social insurance, is a federal competence (Bundeskompetenz) and is thus regulated in federal law (Bundesrecht). The right to give birth at home and the corresponding institutional and financial frameworks are regulated in the context of the statutory social

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63 This paragraph has been introduced with the Gesetz zur Neuausrichtung der Pflegeversicherung (Pflege-Neuausrichtungs-Gesetz) from 23.10.2012 (BGBl. I S. 2246), in force since 30 October 2012.
insurance provisions of the Federal Republic of Germany. The social insurance regulation is a federal legislative prerogative according to the competences allocation in Article 74 section 1 number 12 of the German Basic Law (Grundgesetz – GG). The concrete provisions on childbirth are thus found in the federal Social Code Books (Sozialgesetzbücher) and not on the local level.

55. Paragraph 24f SGB V, entitled ‘Confinement,’ explicitly states that the mother has the right to an ambulant or a stationary childbirth. Furthermore, the provision clarifies that the mother can give birth in a hospital; in an institution, supervised by a midwife (Hebamme) or a childbirth assistant (a male midwife or Entbindungspfleger); in another medically supervised institution; in a midwifery practice; or at home.

56. Paragraph 134a SGB V, entitled ‘Midwifery Assistance’ is of central importance for regulating the contractual relationship between the national health insurance entities and the midwife syndicates, which provides for the financial reimbursement of the midwifery childbirth service. Sentence 2 of section 1 of paragraph 134a SGB V requires the contracting parties (i.e. both the insurance companies and the midwife syndicates according to sentence 1 of the same section) to, inter alia, consider and account for the right of the insured mothers to freely chose the place of birth, enshrined in paragraph 24f SGB V, and to ensure the needed quality of the childbirth assistance accordingly. Since paragraph 24f SGB V explicitly recognises the right of the mother to give birth at home, as seen above, the insured person is entitled to midwifery assistance, if she chooses to give birth at home, and this service is covered by the health insurance of the mother.

57. The Midwife Code (HebG) regulates the professional training, license, and practice of midwives in Germany. As all medical and healing professions, it is also regulated by federal law (Bundesrecht) according to Article 74 section 1 number 19 GG, which allocates the legislative competence prerogative to the federal (Bundeskompetenz) and not to the local level (Landeskompetenz). Paragraph 4 section 1 of the HebG states

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66 Grundgesetz für die Bundesrepublik Deutschland (GG) from 23 Mai 1949 (BGBl. I S. 1).
67 Both female and male childbirth assistants (correspondingly ‘Hebamme’ and ‘Entbindungspfleger’ under German law) will be further referred to as ‘midwives’ for the purposes of this report.
that childbirth assistance can be provided only by medical practitioners (i.e. doctors) and by persons who are entitled to the professional title ‘midwife’ (either in Germany or in another Member State of the European Union in accordance with German and EU law provisions for recognition of professional titles).

58. Paragraph 4 section 2 HebG defines childbirth assistance as the supervision of the childbirth process from the beginning of the first stage pains, assistance in the actual process of confinement and the supervision of the puerperal process.

59. Under paragraph 1 of the HebG, persons are entitled to the professional title ‘midwife’ and thus to practice midwifery after accomplishing the relevant professional training and successfully applying for a license. Both the training and the acquiring of the license are regulated in further paragraphs of the HebG.

60. Another legislative regulation, which mentions home birth, is the Code on the Prevention and Settlement of Pregnancy Conflicts (Schwangerschaftskonfliktgesetz – SchKG)\(^{68}\). The main aim of the code is to provide for a far-reaching protection of the life of the unborn child in cases of unplanned pregnancy through the establishment of a profound pregnancy counselling service. It thus does not explicitly deal with the right of the woman to give birth at home. However, paragraph 26 of the SchKG, which deals with the procedure of a confidential childbirth, states in its section 6 that the midwife, giving childbirth assistance in the case of a home birth, is obliged to notify the date and place of birth of the child immediately after the birth to the counselling station engaged with the concrete confidential childbirth case. This implies that the SchKG also accounts for the right of the woman to give birth at home and extends the protection of both mother and child to cases of home birth, also in the risk group of unplanned pregnancies.

C. Statistical Data Related on Home Birth in Germany

61. The following table provides statistical data about the number of childbirths in Germany in and outside of hospital for a period of 10 years

\(^{68}\) Gesetz zur Vermeidung und Bewältigung von Schwangerschaftskonflikten (Schwangerschaftskonfliktengesetz - SchKG) from 27.07.1992 (BGBl. I S. 1398).
between 2002 and 2012. Its aim is to give an overview about the actual relevance of the matter of home birth in Germany and to show how such cases are dealt with in practice. It has been prepared using data from the reports of the Society for Quality in the extra-clinical Childbirth Assistance (Gesellschaft für Qualität in der Außerklinischen Geburtshilfe e.V. – QUAG) and the Federal Agency for Statistics (Statistisches Bundesamt).

<table>
<thead>
<tr>
<th>1. Year</th>
<th>2. Number of childbirths in Germany in total</th>
<th>3. Number of childbirths in hospital</th>
<th>4. Approximate number of childbirths outside of hospital in total (difference between column 2 and 3)</th>
<th>5. % of the total number of hospital births outside of hospital (column 2)</th>
<th>6. Number of registered childbirths outside of hospital</th>
<th>7. % of the number of registered childbirths outside of hospital out of the total number of out-of-hospital births (column 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>721,9</td>
<td>711,458</td>
<td>10,492</td>
<td>1.45</td>
<td>8,238</td>
<td>78.8</td>
</tr>
<tr>
<td>2003</td>
<td>709,4</td>
<td>699,795</td>
<td>9,625</td>
<td>1.36</td>
<td>8,568</td>
<td>88.8</td>
</tr>
<tr>
<td>2004</td>
<td>708,3</td>
<td>695,885</td>
<td>12,465</td>
<td>1.76</td>
<td>8,715</td>
<td>69.9</td>
</tr>
<tr>
<td>2005</td>
<td>688,2</td>
<td>675,688</td>
<td>12,594</td>
<td>1.83</td>
<td>8,640</td>
<td>68.6</td>
</tr>
<tr>
<td>2006</td>
<td>675,1</td>
<td>663,979</td>
<td>11,165</td>
<td>1.65</td>
<td>8,351</td>
<td>74.8</td>
</tr>
<tr>
<td>2007</td>
<td>687,2</td>
<td>675,892</td>
<td>11,341</td>
<td>1.65</td>
<td>8,221</td>
<td>72.5</td>
</tr>
<tr>
<td>2008</td>
<td>684,9</td>
<td>674,751</td>
<td>10,175</td>
<td>1.49</td>
<td>8,326</td>
<td>81.8</td>
</tr>
<tr>
<td>2009</td>
<td>667,4</td>
<td>656,265</td>
<td>11,199</td>
<td>1.68</td>
<td>8,769</td>
<td>78.3</td>
</tr>
<tr>
<td>2010</td>
<td>680,4</td>
<td>668,950</td>
<td>11,463</td>
<td>1.68</td>
<td>9,045</td>
<td>78.9</td>
</tr>
<tr>
<td>2011</td>
<td>665,0</td>
<td>654,243</td>
<td>10,829</td>
<td>1.63</td>
<td>8,828</td>
<td>81.5</td>
</tr>
<tr>
<td>2012</td>
<td>675,9</td>
<td>665,780</td>
<td>10,164</td>
<td>1.50</td>
<td>9,090</td>
<td>84.5</td>
</tr>
</tbody>
</table>

62. It must be remarked that there is no national source in Germany, which provides comparable statistics about the precise number of out-of-hospital childbirths in total, since not all of these are planned or registered. Column 4 gives the difference between the total number of registered childbirths (according to data of the civil registry offices) and the number of childbirths in hospital (which are regularly registered by the hospitals). This difference gives an approximate idea about the number of births, which happen outside of hospitals.

63. For the year 2012 this number has been 1,50% of all childbirths in Germany. In this regard it must be considered that this number includes

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69 The numbers, provided in columns 2-4 and 6, are in thousands.
not only the planned home births, assisted by a midwife, but also births in birth centres, and all unplanned births outside of hospital without midwifery assistance. Column 6 shows the number of planned and registered births outside of hospital, which for the 2012 is 9,090 or 84.5% of the approximate total number of all births outside of hospital for this year. This shows that most out-of-hospital births are planned, which speaks for an established practice in this regard despite the relative low number of such births. Out of this number, 3,689 home births (or 36.3% of the approximate number all out-of-hospital births for 2012), 7,024 births in midwife-led institutions like independent birth centres, and 21 births in centres run by an obstetrician have been registered for 2012. Of all women giving birth out of hospital, 96% had no specific problems. During birth, 16.8% of the women were transferred to a hospital. No woman died during or after such birth.

64. The statistics show that most childbirths in Germany still take place in hospitals. However, there is a considerable amount of home births as well (more than 1/3 of all out-of-hospital births) and most of the out-of-hospital births are planned, assisted by a midwife, and run without complications. These results can be linked to the right of a woman to freely choose where to give birth and the fact that the national insurance companies cover the birth expenses. The standardised average amount of home birth financial assistance, which health insurance agencies cover in Germany, is approximately 1058 Euro for a day-time home birth and approximately 1208 for a home birth in the night. This is the estimated amount based on the contractual relationship regulated in paragraph 134f SGB V. This amount covers all expenses related to the childbirth, including the midwifery assistance and service. The only amount, not


74 ibid.

75 Deutscher Bundestag, op. cit. (n 9) 4.
covered by the health insurance, is the on-call-duty service fee for the midwife, which amounts to 200-300 Euro.\textsuperscript{76}

65. Further data by the Federal Agency for Statistics shows that there is an increasing demand for out-of-hospital midwifery service.\textsuperscript{77} The number of midwives in Germany has risen from approximately 16,000 in 2000 to ca. 21,000 in 2011. The number of midwives, who work in hospitals only part time has also increased over the last years. It must also be noted that many midwives are employed by a hospital, while working as freelancers at the same time. Although there is no clear statistical evidence about the exact number freelance midwives, who give home birth assistance, according to the GKV-Spitzenverbandes, some 17,700 midwives were working as freelancers as of December 2013 and 5,140 have also given freelance midwifery birth assistance. These numbers have increased since 2009. The German Midwifery Association (\textit{Deutscher Hebammenverband e.v.} – DHV) estimates that some 3,500 freelance midwives are currently in charge of giving (mostly) out-of-hospital birth assistance.

66. Out-of-hospital births (including home births) are normally assisted by freelance midwives, i.e. midwives who are not permanently employed by and working only in a hospital. Therefore the provided data about the increase of the number of freelance midwives, practising out of hospitals, can be interpreted as reflecting an increasing demand for out-of-hospital births, including home births, and the effort of the German State to ensure far-reaching childbirth assistance, mother and child protection, and health insurance for such cases.

D. Governmental Support for the Right to Home Birth

67. There does not seem to be a lot of legislative or public debate in Germany on the topic of the woman’s right to home birth. This is possibly due to the fact that such a right, including the health-insurance covered right to be assisted by a midwife during a home birth, has been considered as self-evident by the German populace and explicitly


\textsuperscript{77} The following data is from Deutscher Bundestag, \textit{op. cit.} (n 9) 4.
recognised as a social right in the above mentioned provisions of SGB V.
As already mentioned above, the right of the woman is enshrined in the
federal social codes of the country and referred to in peripheral
legislative provisions related to pregnancy, childbirth, medical assistance,
and health insurance.

68. The federal government in Germany has explicitly stated the importance
of the women’s right to freely choose where to give birth and its support
of this right. This has been stated, e.g., in the Federal Government’s
reply to the enquiry of several Members of Parliament on the financial
situation of midwives in Germany from 25 October 2010. In its reply,
the Government explicitly confirmed its commitment to the protection of
the right of all women to freely choose where to give birth. It also
reassured the Parliament that, correspondingly, all hospitals, medical
institutions, associations and their medical personnel are obliged to
provide the insured women with childbirth assistance, necessary for the
efficient exercise of this right.

69. The commitment of the new Federal Government to this issue has been
repeatedly restated in its reply to a similar MP enquiry from 24 March 2014. It
reassured that the provision of a comprehensive nationwide childbirth
assistance is an important aim on the agenda of the new broad coalition,
governing Germany. It is enshrined in the coalition contract in the basis
of the new government’s mandate and includes the opportunity and right
of the woman to freely chose where to give birth, be it in a hospital, at
home, in a birth centre, or in a midwifery practice.

E. Public Debate

70. The researcher did not come across any evidence that the right of a
woman to give birth and home and receive the necessary medical
assistance is much contested by any of the State institutions in Germany
or by the public. However, there is some debate about whether this right

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Bundesregierung auf die Kleine Anfrage der Abgeordneten Dr. Martina Bunge, Cornelia Möhring, Diana
Golze, weiterer Abgeordneter und der Fraktion DIE LINKE – Drucksache 17/3255 – Zur Situation der
Hebammen und Entbindungspfleger in Deutschland nach der Honorareinigung in der Schiedsstelle’ 2
79 In power since 17 December 2013.
80 Deutscher Bundestag, op. cit. (n 9), 2 and 8.
can be considered as anchored even constitutionally in the German Basic Law (Grundgesetz – GG). The German Midwifery Association states in an advisory opinion to an enquiry by the Green Party in Germany regarding the service, which pregnant women are entitled to, that the woman’s right to freely choose where to give birth stems from the constitutionally enshrined general right to privacy and personality in Article 2 of the GG (Allgemeines Persönlichkeitsrecht).81

71. The DHV e.V. also describes the right to freely choose where to give birth as a constitutionally guaranteed right of self determination of the women. The DHV e.V. calls out for political activism, aimed at securing this right and enhancing the standards for midwifery assistance when exercising this right.82

72. In an open letter, Ms. Katharina Jeschke, member of the Executive Committee of the DHV e.V., even links the right to home birth to the right to human dignity in Article 1 GG.83 In German law this article enjoys the highest possible standard of legal and constitutional protection, which can be by no means derogated from. Moreover, the letter makes a reference to the jurisprudence of the ECtHR, stating that in 2010 the ECtHR has decided that the European State-parties to the ECHR are obliged to respect the woman’s right to freely chose where to give birth and to guarantee that medical assistance is to be provided for every childbirth, regardless of where it takes place. The author makes reference to the ECtHR Case of Ternovszky v. Hungary84.

73. This decision seems to be referred to in many public debate forums on pregnancy and the women’s right to choose where to give birth in support of this right. In most of these cases the debating parties refer to

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84 Ternovszky (n 6).
the authority of the ECtHR in order to stress the fundamental importance of this right not only in Germany but across Europe.

74. In her book ‘Hausgeburt und Gebären im Geburtshaus: Mit Erfahrungsberichten von Frauen, die Mut machen,’ Christine Trompka advocates that women and public organisations should campaign for an explicit constitutional entrenchment in the GG of the women’s right to freely choose where to give birth. She urges that the matter is raised by addressing Members of Parliament with this demand and organising public demonstrations.

75. These examples manifest the government’s and the populace’s positive attitude towards home birth in accordance to the exercise of the mother’s fundamental right to choose where to give to her baby.

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85 Christine Trompka, Hausgeburt und Gebären im Geburtshaus: Mit Erfahrungsberichten von Frauen, die Mut machen (Fidibus Verlag 2011).
III. ITALY

A. Summary

77. Despite the lack of a uniform legislation at national level, home birth in Italy is certainly a permissible activity, if not a right of the expectant mother. Numerous Regions have provided statutory regulation on the matter and a bill is currently before the national Parliament. At the moment, the major issue is the cost of the procedure and the availability of a rebate. The home birth practice is still rather scarce, but a number of initiatives by midwifery associations are gradually encouraging the recourse to this procedure. National courts have never directly addressed the issue, but the right to home birth has been incidentally affirmed in some recent cases.

B. Legal Framework

Relationship between State and Regions – National Level

78. In Italy, the legislative competence to regulate public health is shared between the national parliament and regional councils. At the central level, the State ensures that all citizens benefit from equal health standards by enacting ‘framework legislation,’ which contains fundamental principles and guidelines. At the local level, each Region has the power to enact complementary legislation in compliance with the rule set out at the national level. In addition, the Regions have broad and almost exclusive administrative powers in the matter, which include various aspects of management, funding and monitoring of local health centres and the services they provide.

79. The issue of home birth is not expressly regulated at national level. However, the legal basis for recognising freedom of choice in relation to the setting and modalities of childbirth can be found both in principles enshrined in the Constitution and in a number of legislative instruments.

Constitutional Principles

80. The women's right to freely choose how and where to give birth could be considered a direct consequence of the right to self-determination established under Article 2 of the Italian Constitution. With regard to
medical treatments, this principle receives specific protection pursuant to Article 32(2), which reads as follows:

No one may be obliged to undergo any health treatment except under the provisions of the law. The law may not under any circumstances violate the limits imposed by respect for the human person.

81. Another right that may be relevant in this context is the inviolability of personal freedom recognised under Article 13. The strict correlation between these principles and the women’s right to home birth is explicitly mentioned in certain draft legislation on home birth and in recent decisions. 86

Legislation on Implementation of National Health Service

82. A fundamental act in the matter of medical treatments is the Legge 833/1978, which provides for the creation of the Servizio Sanitario Nazionale (National Health Service or SSN). According to Article 33 of this act, any form of medical inspection or treatment is in principle subject to the consent of the individual. In the case of mandatory medical treatments, these must be prescribed by law and carried out ‘in compliance with human dignity, civil and political rights, including, to the extent that is possible, the freedom of choice of the practitioner and the venue where the treatment will occur.’ 88

83. The principle of freedom of choice in the undertaking of medical treatments underpins the entire legislation and extends to home health care. With specific regard to this, Article 13 of the Legge lists, among the services that the Local Health Units must provide, ‘general medical assistance and nursing, both at home and in specialised facilities’. In addition, Article 25 – upon specifying that health services comprise general health care, specialist health care, nursing and pharmaceutical service – provides that ‘specialist treatments can be offered at home on conditions that allow a decrease in the number of hospitalisations.’

87 See below, Section D.
Other National Instruments

84. Despite the lack of uniform legislation on the matter, the home birth practice seems widely acknowledged by the national legislator. Evidence of this can be found in a number of acts that take into account home birth in the context of planning various aspects of the Servizio Sanitario Nazionale. In the ‘Third biannual plan of actions and interventions to promote the protection and development of infants and children’, the ‘development of forms of childbirth assistance outside the hospital within the SSN’, such as ‘maternity houses’, home birth units, and childbirth centres, has been put on the government agenda as one of the measures to ‘improve the quality of childbirth’. Another example can be found in the collective agreement between State, Regions, and representatives of the health care trade unions, which includes home birth among the treatments for which minimum rates of pay are established.

Regional Legislation

85. In the absence of a uniform national regulation, various Regions have enacted legislation on home birth. These include Lombardy, Piedmont, Marche, Emilia Romagna, Lazio, and the Autonomous Provinces of Trento and Bolzano. The degree of specificity of each legislative act varies, but they all present some common traits.

86. The expectant mother is normally given the freedom to choose between three possible birth settings: (i) hospitals; (ii) out-of-hospital birth centres, or ‘maternity houses’; (iii) home. Home birth is generally allowed

for low-risk pregnancies, but in some Regions it may be subject to the pre-approval of a specialist. The out-of-hospital and home birth health care is provided by qualified midwives, who must carry with them certain medical equipment and follow a specific procedure that is outlined in detail. The condition of the house and the availability of emergency aid are also elements taken into account by these statutes when providing for the choice of home birth. In all cases, the new-born must be visited by a paediatrician within 12 or 24 hours.

87. The most significant issue with out-of-hospital birth relates to the cost of the health care service. When provided in a hospital or in a SSN-run health centre, the procedure is completely free. However, when the expectant mother decides to give birth in an out-of-hospital birth centre, such as a maternity house, or at home, she has to bear the entire cost of the procedure. In the light of this disparity, and acknowledging that the choice of out-of-hospital birth may lead to long-term savings for the SSN, some Regions have set up a system of rebates. The problem is that the differences among Regions can be dramatic. As seen above, only a small number of Regions have enacted legislation on the matter; in the majority of cases, the availability of a compensation for homebirth – not to mention the availability of the procedure itself – remains vague. Additionally, not all the Regions that laid down a normative framework have also provided for the possibility of financial aid. Finally, the amount awarded is subject to significant fluctuation from Region to Region, and ranges from a partial compensation of 750 Euro to the entire cost of the procedure, up to 2-3000 Euro. Although this does not affect the abstract availability of the health care service, it creates significant disparities and may concretely hamper this possibility for families on a low income.

Draft Legislation

88. Considering the fragmented normative framework and the pressing social need in the matter of home birth, various bills have been introduced before the Parliament in order to provide a more detailed and consistent regulation. The latest draft legislation, presented on 16 April 2013, includes and strengthens various elements of the current Regional
legislation. It aims, among other things, at promoting an adequate medical assistance towards childbirth, safeguarding the health of the expectant mother, and promoting a degree of midwifery service apt to the risk of the pregnancy. The bill reaffirms the freedom of choice on the birth setting, creates incentives for natural and spontaneous births, lays down detailed instructions on the service to be provided by the midwives, and, most importantly, direct the Regions to create specialised teams to provide home birth health care free of charge. The bill has not yet been discussed by the Parliament.

C. Public Debate and Practice

89. The choice to give birth at home is still rather uncommon in Italy. According to a survey conducted by the Ministry of Health in 2010, the number of home births is very low, amounting to approximately 0.4% of the total. The limited recourse to this procedure can be explained in the light of the general mistrust that surrounds it. Indeed, the medical community seems prevailingly oriented against home birth. Representatives of the main associations of Gynaecology and Obstetrics have expressed major doubts on the safety of the procedure and the adequacy of the means that the SSN can put in place in order to provide this kind of health care.

90. However, a new trend has emerged in the last decades seeking to encourage the choice of home birth when the health conditions of the mother do not necessitate hospitalisation. A midwifery association explicitly endorsing home birth has elaborated a set of guidelines to promote awareness of this practice and regulate the conditions that allow it and the procedure to be followed. An ever-growing phaenomenon is

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the creation of the so-called ‘maternity houses’. These are out-of-hospital facilities, which are designed to host women at the latest stages of their pregnancies in a comfortable environment that resembles a private residence. These places are usually run by midwifery organisations and provide services closely related to home birth. Their prominence is such that they are explicitly mentioned in the list of possible birth settings set out by a number of legislative instruments.\footnote{See Section B above.}

D. Overview of Case Law

91. The issue of home birth has never come under the scrutiny of national courts as such. This is an important element to consider when assessing the existence of a right to home birth in Italy; the mere fact that this right has never been questioned directly before a court is an important indicator of its significance. This relevance has recently found confirmation in two different cases.

92. The first case was brought before the Tribunale Amministrativo Regionale (Regional Administrative Tribunal or TAR) of Tuscany by a number of women who availed themselves of midwifery service during their home births.\footnote{T.A.R. Firenze sez. II, 03/09/2009 n. 1412, in Foro amm. TAR 2009, 9, 2419.} Upon denial of their requests for rebate by the Regione Toscana (Region of Tuscany), they filed an appeal before the TAR in order to obtain redress for the violation of their right to health. The TAR dismissed the appeal on the grounds of lack of jurisdiction, but in so doing, it affirmed an important principle. According to the TAR, the claimants are entitled to a ‘full subjective right’ to receive fundamental medical treatments provided for by the SSN, which include home health care during childbirth. Their right is encompassed in the right to health as enshrined in Article 32 of the Constitution and cannot be abated as to become a mere ‘interest’. Their cases must therefore be heard by ordinary civil courts.

93. The second case is a civil claim brought before the Tribunale di Firenze (Court of First Instance of Florence) against the local Health Service Unit (USL) by two parents of a child born with serious physical
disability. The plaintiffs had decided to use an out-of-hospital birth centre administered by the USL in order to perform a natural childbirth. Upon the insurgence of certain birthing complications, it is claimed that the midwives were unable to take the necessary measures to prevent damage to the infant. The Tribunale was persuaded of the negligence of the midwives, but did not grant the relief sought by the plaintiffs. Indeed, the Tribunale acknowledged that the birth centre was not equipped to respond to a similar emergency and even where the midwives had acted promptly, they could not have possibly avoided the causation of the damage to the new-born. Since the causal nexus between the conduct of the midwives and the damage is lacking, they cannot be held responsible for it. According to the Tribunale, the parents were aware of the risks inherent in the procedure being carried out in this centre and, having voluntarily requested this procedure, they accepted those risks similarly to what occur during home birth. Thus, the Tribunale reaffirms that the decision on the setting and the modalities of the childbirth is ultimately left to the parents, but they also bear the risk of any collateral damage inherent in the procedure of their choice.

102 Tribunale Firenze, 03/09/2013, in Responsabilità Civile e Previdenza 2014, 2, 605.
IV. FRANCE

94. French law does not specifically address the issue of home birth. Correspondingly, the legislature has not had to interpret the right to home birth, or generally, the right to physical autonomy and private life.

95. Home birth, however, seems to have been always legal in France. It used to be a standard practice, in 1950, for instance, when 54% of all births took place at home.103

96. Nevertheless, since 2002 midwifery services have become an on-going topic of public discussion in the context of regulation of insurance for civil responsibility. In particular, as a consequence of the so-called ‘loi Kouchner’ (named after the then-minister who initiated the law) Article L1142-2 has been inserted into the Code of Public Health according to which all ‘health professionals’ including midwives must subscribe to insurance for civil responsibility.104

97. Therefore, midwife’s attendance at home birth is legal, provided that they have contracted insurance for civil liability. However, it is possible to assert that home birth is currently effectively impossible in France due to this insurance obligation (and not the lack of legislation).

98. While hospitals need to cover the fees for civil responsibility insurance of the midwives working there, midwives that would attend home birth are liable to cover costs themselves. Media reports,105 as well as midwifery organisations106 situate the insurance costs of a midwife attending home birth between 19,000 and 25,000 Euro per year, almost the same amount as a midwife’s yearly salary.

99. A 2011 report of the French ‘Cour des comptes’ states that among the 72 midwives that declare assisting home birth, solely 4 were ensured.107 The French Cour des comptes found this to be unacceptable in 2011 and called

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107 Cour des comptes (n 102) 189.
upon the State to strictly enforce the obligation to undertake insurance against non-complying midwives.\(^ {108}\)

100. This results in a situation where the practice of home birth, while not being illegal, becomes *de facto* impossible. This has triggered some public opposition with demonstrations taking place to this effect in France in October 2013.\(^ {109}\) It seems that there are about 1000 to 3000 home births out of 800 000 births in France each year.\(^ {110}\)

101. There seem to be no plans to amend the current state of the law with regard to home birth. A related evolution is, however, taking place as midwives are trying to introduce ‘birth houses’ (*maisons de naissance*), which seek to provide women with a mid-way solution between hospital birth and home birth in light of the problems associated with the latter.

102. There has been no case law with relation to women’s right to home birth, physical autonomy or private life, as the lawfulness of home birth is not in doubt in France. The public debates seem to be centred around the insurance issue.

103. French law generally regulates home health care, including home care for the elderly. In particular, Articles L312-1, 6° and 7° of the Code for Social Action and Families regulate home health care,\(^ {111}\) which does not cover midwifery services.

\(^{108}\) Ibid, 189.

\(^{109}\) Damge (n 103).

\(^{110}\) Ibid.

V. SWEDEN

A. Legal Framework

104. There are no express laws regulating the issue of home birth. Under section 2 of the Health and Sickness Care Act (1982:763), care is to be provided ‘with respect for all individual’s equal worth and for the specific individual’s dignity.’  

105. Under section 2a of the same act, health care is to be provided in the manner that fulfils the requirements of good care. This specifically means under point 1, ensuring the patient’s need for security in care and treatment, and under point 3, based on respect for the patient’s right of self-determination as well as integrity.

106. The Patient Act (2014:821) has as its objective strengthening and clarifying a patient’s status within health and sick care operations, as well as promoting a patient’s integrity, self-determination and participation.

107. The Patient Act also addresses choice of treatment. According to section 7:1, if there are several treatment alternatives that are consistent with scientific and proven experiences, the patient is to be given the

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1. vara av god kvalitet med en god hygienisk standard och tillgodose patientens behov av trygghet i vården och behandlingen,
2. vara lätt tillgänglig,
3. bygga på respekt för patientens självbestämmande och integritet,
4. främja goda kontakter mellan patienten och hälso- och sjukvårdspersonalen,
5. tillgodose patientens behov av kontinuitet och säkerhet i vården. (effect 1 Jan. 2015).

114 Patientlag (2014:821), § 1 Denna lag syftar till att inom hälso- och sjukvårdsverksamhet stärka och tydliggöra patientens ställning samt till att främja patientens integritet, självbestämmande och delaktighet. This act is available in Swedish at <www.notisum.se/rnp/sls/lag/20140821.htm> accessed 15 February 2015.


possibility to choose the treatment she prefers. The patient is to receive
the chosen treatment, if it seems reasonable as assessed against the
medical condition at issue and the costs for the treatment. 117

108. From 1990 until 2005 there was a governmental agency regulation
concerning advice as to home birth (SOSFS 1990:22, Allmänna råd vid
hemförlossning, repealed by SOFS 2005:14 without being replaced).

109. Against the statutory background above, the information and advice
available to individuals in the Care Guide (1177 vårdguiden, 111.1177.se)
as promulgated by the Swedish Health Authorities (Sveriges landsting och
regioner), states the following in Swedish: 118

Birth not at a Hospital
Planned Home Birth
Almost all women choose to give birth at a hospital, but
several midwives offer the choice of giving birth at home.
Planned home births are becoming more common. Even if
the majority of births are successful, there always is the
risk that something unexpected will occur. A mother then
might need to go to the hospital in an ambulance during
the birth. In addition, you should contemplate that the
same pain medications are not available at home as at a
hospital.

If it is a first birth, you ought not choose to have a home
birth as you do not know how you will react to the birth.
In addition, the risks are greater with a first child. The
pregnancy must be normal and you ought to in advance
contract with a midwife on how the birth is to proceed.
The birthing center at your local hospital ought to also be
informed.

110. Each of the twenty health care regions (Landsting) in Sweden makes
the decision as to whether a home birth is covered by the health care
system. The majority of health care regions have decided not to be the
costs of home birth, leaving those with the mother. The Stockholm
Health Care Region decided in 2002 that women fulfilling the
requirements they set out had the right to economic compensation for

117 Patientlag (2014:821), § 7:1 När det finns flera behandlingsalternativ som står i överensstämmelse med
vetenskap och beprövad erfarenhet ska patienten få möjlighet att välja det alternativ som han eller hon
föredrar. Patienten ska få den valda behandlingen, om det med hänsyn till den aktuella sjukdomen eller
skadan och till kostnaderna för behandlingen framstår som befogat.
118 Translated by the researcher.
the costs of midwives at a home birth. The costs for a midwife at a home birth are estimated at about €2500 in uncomplicated cases.\textsuperscript{119}

111. The Stockholm Health Care Region requires the presence of two licensed midwives with home birth. Forty-one women applied for the compensation in 2002 and 34 were granted it.\textsuperscript{120}

112. As seen from the above discussion, home birth is permitted in Sweden. A doctoral dissertation from the Karolinska Institutet by Lindgren, \textit{Hemförlossningar i Sverige 1992-2005, förlossningsutfall och kvinnors erfarenheter} [Home Birth in Sweden, 1992-2005, Birth Results and Women’s Experiences], is the first national survey of planned home birth in Sweden. It identified the ratio of 0.95 for each one thousand women, with an average of 100 women each year planning on a home birth. Another source has cited the statistic 100-200 home births per one thousand annually.\textsuperscript{121}

113. Home birth has always been permitted by law. The societal trend has been traced by Lindgren, with over 90 \% of the births in Sweden in 1890 were home births, in 1940 homes births were app. 30 \%, and in 2005, home births were less than 1 \%. According to Lindgren, this trend is a reflection of, as well as cause for, better prenatal and pregnancy health care over this period.\textsuperscript{122}

114. Assistance by midwives is tolerated by the State. However, midwives cannot write prescriptions for medicines, so if such are needed a doctor must issue the prescription.

115. There are NGOs in Sweden, such as \textit{Föda Hemma} (Birthing at Home), which provides information to women interested in birthing at home as well as the names of midwives willing to assist in home birth.\textsuperscript{123}

116. The provision of care by midwives is regulated by the same standards of conduct regardless of whether the care is provided at a hospital or at home, and regardless of whether the midwife is employed by the public

\textsuperscript{119}See eg the midwives website at <www.egenbarnmorska.se/priser> accessed 15 February 2015.
\textsuperscript{120}Ingela Wiklund et al., \textit{Stockholms läns landsting betalar hemförlossning i vissa fall}, Läkartidningen No. 51-52, Vol. 100, 4272 (2003).
\textsuperscript{121}Josefin Jönsson and Malien Perstenius, \textit{Barnmorskas tankar och upplevelser kring planerade hemförlossningar – En kvalitativ interview studie} (Lund University, Master’s Thesis 2014) 5.
\textsuperscript{123}Föda hemma’s website is at <https://fodahemma.wordpress.com/2005/07/06/foreningen-fodahemma/> accessed 15 February 2015.
health care system or works privately. The equipment the midwife is to have is also set out by regulation. The Swedish law does not draw a distinction between ‘home health care’ as opposed to hospital care in the provision of health care.
VI. BOSNIA AND HERZEGOVINA

A. Legal Framework

117. Home birth and midwifery services are regulated by the following laws of the Federation of Bosnia and Herzegovina (FBiH):

   1) The Law on Health Protection of FBiH
   2) The Law on Nurses and Midwives of FBiH
   3) The Law on Rights, Obligations and Responsibilities of the Patients of FBiH.

Home birth is not explicitly allowed by the FBiH legislation, however, it is not prohibited either. Therefore, women can arrange home birth (and they actually do it surprisingly often). However, they do it without any medical assistance, incurring all the potential risks. Although midwives and health professionals are not expressly prohibited from assisting at home birth, they are still not allowed to assist at home birth by the medical institutions where they work. Accordingly if they would assist at home birth, they could risk losing their jobs. Anecdotal evidence suggests that women do try to find and engage midwives to assist with home birth, but it appears to be impossible owing to the reasons outlined above.

118. The Law only regulates the scope of the duties of midwives and the place where their services should be provided. The Law also stipulates that midwifery services can only be performed ‘in the manner and under the conditions established by this Law, and special regulations on health care.’ As home is not listed as one of the places for the provision of

124 This report concerns only the legal regulation of home birth and midwifery services in the Federation of Bosnia and Herzegovina (FBiH), and does not cover the Republic of Srpska.
midwifery services,\textsuperscript{131} the assistance by midwives could potentially be considered as prohibited by an \textit{a contrario} interpretation of this provision.

119. Article 13 of the Law, however, stipulates that midwifery services, among others, could be provided in a ‘community,’ which is interpreted as local community or local ambulance, where future parents can get necessary information.\textsuperscript{132} Mostly this term is used with reference to nurses, who visit mothers \textbf{after birth} and show them how to handle and take care of a baby. Therefore, the term ‘community’ cannot be interpreted as allowing home birth.

120. The Law requires a medical institution to have all the equipment needed so as to enable providing assistance in case of complications during labour, which makes any options apart from medical institutions effectively unavailable for women to give birth.

121. The Law effectively sanctions midwives for assisting in home birth.\textsuperscript{133} Specifically, the Law prescribes that midwives will be punished with a fine amounting from 250 BAM to 1000 BAM, if they provide midwifery care contrary to the provisions of this law. The Law, however, does not provide specifically what constitutes assistance in home birth.

122. The Law does foresee assisting the patients in cases of medical emergency. Unplanned home birth is not specifically listed (nor any other cases of emergency), but the Law assigns the duty to midwife to assist in cases of emergency. Those cases are the ones where not providing assistance would lead to permanent injuries or severe consequences to health or life of a patient.

123. It is reported that there are exceptional cases, where a number of Roma women, who do not have health insurance and access to health care, have birth at home. In these cases, the women are assisted by ambulance, which usually does everything in its power to transfer pregnant women into a hospital. The costs of birth in these cases are

\textsuperscript{131} ibid, art 13.
\textsuperscript{132} ibid.
\textsuperscript{133} Zakon o Sestrinstvu i Primaljstvu (n 122).
covered from the budget funds pursuant to the Decision of the FBiH government.\textsuperscript{134}

124. Following birth, women who have chosen home birth, have also reported difficulties with registering their children in the registry of citizens, as they request that a child has been examined by a doctor and a midwife.

125. Additionally, the medical insurance does not cover midwifery services provided at home. Women who chose to have labour at home have to pay for midwifery services themselves.

\textbf{B. Home Health Care}

126. The Law on Basis of Social Care, Care for Civil Victims of War and Care for Families with Children of the FBiH foresees home care. Home health care includes helping with daily tasks such as bathing, eating, cleaning the home and preparing meals. Persons entitled to home care are people entirely incapable to work, men older than 65 and women older than 60, and persons with permanent mental and physical difficulties. The provisions on home health care, however, are not applicable to the case of home birth.

VII. RUSSIAN FEDERATION

A. Summary

127. In the Russian Federation the issue of home birth is not specifically regulated by the legislation. Home birth as such is implicitly allowed since voluntary consent is a necessary condition for any medical intervention. However, according to the Russian legislation, medical assistance to birth is an activity that requires license and could be provided only by and in appropriate medical organisations. Assistance in delivery provided with breach of license’s terms as well as provided without license constitutes an administrative offence. This de facto prevents midwives from assisting at home birth. Assistance without license if has caused harm to health or death, constitutes a criminal offence.

B. Legal Framework

Assistance in Delivery as a Type of Medical Activity Requiring License

128. Under Article 12 (46) of the Federal Law ‘On licensing of certain types of activity,’135 medical activity is included in the range of those, requiring appropriate license. Under Article 3 of the Regulation on licensing of medical activity,136 medical activity constitutes works (services) under the list in accordance with to the annex thereto. According to the Annex to Regulation on licensing of medical activity,137 ‘obstetrics’ and ‘obstetrics and gynecology’ fall within the list of activities that constitute medical activities, and are subject to licensing in accordance with the Regulation.

Rules Concerning Medical Assistance in Delivery

136 Regulation on licensing of medical activity (excluding activity, provided by medical organisations and other organisations, included into private system of health care within the territory of innovation center ‘Skolkovo’ <http://www.consultant.ru/document/cons_doc_LAW_145228/?frame=1> accessed 5 February 2015.
137 List of works (services) comprising medical activity: Annex to the Regulation on licensing of medical activity (excluding activity, provided by medical organisations and other organisations, included into private system of health care within the territory of innovation center ‘Skolkovo’ <http://www.consultant.ru/document/cons_doc_LAW_145228/?frame=1> accessed 5 February 2015.
129. According to Article 37 (1) of the Federal law ‘On fundamentals of health protection of citizens in the Russian Federation,’ 138 medical assistance is organised and provided in accordance with procedures of providing medical assistance, which are mandatory for compliance within the territory of Russian Federation by all medical institutions, as well as on the basis of standards of medical assistance.

130. Pursuant to Article 26 of the Procedure of providing medical assistance (under the heading ‘obstetrics and gynecology’) 139 medical assistance to women during delivery and post-delivery periods is provided by specialised and urgent medical assistance in medical organisations with a license for medical activities, including services of obstetrics and gynecology. The requirements concerning organising the activities of such organisations, their personnel and equipment are laid down in the Annexes 6-11 to the Procedure. The Procedure does not provide for the possibility of personnel of these organisations assisting at home birth including urgent cases.

131. Thus, under Russian legislation, assistance in conducting delivery is a form of medical activity and can be provided only in a medical organisation, which has a relevant license.

Consent to Assistance in Delivery as a Form of Medical Interference

132. Article 2 of the Federal Law ‘On fundamentals of health protection of citizens in the Russian Federation’ defines the notions of medical assistance, medical service and medical intervention. Medical assistance are actions aimed to support or recover health including providing medical services. Medical service is a medical intervention(s) aiming at preventive care, diagnosing and curing of diseases, medical rehabilitation and having an independent final significance; medical intervention includes conducting by a medical professional towards a patient of kinds of medical examinations and/or medical manipulations affecting physical

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or mental state of a person and having a preventive, investigative, diagnostic, curative or rehabilitation purpose. Thus, assistance in delivery, being a form of medical service, is a medical intervention(s).

133. According to Article 20 (1,3) of the Federal Law ‘On fundamentals of health protection of citizens in the Russian Federation,’ medical intervention towards a person can be conducted only on the basis of his/her consent to it, and any person (or a parent or a legal representative under relevant circumstances) has a right to deny medical intervention and to demand its termination (except certain cases not related to delivery).

134. Thus, according to Russian legislation, assistance to delivery can only be conducted with the consent of the woman, and the possibility of a planned home birth without medical assistance is neither excluded nor prohibited.

Potential Liability for Assistance in Delivery

135. There is no rule in Russian legislation that explicitly provides for liability in a specific case of assistance in delivery at home or otherwise without license, but such assistance can constitute an administrative or criminal offence if i) provided as a business or non-business activity in breach of terms of license, ii) without license, as a business activity, iii) without license, as a non-business activity, iv) without license, if has caused harm to health or death.

136. (i) Assistance in delivery in breach of terms of license:

- Under the the Code of the Russian Federation on administrative offences, conduct of business activity in breach of terms of special allowance (license), entails administrative penalty in the form of a warning or a fine. If the breach of license is gross, it entails an administrative penalty in the form of fine or suspension of activity.

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140 A business activity is an independent activity, performed at one's own risk, aimed at systematically deriving profit from the use of property, sale of commodities, performance of work or rendering of services by persons, registered in this capacity in conformity with the law-established procedure. Civil Code of the Russian Federation of 30 November 1994 No 51-FZ <http://www.consultant.ru/popular/gkrf1> accessed 5 February 2015, art 2(1).


142 ibid, art 14.1 (4).
• Conduct of activity not connected with deriving profit also entails administrative penalty in the form of warning, fine or suspension of activities, if in breach or in grave breach of terms or conditions of special allowance (license), if such allowance (license) is mandatory.\textsuperscript{143}

• Thus, medical assistance in delivery by a licensed organisation \textbf{outside the premises} of its venues equipped in accordance with prescribed requirements, being a breach of the license’s terms, \textbf{potentially constitutes an administrative offence} whether conducted as a business or a non-business activity.

137. (ii) Assistance in delivery \textbf{without} license as a \textbf{business activity}:

• Conduct of business activity without special allowance (license), if such allowance (such license) is mandatory, constitutes an administrative offence and entails administrative penalty in the form of fine with or without confiscation of goods produced, instruments of production and raw materials.\textsuperscript{144}

• Thus, assistance in delivery without license if conducted as a business activity \textbf{constitutes an administrative offence}.

138. (iii) Assistance in delivery \textbf{without} license as a \textbf{non-business activity}:

• Conduct of activity not connected with deriving profit, without special allowance (license), if such allowance (license) is mandatory, constitutes an administrative offence and entails an administrative penalty in the form of warning, fine with or without confiscation of goods produced, instruments of production and raw materials, or suspension of activity.\textsuperscript{145}

• Thus, assistance in delivery without license if conducted as a non-business activity \textbf{constitutes an administrative offence}.

\textsuperscript{143} ibid, art 19.20 (2 and 3).
\textsuperscript{144} ibid, art 14.1 (2).
\textsuperscript{145} ibid, art 19.20 (1).
139. (iv) Assistance in delivery without license if has caused harm to health or death:

- Medical or pharmaceutical activities conducted with negligence by a person without a license, given that such license is mandatory, that caused infliction of harm to human health or health are punished by a penalty in the form of fine or by restraint or deprivation of liberty.\(^{146}\)

- Thus, assistance in delivery, being a form of medical activity, without license that has caused harm to health or death is a **criminal offence**.

C. Overview of Case Law

140. The only widely discussed case concerning assistance at home birth is a criminal case, in which in 2009 Elena Ermakova and her husband Alexey Ermakov, were found guilty under Article 235 of the Criminal Code (cited above) for providing medical assistance at home birth, which had caused death of six newborns and harm to health of one newborn. The judgment is not available, and the information is provided according to a media news item.\(^{147}\)

D. Registration of Birth

141. Another problem, arising for mothers rather than midwives, which is now debated in Russia, concerns registration of birth of those newborns, which were born outside medical institution.

142. According to the existing legislation,\(^{148}\) the grounds for official registration of birth include among others (such as a document of birth, issued by a medical organisation in which the delivery has taken place, etc.) – a statement on birth made by a person who was present at the delivery, in a case of delivery outside medical organisation and without medical assistance. In the absence of any of these grounds, the official


\(^{147}\) Nikita Zeya, ‘Newborns were tossed out with the water: in Petersburg a sentence is passed on the founders of the “Kolybelka” center’ <http://www.gazeta.ru/social/2009/09/25/3265143.shtml> accessed 5 February 2015.

registration is provided on the basis of the judicial decision on establishment of a fact of delivery of the child by the particular woman.

143. In June 2014 the Ministry of Justice of the Russian Federation worked out and submitted for the public discussion a draft law,\(^\text{149}\) which generally excludes the possibility of official registration of a child born outside medical organisation and without medical assistance on the basis of a mere statement of a person who was present at the delivery. Such possibility is only preserved according to the draft law, for cases of delivery in hardly accessible or underpopulated territories, the list of which is for the determination of the Government of the Russian Federation.

144. Among the reasons for this amendment, mentioned in the Explanatory Note to the draft, is a high risk for life and health of women and newborns as a result of delivery without medical assistance.

IX. HUNGARY

A. Introduction

145. Home birth has been an issue taken up by numerous women’s right organisations well before the seminal case of Ternovszky v. Hungary\(^{150}\) at the ECtHR. Ternovszky was the ever first home birth case before the ECtHR where Hungary was found in violation of Article 8 (right to private life). The violation consisted in the ‘legal uncertainty’ that resulted from the lack of clear regulation of home birth. Home birth \textit{per se} was not banned by criminal law but any health professional aiding in the labour at home could face regulatory sanctions such as fines and eventually serious criminal malpractice charges, which were as a matter of fact imposed in several cases.

146. The government responded to the Ternovszky judgment with issuing a decree on the regulation of home birth which was the Government Decree no. 35/2011 on the regulation, conditions of home birth and exclusionary reason from home birth (Decree).\(^{151}\)

B. Government Regulation

147. The Decree sets up a regulatory system that allows home birth under certain conditions set out by the Decree. If a woman who wishes to give birth at home but fails to follow the administrative procedure; or fails to meet all the criteria described within, is not covered by the decree and the health professionals (i.e. the midwives) could face regulatory and even criminal sanctions for malpractice.

148. First, the Decree sets up an \textbf{administrative procedure} through which the pregnant woman should notify the local health administration body. The Decree sets up a deadline for notification: by the end of the 36\(^{th}\) week of the pregnancy the administrative procedure should be started, it also regulates the hygienic conditions of the house where the labour shall take place, the proximity between the house and the closest hospital etc.

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\(^{150}\) Ternovszky (n 6).

149. Second, the Decree also precisely defines the **professional criteria** for health personal allowed to assist as midwives at home birth. The requisite license and experience that are set out in the Decree have been a source of controversy since the beginning because they exclude independent midwives professionals, who have typically not worked in hospital environment (see section C).

150. Third, the Decree contains in its addendum (addendum no. 1) five general **permissibility requirements** and nineteen **exclusionary reasons**, which represent the exhaustive list of eligibility criteria for home birth. The person wishing to give birth outside of hospital should satisfy all the permissibility reasons and not to fall under any of the exclusionary reasons. In case of non-compliance with these norms the birth is considered not allowed under the Decree and hence the various sanctions may follow for the health professional partaking in the labour.

151. The exclusionary reasons can be grouped into two categories. The first deals with conditions with regard to the baby such as her weight (that should be under 4000 gram) etc. The second deals with conditions regarding the mother (she ought not to have HIV+ status, not to suffer from alcohol or drug dependency, etc.), and history of the pregnancy.

**C. Criticism of the Regulation by the CEDAW Committee**

152. The UN’s treaty body on women’s rights, the CEDAW Committee, expressed some criticism of the Hungarian regulation in its ‘Concluding Observations on the combined seventh and eighth periodic reports of Hungary adopted by the Committee at its fifty fourth session (11 February – 1 March 2013).’ The Committee touched on one aspect that was heavily criticised by NGOs, namely the restricted definition of ‘health professionals’ who are allowed by the Decree to help at home birth.

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153. The Committee was ‘concerned (...) at the lack of choice for women to give birth at home or in the hospital, due to various obstacles, including the non-recognition of midwives as independent professionals.’ Based on this criticism, the CEDAW Committee issued the following recommendation:

Ensure women’s choice to give birth at home or in the hospital by recognising trained midwives as independent professionals and by elaborating a legal framework and guidelines on security of home deliveries, and providing training of obstetricians.¹⁵³

D. Assessment of Regulation from NGOs

154. There seems to be a broad consensus amongst the stakeholders that the Decree established an overregulated system that instead of allowing women to exercise their right to choose home birth act as a deterrent. This has been the position of the Hungarian Civil Liberties Union¹⁵⁴ as well as the opinion of an organisation of independent midwives.¹⁵⁵ They criticise the demanding list of mandatory eligibility criteria that do not allow room for individual assessment, therefore – they claim – very few pregnant women can actually enjoy their right to choose.

155. Some points of criticisms are the following:

(i) The Decree sets up a location requirement of the birth: the place of labour should be of maximum 20 minutes distance from the closest hospital. It is seen by many as an important burden on the choice of women.

(ii) The Decree requires the notification of a hospital latest by the end of the 36th week of the pregnancy.

(iii) One of the main points of criticism is that the cost of the home birth is not covered by national security as opposed to the birth in hospital. Therefore, it is seen as discriminatory against those women who cannot afford the cost that can easily attain 500 Euro.

(iv) The Decree sets up an age requirement (18-40) that is seen as unjustified by any medical reason. The weight requirement for the baby has been criticized on similar grounds.

¹⁵³ ibid, Recommendation (e).
¹⁵⁴ Video ‘Hol tart ma az otthonszülés?’ (Where are we with home birth?) produced by the Hungarian Civil Liberties Union 7 April 2013 (the video is in Hungarian).
¹⁵⁵ The websites are only available in Hungarian: <http://www.otthonszules.hu/>; <www.patent.org.hu> accessed 15 February 2015.
(v) Many stakeholders contend that the problems of the Decree stem from the process of consultation that preceded the Decree, which was dominated by the opinion of hospital obstetricians who are traditionally hostile to home birth. Therefore, the opinions of independent midwives were barely taken into account for the elaboration of the Decree.