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Letter in support of Amira Ćerimagić in Ćerimagić v. Bosnia and Herzegovina before the European Court of Human Rights

European Court of Human Rights
Council of Europe
Strasbourg Cedex
67075
France

Honourable judges of the European Court of Human Rights,

I would like to offer my professional opinion on the case of Amira Ćerimagić and offer my support to her cause as well as to all other women in Europe and around the world in a similar situation.

I am a fully qualified clinically practicing midwife with professional experience in acute, community, out of hospital and specialist midwifery care and also neonatal care. I therefore have the necessary expertise to comment on Amira Ćerimagić' case in a professional midwifery capacity.

I would like to express my full support to accessibility of midwifery care provision, including out of hospital care (freestanding birth centres or other similar facilities and homebirth) in pregnancy, during childbirth and early motherhood. But also more broadly, I would like to express my full support to all women deciding wholly about the circumstances of giving birth, whether this includes healthcare professionals or not.

As the ECHR ruled in the case of **Ternovszky v. Hungary** (67545/09) in 2010:
"*The right concerning the decision to become a parent includes the right of choosing the circumstances of becoming a parent. The circumstances of giving birth incontestably form part of one's private life for the purposes of this provision; … The choice of giving birth in one's home would normally entail the involvement of health professionals. Legislation which arguably dissuades such professionals who might otherwise be willing from providing the requisite assistance constitutes an interference with the exercise of the right to respect for private life by prospective mothers.*"

Similar cases to the Ternovszky v. Hungary appeared at the ECHR repeatedly:

Dubská and Krejzová v. the Czech Republic (28859/11 and 28473/12) in 2016
https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-148632%22]}

Pojatina v. Croatia (18568/12) in 2019
https://hudoc.echr.coe.int/eng/#{%22itemid%22:[%22001-186446%22]}

Kosaitė-Čypienė and others v. Lithuania (69489/12) in 2019
https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-193452%22]}

The safety argument

One of the reasons for denying provision of homebirth care named in these cases by the governments is the "safety of mother and baby:" Intrapartum care is only provided in hospitals to ensure safety for both mother and child. And indeed, The Constitutional Court of Bosnia and Herzegovina uses this argument to dismiss Amira's case. Here I would like to remind judge Lemmens' opinion from the Dubská and Krejzová ECHR case, on the matter of alleged safety for mothers and babies:

"*According to the Government, the general interest pursued by the State lies in protecting the health of mothers and their children. However, as I noted above, the law does not prohibit mothers from giving birth in a place of their choice. It is therefore theoretically possible for mothers to give birth at home. Should they choose to do so, however, they are unable to obtain the assistance of a midwife. I cannot understand how such a system, taken as a whole, can be seen as compatible with the stated aim of protection of the health of the mothers and their children."*

It is worth pointing out that the same institutions which argue that minimising or eliminating out of hospital births is a matter of safety for the child and that it protects their health, show none or very little interest in the long term effects on children's and women's health of routinely used medications and practices in institutionalised childbirth, such as opiates, antibiotics, synthetic oxytocin, induction of labour prior to baby's full maturity, continuous fetal monitoring, overuse of caesarean sections and instrumental deliveries, separation of mothers and babies, early cord clamping and many more.

I would like to introduce you to one such intervention in more detail: Early cord clamping - a practice so harmful, yet widespread in maternity hospitals. Immediately after the baby is born, a third of their blood volume is still in the placenta. If the cord is clamped and cut straight away, the baby is deprived of a third of their natural blood volume. There is now vast amount of evidence of the harmfulness of this practice; it can exacerbate hypoxic brain damage, it affects neurobehavioural development of the child and it kills prematurely born babies. Yet the practice continues in hospitals around the world and is often defended by healthcare professionals as necessary for safety (6).

Different hospitals have very different and sometimes contradictory procedures which they claim are necessary for safety. It becomes obvious when you get the chance to practise in different institutions but it is really striking when you have a chance to practise or observe practice in different countries. I have had the opportunity to personally witness both.

The aforementioned illustrates that it is not an actual concern about children's lives and health but rather a sign of paternalistic and hierarchic culture in healthcare where it is believed that the healthcare professional always knows better than the patient/care recipient.

In terms of the aforementioned argument of safety for the mother during childbirth - there is no justifiable reason for states to over-regulate women's choices. Women are perfectly capable of making their own decisions about healthcare, including refusing any particular intervention or refusing to be admitted to a healthcare facility. This is their indisputable human right.

I would like to see how compliant are Bosnian and Herzegovinian maternity hospitals with the WHO recommendations for maternity care (5). How do they document and measure the use of various interventions in childbirth and how do they publish their data, so that all women can be reassured prior to accessing care that their human rights will be respected and the highest possible standard of care will be provided. Sadly, I know the answer, they do not. The only available data is on maternal and perinatal mortality and caesarean section rates. And even this few data is pooled together, making it impossible to find out and compare the safety of care in individual maternity hospitals.

Safety of homebirth

Furthermore, homebirth for healthy women has been proven to be as safe as a hospital birth for babies and safer for mothers. In WHO's practical guide on intrapartum care from 1996 (5), we can read that:
“*A study of perinatal mortality showed no correlation between regional hospitalisation at delivery and regional perinatal mortality. A study conducted in the province of Gelderland, compared the "obstetric result" of home births and hospital births. The results suggested that for primiparous women with a low-risk pregnancy a home birth was as safe as a hospital birth. For low-risk multiparous women the result of a home birth was significantly better than the result of a hospital birth. There was no evidence that this system of care for pregnant women can be improved by increasing medicalization of birth.”*

Of course, since then much more compelling evidence on the safety of homebirth have been gathered from large population data (counting millions of women and babies). There is also emerging evidence of safety for women who are perceived as high risk by the system (2). Often the definition of what is high risk can widely differ between institutions. Therefore, it should not be the institutions or third parties deciding where women can or cannot give birth. Only women themselves should decide that, as they know best what risks are reasonable to take or acceptable in their individual circumstances.

Childbirth and human rights

The WHO clearly states in their most recent recommendations for intrapartum care that the care needs to be provided on the basis of human rights approach and that:
“*A human rights-based approach is about health and not isolated pathologies; it is premised upon empowering women to claim their rights, and not merely avoiding maternal death or morbidity.*” (5)

I would like to ask you, the judges, to pay special attention to how dismissive the healthcare providing institution (the Clinical Centre) is towards Amira's arguments and worries regarding giving birth within their institution. It colourfully illustrates how individual women are perceived within that institution. Here is an example:
"*Regarding the appellant's claims that by giving birth in a health institution she would be forced to share her most intimate sphere with third parties during childbirth, the Clinical Center stated that it assessed this allegation as completely absurd because the primary purpose of medical activity is to protect the health of individuals, families and the entire population, as prescribed by the Law on Medicine, not as encroaching on any intimate sphere of the patient, as the appellant misperceives it, which is certainly her subjective experience.*" (See document: **Decision on admissibility and merits Constitutional Court of BiH, par. 16**)

Birth is a normal bodily function

There is an assumption that institutionalised and medicalised birth equals safer birth. But this cannot be true for a physiological bodily function such as childbirth. Just like you would not assume that having intravenous nutrition administered to you in hospital is safer than eating food (people occasionally die of food poisoning!). Or that urinating and defecating is safest to be done on a medical ward while being watched and monitored by healthcare professionals (what if you have a stroke while on the toilet?).

And would you ever agree that conceiving a child would be safer on a theatre table in a hospital while having your vital functions regularly checked, being watched by several healthcare professionals who coach you to perform better and occasionally examine your penis to make sure it remains fit for the task ahead and works fast enough? (After all people occasionally get injured or die while having sex or as a consequence of having sex!)

Science, evidence-based care and maternal instincts

Science, including medicine, by the very nature of it, always gives us more questions than answers. Scientific recommendations will overturn when newer contradictory scientific evidence emerge. Therefore, we must not pretend that what we think we know at this point is forever guaranteed. Healthcare professionals have to provide advice to the best of their knowledge and openly explain the risks and benefits of their recommendations. In cases where evidence to support certain intervention is missing, they have to honestly disclose that too and let women choose whether they wish to follow the recommendations or opt for a different path based on what is and what is not acceptable to them. Most importantly healthcare professionals must do no harm.

For thousands of years of human evolution women relied on their instincts in pregnancy and childbirth, and they continue to do so. In fact, numerous investigations into serious incidents recognise that serious complications and adverse outcomes in childbirth often happen when women are not listened to in healthcare institutions and their concerns are being dismissed by the health care professionals (4).

No one can ever give a guarantee to the birthing woman of a perfect outcome for both herself and her baby, but it is often presented as if this is possible in hospitals as opposed

to out of hospital where anything bad can happen. Babies and women do suffer harm in hospitals and do die in hospitals. They also often suffer iatrogenic harm and sometimes mistreatment and violence (1, 4). These facts must not be overlooked. Having an option of receiving care in woman's own environment and having access to independent or private care serve as safeguards against institutional malpractice.

It should also be acknowledged that from a global perspective, death of the child is not always the worst possible outcome. For example, letting baby die in utero and birthing vaginally is in some contexts a more reasonable choice than having a caesarean section, risking dying of complications (such as bleeding or wound infection) and leaving older children and whole family behind. Or if the unborn baby has a severe life limiting condition and death is inevitable, a much worse outcome for the woman and her family may be the separation of mother and baby from the rest of the family or the separation of the mother and the baby. It is also important to acknowledge that some cases are not so clear cut.

Some people may consider loss of dignity and loss of their power to decide about their own body in a healthcare institution worse than the risks to their physical health, even if this is perceived as unreasonable or insane by some. The answer to that is improving healthcare services and making them acceptable to everyone, not restricting out of hospital healthcare and independent and private care choices. Some people can have very strong world views or religious views which will affect their decision making. They may only represent a minority in the population but they deserve not to be discriminated.

Women need to be able to choose their own birth care provider and to choose the appropriate care environment for themselves and their babies. Restrictions of care options in childbirth do not enhance safety but do the exact opposite. Because women who for multiple reasons decide not to attend hospitals or not to engage with the system then end up with no care whatsoever (3). Taking us back to the statement cited at the beginning of this letter: "**How is that compatible with the stated aim of protection of the health of the mothers and their children?**"

Yours Faithfully,
Lenka Pazdera
Midwife

Lenka Pazdera

Disclaimer: This support letter has been submitted on a voluntary basis.

1) Reports on violence against women in childbirth:

Human rights in childbirth report on violence against women, its causes and consequences
https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Human%20Rights%20in%20Childbirth.pdf

A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence
https://undocs.org/A/74/137

Report to the United Nations Special Rapporteur on Violence Against Women - Roda, Croatia
https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Roda%20%E2%80%93%20Parents%20in%20Action%20Croatia.pdf

Human Rights Violations in Pregnancy, Birth and Postpartum during the COVID-19 Pandemic
http://humanrightsinchildbirth.org/wp-content/uploads/2020/05/Human-Rights-in-Childbirth-Pregnancy-Birth-and-Postpartum-During-COVID19-Report-May-2020.pdf

2) Studies on safety of homebirth for mother and baby:

Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study
(The Birthplace study) https://www.bmj.com/content/343/bmj.d7400

Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses
https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(19)30119-1/fulltext

Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses
https://www.sciencedirect.com/science/article/pii/S2589537020300638

The Albany Midwifery Practice http://thealbanymodel.com/albany-in-peckham/statistical-outcomes-1999-2007/

Perinatal outcomes of planned home birth after cesarean and planned hospital vaginal birth after cesarean at term gestation in British Columbia, Canada: A retrospective population-based cohort study
https://pubmed.ncbi.nlm.nih.gov/33583048/

Perinatal and maternal outcomes in planned home and obstetric unit births in women at 'higher risk' of complications: secondary analysis of the Birthplace national prospective cohort study
https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1111/1471-0528.13283

3) Why some women (including "high risk") choose to birth outside of the system:

Dahlen H, Kumar-Hazard B, Schmied V. 2020. ***Birthing Outside the System: The Canary in the Coal Mine.*** First edition. Routledge. London and New York. ISBN 9780367506605

4) Investigation reports:

Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (The Ockenden report)
https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

The Report of the Morecambe Bay Investigation (The Kirkup report)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Summary of Themes arising from the Healthcare Safety Investigation Branch Maternity Programme
https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/hsib-national-learning-report-summary-themes-maternity-programme.pdf

5) WHO documents on maternity care:

Care in normal birth: A practical guide (1996)
https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2413/2014/08/WHO_FRH_MSM_96.24.pdf

WHO recommendations: Intrapartum care for a positive childbirth experience (2018)
https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

WHO recommendations on antenatal care for a positive pregnancy experience (2016)
http://apps.who.int/iris/bitstream/handle/10665/250796/9789241549912-eng.pdf?sequence=1

WHO recommendations on maternal health: guidelines approved by the WHO Guidelines Review Committee (2017)
https://www.who.int/publications/i/item/WHO-MCA-17.10

6) Harmfulness of early cord clamping:

Evidence listings:
https://waitforwhite.com/articles-of-interest/
https://waitforwhite.com/references-2/

British Association of Perinatal Medicine: Optimal Cord Management in Preterm Babies - A Quality Improvement Toolkit
https://hubble-live-assets.s3.amazonaws.com/bapm/redactor2_assets/files/831/OCM_Toolkit_Full_For_Launch.pdf

A visual presentation of early cord clamping by Penny Simkin:
youtube.com/watch?v=W3RywNup2CM