MINISTERSTVO ZDRAVOTNICTVÍ ČESKÉ REPUBLIKY

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## Consolidated Proposal Submitted for Comments

# Strategy for the Development of Respectful Care for Mothers and Children During Pregnancy, Childbirth and the Postpartum Period



## Version 1.6 (July 2025)

# Contents

# 1. Introduction

Pregnancy and childbirth represent a major milestone in a woman's life, associated with a number of changes. The early stages **of motherhood** are also **one of the most vulnerable periods in** a woman's **life.** This is why it is particularly important to ensure not only **the quality and safety of** healthcare **services** during pregnancy, childbirth, and the postpartum **period,** but also to **uphold women's rights, dignity, and integrity**.

Adequate support and protection of motherhood[1] is a prerequisite for the prosperity of women, newborns, families, communities, and society as a whole. Research shows that the manner and circumstances of childbirth have **a significant and long-lasting impact on the life of a woman and her family in other areas as well**. It is therefore in the interest of society as a whole that this impact is positive and empowering, rather than traumatic. A negative birth experience has adverse consequences not only for the woman, her child and family, but also wider, undesirable social and economic repercussions.

The Strategy therefore aims to ensure that **health services provided** to mothers and children during this sensitive period are delivered with **an emphasis on safety, quality, and respect for women and children and their needs**. It does not place the needs of women in opposition to those of children; on the contrary, in line with modern scientific knowledge, it treats mother and child as an inseparable unit.

The presented material takes into account current trends in maternity care. In line with international recommendations and standards, in particular those of the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM), the Strategy is based **on evidence-based practice** and the concept **of respectful maternity care.** That is, care that is in line with the latest evidence-based medical knowledge, human rights commitments and standards[2] , respects the individual and family needs of women (woman-centered care, family-centered care) and leads to a positive experience of pregnancy, childbirth and the postpartum period.



The presented strategic document is primarily a contribution to Czech healthcare policy. However, by taking into account not only the medical aspects but also the human rights and psychosocial dimensions of health care provision in early motherhood, it is also an important part of Czech family policy and gender equality policy.

## 1.1 Context of the Strategy's Development

The government tasked the Minister of Health, in cooperation with the Government Commissioner for Human Rights, with developing the strategy by Resolution No. 682 of October 2, 2024.

The government's task *of "creating a strategy for maternal and child care that is in line with current WHO recommendations, ensures continuity of services provided by individual professions and access to care that is in line with the latest evidence-based medical knowledge, human rights commitments and standards (human rights-based), respects the individual and family needs of women (woman-centered care, family-centered care) and leads to a positive experience of pregnancy, childbirth, and the postpartum period"* directly follows measure 4.1.1 Create a unified concept of care for mothers and children during pregnancy, childbirth, and after childbirth.

[1] The document presented here uses a narrower definition of motherhood. In accordance with the definition contained in the Dictionary of the Czech Standard Language, this term refers to the period including the time before childbirth (pregnancy), the time of childbirth, and the time after childbirth (the postpartum period). The material focuses on **women** who **are already pregnant with a wanted pregnancy,** their childbirth, the postpartum period, and any perinatal loss.

[2] For more details, see https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

This measure was part of the first version of the Gender Equality Strategy 2021–2030, specifically of the objective 4.1 “Strengthening women’s ability to choose the manner, place and circumstances of childbirth” in the Health chapter, but was not fulfilled within the specified timeframe. [3]

In addition to the postponement of the deadline, two further changes were made in the course of the task: the Government Commissioner for Human Rights, in cooperation with the Working Group on Obstetrics of the Government Council for Gender Equality [4], was actively involved in the preparation of the strategy together with the Minister of Health, and the original title of the document was changed. Instead of the original title "Concept" (of care for mothers and children), the document is now called "Strategy" (of care for mothers and children). However, the essence of the original government task, which was to develop a comprehensive strategic document on the care of mothers and children during pregnancy, childbirth, and after childbirth, has been fully preserved. The change in terminology from "concept" to "strategy" merely reflects the comprehensive nature of the document, which, in addition to an analytical section, also contains a task section, thereby fulfilling the characteristics of a strategy (rather than a concept) according to the typology of strategic and implementation documents and related terminology set out in[5] .



In the Czech Republic, there has not yet been a single overarching strategic document on the topic of care for mothers and children during pregnancy, childbirth, and postpartum, nor have there been national clinical guidelines within the relevant fields (which care for mothers and children in early motherhood). The present document is therefore the first of its kind in the Czech Republic.

The government embarked on developing the strategy in an effort to improve and supplement the existing system of maternal and child care. The strategy focuses on developing the strengths of the system while addressing the identified shortcomings and gaps, which are discussed in more detail in the following chapters of the document. The weaknesses of the system generate dissatisfaction and difficulties both for care recipients and their families and for healthcare providers. The Czech Republic has been repeatedly criticized for these shortcomings by international organizations (see Chapter 2.5 for more details). Last but not least, this strategy is also the government's response to the Constitutional Court's call[6] of September 2024 to revise legislation while respecting women's reproductive rights and taking into account developments in medicine, science, and law (for more details, see Chapter 3.3.5).

The strategy aims to ensure that the development of the existing maternity care system adequately responds to current social and health challenges. These include, for example, expected demographic developments, staffing of health services, and changes in the values of the current generation of women who wish to become parents. Among other things, the strategy also implements the recommendations of the European Court of Human Rights, which called on the Czech Republic to continuously review the relevant provisions of its legislation in light of developments in medicine, science, and law.[7]

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[3] Originally, this was a task “*to develop a Concept of Care for Mothers and Children during Pregnancy, Childbirth and the Postpartum Period in the Czech Republic*” from 2019, with a deadline set for 2020 (see Government Resolution No. 737 of 14 October 2019). However, in view of the COVID-19 pandemic, the Ministry requested a postponement, i.e. the incorporation of this requirement (with a later deadline) into the Gender Equality Strategy 2021–2030, approved by Government Resolution No. 269 of 8 March 2021 and subsequently updated by Government Resolution No. 682 of 2 October 2024.

[4] For more details on the strategy development process, see Chapter 5.

[5] Set out in the Methodology for the Preparation of Public Strategies, which was approved by the government and recommended for use by Resolution No. 71 of January 28, 2019.

[6] Contained in the grounds of the Constitutional Court's judgment, file no. I. ÚS 2746/23 of August 28, 2024, published on September 3, 2024.

[7] For more details, see the reasoning of the judgment in the case of Dubská and Krejzová v. the Czech Republic, available in Czech translation at:

The document presented here builds synergistically on other existing and planned strategic documents and initiatives of the Ministry of Health and other ministries. Under the auspices of the Ministry of Health, these include, in particular, the Strategic Framework for Health Care Development in the Czech Republic until 2030 (Health 2030), the activities of the National Institute for Quality and Excellence in Health Care (NIKEZ),[8] the Strategy for the Implementation of the World Health Organization and UNICEF Baby-friendly Hospital Initiative 2018 in the Czech Republic, and the draft Concept of Midwifery. Last but not least, the strategy also contributes to the fulfillment of the Government's Program Statement, in which the government committed to supporting women in their choice of care provider during pregnancy, childbirth, and after childbirth by making midwifery care available with an emphasis on continuity of care provided by one person.

### 1.2 Purpose of the Strategy

The primary purpose of the strategy is to realize the rights of women and children and to ensure that women have a positive birth experience and access to appropriate, available, and high-quality health services during pregnancy, childbirth, and the postpartum period. According to the WHO, a positive birth experience includes *"the birth of a healthy baby in a clinically and psychologically safe environment with continuous practical and emotional support from accompanying persons and kind, technically competent healthcare providers. It is based on the assumption that most women want to experience a physiological birth and achieve a sense of personal achievement and control through participation in decision-making, even when medical interventions are necessary or directly requested by women."*[9]



At the same time, the strategy aims to provide healthcare professionals with a clear and stable framework for providing healthcare services during pregnancy, childbirth, and the postpartum period, to strengthen their competencies, and to ensure effective cooperation and continuity between healthcare (and, where necessary, non-healthcare) professions caring for mothers and children during this period. The strategy will also strengthen the legal certainty of these professions and help prevent complaints and lawsuits that they fear when providing care in connection with childbirth.[10]

**To this end, the strategy builds on the strengths of the existing care system and improves its weaknesses. It builds on positive changes that have been achieved in some areas at the government level, by hospital management, or through grassroots initiatives, whether by care recipients or specific healthcare professionals. At the same time, the strategy includes measures to reverse negative trends where they persist or are getting worse.**

### 1.3 Users of the Strategy

Due to the nature of the strategy as a strategic government document, it is primarily intended for the relevant state administration bodies, led by the Ministry of Health. It sets out individual tasks (measures) to be achieved between 2024 and 2030 in order to achieve the defined strategic and specific objectives. The Government Commissioner for Human Rights and the Office of the Public Defender of Rights will also be involved in the process of implementing the strategy.

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http://eslp.justice.cz/justice/judikatura_eslp.nsf/WebSearch/6AA24AD6E570D2D0C12580FA004AE545?openDocument&Highlight=0.

[8] For more details, see https://www.uzis.cz/index.php?pg=centra--mc-nikez#o-centru and https://kdp.uzis.cz/index.php.

[9] WHO recommendations Intrapartum care for a positive childbirth experience, p. 1. Quoted from the Czech translation of the summary available at: https://www.unipa.cz/wp-content/uploads/2018/10/WHO-p%C3%A9%C4%8De-p%C5%99i-porodu-CZ-libre-2.1.pdf. For the original document, see https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf.

[10] For more information, see, for example, Glosová T. and Cibula D. 2018. *Complaints and lawsuits against doctors in the field of gynecology and obstetrics – results of a questionnaire survey.* In Česká gynekologie 2018, 83, no. 4.

The secondary, but no less important, group of users of the strategy includes primarily healthcare providers, hospital management, and health insurance companies. It also includes representatives of non-healthcare professions involved in maternal and child care during the period under review (e.g., psychology, social work, or doulas). The secondary group of users of the strategy also includes relevant professional (especially healthcare) organizations.

The strategy also envisages the involvement of non-governmental non-profit organizations, particularly women's and parents' organizations, and the academic sphere. The ultimate beneficiaries of the strategy are women with children and their families and, ultimately, the general public.

### 1.4 Legislation and Other Relevant Strategic Documents

The strategy is linked to a number of legal regulations and national strategic documents, to the objectives of which the implementation of this strategy should also contribute synergistically. The following regulations and documents will be taken into account in particular when implementing the strategy:

**Legal regulations**

- Constitutional Act No. 2/1993 Coll., Charter of Fundamental Rights and Freedoms
- Convention on Human Rights and Biomedicine
- Convention for the Protection of Human Rights and Fundamental Freedoms
- Convention on the Elimination of All Forms of Discrimination against Women (with emphasis on the Concluding Recommendations of the UN Committee on the Elimination of Discrimination against Women on the 6th periodic report of the Czech Republic)
- Convention on the Rights of the Child and General Comment No. 15 of the UN Committee on the Rights of the Child
- International Covenant on Economic, Social and Cultural Rights and General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights
- Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications and Regulation (EU)
- Act No. 372/2011 Coll., on health services and conditions for their provision, as amended
- Act No. 89/2012 Coll., Civil Code, as amended
- Act No. 48/1997 Coll., on public health insurance, as amended
- Act No. 95/2004 Coll., on the conditions for obtaining and recognizing professional qualifications and specialized qualifications for the practice of the medical professions of physician, dentist, and pharmacist, as amended
- Act No. 96/2004 Coll., on the conditions for obtaining and recognizing qualifications for the practice of non-medical healthcare professions and for the performance of activities related to the provision of healthcare and on amendments to certain related acts (Act on Non-Medical Healthcare Professions), as amended



**National strategic documents**

- Updated Strategic Framework for the Czech Republic 2030 with a view to 2050
- Strategic Framework for Health Care Development in the Czech Republic until 2030 (Health 2030)
- Gender Equality Strategy 2021–2030
- Strategy for the Implementation of the World Health Organization and UNICEF Baby-friendly Hospital Initiative 2018 in the Czech Republic
- Concept of Midwifery Care (in preparation)
- Family Policy Strategy 2023-2030
- Strategic Analyses of the Needs of the Health Sector: Concept Based on Available Data

**International strategic documents, standards, and recommendations**

- WHO recommendations on antenatal care for a positive pregnancy experience
- WHO recommendations on intrapartum care for a positive childbirth experience
- WHO recommendations on maternal and newborn care for a positive postnatal experience
- Implementation manual for the WHO and UNICEF Baby-friendly Hospital Initiative 2018 (Implementation guidance: protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative 2018)
- Ethical Framework for Respectful Maternity Care During Pregnancy and Childbirth
- 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care
- European standards for midwifery units (Midwifery Unit Standards)

### 1.5 Basic Terms Used

The definitions of basic terms used correspond to their established use in relevant international and national documents. In the text of the definitions, words that are equivalent to these terms or closely related to them and also used in the strategy are highlighted in bold.

#### 1.5.1 Health

The strategy uses the definition established by the WHO, which defines it as "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*."[11] This definition is also used in the central Czech strategic document for this area, namely the Strategic Framework for Health Care Development in the Czech Republic until 2030 (Health 2030).[12] The WHO, and by extension the Health 2030 strategy, emphasize that each person's health potential is the highest level of health they can achieve. *"It is also determined by the ability to care for oneself and others, to maintain control over one's life. Society should create conditions that enable people to realize their health potential. Health is determined by a number of factors, such as personal, social, economic, and environmental factors, which are interrelated variables and significantly influence and determine the health status of an individual, group of people, or society. They include the social, economic, and physical environment of the individual, as well as their individual characteristics and behavior (gender, heredity, lifestyle, etc.)."*[13]



#### 1.5.2 Human Rights-Based Approach to Health

The aim of this approach is the simultaneous realization of the right to the highest attainable level of health (or the right to health) and other health-related rights (i.e., the right to dignity, the right to physical and mental integrity, etc.).[14] This approach emphasizes the legal obligation of states bound by the right to health and other health-related rights, including the Czech Republic, to take measures to fulfill these obligations. This means taking measures to ensure that state health policies and interventions reflect the key principles understood as part of a human rights-based approach.

**Research shows that women and children benefit demonstrably from the application of a human rights approach to health, as it contributes to improving their health.**[15]

In addition to the actual fulfilment of the four basic components of the right to health, namely availability, accessibility, acceptability, and quality, this approach also emphasizes that human rights standards and principles, such as non-discrimination and equality, participation, and accountability, should guide the planning of all health-related policies at all stages of the process. *"A human rights-based approach does not simply mean achieving certain goals or outcomes, but achieving them through a participatory, inclusive, transparent, and responsive process."*[16]

[11] WHO 1946, (Health for All, HFA). For more information, see https://www.who.int/about/accountability/governance/constitution.
[12] Health 2030 sets the direction for the development of healthcare for Czech citizens for the current decade, with three main objectives: 1. improving the health of the population, 2. optimizing the healthcare system, and 3. supporting science and research. The document falls under the remit of the Ministry of Health, but has interdepartmental implications.
[13] Health 2030, p. 7. Available at: https://zdravi2030.mzcr.cz/zdravi-2030-strategicky-ramec.pdf.
[14] For more information, see https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.
[15] For more information, see, for example, F. Bustreo, P. Hunt, S. Gruskin, et al., Women's and children's health: Evidence of impact of human rights (Geneva: WHO, 2013). Available at: https://iris.who.int/bitstream/handle/10665/84203/9789241505420_eng.pdf?sequence=1.
[16] Ibid., p. 20.

### 1.5.3 Healthcare Service Provider (Care Provider)

The term "healthcare provider" refers, in accordance with the legal definition, to a legal or natural person who is authorized to provide healthcare services under the Healthcare Services Act. In parts of the strategy that refer to healthcare providers as natural persons, the terms "healthcare professional" or "**healthcare** staff" are used, or the name of the specific medical or non-medical profession. Similarly, in cases where it is necessary to emphasize healthcare providers in the sense of legal entities, the terms "hospital," "maternity hospital," or **"facility**" are used preferentially. The term "**healthcare** facility" refers to a space designated for the provision of healthcare services.

### 1.5.4 Recipients of Healthcare Services (Care Recipient)

A recipient of healthcare services is a woman who is provided with healthcare services (not only) during pregnancy, childbirth, and the postpartum period. According to the terminology of the Health Services Act, this is a "patient" as defined in Section 3(1), i.e. a natural person to whom health services are provided. The strategy uses **the term "patient"** mainly in connection with patient rights and in relation to specific provisions of the Health Services Act, but deliberately prefers the terms "recipient of health services", **"recipient of health care**" or **"client".** By preferring this terminology, the strategy emphasizes the concept of pregnancy and childbirth as primarily physiological processes that can occur without complications for most women and their children. A woman in early motherhood is thus primarily viewed as a person undergoing physiological processes related to pregnancy, childbirth, and the postpartum period, rather than as a patient in the sense of a sick person undergoing treatment.[17] This approach is also consistent with the principles of the bio-psycho-social model of care. Last but not least, the chosen terminology better emphasizes the relationship between the provider and recipient of health services (care) as equal subjects. On one side of this symmetrical relationship is the service provider and on the other side is the service recipient (client).



### 1.5.5 Early Motherhood

The period covering the time before birth (pregnancy), the time of birth, and the time after birth (the postpartum period).

### 1.5.6 Evidence-Based Practice

It refers to a systematic approach to solving clinical problems that allows the best available scientific evidence to be combined with clinical experience[18] and patient preferences.[19] The definition places equal emphasis on all these components and aims to optimize care so that it balances the benefits to the patient's physical health and quality of life. It is a practice that has been proven to improve patient outcomes and has economic benefits for healthcare systems. It was first developed in the 1990s in the field of medicine and then spread to other areas where people who provide care meet those who receive care (e.g., nursing, social work). This is where its other names come from, such as evidence-based medicine (EBM) or evidence-based care. In Czech, the equivalent term for this approach is **praxe založená na důkazech** (practice **based on evidence**).

When deciding on a course of treatment or evidence-based treatment, healthcare professionals take into account:

- their own clinical experience,
- the best available scientific knowledge in the field,

[17] I.e. according to the definition of patient in the Dictionary of the Czech Language.
[18] I.e. individual clinical experience based on a set of knowledge and skills acquired during the study and practice of a healthcare professional.
[19] For more details, see Sackett DL, Straus SE, Richardson WS, Rosenberg W, Haynes RB. *Evidence-based medicine: How to practice and teach EBM (2nd edition).* New York: Churchill Livingstone; 2000.

- the preferences, needs, and wishes of the client receiving care.

Diagram 1: Components of EBP




### 1.5.7 Positive Birth Experience

A positive birth experience is linked to efforts to ensure that the goal of care provided during childbirth is not "mere" survival of women and their children, but also the achievement of their full potential for health and quality of life. The WHO considers **a positive birth experience** to be important for all women who give birth. It defines it as an experience that meets or exceeds a woman's individual and sociocultural expectations and beliefs about childbirth. *"A positive birth experience means, among other things, the birth of a healthy baby in a clinically and psychologically safe environment with continuous practical and emotional support from accompanying persons and kind, technically competent healthcare providers. It is based on the assumption that most women want to experience a physiological birth and achieve a sense of personal achievement and control through involvement in decision-making, even when medical interventions are necessary or directly requested by women."*[20]

To this end, the WHO has formulated 56 specific recommendations. These complement the WHO recommendations on prenatal and postnatal care for mothers and newborns. The content of the recommendations for all three key periods of early motherhood, which aim

[20] WHO recommendations Intrapartum care for a positive childbirth experience, p. 1. Quoted from the Czech translation of the summary available at: https://www.unipa.cz/wp-content/uploads/2018/10/WHO-p%C3%A9%C4%8De-p%C5%99i-porodu-CZ-libre-2.1.pdf. Original document available at https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf.

toensure a positive experience of childbirth, **a positive experience of pregnancy**[21] and **a positive experience after childbirth,**[22] is consistently reflected in the strategy.

### 1.6 Cross-Cutting Principles

The following five mutually reinforcing and interconnected cross-cutting principles will be applied in the implementation of the strategy (see also Diagram 2):

#### 1.6.1 Consistent Respect for the Rights of Women and Children

This cross-cutting principle is based on a human rights approach to health (see subchapter 1.5 for more details) and emphasizes the simultaneous realization of the right to the highest attainable standard of health (or the right to health) and other closely related rights. It emphasizes human dignity as a fundamental and non-negotiable value. Dignity is a principle that is not subordinate to any other fundamental rights, as it is at the core of these rights. **Human dignity** thus plays a role in the interpretation and interconnection of other fundamental rights and also serves as a tool for their protection. The practical application of these rights, as well as all four fundamental components of the right to health (availability, accessibility, acceptability, and quality), in the provision of health services related to early motherhood is clearly analyzed by the strategy for each topic throughout the analytical part of the strategy. Efforts to apply these rights and the patient rights derived from them in practice are also reflected in the content of the measures included in the task section.



#### 1.6.2 Women and Child as an Inseparable Unit

In line with this principle, the strategy does not, a priori, place the interests of women in opposition to those of children. Care for the mother has a significant impact on the child, just as care for the child also affects the mother. In line with evidence-based practices, the strategy treats the mother and child as a unit, or an indivisible unit (mother-baby dyad, woman-newborn dyad), and strives to ensure that the care provided to them is not dualistic or segmented and, above all, does not result in **the unjustified separation of the mother and child** from each other. The application of this principle is particularly important during the postpartum period and immediately after birth, when it is crucial to ensure immediate, **uninterrupted skin-to-skin contact** between mother and child for at least 60 minutes. Unless serious health reasons prevent it, all procedures are performed with the child remaining with the mother (parent), including basic newborn care. When a woman stays in the hospital with her baby during the first days after birth, or when only one of them needs to be hospitalized, the mother stays with her baby in the same room (**rooming-in)** from immediately after birth or from the time she is able to respond to her baby until discharge.[23] During the six weeks after giving birth, the mother has the option of using the visiting services of a midwife or other healthcare provider competent to provide care for both her and her child.

#### 1.6.3 Women and Their Families at the Center of Services Provided

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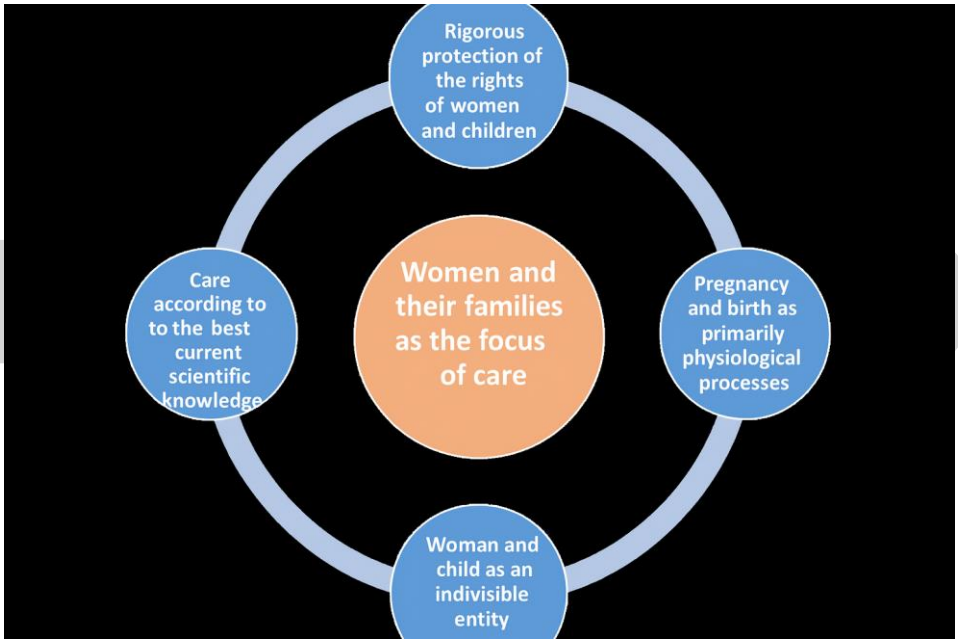
[21] *"A positive pregnancy experience is defined as maintaining physical and sociocultural normality, ensuring a healthy pregnancy for both mother and child (including treatment and prevention of risks, illness, or death), an effective transition to a positive birth, and achieving a positive experience of motherhood (including maternal self-confidence, feelings of competence, and autonomy)."."* Quoted from the Czech translation of the summary of relevant recommendations available at: https://www.unipa.cz/wp-content/uploads/2018/10/WHO-p%C3%A9%C4%8De-p%C5%99i-porodu-CZ-libre-2.1.pdf. For the original version of the recommendations, see https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf.

[22] *"A positive postpartum experience is defined as an experience in which women, newborns, partners, parents, caregivers, and families receive information, reassurance, and assistance."* For more information, see https://www.who.int/publications/i/item/9789240045989.

[23] I.e. they are together throughout the day and night.

The central cross-cutting principle of the entire strategy is the concept of woman-centered care[24] combined with family-centered care. [25]This cross-cutting principle is based on the bio-psycho-social model of care and develops a pro-patient approach, or the concept of people-centered care (person-centered care, patient-centered health care) for the context of early motherhood. At the core of these concepts is **a** respectful, **partnership-based approach on the part of healthcare professionals** who provide health services to women and their families. An inherent part of this approach is respect for the autonomy and wishes of women, their mental and physical integrity, and the needs of their families, which is reflected, among other things, in the communication of healthcare professionals and in **the corresponding organization of healthcare services.** *"The needs of the mother-child pair should take precedence over the needs of care providers, institutions, and the medical industry."*[26]

Diagram 2: Cross-cutting principles




The strategy therefore views the passage through the care system from the perspective of women and strives to make it as least burdensome as possible for mothers and their families, to respect their individual needs, and to lead to a positive experience of care for women. This is also linked to the requirement for universal **access to continuous care**.

The system *of "birth care and its implementation must meet the needs of the mother-child-family triad in order to achieve the full potential of safe and respectful birth care. Throughout the entire continuum of birth care, i.e. during pregnancy, childbirth, and the postpartum period, the mother-child unit and the family should be actively involved in the provision of care, with the aim of reaching a joint decision, with the final decision being made by the mother."*[27]

[24] For more information, see, for example, https://www.who.int/health-topics/maternal-health#tab=tab_3.
[25] For more information, see, for example, COULTER, A. – OLDHAM, J. (2016). Person-centered Care: what is it and how do we get there? In: Future Healthcare Journal, 3(2): 114-116.
[26] For more information, see "Current trends in maternity care" available at: https://pruvodce-porodnicemi.aperio.cz/aktualni-trendy-v-porodni-peci/
[27] For more information, see 12 steps to safe and respectful care for mothers, babies, and families, available at: https://icichildbirth.org/initiative/, available in Czech at: https://czlobby.cz/cs/dokumenty/12-kroku-k-bezpecne-respektujici-peci-o-matku-dite-rodinu-v-cestine-doporuceni-ici.

**Adapting the organization of health services to create conditions for the provision of respectful care in early motherhood is an integral part of supporting women's reproductive health and rights.**

### 1.6.4 Care in Accordance with Current Scientific Knowledge (*de lege artis*)

Another key principle that runs through the strategy is the provision of care at an appropriate level of expertise. The strategy responds to the latest developments in knowledge in the area concerned and emphasizes the need to provide care in a manner consistent with scientifically based practices. By emphasizing evidence-based practice (see also subchapter 1.5 for more details), the strategy emphasizes practices that lead to the consistent fulfillment of the main legal obligation of healthcare providers, which is to *"provide healthcare services in accordance with the rules of science and recognized medical practices, while respecting the individuality of* the patient" ([28] ) (de lege artis), and to the effective application of informed consent as one of the key patient rights.[29] The obligation to proceed de lege artis applies to both medical and non-medical professions.

### 1.6.5 Pregnancy and Childbirth as Physiological Processes

Pregnancy, childbirth, and breastfeeding are fundamentally natural, physiological processes, not diseases. As such, they require optimal, supportive care and attention from professional staff. Care that is adequately tailored at each stage to the degree of risk to the mother and child (or fetus) and avoids *"potentially harmful interventions and procedures for which there is insufficient evidence that their benefits outweigh the risks."*[30] Although some pregnancies and births are associated with specific risks and require some type of intervention, **most** women are normally **able to give birth physiologically.** However, the ability to give birth naturally can be impaired by unnecessary interventions, an inappropriate environment, poor communication from healthcare personnel, and other factors.



The strategy therefore focuses on developing care that supports the physiology of pregnancy and childbirth and corresponding clinical and other procedures, including the creation of an adequate environment for the provision of such care, as this also plays an important role in maintaining the physiology of these processes.[31] Supporting the normal physiological birth process and **eliminating unnecessary and potentially harmful interventions** is not incompatible with the safety and quality of the services provided – quite the contrary. The WHO points out that overmedicalization of childbirth worsens outcomes and the quality of care for women, places an unnecessary burden on healthcare personnel, and is economically inefficient.

*"An interventionist approach is not sufficiently sensitive to the personal needs, values, and preferences of women (and their families) and may undermine their own abilities during childbirth and negatively affect their birth experience."*[32]

The strategy aims to ensure that all interventions in the pregnancy and birth process are carried out in direct response to the confirmation of a specific risk or complication, rather than routinely or for other medically unjustified reasons.[33]

[28] Section 4(5) of the Health Services Act
[29] For more details, see Section 34 of the Health Services Act.
[30] For more details, see step 7 of the 12 steps towards safe and respectful care for mothers, children, and families, available at: https://icichildbirth.org/initiative/, available in Czech at: https://czlobby.cz/cs/dokumenty/12-kroku-k-bezpecne-respektujici-peci-o-matku-dite-rodinu-v-cestine-doporuceni-ici.
[31] MU Standar available at https://apodac.org/wp-content/uploads/MUNET-Standards_4_2021_CZ1.pdf.
[32] WHO recommendations Intrapartum care for a positive childbirth experience, p. 8.
[33] E.g. "prevention of complaints," or out of fear that the mother will complain or file a lawsuit; for the purpose of increasing reimbursement for care provided, etc.

## 1.7 Preliminary SWOT analysis

The preliminary SWOT analysis briefly summarizes the main strengths, weaknesses, opportunities, and threats identified in the initial phase of strategy preparation. **The** individual **points** are placed in a broader context in **the following chapters**, **analyzed in detail**, and supplemented with relevant sources.

| **Strengths** | **Weaknesses** |
|---|---|
| – Existence of a public health insurance system (Chapter 2.1)<br>– Dense network of maternity hospitals with a three-tier model of care ensuring that there is at least one PCIMP or PCIP in each region (Chapter 2.1)<br>– Most women start prenatal care by the 12th week of pregnancy (Chapter 2.1)<br>– Long-term low neonatal mortality rate (Chapter 2.1)<br>– A system capable of early classification of women into low-risk and high-risk categories (Chapter 2.1)<br>– Women who need highly specialized care receive it in a timely manner (Chapter 2.1)<br>– Low maternal mortality (chapter 2.1)<br>– Building a database for the National Reproductive Health Register and satisfactory validation results from independent data sources (Chapter 3.1)<br>– Obligation to publish statistical data at the level of healthcare providers and newly introduced benchmarking option (Chapter 3.1)<br>– Strategic commitment to strengthening primary care (Chapter 1.4) | – High levels of dissatisfaction with care are also evident in comparison with other medical fields (Chapter 2.2).<br>– Unmet demand for respectful care (Chapter 2.2)<br>– Persistent routine practices and higher rates of intervention (Chapter 3.1)<br>– Significant differences in the quality of care provided across individual facilities and regions (Chapter 3.1)<br>– Lack of national clinical guidelines (Chapter 3.1)<br>– Fragmentation and duality of care (mothers are not cared for as indivisible units) – reflected across several chapters<br>– Ineffective cooperation between different professions (Chapter 3.2)<br>– Inappropriate interference by medical professions in the competences and professional self-government of midwives (Chapter 3.2)<br>– Legislative barriers preventing midwives from fulfilling their competences (chapter 3.2)<br>– Restrictions on women's choice of place, manner, and circumstances of birth due to the lack of independent birth centers and the inability to use health services during birth in their own social environment (Chapter 3.3) |

| | |
|---|---|
| | – Poor outcomes in perinatal mental health (Chapter 3.6)<br>– Decline in the number of exclusively breastfed children during their stay in the maternity ward/upon discharge from the maternity ward (Chapter 2.1)<br>– High level of complaints and lawsuits from women and their families (Chapter 2.3)<br>– Failure to comply with the Czech Republic's international human rights obligations (Chapter 2.4)<br>– Insufficient continuity of birth and postnatal care (Chapter 2.1)<br>– Insufficient legal awareness of healthcare professionals about patients' rights and the obligations of healthcare providers (Chapter 3.4)<br>– Poor and insensitive communication by healthcare personnel (Chapter 3.4 and 3.5)<br>– Stigmatization of women and families who prefer non-clinical or outpatient birth (Chapter 3.2)<br>– Absence of regular supervision<br>– Shortcomings in the application of free and informed consent (chapters 3.4 and 3.5) |
| **Opportunities** | **Threats** |
| – Establishment of the NIKEZ methodological center (Chapter 3.1)<br>– Existing international standards and clinical practices, including possibilities for their adaptation to the Czech Republic (Chapter 3.1)<br>– Possibility of technical assistance from the WHO and other international organizations (Chapter 3.1) | – Insufficiently respectful care and violations of the principles of informed consent (Chapter 3.4)<br>– Current or increasing rate of routine interventions contrary to evidence-based practices (Chapter 3.1)<br>– Persistent shortcomings in communication by healthcare personnel (chapter 3.1)<br>– Unnecessary separation of women and children and complications in |

| | |
|---|---|
| – Emphasis on primary care and associated savings in public funds (Chapter 3.3)<br>– Revision of educational curricula, including an emphasis on building and improving the communication skills of healthcare professionals (chapters 3.4 and 3.5)<br>– Introduction of regular supervision (Chapter 3.4)<br>– Well-considered investments in infrastructure, including the use of EU funds (chapter 3.3)<br>– Possibility to build on existing grassroots initiatives (from care recipients, individual healthcare professionals, and hospital management) – reflected across several chapters<br>– Public awareness and the possibility of developing NZIP – reflected across several chapters<br>– Continuing digitization of healthcare with the associated reduction in administrative burdens and more accurate data collection (Chapter 3.1)<br>– Decrease in the number of births in terms of facilitating the transition and organizational changes in facilities towards the provision of individualized and woman-centered care (chapter 2.1)<br>– Fulfillment of the government's commitment from its program statement (Chapter 1.1)<br>– Constitutional Court ruling on home births attended by midwives (Chapter 3.3) | establishing their relationship and family functions – reflected across several chapters<br>– Worsening health impacts on women, at least in the mental health area, including related economic impacts (Chapter 3.6)<br>– Legal uncertainty among healthcare personnel and the associated higher level of interventions (carried out “to be on the safe side”) – (Chapter 3.4) Burnout among healthcare workers (Chapter 3.4)<br>– Lawsuits against healthcare providers and the Czech Republic (Chapter 2.3)<br>– Lack of qualified personnel due to demotivation to enter the relevant medical or healthcare field, or departures from it (Chapter 2.3 and 3.4)<br>– Threat of closure of some maternity hospitals (Chapter 2.1) Inefficient use of public funds (Chapter 3.3)<br>– Criticism from the international community (Chapter 2.4) |



## 2. Definition and Analysis of the Problem Addressed

The strategy addresses problems in the current system of care for women and children in early motherhood, with an emphasis on a human rights-based approach to health, access to continuous care, and ensuring a positive experience of pregnancy, childbirth, and the

postpartum period.[34] It is based on the premise that every woman and newborn should receive high-quality, safe, and respectful care throughout pregnancy, childbirth, and the postpartum period. The strategy therefore focuses on identifying and removing barriers that currently prevent women from accessing safe, respectful, and individualized care at every point of contact (with the person or small group of people providing care to the woman) with the application of effective clinical practices and the provision of relevant and timely information, including psychosocial and emotional support, by healthcare personnel with good clinical and interpersonal skills within a well-functioning healthcare system whose components and individual professions cooperate effectively with each other.[35]

The overarching goal of the strategy is to make care that meets the above criteria universally accessible to all women in all regions and facilities as a standard of care covered by public health insurance. It should also be available to women who are in a more difficult economic situation or face other disadvantages.[36] At the same time, the strategy aims to ensure that access to this care is not obstructed by preventing the choice of healthcare provider or by insufficient cooperation between the professions that are supposed to provide it.

### 2.1 Basic Overview of the Situation in the Czech Republic

Approximately 100,000 women give birth in the Czech Republic every year. With the exception of 2021, however, there has been a downward trend in the number of births since 2018. Between 2000 and 2022, the average annual number of births was 104,818. The average age of women at childbirth during this period rose from 26.8 to 31.1 (to 31.08 in 2022 and 31.10 in 2023). The total fertility rate (average number of children per woman)[37] fell to 1.62 in 2022. This was followed by another year-on-year decline in 2023 to 1.45 children per woman. The year-on-year decline in births in 2022 was more pronounced than in previous years, and 2023 also saw a significant decrease in the number of births. Specifically, the year-on-year decline in the number of births was 10%, from 100,464 births in 2022 to 90,369 births in 2023. This was the largest decline since the mid-1990s, and the decline in the number of births is expected to deepen this year and in the coming years.[38]



The above trends have complex socio-cultural causes and are linked to changing values in society. These individual structural causes (including, for example, insufficient capacity in pre-school education facilities) are addressed in more detail in other government policy and strategy documents[39] and it is not the purpose of this strategy to deal with them. However, by focusing on the development of respectful care in early motherhood for women who are already pregnant and want to have children, the strategy may secondarily contribute to addressing one of the many causes of the declining birth rate. This is the fear of further pregnancy and childbirth arising from poor experiences with care or exposure to obstetric violence. Research shows that this traumatic experience is one of the factors that lead women to decide not to have another child (see Chapter 3.5.4 for more details). Last but not least, the declining birth rate is also relevant in view of the future risk of some maternity hospitals having to close and the increasing pressure to improve the quality of care and meet women's expectations and needs if healthcare providers want to retain their clients.

[34] For the definition of a positive birth experience and related definitions of positive pregnancy and postpartum experiences used by the WHO, see subchapter 1.5.
[35] For the purpose of the strategy, see also subchapter 1.3.
[36] I.e., it should not be a paid or otherwise unavailable extra service that some women cannot afford due to poverty or other disadvantages.
[37] I.e. the average number of live births per woman aged 15-49, assuming that age-specific fertility rates in a given calendar year remain unchanged (for more details, see https://www.czso.cz/csu/gender/gender_obyvatelstvo-metodika).
[38] Data source: NRRZ and ČSÚ.
[39] E.g. in the Family Policy Strategy 2023-2030.

*Graph 1: Total number of births in the Czech Republic in 2000-2023*

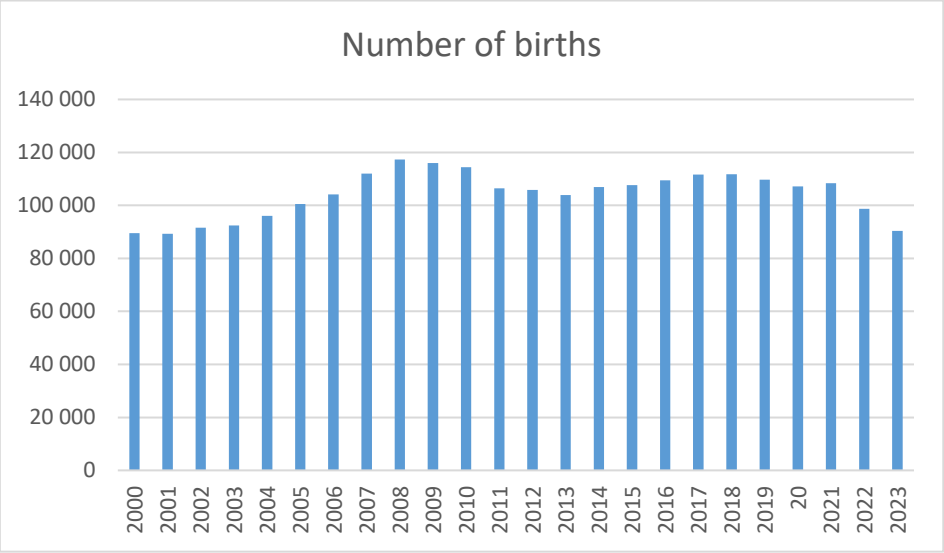
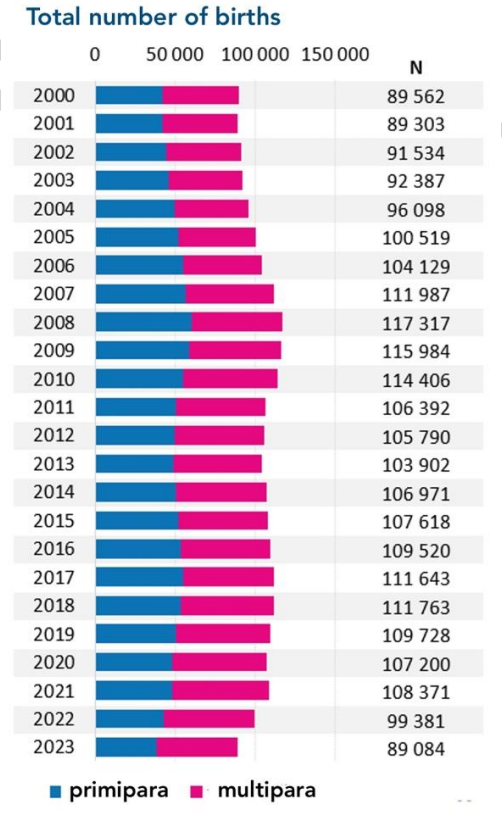



*Chart 2: Total number of births in the Czech Republic in 2000-2023, broken down by first-time mothers and multiparous women*

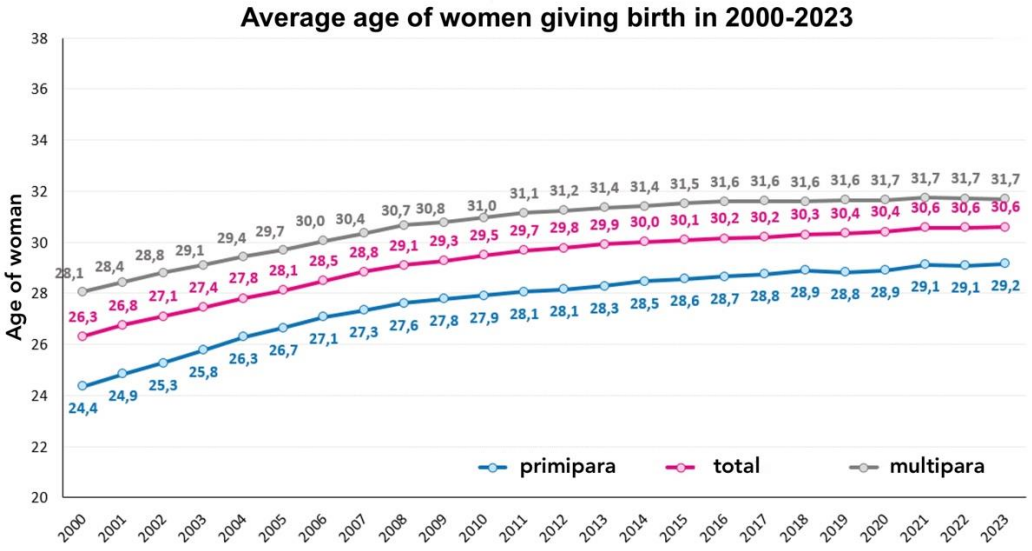





*Source: ÚZIS ČR – NRRZ – Module Rodička*[40]

[40] Corresponds to the status of the register as of November 15, 2024.

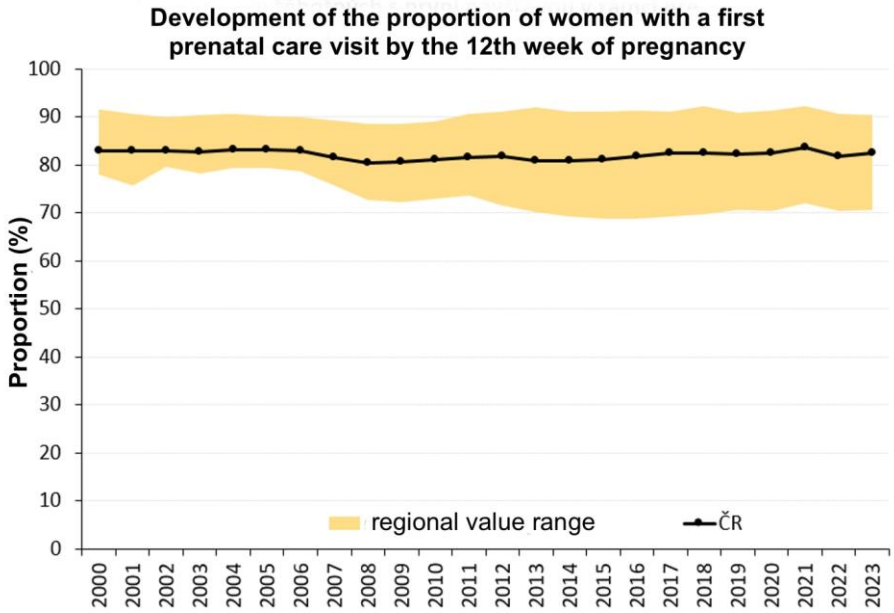
*Graph 3: Average age of women giving birth in 2000-2023*




Most pregnant women in the Czech Republic have their first contact with healthcare professionals by the 12th week of pregnancy and undergo nine check-ups as part of prenatal care. The proportion of women who start prenatal care by the 12th week was 82.4% in 2023. This proportion has remained stable over the long term (see Chart 4). There was a slight decrease in the average number of prenatal check-ups during the period under review (from 12 in 2000 to 9 in 2023 – see Chart 5), but this is not contrary to professional recommendations. The WHO recommends prenatal care models with at least 8 contacts[41] to reduce perinatal mortality and improve women's experience of care, noting that studies do not indicate any significant difference in health outcomes between models that included at least 8 contacts and models that included 11 to 15 contacts.

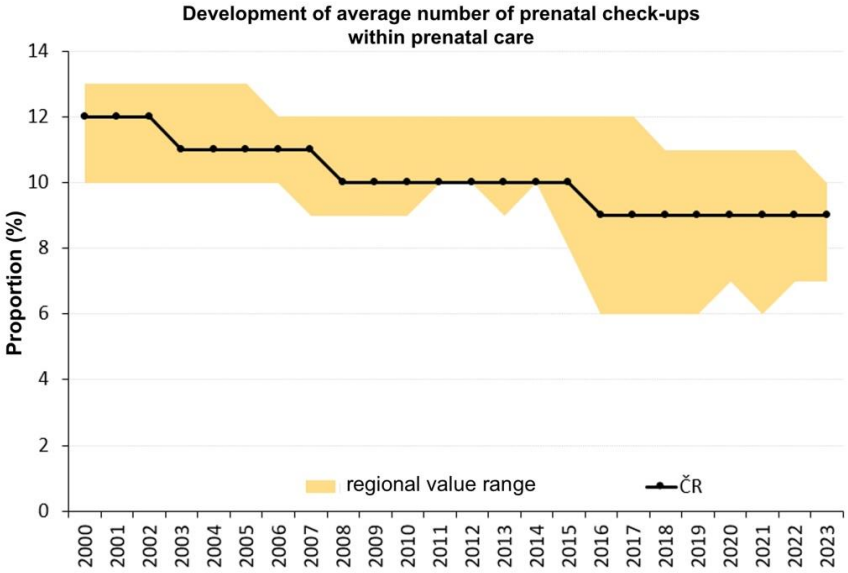


*Chart 4:*




[41] Recommendation E.7.

*Chart 5:*




Healthcare for women in early motherhood, especially during pregnancy and childbirth, is currently concentrated in the Czech Republic in the hands of doctors specializing in gynecology and obstetrics. Under the current system**,** only they can be **the primary registering provider** for women during pregnancy**,** who can provide them with care covered by public health insurance. In practice, they are also predominantly the ones who decide on the degree of risk and classify pregnant women into the following groups:



- low-risk pregnant women,
- pregnant women with a defined specific risk (high-risk).

The system provides timely specialized care to women at high risk. However, the assessment of which category a woman falls into is, to a certain extent, arbitrary, as there are no uniform national standards according to which both groups would be defined, or according to which at least one of them would be uniformly defined.[42] Risk scoring therefore varies across workplaces (and, by extension, regions). Similarly, there is no nationally defined procedure for when a woman should be transferred from the care of a midwife to medical care – it is therefore up to individual healthcare professionals to assess this, or some facilities define these criteria internally and they are only applied within individual workplaces (e.g., hospitals with midwifery centers, which offer women, among other things, pregnancy counseling provided by midwives). This degree of inconsistency encourages **excessive medicalization of pregnancy, even in low-risk women who do not necessarily need a higher level of care.** Clarifying the distinction between these two groups of pregnant women and the indications for when a midwife should refer a woman to medical care and when she can take her back does not lead to a reduction in the quality of care, but rather to higher quality and prevents the overuse of specialized care.

During pregnancy, women must pay for midwifery care themselves or obtain consent from their attending physician, typically (but not necessarily) from the field of gynecology and obstetrics.[43]

[42] The list of specific risks contained in the recommended procedure of the ČGPS ČLS JEP, or *the Principles of Dispensary Care in Pregnancy,* is only illustrative, not exhaustive. The definition of a low-risk woman is completely absent from the procedure.

[43] The law does not regulate the medical field that can provide an indication for reimbursement of midwife care. It may therefore also be indicated, for example, by a general practitioner or doctor for adults or upon discharge from the maternity hospital.

In practice, midwives are not often authorized to provide comprehensive examinations[44] and subsequent check-ups for pregnant women[45] , and any indication for these services usually applies only to midwives working in a hospital outpatient clinic or in the office of a registered gynecologist.

The current privileged position of doctors in the care of pregnant women is reinforced by the linking of reimbursement mechanisms for pregnancy care with the recommended procedures of the Czech Gynecological Society (ČGPS ČLS JEP) and *the Principles of Dispensary Care in Pregnancy*, which do not provide for the involvement of midwives in the care of pregnant women. Outpatient gynecologists are reimbursed for the care of pregnant women in the form of aggregate payments linked to individual trimesters. If part of this care is provided by a non-registered healthcare provider, they are reimbursed through the reimbursement of individual currently valid healthcare services, which are then deducted from the registered provider.

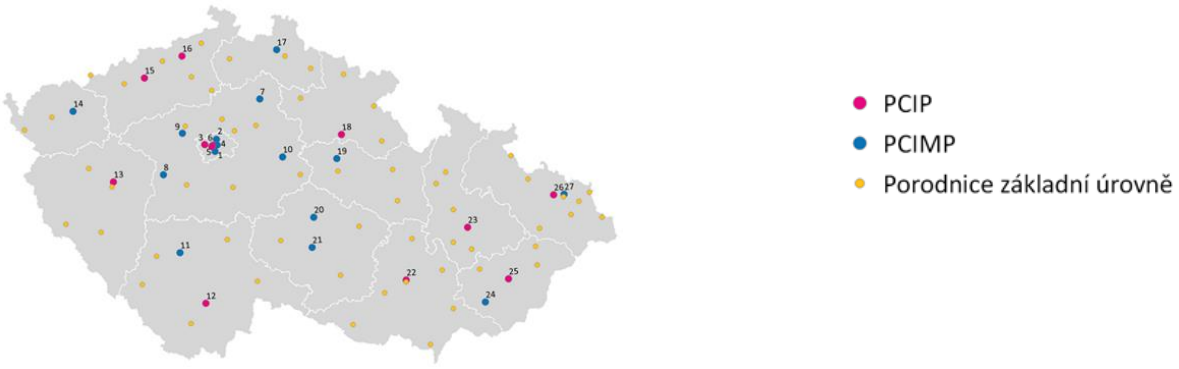
Childbirth care in the Czech Republic is currently covered by health insurance companies exclusively in the form of inpatient care. After giving birth, women are recommended to stay in hospital with their baby for up to three days. If a woman leaves within 48 hours of giving birth, the maternity hospital receives a reduced payment from the insurance company for the hospital stay. Childbirth in a separate birthing center is not possible, as there are currently none in the Czech Republic due to strict legislation (see Chapter 3.3.3 for more details). In recent years, birth assistance centers have been established in a few maternity hospitals, but there is currently no national standard governing them. At the same time, women must pay extra from their own pockets for individualized care from a midwife, which, in addition to the overall low capacity of these centers, is another reason why they are difficult for most women to access (see Chapter 3.3.3 for more details). If a woman chooses to give birth in her own social environment, the care she can receive does not fall within the scope of the Health Services Act. She is therefore not currently entitled to reimbursement from public insurance (for more details, see Chapter 3.3.5). The exception is emergency care, which is a health service within the meaning of the Act of the same name (for more on the causes and consequences of this inconsistency and duality, see Chapter 3.3.5).



The emphasis on providing care to women in labor in inpatient healthcare facilities is reflected in a dense network of maternity hospitals. There are currently 86 maternity hospitals in operation in the Czech Republic, of which 60 provide basic healthcare, 15 are intermediate care centers (PCIMP), and 12 are intensive care perinatal centers (PCIP) – see Figure 1. Each region has at least one perinatal intensive or intermediate care center to ensure that all mothers have access to specialized care close to their homes. Thanks to this network of state-of-the-art intensive and intermediate care perinatal centers, which centralize care for women with pathological pregnancies, the Czech Republic has long had one of the lowest perinatal mortality rates in Europe.

[44] For more information, see https://szv.mzcr.cz/Vykon/Detail/06021.
[45] For more information, see https://szv.mzcr.cz/Vykon/Detail/06023.

Figure 1: Location of maternity hospitals in the Czech Republic




Basic level

- 59 first-level maternity hospitals
- Closest to the pregnant woman's place of residence
- With the exception of the capital city of Prague, at least two such facilities in each region

Perinatal center for intermediate care

- Second level of care for pregnant women and women in labor
- 15 facilities in a total of 9 regions
- Care for moderately serious cases and pathologies, concentrating on premature births from 31+0 weeks of pregnancy



Perinatological center for intensive care

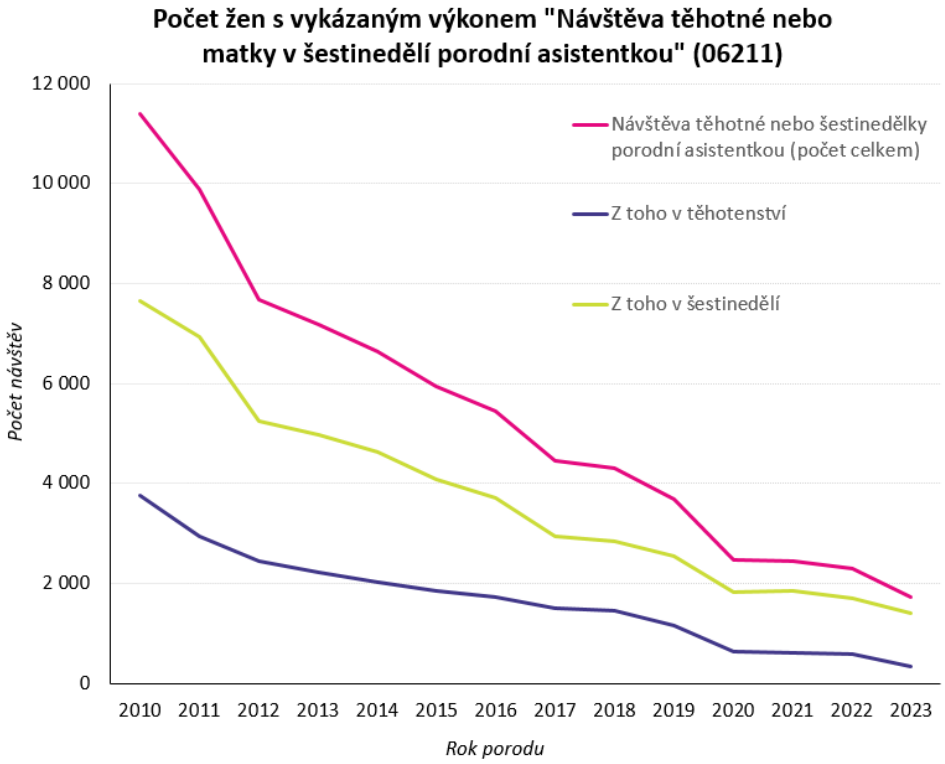
- Level 3 care for pregnant women and women in labor
- 12 facilities in a total of 9 regions
- Care for the most serious cases and pregnancy pathologies, focusing on premature births from 23+0 to 31+0 weeks of pregnancy

Given the declining number of births, some maternity hospitals are now at risk of closure. The low number of births leads to inefficient use of healthcare personnel, who are already in short supply in some regions, and also has a negative economic impact on the operation of these facilities. The pressure to streamline operations, and thus to gradually close or merge, is particularly strong in maternity hospitals located in close proximity to one another. Hospitals with low birth rates also risk losing their accreditation for specialized training in gynecology and obstetrics. The Accreditation Commission for Gynecology and Obstetrics at the Ministry of Health has set a condition for maintaining this accreditation of at least 600 births in the last calendar year or an average of 600 births per year over the last three calendar years. Currently, 20 facilities do not meet this condition. The threat of losing accreditation also discourages young doctors from joining these facilities, as their practice there would not count towards their pre-certification training. However, the closure of maternity hospitals may also be an opportunity – the vacated premises could be used, for example, to set up facilities run autonomously by midwives (see Chapter 3.3).

Postnatal care for women and newborns is usually provided during the first three days after birth as part of hospitalization related to childbirth, during which newborn screening is also performed. If a woman leaves the maternity hospital before the recommended period of 72 hours after delivery, or gives birth at home, she has more difficult access to newborn screening. The first examination of the newborn by the PLDD should take place no later than two days after discharge from the maternity hospital. During the postpartum period, the system also

provides for the reimbursement of preventive examinations of newborns in the second and sixth weeks of life. Care for women during the rest of the postpartum period is not adequately provided, as women return to the gynecological clinic at the end of the postpartum period or after it has expired. The so-called visiting service provided by midwives is also not adequately used. In 2022, the number of women for whom this health service was reported during the postnatal period was only 1,712 (see Chart 6).

*Chart 6*




While three preventive check-ups are recommended and performed for infants during the postpartum period, no preventive check-ups are planned for mothers, and only acute conditions are actually addressed. However, inadequate prevention for women during the postpartum period can also have later effects, such as premature cessation of breastfeeding, problems related to poor healing of birth injuries, or mental health or musculoskeletal problems. **Inadequate care for women during the postpartum period is in stark contrast to the intensive monitoring they receive during pregnancy and childbirth.** It is also contrary to WHO recommendations, which recommend at least three additional postnatal contacts for healthy women and newborns after discharge from the maternity ward,[46] , preferably in the home environment and with an emphasis on treating the mother and child as an indivisible unit (mother-baby dyad).

The current care system has its strengths and weaknesses, which, together with opportunities and threats, are briefly summarized in a SWOT analysis (see Chapter 1.7). Individual issues are addressed in more detail in separate chapters in the next section of the strategy.

[46] If the birth takes place in a health facility, healthy women and newborns should receive postnatal care in that facility for at least 24 hours after birth, according to the WHO. If the birth takes place at home, the first postnatal contact should be as soon as possible within 24 hours after birth. At least three additional postnatal contacts are recommended for healthy women and newborns, within 48 to 72 hours, 7 to 14 days, and during the sixth week after birth.

The suitability of the current healthcare system has so far been assessed mainly in terms of low perinatal mortality. Although this factor is important and it is in the public interest to keep it low, it is not a suitable umbrella tool for measuring the overall quality of care provided during early motherhood. The quality of maternity care must also be measured with regard to the subjective perceptions of women giving birth[47] , which are discussed in more detail in Chapter 2.3). Furthermore, the perinatal mortality rate indicator reflects in particular the success and quality of highly specialized care for the most complicated pregnancies and premature and otherwise at-risk newborns. In countries with comparable or even better results in this area (e.g., Sweden), midwives may be the primary healthcare providers, and procedures to ensure respectful care are applied in practice. Such countries then have, in addition to high-quality perinatal outcomes, significantly better outcomes in women's care (e.g., in the rate of episiotomies), which is also reflected in higher levels of women's satisfaction with care and other relevant indicators. The analytical part of the strategy therefore focuses primarily on the weaknesses of the system, offering ways to remedy them.

### 2.2 Survey on Women's Satisfaction with Care

*"Women's positive experience of maternity care is linked to the quality of care and is just as important as objectively measurable perinatal outcomes."*[48] Accurate identification of the determinants of women's satisfaction with care is a key prerequisite for changing current practice and developing respectful care in early motherhood. The main conclusions from selected research and surveys[49] in the Czech Republic are therefore presented in more detail below, in particular those in which a higher number of female respondents participated, or those initiated, implemented or otherwise supported by the Ministry of Health.



One of the first surveys to look at women's satisfaction with care in Czech maternity hospitals was carried out as part of *the Quality Through the Eyes of Patients* project. The project was developed in cooperation between the Ministry of Health and the STEM/MARK agency and is still partially running today.[50] The methodology for distributing and collecting questionnaires for evaluating patient satisfaction was published by the Ministry in 2008.[51] In the introduction to the methodology, it emphasized that patient satisfaction is an important indicator of the quality of health services and that publicly available information on the quality of individual healthcare facilities, on the basis of which people can make decisions, is a prerequisite for fulfilling *the "patient's* right *to free choice of doctor and healthcare facility.*"[52]

The survey found that **maternity wards often failed to meet the so-called standard of good care**, while most other hospital departments did. The poorer results of maternity wards were explained by the possibility of bias caused by postpartum depression in patients and were therefore not included in the overall satisfaction assessment for the entire healthcare facility. The assumption of this one-sided bias in the assessment by clients was later refuted.

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[47] See, for example, Lavender DT. Improving quality of care during labor and childbirth and in the immediate postnatal period. Best Pract Res Clin Obstet Gynaecol. 2016 Oct;36:57-67. doi: 10.1016/j.bpobgyn.2016.05.011. Epub 2016 Jun 25. PMID: 27422744. Available at https://pubmed.ncbi.nlm.nih.gov/27422744/.

[48] WILHELMOVÁ, Radka, Lenka VESELÁ, Iva KORÁBOVÁ, Simona SLEZÁKOVÁ, and Andrea POKORNÁ, 2022. Determinants of respectful care in midwifery. *Kontakt* [online]. 2022-12-19, 24**(**4), 302-309. ISSN 12124117. Available at: doi:10.32725/kont.2022.035. Available at https://kont.zsf.jcu.cz/pdfs/knt/2022/04/07.pdf.

[49] Other surveys have also been conducted in the Czech Republic, but on a smaller scale or focusing not on the entire country, but on specific facilities or regions.

[50] For more information, see http://www.hodnoceni-nemocnic.cz/. The organizer of the survey *Quality Through the Eyes of Patients* subsequently created a follow-up project *called Natural Birth in the Maternity Ward (*PPP) in cooperation with Babyweb.cz. The PPP project aims to "improve the standard of maternity care throughout the Czech Republic." Maternity hospitals that participated in the project and successfully passed the assessment of childbirth in individual points of the ten commandments by mothers, as well as meeting predefined professional criteria, were awarded symbolic PPP certificates. For more information, see http://www.prirozenyporodvporodnici.cz/o-projektu-prirozeny-porod-v-porodnici/. For the PPP ten commandments, see http://www.prirozenyporodvporodnici.cz/desatero-ppp-prirozeny-porod-v-porodnici/.

[51] See the Bulletin of the Ministry of Health of May 30, 2008, Chapter 14, available at https://www.mzcr.cz/wp-content/uploads/wepub/2035/6204/V%C4%9Bstn%C3%ADk%2003_2008.pdf

[52] Ibid., p. 67.

The authors of the first nationwide survey on satisfaction with perinatal care in the Czech Republic, which was conducted on a representative sample of 1,195 women who gave birth in a healthcare facility in the Czech Republic between 2005 and 2012, also pointed out the fallacy of the above premise.[53] The authors argued that the quality of the psychosocial environment of the maternity hospital and the attitude of the staff towards women both during childbirth and during their subsequent hospitalisation may also influence the development and course of postpartum subdepression. At the same time, they emphasized that previous satisfaction surveys conducted as part of *the Quality Through the Eyes of Patients* project were an important and relevant source of information, but were limited by the use of uniform questionnaires for all hospital departments, and *"the quality of obstetric care was therefore not captured in its specific moments".*[54] They therefore conducted their survey with the aim of filling this gap and *"evaluating women's satisfaction with obstetric and postnatal care using a diagnostic method specifically designed for evaluation and self-evaluation purposes in maternity hospitals."*[55]

Overall satisfaction with care in the maternity ward (delivery room) was 70%, and with care in the postnatal ward 61%. **The lowest satisfaction** was **detected in the dimension of control of the mother, or the woman's participation in decision-making (only 34%). In** the evaluation of individual items in this dimension, **only 35% of women** said they had **the opportunity to refuse routine procedures and examinations.** Just under 42% of women said they felt that the healthcare staff respected their own pace of delivery. **Only 24% of women were able to choose the position for delivery,** although women who were unable to respond to this item due to operative or instrumental delivery were not included in the evaluation of this criterion.[56]



The survey results showed that despite its strengths and excellent results in other aspects of care, Czech obstetrics faces some shortcomings in the psychosocial area, which have a negative impact on the overall quality of health services and, consequently, reduce women's satisfaction with their provision. Based on the survey results, the authors identified key determinants of satisfaction among women giving birth in Czech maternity hospitals and formulated specific **recommendations** for practice.[57] The recommendations included a focus on **strengthening the psychosocial competencies (especially communication skills) of healthcare professionals.** Based on the feedback from the survey participants, the recommendations also included other specific requirements, such as standardizing the information (especially regarding childcare) provided to women by healthcare professionals in postpartum wards. The results of the survey and related recommendations clearly showed that **improving the quality of care in Czech maternity hospitals requires strengthening the position of women** in childbirth throughout the entire system of care provision.

This nationwide survey of satisfaction with perinatal care, based on feedback from women who gave birth in healthcare facilities between 2005 and 2012, was the first and so far the only systematic survey of women's satisfaction with childbirth and postnatal care in the Czech Republic in terms of its scope, methodology, and representativeness of the sample. However, other surveys and studies focusing on specific aspects of the quality of care provided during early motherhood (e.g., breastfeeding support) or working with less or insufficiently representative samples or using different methodologies have also yielded important conclusions and recommendations.

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[53] Takács, L., Seidlerová, J., Horáková Hoskovcová, S., Šulová, L., Štětovská, I., Zejdová, H., Kolumpková, M. *Psychosocial aspects in contemporary Czech obstetrics. The quality of perinatal care through the eyes of mothers.* FF UK, 2012.

[54] Takács L., Seidlerová J. *The psychosocial climate of maternity wards through the eyes of mothers I. Results of a nationwide survey of satisfaction with perinatal care in the Czech Republic among a representative sample of 1,195 mothers.* In Česká gynekologie 2013, 78, no. 2, p. 158.

[55] Ibid., p. 159.

[56] Ibid., p. 164.

[57] Takács L., Seidlerová J. *The psychosocial climate of maternity wards through the eyes of mothers II. Predictors of satisfaction with perinatal care in the Czech Republic.* In Česká gynekologie 2013, 78, no. 3.

In 2016, the Ministry of Health conducted its own survey on the satisfaction of women who had given birth with the care they received via the social network Facebook,[58] . In the first three weeks, almost 500 diverse contributions were received, some of which received more than 200 further responses. Although this is a relatively high number of responses, which provide a certain cross-section of feedback from care recipients, unlike the above-mentioned survey, they do not come from a representative sample. However, the discussion posts in response to the survey question on the Ministry of Health's Facebook profile also revealed **a demand for change to the current system of medically-led childbirth and care with a high level of intervention.** *"Virtually all of the recommendations proposed are aimed at enabling non-interventionist births. They also concern the choice of place of birth, calling for births to be allowed in settings other than hospitals. They also call for the plurality of the latest scientific findings, only some of which are used in the Czech environment, according to them, and there is a lack of discussion on alternative options, which are also used by renowned organizations such as the World Health Organization."*[59]

In 2019, the Ministry of Health commissioned the STEM analytical institute to conduct a survey of women's opinions on breastfeeding, vaccination, and places to give birth.[60] One of the reasons for commissioning this survey was the long-standing social demand, as perceived by the Ministry of Health, for a respectful approach and humanization of obstetrics. The Ministry began to respond to this demand by working on conceptual support for birth assistance centers[61] within maternity hospitals, and one of the purposes of the survey was to verify how women respond to this concept and whether they would consider such a center as a possible place to give birth. The survey was conducted via online questioning (CAWI) and a total of 1,009 women from across the regions took part. Although it did not focus directly on verifying their satisfaction with care, it revealed at least two findings that are also relevant for reflecting on the current setup of the maternity and postnatal care system from the perspective of its clients. Firstly, **the concept of birth centers**, where a midwife would take care of the entire birth, **appealed to two-thirds of the respondents.** Secondly**,** the survey participants placed **great emphasis on communication between those caring for women.** In their assessment, communication was considered a more important factor than modern medical equipment or a pleasant hospital environment.



However, the survey conducted in 2019 for the Ministry of Health also had significant methodological limitations. These limitations lay in the selection of respondents—the sample of women surveyed was far from the average age of women giving birth, which is currently 31.1 years in the Czech Republic, compared to 30.8 years at the time of the survey. More than half of the sample consisted of women who were either no longer of reproductive age or were in the last third of their reproductive age, so the choice of place of birth was not as relevant to them or was not as topical an issue as it was for younger women in the other two age categories. Women aged 50-60 specifically made up 26% of the sample, the 40-49 age group was also represented by 26%, as were women aged 30-39, while the proportion of women aged 18-29 was 22%. The limited choice of possible answers to some questions also contributed to further distortion. For example, the conclusion that women *"get the best information about places to give birth primarily from doctors" (*[62] *)* was based on a set of answers that did not include the option of obtaining information from a midwife. The absence

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[59] Vondráčková L., Šmídová I. 2016. Research report for the Working Group on Obstetrics at the Government Council for Gender Equality. Analysis of the discussion "Experiences from maternity hospitals" launched by the Ministry of Health on Facebook. Available at: https://www.vlada.cz/assets/ppov/rovne-prilezitosti-zen-a-muzu/dokumenty/Analyza-diskuse-_Zkusenosti-z-porodnic_-na-Facebooku-Ministerstva-zdravotnictvi-CR-.pdf.

[60] Results of quantitative research by STEM Women's opinions on places for childbirth, breastfeeding and vaccination, dated September 25, 2019.

[61] For more information on the establishment and operation of birth centers in the Czech Republic, see Chapter 3.3.3).

[62] Ibid., p. 22 (in a partial summary of the survey results on p. 12, available at: https://www.mzcr.cz/wp-content/uploads/2020/07/Centra-porodn%C3%AD-asistence.pdf)

of this option was also lacking across other topics, including the question about the most trusted source of information on breastfeeding.

Support for breastfeeding in maternity wards from the perspective of care recipients was the subject of a survey conducted by the Šestinedělky initiative, in which 3,894 women from across the Czech Republic took part.[63] Feedback was also collected via an online questionnaire[64] , which focused on the experiences of women who gave birth in a Czech maternity ward between 2014 and 2017. The questions in the questionnaire were directly linked to *the Ten Steps to Successful Breastfeeding,*[65] , which form the core of the WHO and UNICEF Baby-friendly Hospital Initiative and summarize the basic evidence-based practices that hospitals should follow as a minimum standard when caring for mothers and newborns. The WHO and UNICEF Baby-friendly Hospital Initiative was not mandatory for all hospitals before 2018, but in the Czech Republic, about two-thirds of maternity hospitals voluntarily joined the initiative and committed to complying with its objectives. However, the survey revealed that none of them complied with all *Ten Steps to Successful Breastfeeding*.

Survey participants reported that **support for new mothers was inadequate** and that information from staff was often contradictory. **More than half of the babies did not have immediate and uninterrupted skin-to-skin contact with their mothers for at least one hour after birth**, and women were not adequately informed about the importance of this contact and its benefits. About half of the respondents added a written comment to their answers. However, not every woman gave her consent for it to be published. The published comments covered both positive and negative experiences of women during their stay in the postnatal wards. The comments of women with negative experiences provided specific disturbing evidence of inappropriate staff behavior, ranging from humiliating comments directed at women to violent handling of women in postpartum care and their children.[66]



Although this survey was not primarily focused on assessing women's overall satisfaction with care, it did provide relevant findings in relation to this topic. Although these findings are limited to experiences in the postpartum ward, they correspond to the findings of the aforementioned nationwide survey on satisfaction with perinatal care in the Czech Republic conducted between 2010 and 2012.

Another dimension of client dissatisfaction with the quality of care was revealed by a unique study from 2021, which mapped home births in the Czech Republic. The study was based on a questionnaire survey of 642 women who gave birth at home between 2015 and 2020.[67] *"A key finding of the research is that the women surveyed do not want to give birth in Czech maternity hospitals. They identified the fact that* ***the abilities and competence of the mother*** *are* ***belittled and procedures are carried out without her consent (almost 100% of women are very or somewhat bothered by this)*** *as the greatest weakness of maternity care in the Czech Republic. Other extremely problematic circumstances include humiliation, ridicule, manipulation of mothers, routine episiotomy, routine administration of oxytocin, and sharing of intimate matters in the waiting room (96–99% very or somewhat bothered). Among* ***women***

[63] For more details, see http://sestinedelky.cz/pruzkum-o-kojeni/, which also describes the methodological limitations of this survey.
[64] With the exception of several dozen responses collected through the printed version of the questionnaire.
[65] For more details, see https://www.who.int/teams/nutrition-and-food-safety/food-and-nutrition-actions-in-health-systems/ten-steps-to-successful-breastfeeding, in the Czech translation by the Šestinedělky initiative, see http://kojeni.cz/wp-content/uploads/2015/04/deset_kroku.pdf.
[66] For example: "The nurse *didn't exactly take my breast gently and almost forced it into my son's mouth. She didn't respond to my arguments that he probably didn't want it because he had just been fed, and she continued until she made him cry."* Page 83 from a selection of women's comments (for more details, see http://sestinedelky.cz/wp-content/uploads/2017/03/V%C3%BDb%C4%9Br-z-koment%C3%A1%C5%99%C5%AF-VF.pdf).
[67] Durnová A. and E. Hejzlarová (2021). *Home births in the Czech Republic: motivations, reasons, and opinions of women who gave birth at home by choice (2015-2020).* Available at https://iss.fsv.cuni.cz/veda-vyzkum/granty/aktualne-resene-projekty/domaci-porody-v-cesku.

***who chose home birth only after having experienced childbirth in a maternity facility, 69% said that it was precisely because of their previous bad experience.***[68]

During the study, women were also asked under what circumstances they would not give birth at home, with 66% saying that if they could choose a midwife in maternity hospitals and 65% if there were birthing centers. *"These are part of maternity care in neighboring Austria and Germany, for example, as well as in the United Kingdom. Sixty-two percent of women said they would consider giving birth in a hospital if the attitude towards mothers changed."*[69]

A research project *entitled "The quality of prenatal and perinatal care from the perspective of Czech women*" is currently being carried out with the support of the Ministry of Health.[70] The project focuses on identifying key determinants that influence women's satisfaction with the care provided during early motherhood, with an emphasis on the subsequent practical application of these findings. One of its outputs will therefore be recommendations for a methodology, a tool for nationwide monitoring of women's satisfaction, and educational materials, which will then be tested in clinical practice. The experience and, by extension, the level of women's satisfaction with care is assessed using a standardized questionnaire developed in Norway. The questionnaire is intended for women between 6 weeks and 6 months after giving birth. An analysis of the free-text comments contained in one-third of the first 2,287 responses showed that *"the most frequently mentioned experiences of women come from the period of childbirth (**lack of support, disrespect, manipulation, interventions without consent, obstetric violence)** and the postpartum period (**lack of support for women as mothers, conflicting information, lack of support for breastfeeding, inappropriate environment and diet)*."[71] On the other hand, positive experiences included, for example, giving birth with a person or in a place of the woman's own choosing, and the provision of clear information.[72]



As part of the research, therefore, a comprehensive review of significant determinants of women's satisfaction with care was conducted prior to the launch of the questionnaire survey. These determinants were identified across different countries, particularly (but not exclusively) in the European context.[73] As outlined in the introduction to this subchapter, their precise identification is a key condition for changing current practice and developing respectful care in early motherhood. *"The assessment of the quality of care provided to women in motherhood is inextricably linked to the specific experience of the woman. The experience is conditioned by specific determinants related to the individual stages of motherhood and specific to different sociodemographic groups of women and groups of women with increased care needs. However, there are also determinants that apply to all women without distinction. These include continuous respectful care, communication between partners, fulfillment of women's personal expectations, a high degree of professionalism, support from healthcare professionals, involvement of women in decision-making, and respect for their choices."*[74]

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[68] Quoted from a related press release available at https://fsv.cuni.cz/kontakty/pro-media/tz-vysledky-studie-fsv-uk-cesky-rodi-doma-hlavne-kvuli-stavu-porodni-pece.

[69] Ibid.

[70] The project was supported by a grant from the Czech Health Research Agency as part of the Program for the Support of Applied Health Research for 2020-2026. For more information, see https://www.med.muni.cz/aktuality/chceme-sledovat-kvalitu-poskytovane-prenatalni-a-perinatalni-pece-dotaznik-zenam-ktere-nedavno-porodily.

[71] WILHELMOVÁ, Radka, Lenka VESELÁ, Iva KORÁBOVÁ, Petr JANKŮ, Miloslava KAMENÍKOVÁ, Lukáš HRUBAN, and Andrea POKORNÁ, 2023. Czech women's experiences with maternity care – analysis of free text comments. *European Journal of Midwifery* [online]. 7**(**Supplement 1). ISSN 2585-2906. Available at: doi:10.18332/ejm/172315, p. 38. Available at https://www.europeanjournalofmidwifery.eu/Czech-women-s-experiences-with-maternity-care-analysis-of-free-text-comments,172315,0,2.html.

[72] Ibid.

[73] WILHELMOVÁ, Radka, Lenka VESELÁ, Iva KORÁBOVÁ, Simona SLEZÁKOVÁ, and Andrea POKORNÁ, 2022. Determinants of respectful care in midwifery. *Contact* [online]. 2022-12-19, **24(**4), 302-309. ISSN 12124117. Available at: doi:10.32725/kont.2022.035. Available at https://kont.zsf.jcu.cz/pdfs/knt/2022/04/07.pdf.

[74] Ibid., p. 307

**Care that respects the key determinants of women's satisfaction with care can reduce the number of complications, unnecessary interventions, and economic costs.**[75]

### 2.3 Complaints to the Public Defender of Rights, Grievances, and Lawsuits

Dissatisfaction with care is also reflected in the number of complaints and lawsuits. Indeed, some doctors describe gynecology and obstetrics as the most sued medical field (although there is no official summary record in the context of the Czech Republic) and report that the increased number of complaints and lawsuits has a negative impact on their practice, or on their mental and physical health and the quality of care provided, and leads, among other things, to them leaving their jobs[76] (for the need for supervision and support for healthcare personnel, see also Chapter 3.4.6).

Women who have encountered inappropriate care or misconduct by healthcare personnel and wish to actively address these shortcomings usually make use of the possibility of filing a complaint against the provider's conduct in the provision of healthcare services or against activities related to healthcare services.[77] If they are unsuccessful, they turn to the relevant administrative authority, which is usually the regional authority or the Prague City Hall. Some dissatisfied women and their families also use other legal remedies, including the possibility of taking the matter to court.

The results of a questionnaire survey conducted in 2018 and published in the journal Česká gynekologie (Czech Gynecology) showed that in the last five years, **26%** (17% of women and 35% of men) of the total number of 203 respondents **had encountered complaints against themselves**. **Criminal complaints** were **filed against 7% of the doctors surveyed** during the period under review**, and 28% faced civil lawsuits** against hospitals or outpatient clinics.[78]



Another tool for resolving dissatisfaction is the possibility of filing a complaint with the Public Defender of Rights – in cases where the regional authority or other competent administrative authority fails to act on a complaint, fails to respond to all points contained in the complaint, or fails to disclose the name and surname of the appointed independent expert. The current public defender of rights, like his predecessor and former deputy, has repeatedly investigated complaints in which the regional authority failed to address allegations by parents that the behavior of maternity ward staff was unethical, rude, or contemptuous.[79] Mothers disputed procedures to which they had not given informed consent, such as the administration of medication, pressure on the abdomen, artificial rupture of the amniotic sac, immediate cutting of the umbilical cord, episiotomy, etc., or disputed the birth strategy itself (the necessity of a caesarean section). Even more frequently, they pointed out that their wishes regarding the birth had not been heard. Parents also complained that they were separated from their children immediately after birth or that the partner of the mother (the father of the newborn) was not allowed to be present at the birth due to an emergency caesarean section. *"We criticized the regional authorities that handle parents' complaints about maternity hospitals for not handling the complaints properly: they failed to sufficiently ascertain the facts, giving unjustified preference to the claims of the maternity hospitals over those of the mothers, assessed the medical aspects of the case without the opinion of an independent expert, and did not address (or did not adequately address) legal issues such as informed consent or the presence of legal representatives. In addition, the regional authorities sometimes refused to admit their mistakes, and we had to turn to the Ministry of Health, which agreed with us. It is clear that obstetrics is a very sensitive area for all parties, so our main aim was to improve the regional authorities'*

[75] Ibid.
[76] For more details, see GLOSOVÁ, Táňa and David CIBULA, 2018. Complaints and lawsuits against doctors in the field of gynecology and obstetrics – results of a questionnaire survey. *Czech Gynecology.* **2018(**83), 312-318.
[77] Within the meaning of Sections 93 to 97 of the Health Services Act.
[78] See Glosová and Cibula.
[79] For more details, see, for example, the final opinions available at https://eso.ochrance.cz/Found/Edit/10036, further https://eso.ochrance.cz/Nalezene/Edit/11280, further https://eso.ochrance.cz/Nalezene/Edit/10222 or https://eso.ochrance.cz/Nalezene/Edit/10126.

*practices in handling complaints so that their conclusions were credible and verifiable,"* said[80] , spokesperson for the Office of the Public Defender of Rights, in 2023.

### 2.4 Criticism of Shortcomings by International Organizations

For shortcomings in access to healthcare services for women in early motherhood – from preventing contact between mother and child immediately after birth, through the de facto impossibility of choosing a midwife as a provider of reimbursed care, to violations of the principles of free and informed consent, etc. The Czech Republic has been repeatedly criticized for this by international organizations, especially UN bodies, the Council of Europe, and the European Union. International criticism has already been the driving force behind some of the changes the Czech Republic has made in early motherhood care. For example, following the Hanzelka complaint against the Czech Republic before the European Court of Human Rights, the Ministry of Health updated its methodological guidelines on the procedure for discharging newborns from maternity wards to their own social environment in 2013[81] in order to prevent the risk of a possible repetition of the practice of healthcare providers in violation of the right to respect for private and family life guaranteed by Article 8 of the Convention for the Protection of Human nd Fundamental Freedoms (hereinafter referred to as the "Convention"), which the court ultimately found to have been violated in the Hanzelka case[82] .[83]



This strategy responds to the unheeded calls and recommendations addressed to the Czech Republic in connection with its international human rights obligations regarding the respect of women's rights in the provision of health services in early motherhood. The proposed measures are aimed in particular at implementing the recommendations of the UN Committee on the Elimination of Discrimination against Women from 2016. They also reflect the call of the European Court of Human Rights, which, in the same year, when considering the complaints of Dubská and Krejzová, urged the Czech authorities to change their practice and to constantly review the relevant provisions of legislation in the light of developments in medicine, science, and law.[84]

The recommendations of the UN Committee on the Elimination of Discrimination against Women on the 6th periodic report of the Czech Republic on the implementation of the relevant convention include, among other things, ensuring *"the adoption and enforcement of a protocol on normal obstetric care that ensures respect for the rights of patients and prevents unnecessary medical interventions, ensure that all interventions are carried out only with the free, prior, and informed consent of the woman, monitor the quality of care in maternity hospitals, and provide mandatory training for all health care professionals on patients' rights*

[80] For more details, see https://www.vlada.cz/assets/ppov/rovne-prilezitosti-zen-a-muzu/Pracovni_skupina_k_porodnictvi/PLOHA1_1.PDF.

[81] The new methodological guideline was published in December 2013 (one year after the complaint was reported to the Czech government) in the Bulletin of the Ministry of Health No. 8/2013.

[82] The complainant, Ms. Hanzelková, gave birth to a child (the second complainant) in a maternity hospital, which she left after a few hours. Although the birth was uncomplicated and neither the mother nor the child had any health problems, the medical staff did not agree with the complainant's departure and contacted the competent social and legal protection authority for children. The latter filed a motion with the district court for a preliminary measure to place the child in the care of the hospital, which the court granted immediately. On the same day, the preliminary measure was enforced and the complainant was taken back to the hospital by ambulance, accompanied by the police. The child did not show any health problems. The complainant spent another two days in the hospital with her child without any medical treatment being provided, and they were then discharged home. According to the European Court of Human Rights, this constituted a violation of their right

[83] Together with a violation of Article 13 (guaranteeing the right to an effective remedy) of the Convention. For more details, see the judgment of 11 December 2014 in case no. 43643/10, available at http://eslp.justice.cz/justice/judikatura_eslp.nsf/WebSearch/2E6BD5AE1C2952DAC1257E3E0047C229?openDocument&Highlight=0.

[84] For further details, see the Grand Chamber judgment of 15 November 2016 in cases nos. 28859/11 and 28473/12, available at http://eslp.justice.cz/justice/judikatura_eslp.nsf/WebSearch/6AA24AD6E570D2D0C12580FA004AE545?openDocument&Highlight=0. The Court found no violation of Article 8 of the Convention, but stated in its reasoning that the Czech authorities should nevertheless *"subject the relevant [domestic] legislation to constant review, taking into account medical, scientific and legal developments*."

*and related ethical standards; and continue to raise patients' awareness of their rights, including through the dissemination of information"* and *"take measures, including legislation, to make birth outside a hospital with the assistance of a midwife a safe and affordable option for women."* [85]

In addition to these direct calls specifically focused on the local situation, the Czech Republic is also the recipient of other general recommendations concerning the fulfillment of women's rights in the area of reproductive health. These include, for example, the 2019 recommendations of the UN Special Rapporteur on violence against women, Dubravka Šimonović, which are part of the Report on a human rights approach to ill-treatment and violence against women in reproductive health care with a focus on childbirth and obstetric violence (see Chapter 3.5 for more details).[86] Similarly, in 2021, the European Parliament called on Member States to *"take measures to ensure access for all women to quality, accessible, evidence-based and respectful maternal care during pregnancy and in connection with childbirth, without discrimination, including birth assistance, prenatal, childbirth and postnatal care and mental health support for mothers, in line with current WHO standards and evidence, and subsequently reform laws, policies and practices that exclude certain groups from access to maternal, pregnancy and childbirth care."*[87]

Criticism of existing shortcomings by international organizations, including recommendations for their remedy, together with developments in medicine, science, and law, are consistently reflected throughout the strategy and the proposed measures.



# 3. Room for Intervention: Analysis and Proposed Solutions

## 3.1 Absence of Care Standards and Disparities in the Quality of Healthcare Services

### 3.1.1 Disparities in the Quality of Healthcare Services

Data from the National Reproductive Health Register show that **there are differences between individual maternity hospitals and regions in the care provided** and, consequently, in the approach of healthcare personnel to clients, diagnosis, treatment methods, and the use of interventions. The extent of intervention in a woman's delivery is therefore not only determined by whether she has complications, but also by the region in which she gives birth and the practices applied in maternity hospitals or universities in that area. The different approaches are particularly evident when comparing the rates of caesarean sections or episiotomies across different facilities. These are differences that cannot be explained solely by differences in the concentration of high-risk cases, as they are also evident within individual levels of care (see Charts 7 and 8). These differences are particularly evident when compared with developments over time and with foreign practice, where these procedures are performed significantly less frequently, for example in Sweden and the United Kingdom (see Chart 9 and Chart 10). Although the number of episiotomies has decreased in the Czech Republic over the past ten years, it is still high compared to other countries,

[85] For more information, see https://documents.un.org/doc/undoc/gen/n19/363/06/pdf/n1936306.pdf?token=3eCFcvBJicGBryBxfm&fe=true, Czech translation available at https://www.tojerovnost.cz/wp-content/uploads/2021/07/Broura_CEDAW.pdf.
[86] Šimonović, Dubravka. "A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence." New York: UN, July 11, 2019. Available at https://digitallibrary.un.org/record/3823698.
[87] For more information, see the European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the context of women's health. A9-0169/2021. Available at https://www.europarl.europa.eu/doceo/document/A-9-2021-0169_EN.html#_section6.

indicating a need for a more uniform approach to maternity care and, above all, more consistent application of evidence-based practices.

*Chart 7: Proportion of cesarean deliveries, 2023*

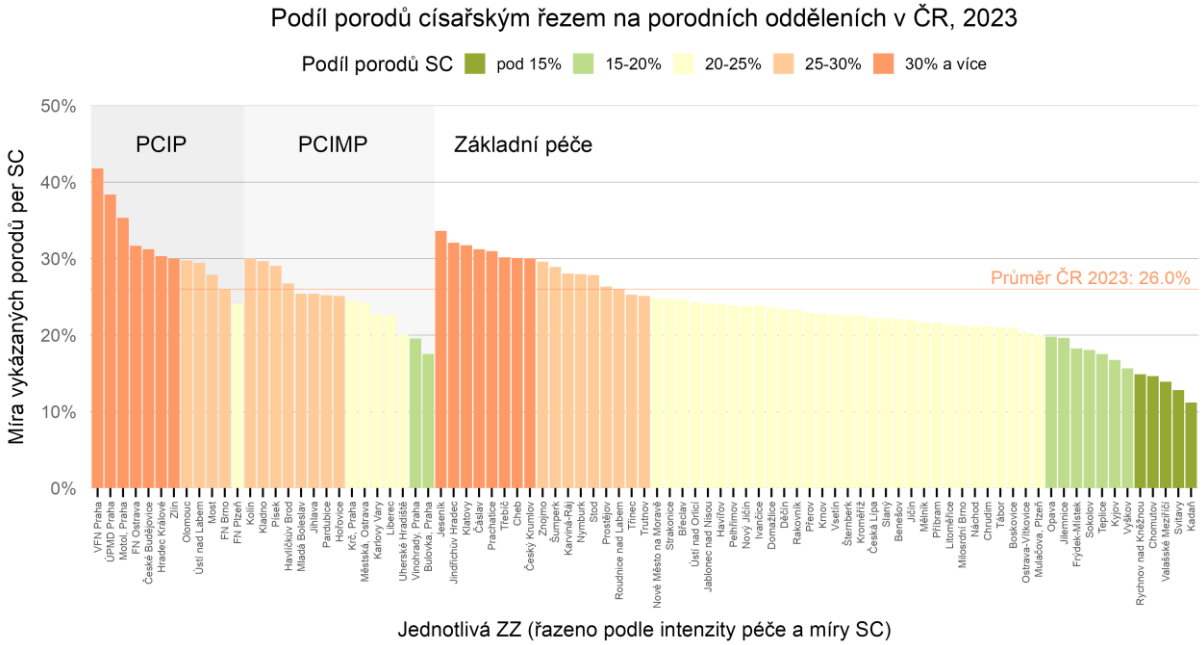



*Chart 8: Proportion of vaginal births with episiotomy, 2023*



*Nationwide 25%, SD 10%, maximum 49%*

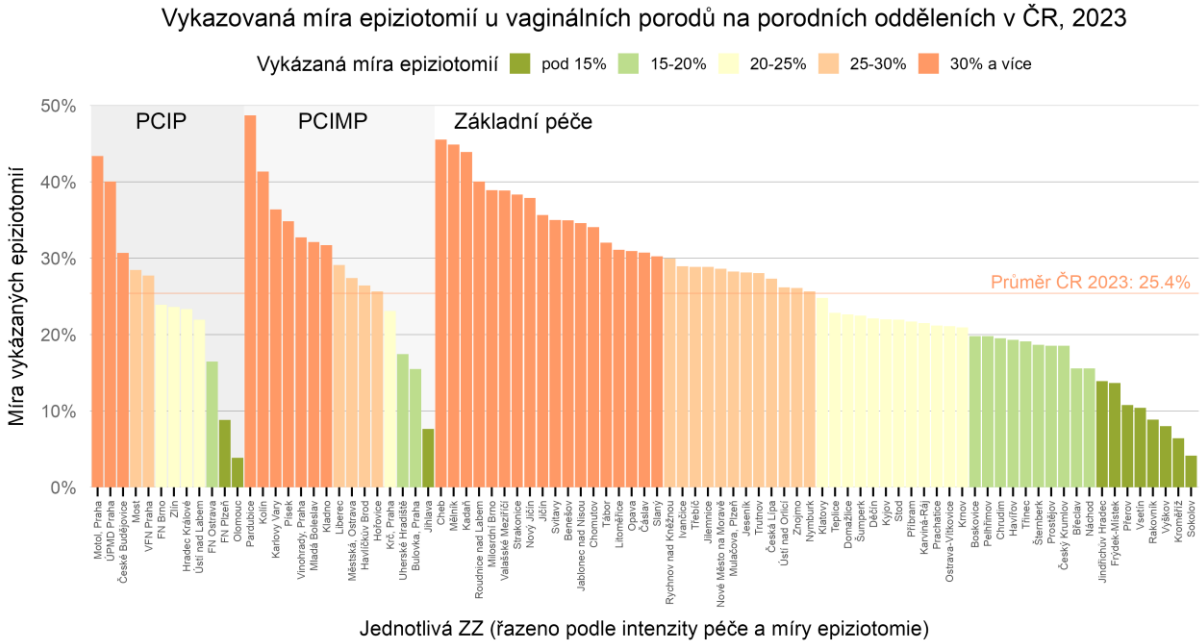


*Chart 9: Reported rate of episiotomies in England 2022-2023*

*nationwide 23%, SD 4%, maximum 33%*

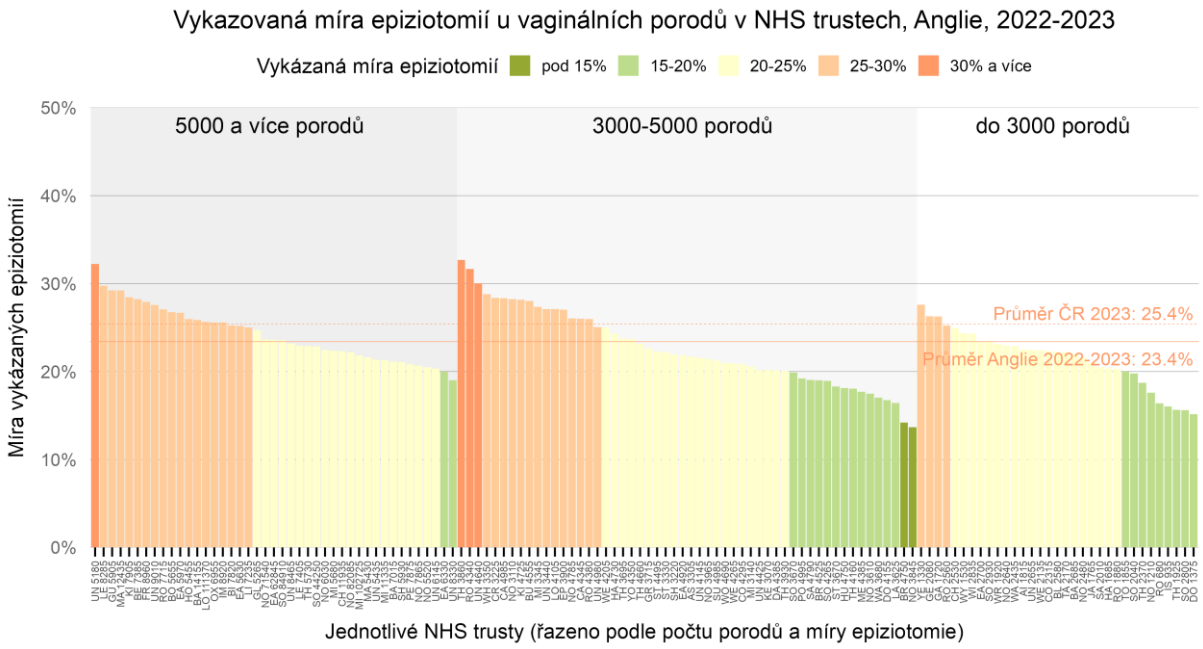





*Chart 10: Reported rate of episiotomies in maternity hospitals in Sweden, 2022*
*nationwide 5%, SD 2%, maximum 9%*

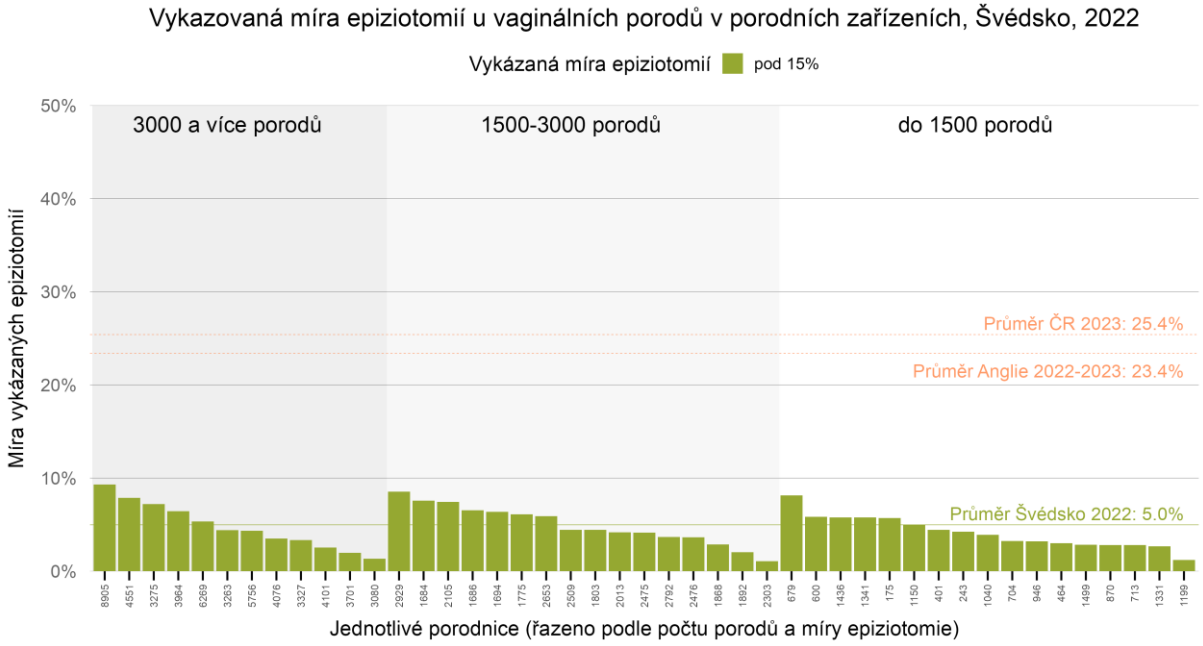


*Chart No. 11*

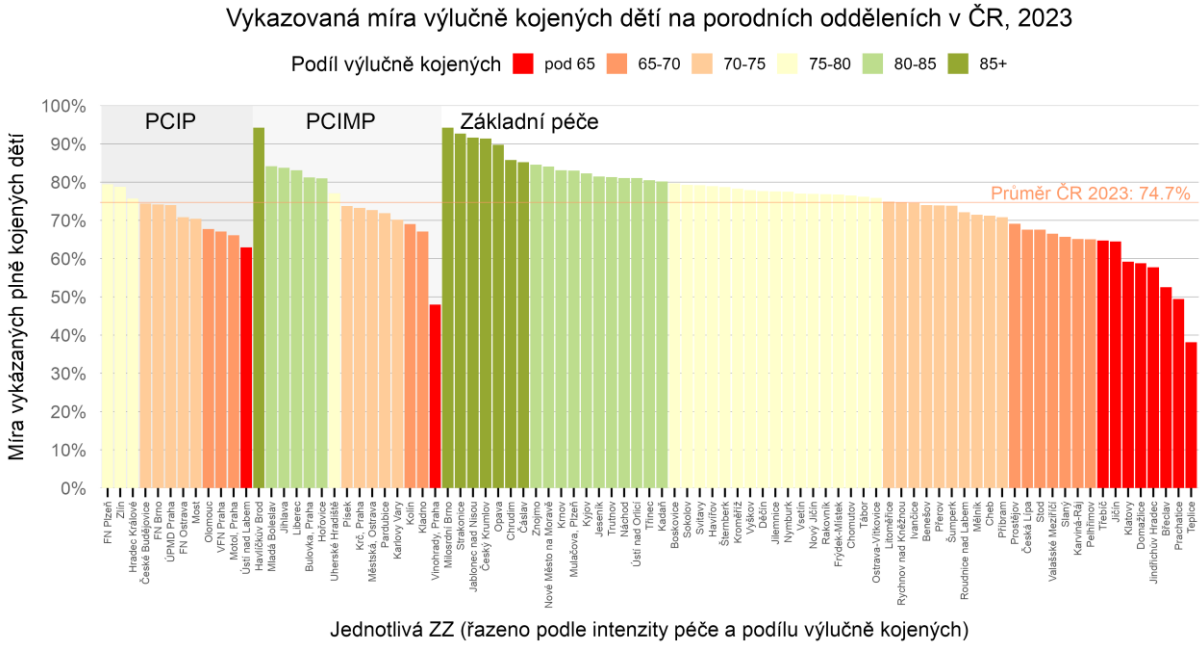
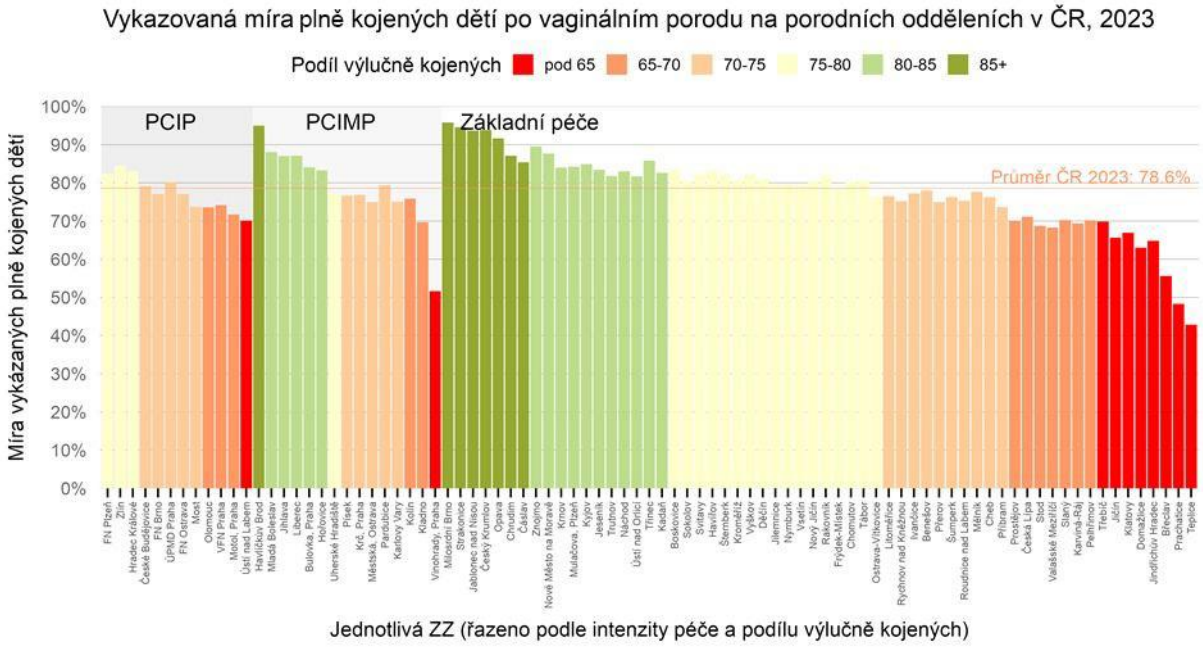





*Chart No. 12*




### 3.1.2 Absence of Evidence-Based Resources for Clinical Decision-Making

One of the reasons for the difference in the quality of healthcare services provided in this area is **the absence of comprehensive clinical guidelines supported by systematic reviews of the best available evidence**.

In the Czech environment, it is common for clinical care standards to be part of non-legal, rather than legal, regulations.[88] In the context of maternity care, these standards have so far mainly taken the form of recommended procedures developed for specific issues either by voluntary professional healthcare organizations,[89] or in cooperation with the Ministry of Health and organizations under its direct authority, such as the National Center for Nursing and Non-Medical Healthcare Professions, and subsequently published in the Bulletin of the Ministry of Health.[90] The disadvantage of the existing recommended practices is that they only cover specific topics and/or focus exclusively on care provided by a specific healthcare profession. Most of the recommendations developed by voluntary professional healthcare organizations do not meet the basic criteria for clinical guidelines[91] in terms of their content and development process, and therefore do not provide a sufficient basis for ensuring coordinated, effective, and evidence-based healthcare and corresponding communication with clients. Moreover, some of them contradict the available scientific evidence. For example, *the Recommendations for Assisting Women in the Second Stage of Labor,* prepared by the Czech Society of Obstetrics and Gynecology (ČGPS ČLS JEP)[92] , do not contain any references to professional literature and list holding the uterus as one of the techniques for assisting women during the second stage of labor, a practice that the WHO[93] does not recommend. According to information from the Cochrane Library, there is also insufficient evidence of the benefits of this practice.[94]



From the perspective of the best available evidence, the current definitions of some procedures on the list of health services with point values, which form the basis for reimbursement of care from public health insurance funds, are also highly problematic.[95] The descriptions of the content of health services related to childbirth contain outdated practices (such as routine rectal examination of women in labor every hour),[96] which are contrary to current scientific knowledge and may be harmful to health in some respects and increase the risk of complications.

The lack of uniformity of procedures and inconsistency with best practice impairs interdisciplinary cooperation and complicates the achievement of consensus among Czech professionals. This has a negative impact, particularly on women and their children and on the quality of care provided to them, which is also reflected in the long-term level of dissatisfaction among care clients (see Chapter 2.3 for more details). Although some facilities compensate for the absence of comprehensive clinical guidelines with their own standards, this is not a systemic solution for the whole of the Czech Republic, as it does not eliminate inequalities in access to evidence-based practice.

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[88] ŠUSTEK, P. – HOLČAPEK, T. 2016. Health Law. Prague: Wolters Kluwer, p. 276.

[89] For more information, see, for example, the Recommended Procedures of the Czech Medical Association of J. E. Purkyně available at https://www.gynultrazvuk.cz/doporucene-postupy or Principles of Care in Midwifery – 2021 revision available at https://www.unipa.cz/principy-pece-v-porodni-asistenci-revize-2021/.

[90] For more information, see, for example, National Nursing Procedure for Skin Care and Umbilical Stump Care in Newborns, available at https://mzd.gov.cz/wp-content/uploads/2020/02/NOP-P%C3%A9%C4%8De-o-k%C5%AF%C5%BEi-a-pupe%C4%8Dn%C3%AD-pah%C3%BDl-novorozence.pdf.

[91] High-quality recommended practices are based, among other things, on systematic reviews of the best available evidence, are developed and endorsed by an interdisciplinary panel of experts and representatives of interested groups, take into account important subgroups of care clients and their preferences, provide clear explanations of alternative health outcomes, allow for revision and updating when new evidence becomes available, and use transparent processes to minimize errors and conflicts of interest. For more information, see, for example, https://nikez.mzcr.cz/cs/postupy-doporuceni/doporucene-postupy-operativni-doporuceni/.

[92] The document was created in 2012 and is listed as current in the relevant database. For more information, see https://www.gynultrazvuk.cz/uploads/recommendedaction/82/doc/p-2012-doporuceni-k-pomoci-rodicce-pri-tlaceni-ve-druhe-dobe-porodni.pdf.

[93] For further justification of WHO recommendation No. 40, see pp. 155-158, available at https://www.who.int/publications/i/item/9789241550215.

[94] For more details, see Hofmeyr GJ, Vogel JP, Cuthbert A, Singata M. Fundal pressure during the second stage of labor. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD006067. Available at https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006067.pub3/full.

[95] See https://szv.mzcr.cz/Vyhlaska and the annually updated decree of the same name, No. 134/1998 Coll.

[96] See the description of vaginal delivery – head first (code 63119), available at https://szv.mzcr.cz/Vykon/Detail/63119/.

Foreign experience shows that in countries where national centers for supporting excellence and developing clinical guidelines have been established, the quality of health e care has improved.[97] An example of such a center is the British National Institute for Health and Care Excellence (NICE).[98] Clinical guidelines are systematically developed statements based on the best available scientific evidence. They are an important tool for decision-making on appropriate healthcare, not only for healthcare professionals but also for those receiving care. They contribute to improving both clinical and cost effectiveness. They help reduce health inequalities by promoting standardized care across different regions and facilities.[99] An essential element of clinical guidelines is the promotion of comprehensive patient management and high-quality communication with care recipients, enabling them to make informed decisions about the health services they receive. Clinical guidelines can serve as a basis not only for diagnosis, treatment, and decision-making on the choice of appropriate specific interventions, but also for the development of criteria for evaluating the quality and safety of healthcare and their subsequent analysis. They also serve as teaching materials for undergraduate and postgraduate education of healthcare professionals. [100]

In the Czech Republic, a pilot project to develop clinical guidelines based on recognized international methodologies was launched by the Czech Health Research Agency with the support of the Ministry of Health and the Institute of Health Information and Statistics of the Czech Republic.[101] The project was completed in 2022, and the development of guidelines is currently managed systematically by the National Institute for Quality and Excellence in Healthcare (NIKEZ).[102] However, at the time of this strategy's creation, no recommended procedures or operational recommendations directly related to care during pregnancy, childbirth, and the postpartum period had been completed. [103]



### 3.1.3 Data Feedback

In addition to future clinical standards accepted at the national level, **data feedback** can already be used to ensure consistent quality of care across different facilities and regions. The National Reproductive Health Registry underwent significant development in 2023: the IHIS made data on maternity care available at the level of individual providers and published long-awaited data for the missing six years (i.e., 2016–2021). It gradually began to publish additional data outputs, and even developed a visualization tool for some of them. In connection with these changes, a data section was added to the National Health Information Portal.[104] This data is available to healthcare providers in a benchmarking format, allowing them to compare themselves with other healthcare facilities. The possibility of comparison and feedback leads to improvements and enables healthcare staff and facilities to follow evidence-based care principles rather than outdated or distorted information. **The publication of data** benefits not only care recipients, who are able to make informed and free choices, but also healthcare providers and the healthcare system as a whole. Public scrutiny also improves the reporting process and leads to the collection of higher-quality data that is more representative of reality.

[97] For more details, see https://kdp.uzis.cz/index.php?pg=vzdelavani-a-e-learning--vzdelavaci-akce.
[98] For more details, see https://www.nice.org.uk/.
[99] For more information, see https://www.nice.org.uk/about/what-we-do/into-practice/benefits-of-implementing-nice-guidance.
[100] For more details, see https://kdp.uzis.cz/index.php?pg=metodika.
[101] For more information, see https://kdp.uzis.cz/index.php?pg=o-projektu.
[102] For more information, see https://nikez.mzcr.cz/.
[103] In the field of gynecology and obstetrics, a KDP for cervical cancer screening was completed as part of the pilot project (available at https://kdp.uzis.cz/index.php?pg=kdp&id=30), which was subsequently transferred to the NIKEZ Central Register (see https://nikez.mzcr.cz/guideline/21-kdp-pro-screening-karcinomu-hrdla-delozniho/). At the time this strategy was developed, several partial operational recommendations related to early maternity care were in the process of being approved or developed (not completed) in the registry.
[104] For more details, see https://www.nzip.cz/nrrz.

### 3.1.4 Strategic and Task-Oriented Section – Set of Measures No. 1

The measures proposed in this part of the strategy are primarily aimed at supporting the implementation of effective clinical practices in the field of maternity care. To this end, it is first necessary to provide with the necessary background information to enable clinical decision-making based on the best available evidence and to improve interdisciplinary cooperation. To address the lack of clinical guidelines in early maternity care, the adoption or adaptation of existing comprehensive standards from the British NICE institute appears to be the optimal solution.[105] The recommended practices should be followed by updating the content of healthcare professionals' education and improving their competencies in the field of EBM/EBP.

In order to ensure the safety and quality of the services provided, the strategy also includes a requirement to review the list of health services and to conduct thorough investigations into the causes of all maternal deaths during pregnancy and up to one year after delivery, as well as perinatal deaths.

Another part of the measures is aimed at using recommended procedures to create criteria for evaluating the quality and safety of healthcare services in early motherhood. The strategy also requires the use of recommended procedures to improve communication with care recipients about the procedures necessary to provide informed consent for the performance of relevant procedures (for more details, see Chapter 3.4).

Last but not least, data feedback can be used to ensure consistent quality of care across facilities and regions. Other government initiatives and documents also address this area from multiple perspectives. This section of the strategy therefore highlights partial synergies with existing tasks in other documents [106] and emphasizes the need for data feedback in line with EBM principles and the findings presented in subchapter 3.1.1.



[105] For more information on existing *guidelines,* see the guide at https://www.nice.org.uk/hub/indevelopment/gid-hub10001.
[106] See, for example, synergistic measures 4.3.3 and 4.3.4 in the chapter on health in the updated Strategy for Gender Equality for 2021–2030.

## Breakdown of Tasks for the Chapter Lack of Care Standards and Differences in the Quality of Health Services

| **Strategic objective 1** | | **Application of effective clinical practices in the area of prenatal, childbirth and postnatal care** | | | | |
|---|---|---|---|---|---|---|
| Specific objective | Measure | Description of measure | Duration of measure / deadline for completion | Criteria for fulfillment | Responsible institution (manager) | Cooperating entities (co-manager) |
| **1.1 Ensure the availability of evidence-based clinical decision-making** | 1.1.1 Develop clinical guidelines for antenatal, intrapartum, and postnatal care through the adaptation of existing NICE standards. | In line with the *Methodology for the Development and Updating of Clinical Guidelines and Operational Recommendations in Healthcare*, develop comprehensive guidelines for antenatal, intrapartum, and postnatal care to be used by relevant healthcare professions. This should be carried out through the adaptation of existing NICE (National Institute for Health and Care Excellence) standards. Ensure a transparent and explicit description of the adaptation process and the participation of relevant stakeholder groups, including representatives of care recipients. | July 1, 2025 – July 1, 2026, then respond to new evidence as it emerges | The adopted standards are registered as comprehensive clinical guidelines in the NIKEZ Central Registry and used by the relevant healthcare professions. They are continuously updated in response to newly emerging evidence. | MoH (NIKEZ) | relevant professional institutions and entities, Office of the Government of the Czech Republic (Working Group on Obstetrics) |
| | 1.1.2 Develop national standardized operating protocols to support the implementation of the midwife-led continuity of care model. | Develop new national standardized operational protocols, or, where appropriate, transform existing national nursing protocols, in order to support the implementation of the midwife-led continuity of care model in line with WHO recommendations. Ensure that the NSOPs are consistent with the principles of EBP/EBM (Evidence-Based Practice/Evidence-Based Medicine). | July 1, 2025 – December 31, 2030 (ongoing) | Operational protocols supporting the model of midwife-led continuity of care are registered in the Central Registry of NSOP. They are continuously updated in response to newly emerging evidence. | MoH (NIKEZ), NCO NZO | relevant professional institutions and entities, Office of the Government of the Czech Republic (Working Group on Obstetrics) |
| **1.2 Update the content of healthcare professionals' education and improve their competence in the field of EBP/EBM** | 1.2.1 Develop and subsequently distribute educational materials on EBP/EBM for secondary schools, higher vocational schools, universities, and continuing professional education. | Building on measure 1.1.1, develop educational materials for secondary schools, universities, and continuing education to support the strengthening of competencies in EBP/EBM. Ensure their distribution to schools and other relevant institutions in an appropriate form. Create or adopt and subsequently publish on the ministry's web platform informational educational videos on the application of EBP/EBM principles in antenatal, intrapartum, and postnatal care. Actively promote the availability of these materials and ongoing continuing education courses on the topic. | July 1, 2026 – December 31, 2027 | Creation and distribution of educational materials. Creation or adoption and subsequent publication of informational (educational) videos. | MoH, IPVZ, NCO NZO | LLP, WHO, Public Defender of Rights, Office of the Government of the Czech Republic (Working Group on Obstetrics), relevant professional institutions and entities |
| | 1.2.2 Organize an international awareness-raising conference on the application of EBP/EBM | For the purpose of educating the professional healthcare community, organize an international awareness-raising conference on the application of EBP/EBM principles in antenatal, intrapartum, and postnatal care. Subsequently, carry out ongoing awareness | Organization of an international conference on December 31, | Organization of an international conference, ongoing implementation of | Office of the Government of the Czech Republic MoH | MoH, NGOs, relevant professional |

| | | | | | | |
|---|---|---|---|---|---|---|
| | principles in antenatal, intrapartum, and postnatal care. | activities, e.g., on the occasion of World Evidence-Based Healthcare Day. | 2027, and ongoing until December 31, 2030 | awareness-raising activities. | | institutions and entities instituce a subjekty |
| **1.3 Align reimbursements and definitions of healthcare procedures with the findings of evidence-based medicine and care** | 1.3.1 Invite medical and non-medical professional and expert organizations to actively cooperate in revising the definitions of healthcare procedures | By means of a letter from the Minister of Health, invite medical and non-medical professional and expert organizations to actively cooperate in revising the definitions of healthcare procedures in the field of antenatal, intrapartum, and postnatal care so that they are aligned with the latest knowledge of evidence-based medicine and care. Strongly emphasize the need for mutual cooperation and the expansion of opportunities for reporting relevant procedures by other professional groups, including midwives. | by July 31, 2025 | Sending of a letter from the Minister of Health with an invitation to the relevant stakeholders. | MoH | |
| | 1.3.2 Amend the decree issuing the List of Healthcare Procedures | For the purpose of ensuring safe and high-quality healthcare services, implementing the principles of EBP/EBM, supporting the continuity of midwife-led care, as well as fulfilling the cross-cutting principles and other objectives of this strategy, conduct a comprehensive revision of healthcare procedures in the field of antenatal, intrapartum, and postnatal care, accompanied by the corresponding amendment of Decree No. 134/1998 Coll. | July 1, 2025 – December 31, 2030 | Comprehensive revision of medical procedures in the field of antenatal, intrapartum, and postnatal care, with corresponding amendments to Decree No. 134/1998 Coll. | MoH | relevant professional institutions and entities |
| | 1.3.3 Ensure the gradual harmonization of reimbursement rates for vaginal birth and cesarean section | Through the amendment of the reimbursement decree and reimbursement methodologies, ensure the gradual harmonization of payments for vaginal birth and caesarean section from public health insurance funds. In line with FIGO recommendations, contribute to eliminating financial incentives for performing caesarean sections without medical justification. | by December 31, 2027 | Implementation of a normative intervention in reimbursement mechanisms in the public interest.. | MoH | health insurance companies |
| | 1.3.4 Conduct a cost-benefit analysis of implementing the midwife-led continuity of care model, with an emphasis on eliminating duplication in reimbursements | Ensure the evaluation of the economic and systemic impacts of introducing a model that enables women to choose continuity of care led by a midwife during pregnancy, childbirth, and the postpartum period. Analyze both the direct and indirect costs and benefits of this model, including the assessment of public resource efficiency, the potential to reduce the burden on secondary care, and the elimination of systemic duplications in reimbursement. Emphasize the identification and design of financing mechanisms that allow for a genuine choice without unnecessary duplication of care. Include the possibility of utilizing the structure of the home care providers' reference network as a tool for organizing and coordinating this form of care, including data sharing and the establishment of monitoring mechanisms. | by December 31, 2027 | Preparation of an impact analysis with specific recommendations for adjustments to the reimbursement system so that it reflects the needs of women using care and supports models of healthcare service organization in line with evidence-based medicine. | MoH (NIKEZ), Office of the Government of the Czech Republic | ÚZIS ČR, health insurance companies |
| **1.4 Evaluate the quality and safety of the care provided, and monitor and thoroughly analyse** | 1.4.1 Link the basic criteria for evaluating the quality and safety of care provided with the recommended guidelines | In follow-up to Measure 1.1.1, link the criteria for evaluating the quality and safety of care provided with the recommended guidelines. (This measure does not replace the monitoring of other quality criteria for the services provided, which are required in other parts of the strategy). | July 1, 2025 – July 1, 2026, then respond to new evidence as it emerges | The recommended clinical guidelines include criteria for assessing the quality | MoH (NIKEZ) | relevant professional institutions and entities, Office of the Government of |

| | | | | | | |
|---|---|---|---|---|---|---|
| **the causes of maternal and neonatal mortality.** | | | | and safety of the care provided. | | the Czech Republic (Working Group on Obstetrics) |
| | 1.4.2 Establish a specialized interdisciplinary and intersectoral working group to conduct thorough investigations of all maternal and perinatal deaths | Following the example of MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), establish a specialized interdisciplinary and interdepartmental working group to conduct thorough investigations of all maternal deaths during pregnancy and up to one year postpartum, as well as perinatal deaths, including late miscarriages, stillbirths, and neonatal deaths. The outcomes of the group's activities should be communicated to both the professional community and the wider public. | 1. 7. 2025 – 31. 12. 2030 (ongoing) | Conducting analyses. Establishment of an interdisciplinary and inter-ministerial working group, and informing both the professional community and the general public about the results of its activities. | MoH, ÚZIS ČR | relevant professional institutions and entities, Office of the Government of the Czech Republic (Working Group on Obstetrics) |
| | 1.4.3 Based on the analyses, identify areas where care can be improved and the risk of maternal and child deaths reduced | Based on investigations of all maternal deaths during pregnancy and up to one year postpartum, as well as perinatal deaths including late pregnancy losses, stillbirths, and neonatal deaths, formulate recommendations to improve care and reduce the risk of maternal and child deaths. Communicate these recommendations to both the professional community and the wider public. | 1. 7. 2025 – 31. 12. 2030 (ongoing) | Formulation of recommendations, and informing both the professional community and the general public about the results of its activities. | MoH, ÚZIS ČR | relevant professional institutions and entities, Office of the Government of the Czech Republic (Working Group on Obstetrics) |

### 3.2 Options and Limitations in Choosing a Healthcare Provider

One of the obstacles to the development of respectful care for mothers and children is the limited ability of women to choose their healthcare provider. At a general level, the right of patients to freely choose a healthcare provider or facility that meets their needs is guaranteed in Section 28 of the Health Services Act. The Act emphasizes that clients have the right to care *"in the least restrictive environment while ensuring the quality and safety of the health services provided."*[107] However, in the case of early motherhood care, this right is restricted by other legal regulations and additional systemic barriers. These include the absence of nationally accepted clinical standards (see Chapter 3.1) and conflicts of competence between representatives of medical and non-medical professions, particularly between gynecology and obstetrics on the one hand and midwifery on the other.[108]

#### 3.2.1 Barriers to the Use of Continuous Midwifery Care

The Czech **primary healthcare** system only provides for a registered physicians in four basic fields: general practice, paediatrics, dentistry, and gynaecology and obstetrics.[109] Unlike some other countries, the Czech Republic does not classify midwifery as a medical profession. Women cannot choose a midwife as their primary registered care provider during pregnancy, childbirth, and the postpartum period, despite the fact that **midwives** are **competent to provide care to women and newborns independently and without medical supervision** under both EU and Czech law**.**



The Act on Non-Medical Health Professions defines the profession of midwife as *"providing health care in midwifery, i.e. ensuring the necessary supervision, providing care and advice to women during pregnancy, childbirth and the postpartum period, if these proceed physiologically, managing physiological childbirth and providing care for newborns; this healthcare also includes nursing care for women in the field of gynecology. In addition, midwives, in cooperation with doctors, participate in preventive, therapeutic, diagnostic, rehabilitative, palliative, emergency, and dispensary care."*[110] This provision reflects the minimum set of activities that EU member states must ensure midwives have access to.[111] It also includes nursing care in the field of gynecology, an activity that is not consistent with the international definition of midwifery,[112] which was originally formulated by the International Confederation of Midwives (ICM) in collaboration with the International Federation of Gynecologists and Obstetricians (FIGO) and the WHO.[113] According to the international definition, midwives are not considered nursing professionals. Although nursing care and midwifery care are not explicitly separated in Czech law, there are several fundamental differences between them, relating to their functions, education, and the competencies of the representatives of these professions.

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[107] Section 28(3)(k) of the Health Services Act

[108] For more information on the historical and gender-specific aspects of the competence disputes in question, see, for example, TINKOVÁ, Daniela, 2010. *Body, Science, State: The Birth of the Maternity Hospital in Enlightened Europe.* Prague: Argo. Everyday Life. ISBN 978-80-257-0223-9. For the Czech context, see, for example, CANDIGLIOTA, Zuzana. 2020. How midwives were eradicated in the Czech lands. In: ŠIMÁČKOVÁ, Kateřina, Barbara HAVELKOVÁ and Pavla ŠPONDROVÁ, ed. *Men's rights: are legal rules neutral?* Prague: Wolters Kluwer, pp. 829-852. Legal monograph (Wolters Kluwer ČR). ISBN 978-80-7598-761-7.

[109] Section 5(5) of the Health Services Act

[110] Section 6(2) of the Act on Non-Medical Health Professions

[111] Directive 2005/36/EC of the European Parliament and of the Council

[112] For more details, see https://internationalmidwives.org/resources/definition-of-midwifery/.

[113] For more information, see https://mzd.gov.cz/kdo-je-porodni-asistentka-a-jak-se-stat-porodni-asistentkou/.

*Table 1 – Practice of the profession in the Czech Republic and its reimbursement from public health insurance*[114]

<table>
<tr><td rowspan="2"></td><td rowspan="2">DOCTOR<br>FIELD<br>GYNECOLOGY<br>AND OBSTETRICS</td><td colspan="3">MIDWIFE (PA)</td></tr>
<tr><td colspan="2">SELF-EMPLOYED</td><td colspan="2">HOSPITAL EMPLOYEE</td></tr>
<tr><td rowspan="2">PREGNANCY</td><td>unrestricted practice</td><td colspan="2">unrestricted practice</td><td rowspan="2">does not provide care</td><td>Some workplaces offer prenatal counseling led by a PA from the 37th week of pregnancy, but this is not continuous MW care.</td></tr>
<tr><td>care covered</td><td colspan="2">payment is conditional on medical indication, typically from the registering gynecologist (§ 18 ZVZP) + usually only one visit is covered (procedure no. 06211, or no. 06021 and no. 06023), but insurance companies do not have sufficient contracts with PAs</td><td>not covered, or covered as part of outpatient services contracted by the hospital with the insurance company</td></tr>
<tr><td rowspan="2">CHILDBIRTH</td><td>unrestricted practice</td><td>restricted authorization except for conducting physiological childbirth in the woman's own social environment + in a hospital only as a consultant (2/2b and 28/3c ZZS)</td><td>in the woman's own social environment non-medical service, only health care (§ 2636 OZ) without the need for authorization to provide health services (§ 16 ZZS)</td><td>MW in the role of assistant to a doctor</td><td>Some workplaces allow PAs to manage physiological births, but this is not continuous MW care</td></tr>
<tr><td>care covered during hospitalization</td><td colspan="2">No reimbursement</td><td colspan="2">care covered during hospitalization</td></tr>
<tr><td>SIX-MONTH PERIOD</td><td>unrestricted professional practice</td><td colspan="2">unrestricted practice</td><td>provides care on a limited basis (typically up to 72 hours after birth), then does not provide care</td><td>some workplaces now offer a visiting service in the patient's own social environment, but this is not continuous MW care</td></tr>
</table>

[114] Partially taken from the outputs of the project *Development of Continuous Care in Obstetrics* implemented by the League of Human Rights, see https://llp.cz/wp-content/uploads/Vystup_4_Navrh_legislativnich_zmen.pdf for more details. The table has been adapted for the purposes of the strategy and in light of recent socio-legal developments.

| | | | | |
|---|---|---|---|---|
| | care is covered | payment is conditional on medical indication, typically from the registering gynecologist (Section 18 of the Health Insurance Act) + usually three visits are covered (service no. 06211), but insurance companies do not have sufficient contracts with MWs | care covered during hospitalizatio n | not covered, or covered as part of outpatient services contracted by the hospital with the insurance company |

Midwifery is a *sui generis* healthcare profession. The essence of this unique profession in the current legal framework is best captured by the EU minimum standards transposed into the above-mentioned provision of the Act on Non-Medical Healthcare Professions. However, other legal regulations prevent the actual fulfillment of these competencies in the Czech Republic (see Table 1), which has a negative impact not only on midwives but also on women who are limited in their choice of healthcare provider and are denied access to the optimal model of care in early motherhood as recommended by the WHO. This is *"continuous care provided by midwives, in which a known midwife or a small group of known midwives provide a woman with continuous care and support before, during, and after childbirth."*[115]

The main restrictions include, in particular, the requirement for a medical indication for the reimbursement of midwifery care, resulting from the provisions of Section 18 of the Public Health Insurance Act. The restriction of midwives in the independent practice of their profession through the above provision has long been the subject of criticism not only from international organizations (see Chapter 2.5), but especially from women who are interested in using this care and having it covered by public health insurance. However, Czech professional organizations of gynecologists have long been publicly opposed to changing this provision. Available scientific evidence shows that integrating midwifery care into the health care system does not compromise quality and safety, but rather enhances it. Midwifery care models are beneficial not only for women and their families, but also for the public health insurance system, as they bring savings.[116] This is one of the reasons why midwifery care is standard and covered by public health insurance in other countries, including neighboring Austria and Germany.



In 2019, in an effort to support the development of so-called CPA (hybrid birth centers) (see Chapter 3.3.3), the Ministry of Health attempted to resolve the situation by proposing to abolish the requirement for a medical indication for the reimbursement of midwifery care *"in the case of a physiological birth in an inpatient healthcare facility*."[117] However, this amendment does not sufficiently address the situation of midwives being restricted in the independent practice of their profession and the reimbursement of their care from public insurance, and continues to cause a number of practical problems in practice. Without a medical indication, it still does not allow, for example, reimbursement for visits to pregnant women or mothers in the postpartum period. *"[I]f a pregnant woman or a mother must first obtain an indication from her physician, for which she has to go in person, the very purpose of the visiting service is lost."*[118]

Provided that there is a medical indication and a contract with an insurance company, a midwife may, in accordance with a subordinate regulation to the Public Health Insurance Act, independently perform only three reimbursable services: comprehensive examination of a

[115] WHO recommendations Intrapartum care for a positive childbirth experience, see https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf.

[116] For more details, see Sandall J, Fernandez Turienzo C, Devane D, Soltani H, Gillespie P, Gates S, Jones LV, Shennan AH, Rayment-Jones H. Midwife continuity of care models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2024, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub6. Available at: https://www.cochrane.org/CD004667/PREG_are-midwife-continuity-care-models-versus-other-models-care-childbearing-women-better-women-and.

[117] Section 18 of the Public Health Insurance Act

[118] Quoted from the comments of the Public Defender of Rights on the government amendment to the ZVZP of 2019.

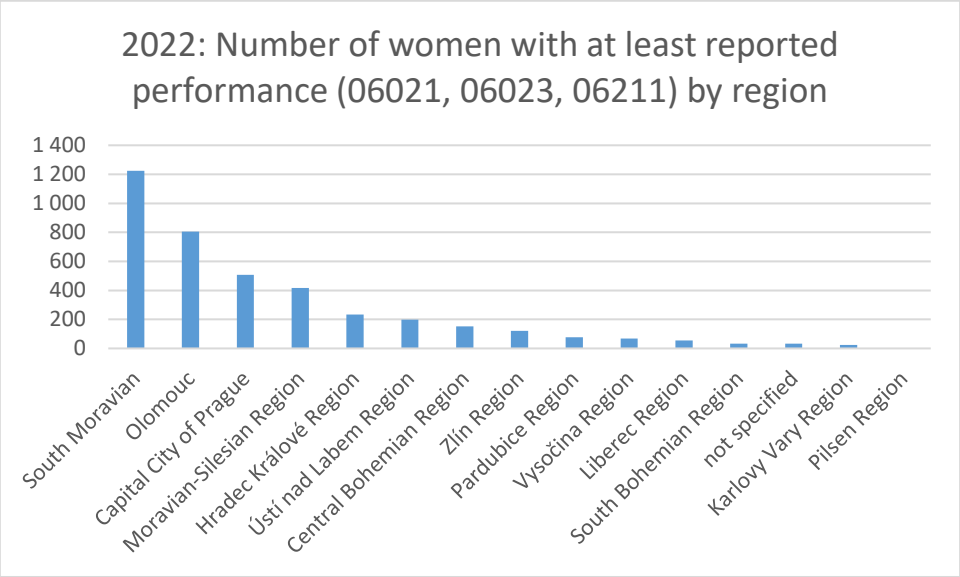
pregnant woman by a midwife (code 06021), follow-up examination of a pregnant woman by a midwife (code 06023) and visit to a pregnant woman or mother in the postpartum period by a midwife (code 06211).[119] There is no service for the provision of care during childbirth by a midwife without medical supervision, even though "*management of physiological childbirth*"[120] is, according to the Act on Non-Medical Health Professions, an inherent part of the profession of midwife. The list of healthcare services does not take into account other competences of midwives guaranteed by law and prevents them from performing other reimbursed services related to the care of women and children, such as lactation education (code 34007) or sampling for newborn screening or rescreening for congenital defects in newborns (code 02210).[121]

Despite its health benefits, safety, and financial advantages, the share of independently provided reimbursed care by midwives has been declining for a long time. This trend is partly due to the attitude of professional organizations of doctors in the field of gynecology and obstetrics, which not only disagree with legislative changes towards the full involvement of midwives in the healthcare reimbursement system, but also repeatedly discourage their members from recommending this care.[122] Moreover, even in cases where midwife care is medically indicated, women are often unable to use this service because insurance companies in some regions do not conclude contracts with midwives,[123] or only contract them for one of the three services mentioned above. The combination of the above factors leads to significant regional disparities in access to reimbursed midwife care. While in 2022, the number of women with at least one reported service (06021, 06023, 06211) in the South Moravian Region was 1,224, in the Pilsen Region it was only 2 women in the same year (see Chart 12 for more details). A similar disparity continued in 2023, when the number of these women in the South Moravian Region was 1,245, while in the Pilsen Region it was only 9.



[119] See Decree of the Ministry of Health No. 134/1998 Coll., which issues a list of medical services with point values. The decree serves to describe in detail, evaluate, and subsequently reimburse individual services (using points that are used as the basis for calculating reimbursements according to the rules set out in the reimbursement decree).
[120] Section 6(2) of the Act on Non-Medical Health Professions
[121] For more information on the need for a more thorough revision of the list of medical services due to outdated definitions that are inconsistent with evidence-based practice, see Chapter 3.1.
[122] See, for example, the 2023 opinion of the Committee of the Czech Gynecological and Obstetric Society of the Czech Medical Association of Jan Evangelista Purkyně (hereinafter referred to as "ČGPS ČLS JEP"), supported by the Association of Private Gynecologists of the Czech Republic. The original email with the opinion of the ČGPS ČLS JEP committee is attached to the open letter responding to it, available at: https://chcisvojiporodniasistentku.cz/index.php/ot-dopis-2023/.
[123] Ombudsman, "Women have the right to paid midwifery care | Ombudsman," viewed February 28, 2024, https://www.ochrance.cz/aktualne/zeny-maji-pravo-na-hrazenou-peci-porodnich-asistentek/.

*Chart 12*




Although the trend in the use of midwives in the Czech Republic between 2010 and 2022 shows an overall decline, data for recent years indicate a possible change. [124] , the highest proportion of women who used paid care provided by an independent midwife at least once was in 2010 (8.6%), after which their share gradually declined until 2020 (2.6%), when it reached its lowest level. In 2021 (3.4%) and 2022 (4.0%), there was a slight increase (see Chart 13 and Table 2 for more details).



[124] In an outpatient clinic or in their own social environment.

*Chart 13 – Reimbursed outpatient services provided by midwives as a percentage of total births*

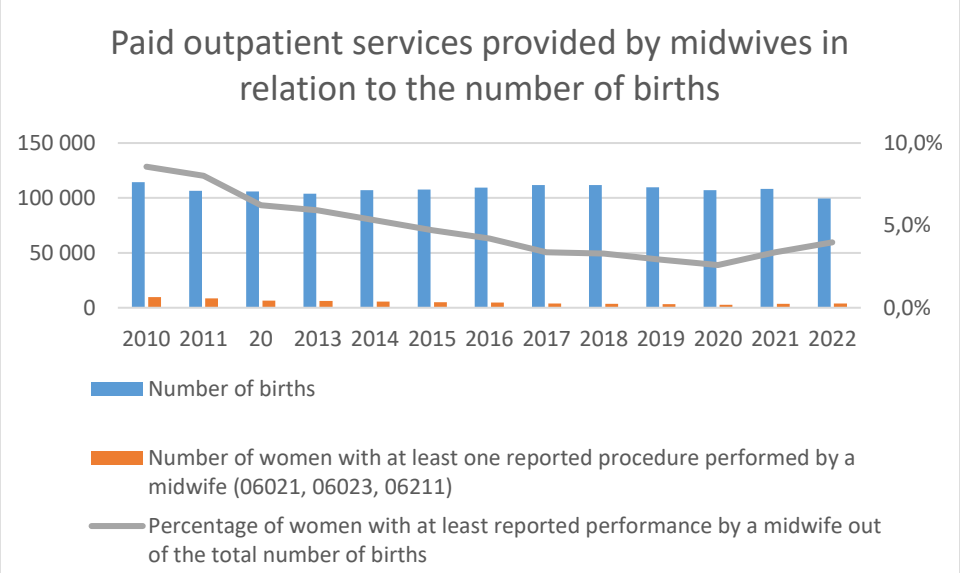





*Table 2 – Reimbursed outpatient services provided by midwives as a percentage of total births*

| Rok | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Počet porodů | 114 406 | 106 392 | 105 790 | 103 902 | 106 971 | 107 618 | 109 520 | 111 643 | 111 763 | 109 728 | 107 200 | 108 371 | 99 381 |
| Počet žen s alespoň vykázaným výkonem provedeným porodní asistentkou (06021, 06023, 06211) | 9 797 | 8 535 | 6 576 | 6 140 | 5 689 | 5 063 | 4 606 | 3 760 | 3 682 | 3 203 | 2 780 | 3 659 | 3 953 |
| Procentuální poměr žen s alespoň vykázaným výkonem provedeným porodní asistentkou k celkovému počtu porodů | 8,6% | 8,0% | 6,2% | 5,9% | 5,3% | 4,7% | 4,2% | 3,4% | 3,3% | 2,9% | 2,6% | 3,4% | 4,0% |

Midwives working independently in their profession are also limited by **prescription restrictions**.[125] In addition to not being able to prescribe medication, midwives also face challenges when administering it. Without professional supervision and indication, they are only authorized *to "receive, check, store, and handle medicinal products and ensure their sufficient supply*."[126] The restrictive interpretation of their powers in handling medicines, which is often applied in practice, contrasts with their other competences and activities, such as caring for women *"at all stages of childbirth and conducting physiological deliveries, including episiotomy if necessary"* and *"treat birth and postnatal injuries,"*[127] in which the administration of medication may be necessary. For example, performing an episiotomy or suturing a postnatal injury without the use of local anesthetics would be contrary to proper professional practice. Therefore, *"in order for a midwife to properly provide health care for which she is legally authorized without professional supervision and without indication, she necessarily needs certain medication to perform her duties in accordance with the lege artis standard."*[128] A midwife may therefore use selected medicinal products,[129] but she cannot obtain them

[125] Act No. 378/2007 Coll., on Medicinal Products.
[126] Section 5(1)(h) of Decree No. 55/2011 Coll., on the activities of healthcare professionals and other professionals
[127] Ibid., Section 5(1)(f) and (g).
[128] Jedličková, V. 2021. Medication that midwives are authorized to use in postnatal care for mothers, p. 3. Available at: https://www.unipa.cz/wp-content/uploads/2021/07/Medikace-kterou-je-porodni-asistentka-opravnena-pouzivat-v-ramci-poporodni-pece-o-rodicku.pdf.
[129] At least when treating birth and postpartum injuries and when providing professional first aid to stop postpartum bleeding.

herself. Midwives also do not have the option of indicating selected examinations (e.g., ultrasound) or biological material sampling.

In hospitals where medical staff are always present and where interdisciplinary cooperation works well, these restrictions do not pose a significant practical problem. Nevertheless, even here there is legal uncertainty and concern among medical staff about the possible legal consequences of situations that could be interpreted as the doctor having only formally indicated the administration of a medicine. If a woman wishes to choose a midwife as her primary healthcare provider, the legislation on medicines prevents her from doing so, as midwives—although authorized to provide postnatal care without professional supervision—are unable to fully implement the continuous care model due to these restrictions.

Women's access to the model of continuous care provided by midwives is further hampered by implementing regulations concerning staffing and technical and material equipment in healthcare facilities.[130] The relevant decrees contain conditions that effectively prevent the establishment of freestanding midwifery units in the Czech Republic. They set strict requirements for the equipment and premises of birth centers that do not correspond to the actual needs for this type of health service. For example, a technical decree requires that a birth center have rooms for the care of women and newborns after birth, even though care in birth centers usually (intentionally) takes place in one room where the woman remains throughout the birth and after. The technical and material equipment required by the decree, which cannot be provided in a home environment, was the reason why regional authorities in most cases (though not consistently) restricted the authorisation of midwives to exclude them from delivering babies outside healthcare facilities. The Constitutional Court confirmed this practice as consistent with current legislation, but emphasized that assistance during childbirth in the woman's own social environment is legal, but does not constitute a health service within the meaning of the Health Services Act.[131] The unavailability of midwifery facilities where physiological births are conducted and the restrictions on women's choice of place of birth are discussed in more detail in section 3.3 below.



In an effort to at least partially support the indication and provision of midwifery care, the Ministry of Health has newly included in the reimbursement decree for 2025 a bonus for integrated postnatal care in complicated births.[132] The bonus will provide hospitals with a fixed amount for each complicated birth if a midwife takes over care after hospitalization. This is a partial improvement, but the proposal does not address the above-mentioned systemic barriers to the development of a model of continuous care provided by midwives.

### 3.2.2 Strategic and Task-oriented Part – Set of Measures No. 2

The aim of the proposed measures is to enable women to choose their healthcare provider during early motherhood and to ensure that the option of continuous care provided by a midwife is an integral part of this choice. The measures aim to ensure women's access to the optimal model of care in early motherhood, as recommended by the WHO. In order to ensure wider availability of this model of care (where a known midwife or a small group of known midwives provide continuous care and support to women before, during, and after childbirth) in the Czech Republic, several legislative changes are necessary. These mainly concern the removal of internal contradictions in the legal regulation of the midwifery profession and the reimbursement of midwifery care from public health insurance funds.

However, the Ministry of Health is aware of the sensitivity of some legislative changes, particularly considerations regarding the expansion of the range of primary registering providers of health services during pregnancy, during childbirth and in the postpartum period, which in the current system can only be performed by doctors specializing in gynecology and

[130] Decree No. 92/2012 Coll., on requirements for minimum technical and material equipment of healthcare facilities and home care contact points, Decree No. 99/2012 Coll., on requirements for minimum staffing levels for healthcare services.
[131] Constitutional Court ruling ref. no. I. ÚS 2746/23 of 28 August 2024, published on 3 September 2024.
[132] See https://mzd.gov.cz/uhradova-vyhlaska-2025/.

obstetrics, as well as issues related to the possible relaxation of prescription restrictions. At this stage, therefore, the Ministry of Health ( ) is not considering any intervention in the basic structure of the system in terms of elevating midwives to the status of primary care physicians. The strategy opts for a gradual and cautious approach that supports the development of continuous care provided by midwives within the limits of currently politically acceptable changes, with an emphasis on interdisciplinary cooperation and the search for a broader consensus.

By removing these inconsistencies, the strategy will also contribute to responding to the call of the Constitutional Court from 2024 and the European Court of Human Rights from 2016 to revise legislation while respecting women's reproductive rights and taking into account developments in medicine, science, and law. The need for these changes is also reflected in the updated Gender Equality Strategy 2021–2030, so that the proposed measures further develop and build on existing tasks.

In addition to legislative changes, the strategy also includes measures to ensure sufficient human resources in professions caring for mothers and children during this period, including the creation of residential positions for community midwives.

Given the ongoing disputes over competences between medical and non-medical professions, in particular gynecologists and midwives, and the potentially conflicting economic and professional interests of these professions, the strategy includes measures to improve interdisciplinary cooperation while supporting a continuous model of care.

## Breakdown of Tasks for the Chapter Options and Limitations of Choice of Healthcare Provider

| **Strategic Objective 2** | | **Choice of Healthcare Provider and Development of a Model of Continuous Care Led by a Midwife** | | | | |
|---|---|---|---|---|---|---|
| Specific objective | Measure | Description | Duration of measure / deadline for completion | Criteria for fulfillment | Responsible institution (manager) | Cooperating entities (co-manager) |
| **2.1 Make legislative changes to ensure full professional autonomy for midwives** | 2.1.1 Remove restrictions on the exercise of the statutory powers of midwives and remedy internal inconsistencies in the legislation governing the practice of this profession and the reimbursement of care provided | Through an amendment to Act No. 48/1997 Coll., on public health insurance; Decree No. 99/2012, on minimum staffing requirements for health services; Decree No. 92/2012 Coll., on minimum technical and material requirements for healthcare facilities and home care contact points; Decree No. 134/1998 Coll., which issues a list of medical services, and other related regulations, while maintaining the role of doctors in the field of gynecology and obstetrics as primary registering providers, ensure full professional autonomy for midwives, enable them to practice independently, and remove barriers that prevent women from accessing continuous midwifery care. | Ongoing, but no later than December 31, 2030 | Government proposals for amendments to the relevant regulations reflect the content and requirements of this strategy. | MZD | |
| | 2.1.2 Align the content of explanatory memoranda to the amended regulations with the analytical part of this strategy | When drafting the general and specific parts of explanatory memoranda to regulations amended in connection with the implementation of measure 2.1.1, the content of this strategy should be used as a basis, in particular (but not exclusively) its analytical part. | Ongoing, but no later than December 31, 2030 | Explanatory memoranda shall reflect the content and requirements of this strategy. | MZD | |
| **2.2 Ensure the necessary human resources in relevant fields of expertise** | 2.2.1 Strive to ensure sufficient human resources across different specializations and regions, with an emphasis on supporting the model of continuous care | As part of policies for personnel stabilization in the health sector, pay specific attention to ensuring the necessary human resources in relevant professions and specializations so that the development of a model of continuous, individualized care for mothers and children can be supported. Increase the attractiveness of the relevant fields, including through adequate remuneration and support for the reconciliation of professional and personal (family) life. If necessary, increase the number of students in fields with capacity constraints. Support the establishment of targeted incentives by health insurance companies in regions with staff shortages. | July 1, 2025 – December 31, 2030 (ongoing) | Staffing levels in healthcare services correspond to the support for a continuous care model. | Ministry of Finance, Ministry of Education, Youth and Sports | Health insurance companies |
| | 2.2.2 Consider support for residential positions for community midwives | Consider including community care in midwifery among the specializations supported by the grant program for residential positions, and thereby support the creation of residential positions for community midwives who will gain experience in caring for pregnant women, women in labor, and women in the postpartum period outside of a hospital setting. Ensure residential positions with experienced midwives working in the community, in independent birth centers, or in certified birth centers run by midwives. This will ensure high-quality professional training and the development of | July 1, 2026 – December 31, 2030 (ongoing) | Annually strive to include the field of community care in midwifery in the call for proposals for subsidies to support residential places in specialized training in non-medical fields. | MZD | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | skills that will support the wider availability and quality of community midwifery care. | | | | |
| **2.3 Support and improve interdisciplinary cooperation** | 2.3.1 Create recommended organizational procedures to support a continuous care model | Create recommended organizational procedures to support a continuous model of care, with an emphasis on the woman's experience of the system. Define the connection between the health services provided by midwives and other care systems. Include all relevant expertise and specializations in the procedures, including gynecological physiotherapy and perinatal psychiatry, and define the optimal trajectory for women between individual services. Set up cooperation across the entire care system during pregnancy, childbirth, and the postpartum period so that the manner and circumstances of healthcare services provided take into account the individual needs of women and their families, minimize stress, and lead to a positive experience for women with care. Provide financial incentives for consistent adherence to the procedure, or ensure its financial viability and sustainability. In cooperation with health insurance companies, create additional incentive mechanisms that will contribute to the promotion of such organized care. | By July 1, 2026, create a procedure, then implement it by December 31, 2030. | Publication of the recommended procedure in the MZD Bulletin. A mechanism has been created for reimbursement bonuses for compliance with the procedure, or to ensure its financial viability and sustainability. | MZD, ÚV ČR (Working Group on Obstetrics) | Professional organizations of healthcare professionals, relevant professional institutions and entities, health insurance companies |
| | 2.3.2 Support the development of concepts for relevant fields and care organization methodologies that reflect the need for an interdisciplinary approach | In order to increase the effectiveness, quality, and comprehensiveness of care, support the development of concepts for relevant fields and specializations involved in the care provided to women in early motherhood (or methodologies for organizing the care they provide), with an emphasis on their mutual compatibility, cooperation, and consistency with this strategy. This applies in particular to: midwifery, gynecology and obstetrics, neonatology, pediatrics, anesthesiology, general practice, physiotherapy, neonatal and pediatric nursing, emergency medical services, nursing, psychiatry, psychology, social work, nutritional therapy, and other health and non-health care professions, including doulas. | July 1, 2025 – December 31, 2030 (ongoing) | Development of concepts for relevant fields, or care organization methodologies, which also reflect the need for an interdisciplinary approach. | MZD, NCO NZO | Professional organizations of healthcare professionals, relevant professional institutions and entities |

### 3.3 Unavailability of Birth Centers (Freestanding, Alongside) and Restrictions on the Choice of Place of Birth

Restrictions on the choice of healthcare provider are also linked to restrictions on the place, manner, and circumstances of birth. While in many countries[133] it is common for women to be able to choose between giving birth in a hospital, a birth center affiliated with a hospital, a separate birth house, or in their own social environment, this choice is limited in the Czech Republic. The main reason for this is the current legal framework and the way in which maternity care is financed.

Childbirth care is **currently** covered by health insurance companies **exclusively in the form of inpatient care**, which means that hospitals receive payments for the hospitalization of women during and after childbirth. The recommended length of stay in hospital is three days after giving birth. If a woman leaves before 48 hours, the hospital receives a reduced payment from the insurance company, which motivates healthcare facilities to keep women in hospital longer. The emphasis on hospital care during childbirth is **particularly beneficial for pregnant women with specific risks** (for the network of maternity hospitals in the Czech Republic and the centralization of care for women with pathological pregnancies, see Chapter 2.2). However, the hospital environment may not always be suitable for women with low-risk pregnancies. This is the reason for the growing interest in births in an environment that emphasizes the natural birth process and limits unnecessary medical interventions. At the same time, the WHO warns that overmedicalization of childbirth can worsen outcomes and quality of care and is also economically inefficient (see Chapter 1.6.5). In contrast, midwife-led models of care contribute significantly to better health outcomes and increased women's satisfaction with the care provided, as well as savings in healthcare.[134]



#### 3.3.1 Freestanding Birth Centers

**Birth centers**, which are a common part of the healthcare system in other countries, do not yet exist in the Czech Republic. An freestanding birth center (freestanding midwifery unit) is **a healthcare facility designed for women with low-risk pregnancies**, providing care led by experienced midwives in an environment that supports the natural course of childbirth with minimal intervention.[135] Care in birth centers is provided continuously from pregnancy through childbirth to the end of the postpartum period and is provided by a known midwife or a small group of known midwives. It also includes visits to the woman's home during pregnancy and the postpartum period. This individualized **care is indicated, provided, and led exclusively by midwives**.

> Birth centers *"offer an environment where women's autonomy can and should be promoted, along with the autonomy of midwives who support women in their free choice."*[136]

The birth center is a separate facility outside the hospital and is guided by the principles of prevention, safety, and efficiency. If medical care is needed, there are clear procedures for transferring the mother to the maternity ward/unit (obstetric unit), which is usually done by car or ambulance.

Unlike hospitals, birth centers allow for maximum continuity of care (see Diagram 3 for more details). In hospitals, women come into contact with multiple care providers who take turns and

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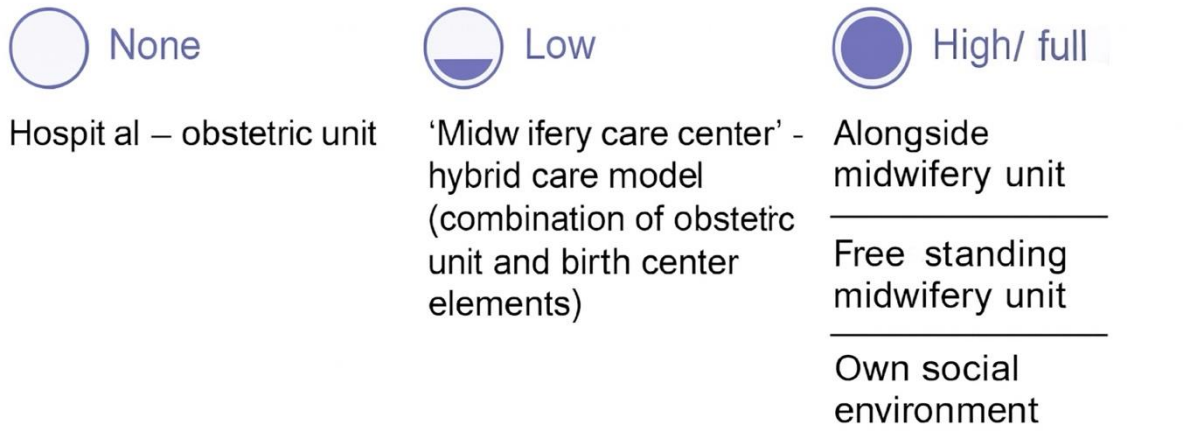
[133] For example, Austria, Germany, Great Britain, France, the Netherlands, and Denmark.
[134] World Health Organization. *Transitioning to midwifery models of care: global position paper.* Geneva: WHO; 2024. Available at https://www.who.int/publications/i/item/9789240098268.
[135] Birth center facilities should be designed to create a calm, home-like environment (i.e., not clinically looking) that minimizes stress and promotes the natural course of labor and birth. Clinical equipment should be hidden from view but easily accessible when needed. The overall design should promote mobility and choice of position during labor and birth.
[136] European Standards for Birth Houses and Centers (authorized Czech translation), p. 21.

whom they often meet for the first time during labor, which prevents them from forming a long-term relationship with a single caregiver. Similarly, due to the specific nature of hospital operations, healthcare staff are unable to get to know the woman sufficiently and understand her individual needs. The hospital model can lead to a lower level of trust and a less personalized approach, which can negatively affect the woman's overall birth experience. In contrast, in a birth center, where continuous care is the standard, women have stable support and the opportunity to form a long-term, trusting relationship with a permanent team or a single midwife who accompanies them throughout early motherhood and provides care. Unlike in hospitals, women in birth centers receive more individualized care tailored to their specific needs, which leads to better outcomes for low-risk women.

*Diagram 3 – Level of continuity of care by type of facility or place of birth*




### 3.3.2 Hospital-based Birth Centers (Alongside Birth Centers/Midwifery Units)

Another option for women to give birth is **a hospital-based birth center** (alongside midwifery unit). Unlike freestandning birth centers, these centers are located directly in a hospital building (maternity ward) or at least within the hospital grounds, but are still run by midwives who care for women during pregnancy and the postpartum period. Unlike birth centers, they allow for non-motorized transport of mothers and newborns to a facility with a higher (more specialized) level of care if necessary. The main difference between a hospital-affiliated birth center and a stand-alone birth center is the availability of medical care. A birth center guarantees easy and quick access to medical intervention if needed. In contrast, a birthing center is a completely independent facility and relies on a planned system of transport to a hospital in cases where medical care is necessary. This difference may influence a woman's choice of place of birth, depending on her health and individual needs.

Hospital-based birth centers are often perceived as a safer option due to their proximity to hospital maternity wards. This proximity provides both mothers and medical staff with a greater

sense of security, as it allows for quick access to medical care in case of complications. Some healthcare professionals believe that having all mothers in one place allows for better monitoring and control, which contributes to a feeling of safety. However, this does not necessarily translate into better outcomes. Studies show that freestanding birth centers achieve better clinical outcomes than hospital-based birth centers.[137] Birth centers also have higher success rates than maternity wards, with better overall outcomes for mothers and comparable outcomes for newborns.[138] In addition to better clinical outcomes, birth centers are associated with high satisfaction among service users and local healthcare staff, and are cost-effective. The difference between objective results and subjective perceptions of safety shows how important it is to improve awareness of the real benefits and risks of different types of healthcare facilities where physiological births take place.

### 3.3.3 Legal and Practical Barriers to the Establishment and Development of Freestanding Birth Centers and Alongside Midwifery Units in the Czech Republic



The United Kingdom, Germany, the Netherlands, and Belgium are examples of countries in Europe where birth centers for women are one of the standard options for giving birth. Women in the Czech Republic have also been demanding this option for a long time (see Chapter 2.1.2 for more details). The current legislation allows for the existence of freestanding birth centers [139] , but under such strict conditions that none have yet been established in the Czech Republic, as the combination of existing technical and personnel requirements would make the operation of such facilities excessively costly and logistically difficult. Moreover, some of the requirements for the premises and equipment of a freestanding birth center do not correspond to the actual needs of this type of healthcare facility and the relevant international standards.[140] For example, Technical Regulation (No. 92/2012 Coll.)[141] requires two separate rooms for the care of women and newborns after childbirth. *"Care in freestanding birth centers is not based on moving women and babies to another room and bed after birth, as in hospitals, but on respecting intimacy and allowing mothers to bond with their babies in the same room after birth, followed by discharge to their own social environment."*[142] Furthermore, *"the equipment of a freestanding birth center does not necessarily have to correspond to the actual needs for this type of health service; some equipment required by technical regulations may seem superfluous from the point of view of midwives, while other equipment may be missing from the regulations."*[143]

The guidelines for facilities, material and technical equipment supplement the requirements for staffing of health services provided in freestanding birth centers, which are regulated by the

[137] Batinelli, L., Thaels, E., Leister, N. *et al.* What are the strategies for implementing primary care models in maternity? A systematic review on midwifery units. *BMC Pregnancy Childbirth* **22,** 123 (2022). https://doi.org/10.1186/s12884-022-04410-x.

[138] For more information, see, for example, Scarf VL, Rossiter C, Vedam S, Dahlen HG, Ellwood D, Forster D, et al. Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: a systematic review and meta-analysis. Midwifery. 2018;1(62):240–55. or Hollowell J, Rowe R, Townend J, et al. The Birthplace in England national prospective cohort study: further analyses to enhance policy and service delivery decision-making for planned place of birth. Southampton (UK): NIHR Journals Library; 2015 Aug. (Health Services and Delivery Research, No. 3.36.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK311289/ doi: 10.3310/hsdr03360.

[139] In the sense of an outpatient healthcare facility for midwives, where physiological births are conducted.

[140] For more details, see, for example, European Standards for Birth Centers.

[141] Decree No. 99/2012 on minimum staffing requirements for health services – Annex No. 1, Part I, point 2.11.2. Health care, including the management of physiological births.

[142] Recommendation of the Government Council for Gender Equality on independent birth centers based on the Initiative of the Working Group on Obstetrics on independent birth centers of June 23, 2017, p. 6. Available at: https://vlada.gov.cz/assets/ppov/rovne-prilezitosti-zen-a-muzu/cinnost_rady/Pracovni-skupina-k-porodnictvi---podnet-k-porodnim-domum.pdf.

[143] Ibid.

Staffing Decree (No. 99/2012 Coll.).[144] In addition to the presence of two midwives, or one midwife and one pediatric nurse or pediatric intensive care nurse or intensive care nurse, it stipulates the obligation of the physical presence of a doctor specializing in gynecology and obstetrics within 5 minutes. However, in the context of the above-mentioned specifics and the safety of the operation of a freestanding birth center, the requirement for the presence of a doctor appears to be superfluous. It is also problematic for economic reasons, as the costs of the physical presence of a doctor would significantly increase the costs of the birth center's health services. Midwives are qualified and competent to provide care during physiological births independently, without the presence of a doctor. They are able to monitor the condition of the mother and fetus, recognize signs of pathology, and, if necessary, refer the mother to a hospital where the necessary equipment is available for possible medical intervention. In non-urgent cases, there is also sufficient time to safely transport the mother to a hospital where she can receive medical care. A doctor who arrives at the freestanding birth center within five minutes would not have access to an adequately equipped delivery room, which would prevent effective intervention. In acute cases, it is therefore necessary to ensure immediate transport to a hospital where an adequate level of care for pathological conditions is available.

Setting clear rules for transfer to a higher level of care is therefore crucial to ensure the safety of the mother and child in the event of complications during childbirth. Both decrees require that within 15 minutes of identifying complications*, "a cesarean section or surgery to terminate the birth be performed",*[145] either through an adequately equipped delivery room, including the presence of a neonatologist/ or by ensuring the transfer of the mother to a hospital with a maternity ward. In view of the above-mentioned international standards and the nature of a freestanding birth center, transfer to a hospital appears to be the most likely solution for meeting the conditions set out in the decrees. The relevant condition must be understood in conjunction with the interpretative opinion of the Ministry of Health, according to which the 15-minute interval *"is interpreted as the time it takes for a midwife to travel from a healthcare facility to another healthcare facility that is authorized and capable of providing specialized care in the field of gynecology and obstetrics to deal with complications arising during childbirth."*[146] However, the problem is that the law on emergency medical services sets the maximum response time for an ambulance at 20 minutes, which is more than the required 15 minutes, and it is not clearly specified whether the transport must be provided by an emergency medical service vehicle or whether it can be carried out by a private vehicle. This creates uncertainty as to how to meet these conditions in practice and whether they are even feasible without placing an unreasonable financial and logistical burden on freestanding birth centres.[147]

Previous efforts to amend the decrees have been hampered by a persistent *culture of risk*[148] and the above-described discrepancy between the subjective perception of safety and the actual clinical results of freestanding birth centers, which are better than those of alongside



[144] Decree No. 92/2012 Coll., on requirements for minimum technical and material equipment of healthcare facilities and home care contact points – Annex No. 2, Part B. Special requirements, point 2.11.2. Midwife's workplace where physiological births are performed.
[145] Ibid.
[146] Dated November 19, 2015, ref. no. MZDR 70563/2015-1/PRO. Available at: https://mzd.gov.cz/wp-content/uploads/wepub/10990/24587/stanovisko%20MZ%20%C4%8CR.pdf.
[147] For example, through the costs associated with the emergency ambulance service during the entire delivery or stay at the birthing center.
[148] The "culture of risk" is the prevailing approach in modern obstetrics, which emphasizes the riskiness of childbirth as a potentially dangerous process. This approach leads to the frequent use of medical interventions, often even in cases where they are not entirely necessary. The "culture of risk" manifests itself in the tendency of medical staff to approach childbirth with excessive caution, influenced by their experience with pathological cases, which can lead to excessive interventions and neglect of physiological processes related to childbirth. For more details, see Takács L. 2016. Psychosocial aspects of childbirth and postpartum care. Dissertation. Available at https://dspace.cuni.cz/bitstream/handle/20.500.11956/82474/140052479.pdf?sequence=1&isAllowed=y. On the perception of risk, see also, for example, MacKenzie Bryers, H., & van Teijlingen, E. (2010). Risk, theory, social and medical models: a critical analysis of the concept of risk in maternity care. *Midwifery, 26(*5), 488–496. Available at https://doi.org/10.1016/j.midw.2010.07.003.

midwifery units (hospital-based) and hospital maternity wards. This is one of the reasons why **the Ministry of Health has so far given priority to improving the quality of services in existing maternity hospitals over supporting the establishment of freestanding birth centers.** The originally planned pilot project for a freestanding birth center was thus replaced by support for the establishment of a so-called CPA ("center for midwifery" , a hybrid model of care, not midwifery-led, within maternity hospitals).[149]

The first such center was opened in 2019 under the auspices of the Ministry of Health at Bulovka Hospital (now a teaching hospital).[150] The center built on a model of care that had already been operating informally in some smaller maternity hospitals. At the same time, however, the center's management, in cooperation with the ministry, sought to establish clear rules and create a nationally transferable model for this model of care in „centres for midwifery" (in Czech "CPA" – a hybrid model of care, combining obstetric-led care with midwifery-led). The pilot operation of this model facility, supported by the ministry, thus also became the basis for the preparation of uniform methodological guidelines (recommendations) for the operation of these „centres for midwifery". Although this was a significant step towards ensuring greater diversity in maternity care in the Czech Republic, legislative barriers preventing midwives from practising independently (see Chapter 3.2.1) proved to be an obstacle to the development of midwifery units and their alignment with standards that are common for facilities run by midwives abroad.



CPAs ("centers for midwifery") are unique to the Czech Republic, combining elements of an obstetric unit and a hospital-based birth center (alongside midwifery unit). Although these centers offer low-risk women the option of care provided by a midwife, they are still run exclusively by doctors. This is again due to legislative restrictions—not only must a doctor first indicate the need for care, but there are also no corresponding medical procedures on the basis of which hospitals operating such centers could claim reimbursement for the exclusive care provided by midwives from public health insurance.[151] However, according to the and Midwifery Unit Network (MUNet), this **hybrid model of care,** which combines elements of obstetric-led care with midwifery-led, prevents midwives from achieving full autonomy and makes it impossible to establish centers where midwives could provide care to women in labor independently.

In addition, the current form and operation of CPAs ("centers for midwifery") vary across the Czech Republic, and **attempts to standardize** them **have been unsuccessful**. The Ministry of Health withdrew its 2020 methodological recommendation for these "centers for midwifery" without replacement in 2022 following criticism.[152] **None** of the Czech "centers for midwifery" currently fully **comply with international standards.**[153] As a result, in 2023, the Czech Republic lost the opportunity to participate in the second round of a European pilot study on

[149] For the connection between *the Government Council's Recommendation on Independent Birth Centers,* its failure to be discussed by the government, and the subsequent support for the establishment of birth assistance centers*,* see *the 2018 Report on Gender Equality,* pp. 44-45, available at https://vlada.gov.cz/assets/ppov/rovne-prilezitosti-zen-a-muzu/dokumenty/Material---Zprava-za-rok-2018-o-rovnosti_FINAL.pdf.

[150] For more details, see https://bulovka.cz/kliniky-a-oddeleni/centrum-porodni-asistence. Na Bulovce Hospital did not officially become a teaching hospital until 2021. Until then, it was known only as Na Bulovce Hospital

[151] The only exception is the medical procedure of vaginal delivery by a midwife under the supervision of a doctor (code 63120). However, this is not sufficient to compile and cover (reimburse) the entire hospitalization case and other aspects of midwifery care. Moreover, the very name of the procedure implies that medical supervision is expected of midwives, even though midwives are competent to provide care independently and without medical supervision according to both EU and Czech legislation (for more details, see Chapter 3.2).

[152] *See Bulletin 12/2022 available at https://www.mzcr.cz/vestnik/vestnik-12-2022/. The "Methodological Recommendation of the Ministry of Health of the Czech Republic for healthcare providers in the field of gynecology, obstetrics, and neonatology for the effective organization of maternity hospitals and for maximum utilization of midwives during childbirth within the existing network of maternity hospitals – concept of so-called Midwifery Centers"* was repealed at the initiative of the Ministerial Commission for Obstetrics, among others.

[153] For more details, see European Standards for Birth Centers, authorized Czech translation available at https://apodac.org/wp-content/uploads/MUNET-Standards_4_2021_CZ1.pdf.

the use of the MUSA (Midwifery Unit Self-Assessment) tool, which is being implemented by the Midwifery Unit Network (MUNet) as a precursor to certification.

### 3.3.4 Own Social Environment

Another option for giving birth is in your own social environment. Most often, this is the home where the woman lives, hence the simplified term "*home birth*."[154] Similar to freestanding birth centers, this option is only suitable **for women with low-risk pregnancies.** For these women**, a planned home birth assisted by an experienced care provider,** typically a midwife, **with ongoing and thorough risk assessment is as safe an option as a planned birth in a healthcare facility.**[155] It maintains and supports continuity of care provided by a familiar midwife or small group of midwives throughout pregnancy, childbirth, and the postpartum period, which has a positive effect on the natural course of childbirth. Compared to hospitals, there are also fewer interventions, less use of medication, and fewer birth injuries in the home environment.

Women with low-risk pregnancies choose to give birth in their own social environment because of the high level of continuity of care (see Diagram 3) and the associated health and other benefits it may have for them. Research among Czech women[156] also shows that they are often motivated to choose home birth by their own negative or traumatic experience of previous births in a healthcare facility. According to research, the main reasons why women in the Czech Republic prefer to give birth in their own social environment include dissatisfaction with maternity care in hospitals, including routine medical interventions without the mother's consent, and insensitive treatment by medical staff (for more details, see also Chapter 2.1.). Another reason is the lack of choice of a freestanding birth center—65% of the 642 women who planned to give birth at home between 2015 and 2020 said they would not have chosen this option if freestanding birth centers existed in the Czech Republic.[157] The preferences of the participants in this study are in line with experiences abroad, where the availability of freestanding birth centers has led to a decline in planned home births, as some of these have been transferred to these facilities run by midwives.



Home births in the Czech Republic are mostly chosen by women with higher education. These are women who tend to actively seek information and consider the benefits and risks associated with different types of care.[158] When choosing to give birth in their own social environment, they are usually well informed, undergo some of the routine examinations (especially ultrasound, blood and urine tests, and screening for developmental defects), and have a backup plan and a hospital ready in case of complications.[159]

In the Czech Republic, approximately 0.5 % to 1 % of births are planned to take place at home each year. However, accurate statistics on home births are not available or are significantly underestimated. This is partly due to the fact that the data collection system for the relevant register was not sufficiently adapted to record births outside healthcare facilities, including the inability to distinguish whether such births were actually planned. Another factor that has

[154] This may also be an environment replacing the home environment of the care recipient, such as a social services facility.
[155] Olsen O, Clausen JA. Planned hospital birth compared with planned home birth for pregnant women at low risk of complications. Cochrane Database of Systematic Reviews 2023, Issue 3. Art. No.: CD000352. DOI: 10.1002/14651858.CD000352.pub3. Available at https://www.cochrane.org/CD000352/PREG_planned-hospital-birth-versus-planned-home-birth.
[156] Durnová, A., Hejzlarová, E. Home births in the Czech Republic: motivations, reasons, and opinions of women who planned to give birth at home (2015-2020). Prague: Department of Public and Social Policy, Faculty of Social Sciences, Charles University, 2021. Available at: https://fsv.cuni.cz/sites/default/files/uploads/files/18-10042s_vyzkumnazprava_Durnova_Hejzlarova_27_1_2021.pdf, further Hrešanová E. Women who desire 'natural childbirth' in hospitals in a highly medicalized birth care system. Health Care Women Int. 2024 Sep 10:1-21. doi: 10.1080/07399332.2024.2397457. Epub ahead of print. PMID: 39255416. Available at: https://pubmed.ncbi.nlm.nih.gov/39255416/.
[157] Ibid.
[158] Ibid. (Durnová, A., Hejzlarová E.).
[159] Ibid.

contributed to inaccuracies in reporting is the fear of possible punishment and stigmatization among mothers and their companions.[160]

The number of women choosing to give birth at home may also increase in response to certain events. For example, during the COVID-19 pandemic, even women who would not otherwise have considered home birth opted for this option out of concern that pandemic measures would require them to give birth in a hospital without the presence of their chosen companion.[161]

Births outside of healthcare facilities can also occur unplanned due to emergency situations, such as traffic accidents or floods, or due to precipitous labor. Some women are forced to give birth without medical assistance. Only for a very small group of women is unassisted birth (freebirth) at home a conscious and free choice. However, **home birth** is **only safe under certain conditions,** which include **low-risk pregnancy and the presence of a qualified midwife capable of recognizing complications in time and ensuring transport** to a hospital **if necessary.** This is one of the reasons why one of the objectives of this strategy is to ensure that women are not forced to choose unassisted home birth because they are unable to access professional care from a midwife.



### 3.3.5 Legal Framework for the Provision of Care During Home Births

Home birth is legal in the Czech Republic. However, until a recent decision by the Constitutional Court[162] , there were two different interpretations in professional literature and, above all, in the decisions of regional authorities as to whether it is also legal to provide assistance to women giving birth at home or to provide health services during childbirth outside a healthcare facility. According to the first interpretation, the right to provide health services in one's own social environment also applies to nursing care[163] during physiological home births.[164] The second interpretation, on the other hand, excludes this possibility on the grounds that it is a medical procedure that requires technical and material equipment that cannot be provided in a home environment.[165]

In practice, the second interpretation prevailed among regional authorities, according to which the assistance of any healthcare professional during such a birth is contrary to the law. For this reason, regional authorities mostly (but not consistently) restricted midwives' authorization to provide healthcare services. Some authorities also fined them for assisting in home births, regardless of whether the mother or child suffered any harm (even when the clients were satisfied with the care provided by the midwife).[166]

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[160] With regard to the Constitutional Court ruling ref. no. I. ÚS 2746/23 of 28 August 2024, published on 3 September 2024, it can be expected that the reporting of home births will improve. However, this will not necessarily mean an increase in their number, but rather an improvement in data collection as a result of the removal of concerns about reporting planned home births. However, a new difficulty will arise in that midwives will not be obliged to report the care provided in this way, as it does not fall within the scope of the Health Services Act (for more details, see Chapter 3.3.5).

[161] See Czech Women's Lobby. 2021. Press release: *Anti-COVID measures negatively affect midwifery practice.* Available at: https://czlobby.cz/cs/zpravy/tz-proticovidova-opatreni-negativne-ovlivnuji-porodni-praxi https://czlobby.cz/cs/zpravy/tz-proticovidova-opatreni-negativne-ovlivnuji-porodni-praxi?fbclid=IwAR3UfTymdvrB1yEx8ajeVOigSTtj3hmVEjFwj0fZy809qxVynt-Y40pKL0g

[162] Constitutional Court ruling ref. no. I. ÚS 2746/23 of 28 August 2024, published on 3 September 2024.

[163] In the sense of the type of care under the Health Services Act and the definition of the activities of a midwife under the Non-Medical Health Professions Act.

[164] See, for example, TELEC, I. Births in one's own social environment according to the law. *Health law and bioethics.* March 3, 2018. Available at https://zdravotnickepravo.info/porody-ve-vlastnim-socialnim-prostredi-podle-prava.

[165] See, for example, ŠUSTEK, P. 2017. *Legal aspects of home births.* In GERLOCH, Aleš and Katarzyna ŽÁK KRZYŽANKOVÁ, ed., 2017. *Private and public in the context of institutional and normative changes in law.* Plzeň: Vydavatelství a nakladatelství Aleš Čeněk. ISBN 978-80-7380-705-4.

[166] See, for example, the case examined by the Regional Court in Plzeň, judgment of December 19, 2022, ref. no. 77 A 159/2020–114, available at https://justice.cz/documents/17369/3240868/77A_159_2020+-+anonymizovan%C3%BD+rozsudek.pdf/24b8f7ce-c722-4949-a4c7-8d919e739387.

The threat of administrative penalties in the form of fines of up to CZK 1 million,[167] , together with previous occasional attempts to criminalize assistance at home births, has led not only to the long-standing underreporting of home births outlined above, but above all to fear among some healthcare professionals to offer and provide this care. This further narrowed and restricted women's ability to freely choose the place, manner, and circumstances of their birth.[168]

Contradictions and ambiguities in the legal regulation of care provision during home births and the inconsistent approach of regional authorities in granting authorisation to midwives have been addressed in the past, primarily through the courts. However, this ambiguity has also been reflected in case law.[169] The aforementioned ruling of the Constitutional Court from 2024 provided some guidance. The Constitutional Court definitively confirmed that **it is legal not only for a woman to choose to give birth in her own social environment, but also for a healthcare professional to be present and assist at such a birth.** However, according to the Constitutional Court, assistance with a planned home birth is an activity that is not covered by the Health Services Act. It is therefore not a health service within the meaning of this Act,[170] but rather health care under the Civil Code.[171]

> *"The Constitutional Court emphasized that childbirth is a unique and delicate moment in a woman's life and that the choice of the place and circumstances of childbirth falls under the protection of her physical and mental integrity, personal autonomy, and related reproductive rights."*[172]



The Constitutional Court thus *"distanced* itself *from the previous practice, which, in its opinion, led to absurd consequences. If a woman can decide to give birth at home and use the assistance of, for example, a doula or other persons without this being prohibited by law, there is no reasonable reason why a woman who is aware of the health and legal risks should not be able to use the services of a person professionally trained in labour and delivery (e.g., a midwife), even if this does not involve the provision of health care."*[173]

The exclusion of assistance with planned home births from the scope of the Health Services Act does not mean that such services are not regulated at all, only that they are not guaranteed by the state. Even in private law relationships, if a person presents themselves as a member of a particular profession or status, they thereby indicate that they are capable of acting with the knowledge and care associated with that profession or status, and if they act without such professional care, this is to their detriment.[174] Many of the obligations associated with healthcare under the Civil Code, such as the obligation to act with the care of a proper professional and in accordance with the rules of their profession,[175] to keep records of the healthcare provided, to provide comprehensible information about the intended examination and proposed care, including the risks and alternative procedures, corresponds to the obligations of healthcare providers under the Act of the same name. In addition, the issue of interference with the right to mental and physical integrity is regulated in such detail in the Civil

[167] I.e., fines so high that they could ruin the person concerned.
[168] This does not necessarily mean that there would be a reduction in the number of planned home births (for the pitfalls of reporting, see section 3.3.4), but the lack of care increased their risks.
[169] See the above-mentioned judgment of the Regional Court in Plzeň of December 19, 2022, ref. no. 77 A 159/2020–114, versus Judgment of the Supreme Administrative Court dated June 1, 2023, ref. no. 1 As 15/2023 - 38, available at https://www.zakonyprolidi.cz/judikat/nsscr/1-as-15-2023-38.
[170] An exception is the provision of care in the event of a premature birth.
[171] Section 2636 of the Civil Code
[172] Questions and answers on the Constitutional Court's ruling on home births and midwives (ruling ref. no. I. ÚS 2746/23), available at https://www.usoud.cz/fileadmin/user_upload/Tiskova_mluvci/Publikovane_nalezy/2024/Ot%C3%A1zky_a_odpov%C4%9Bdi_dom%C3%A1c%C3%AD_porody.pdf.
[173] Ibid.
[174] Section 5 of the Civil Code.
[175] The contracting parties may not agree on care of a lower quality.

Code that its provisions[176] take precedence over the Health Services Act in this area, which is very important for childbirth, when providing healthcare services.

Despite the partial primacy of the Civil Code and the overlap of certain rights and obligations in both laws, the healthcare regime lacks more detailed regulation in some aspects compared to the healthcare services regime, for example with regard to the keeping of medical records.[177] The exclusion of planned home births from the scope of state-regulated health services also makes it impossible for them to be reimbursed from public health insurance funds. There is also no possibility for state authorities to monitor compliance with the obligations of care providers. In the event of misconduct on the part of a midwife (or other healthcare professional), this will constitute a breach of contract and will be dealt with by the civil courts. The dual regime, whereby some of the activities of midwives are considered healthcare services while others are not, is also very confusing for those subject to the legislation, as the Constitutional Court has also noted. According to the Court, the current legal regulation of the midwifery profession is very complex and confusing, making it difficult to understand for both mothers and healthcare professionals.

The Constitutional Court therefore, similarly to the European Court of Human Rights in 2016,[178] called on the state authorities not to remain indifferent to the problems arising from unclear legislation and to resolve the contradictory provisions of the law while respecting women's reproductive rights and taking into account developments in medicine, science, and law.



The strategy deals with these contradictions and proposals for their resolution in detail in the previous subchapters, where it focuses, among other things, on the current wording of the Staffing and Technical decree and the need for its amendment. The predecessor of the current Technical decree, which set out the requirements for the material and technical equipment of individual types of workplaces, imposed an obligation on all home care facilities—i.e., the contact workplace of a general nurse and the contact workplace of a midwife—to be equipped with *a* so-called *visitor's bag.* [179]The repeal of this decree, or rather the institution of the visiting bag, is one of the main causes of uncertainty regarding assistance at home births.[180]

### 3.3.6 Strategic and Task-oriented Part – Set of Measures No. 3

The strategy responds to the above-described problems by proposing specific legislative and organizational changes that are necessary for the realization of informed and free choice of place, manner, and circumstances of birth. The required changes aim to ensure a more predictable legal framework not only for healthcare providers, but above all for women, so that it better meets the needs of women in labor and their children (for more details, see also Chapter 1.6.2) while respecting their rights.

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[176] Sections 91 to 103 of the Civil Code

[177] Although Section 2647 of the Civil Code imposes an obligation on the provider to keep records *"*to *the extent necessary for the provision of proper health care"* and to keep them for as long as *"required by the need for professional care,"* however, these records are not subject to further obligations regarding the keeping of medical records imposed on healthcare providers by the Act of the same name and the related Decree No. 98/2012 Coll. on medical records.

[178] Judgment of November 15, 2016, in case no. 28859/11 and 28473/12 – Dubská and Krejzová v. the Czech Republic.

[179] For more details, see Part IV, point 6.2 of the annex to the previously valid Decree No. 221/2010 Coll., on requirements for the material and technical equipment of healthcare facilities: The midwife's visiting bag contains
a) a device for detecting fetal heartbeat,
b) disposable aids for examining pregnant women,
c) a tonometer,
d) a phonendoscope,
e) a medical thermometer,
f) first aid equipment, including cardiopulmonary resuscitation equipment, i.e. a self-inflating bag with a mask, airways, gloves, scissors, tweezers, equipment for stopping bleeding, and means of securing venous access.

[180] With the adoption of the Health Services Act and the exclusion of the visitor's bag from the mandatory equipment of home care contact points in the new (existing) technical regulation, the management of physiological childbirth became conditional on the technical and material equipment necessary for its performance in a healthcare facility. For more details, see Section 10(3) of the Health Services Act.

The availability of birth centers in accordance with international standards, i.e., run autonomously by midwives, will be facilitated by the amendment of the so-called Staffing and Technical regulations, which will remove unnecessary requirements for these facilities, such as the obligation to have separate rooms for the care of women and newborns after birth. The proposed amendment to the minimum staffing requirements for health services aims to fully support the continuous care model provided by a known midwife (or a small group of known midwives) in line with WHO recommendations. The strategy also plans to support the establishment and development of birth centers by making it possible to draw on EU funds and other financial mechanisms to develop the necessary infrastructure (construction, renovation, modernization, and equipment).

Given the Ministry of Health's stated position that the existing network of maternity hospitals is oversized and that, in view of the declining birth rate, it will be necessary to reduce it in the future rather than create new facilities, measures aimed at systematically supporting the development of freestanding birth centres/midwifery units were not included in the strategy, even though they were discussed during the preparation phase. Instead, the strategy focuses on the effective use of existing infrastructure and capacities, in particular the gradual development of CPAs (“centers for midwifery“) in maternity hospitals, strengthening the competencies of midwives, and interdisciplinary cooperation so that these centers can in the future fulfill the function of birth centers (alongside midwifery units) in accordance with European standards. The aim is to expand midwifery-led care options in a gradual, sustainable, and politically acceptable manner that takes into account women's preferences while reflecting the continuing concern of some members of the medical community, shared by the Ministry of Health, about a possible weakening of the continuous availability of specialized care.

The strategy also includes measures to ensure a safe framework for births in the woman's own social environment. The changes proposed in the strategy aim to quickly eliminate the alleged complexity and inconsistency that has historically arisen from the abolition of the midwife's (and general nurse's) *visiting bag*, which was part of the equipment of the home care contact center. The restoration of this institution will be one of the steps through which it will be possible **to reintegrate home birth assistance into state-regulated health services** within the meaning of the Health Services Act, thereby ensuring state control. The strategy also reflects the long-standing preference of the Ministry of Health for births to take place primarily in healthcare facilities – i.e., in maternity hospitals and birth centers – and it intends to continue supporting this priority by ensuring their coverage by public health insurance without restrictions. In the case of births outside healthcare facilities, regulation is envisaged, with full coverage by public health insurance not guaranteed. However, this does not affect a woman's choice of place, method, and circumstances of birth; the strategy merely reflects that, in line with its priority, the state guarantees reimbursement from public health insurance exclusively for births in healthcare facilities.

The set of measures includes awareness-raising and information activities for professionals and the general public. These include the creation of information materials that provide women with state-guaranteed, objective, and comprehensible information on the advantages and risks of different places of birth.

# Breakdown of |tasks for the Chapter on the Unavailability of Birth Centers (Freestanding, Alongside) and Restrictions on the Choice of Place of Birth

| **Strategic objective 3** | | **Accessibility of birth centers and homes and choice of place of birth** | | | | |
|---|---|---|---|---|---|---|
| Specific objective | Measures | Description | Duration of measure implementation / deadline for measure completion | Criteria for fulfillment | Responsible institution (manager) | Cooperating entities (co-manager) |
| **3.1 Provide accurate information about the options for place of birth, respecting the woman's choice** | 3.1.1 Create comprehensive information materials for women on the choice of place, method, and circumstances of childbirth | Using the HCD (human-centered design) principle, create comprehensive information materials for women on the topic of choice of place, method, and circumstances of childbirth. Ensure that all women have access to understandable, objective, and value-free information about the advantages and risks of different types of birth locations (hospital, medically supervised birth center, midwife-led birth center, independent birth center, own social environment). Involve care recipients as the target group for whom the information material is intended in its preparation. | by December 31, 2025 | Creation of a document that can be used for ministerial web platforms, including NZIP, and printing of information leaflets. | MZD, ÚV ČR (Working Group on Obstetrics) | NGOs (including care recipients), relevant professional institutions and entities |
| | 3.1.2 Update the content of the ministry's website with an emphasis on objectivity, completeness and comprehensibility of information on the choice of place of birth | Following measure 3.1.1, update the content of the Ministry's website and other government web platforms, as appropriate, and ensure that all information on the Ministry of Health's website regarding the choice of place of birth is objective and understandable, without value judgments or incorrect information. Communicate the place, manner, and circumstances of childbirth in language that is understandable to the target group, from a woman-centered perspective, rather than from the perspective of the needs of healthcare providers. | By January 31, 2026, the first comprehensive review of the content of the MZD websites, then continuously until December 31, 2030 | Modification of the content of relevant websites with respect to women's choices. | MZD | Government Office of the Czech Republic (Working Group on Obstetrics) |
| **3.2 Support the establishment and development of birth centers in accordance with international standards** | 3.2.1 Ministry of Health of the Czech Republic ( ) Remove legislative barriers to the establishment and development of birth centers | Amend Decree No. 99/2012 on minimum staffing requirements for health services and Decree No. 92/2012 Coll. on minimum technical and material requirements for healthcare facilities and home care contact points to establish adequate conditions for the establishment and development of birth centers (alongside midwifery units) in accordance with international standards. Remove, in particular, the unnecessary requirement for separate rooms for the care of women and newborns after childbirth. Prepare amendments to other requirements in close cooperation with professional organizations of midwives that are recognized as professional organizations of midwives by the ICM (International Confederation of Midwives) and the Association for Birth Houses and Centers. | Ongoing, but no later than December 31, 2030 | Corresponding amendment to Decree No. 99/2012 and Decree No. 92/2012. | MZD | APODAC, UNIPA, ČKPA |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | MZD | | MZD | MZD | |
| | 3.2.2 Ensure reimbursement for health services provided during childbirth in the form of outpatient or one-day care | Through amendments to the reimbursement decree, the list of medical services, and other regulations and reimbursement methodologies, ensure that public health insurance funds can be used to cover health services provided during childbirth not only in the form of inpatient care, but also in the form of outpatient or one-day care. At the same time, ensure that the amount of reimbursement for such health services is a full equivalent of the amount reimbursed for childbirth during hospitalization. Limit reductions in reimbursement in the event of a woman's early departure to her own social environment or shorter hospitalization in the case of inpatient care, provided that the facility provides follow-up visiting services. | by December 31, 2027 | Reimbursement for health services during childbirth is not linked to the woman's hospitalization. | MZD | Health insurance companies |
| | 3.2.3 Seek opportunities to draw on EU funds and other sources to support and develop the infrastructure of birth centers. | Seek opportunities to draw on EU funds or other financial mechanisms by issuing calls for proposals to support and develop infrastructure (construction, renovation, modernization, and equipment) for birth centers. Make financial support conditional on compliance with international standards for birth houses and centers, and thus on the autonomous management of the relevant facilities by midwives. | July 1, 2025 – December 31, 2030 (ongoing) | Support the publication of calls for proposals for the use of EU funds or other financial mechanisms. | MMR, MZD | |
| **3.3 Ensure a safe framework for births in the woman's own social environment** | 3.3.1 Amend legislation to reintegrate home birth assistance into state-regulated health services | Through an amendment to Decree No. 92/2012 Coll., on the minimum technical and material requirements for healthcare facilities and home care contact points, include a so-called visiting bag in the mandatory equipment of midwives' contact points. At the same time, through amendments to other relevant legislation, enable the reintegration of home birth assistance into state-regulated health services, in accordance with Section 10(3) of the Health Services Act. Prepare specifications for the contents of the visiting bag in close cooperation with professional organizations of midwives that are recognized as professional organizations of midwives by the ICM (International Confederation of Midwives). Establish an obligation for healthcare providers to complete an accredited course in newborn resuscitation. | As soon as possible, no later than July 1, 2026 | Amendment to Decree No. 92/2012 Coll. and other legal regulations in order to classify home birth assistance as a state-regulated health service. | MZD | UNIPA, ČKPA |
| | 3.3.2 Ensure a clear division of responsibilities between individual professions and prevent the stigmatization of women during acute and non-acute transport during childbirth | Following on from measure 2.3.1, include information on the correct division of responsibilities and cooperation between all relevant professionals, including emergency medical services, in situations involving the acute and non-acute transport of women in labor from their own social environment to a healthcare facility in the recommended organizational procedure. Consistently prevent stigmatization of women (or midwives) that could discourage or delay the transfer of women to a higher level of care in case of complications, as well as the sharing of complete information about the woman's health and the course of labor so far. | By July 1, 2026, create a procedure, then implement it by December 31, 2030. | The recommended procedure contains the information required for the transfer situation. | MZD | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 3.3.3 Improve data collection on births in the home environment | Improve data collection on births in the woman's own social environment, i.e., births outside healthcare facilities. Distinguish between planned and unplanned home births, as well as assisted and unassisted births, in the parameters collected. | Effective no later than January 1, 2026 | Existence of an updated data collection methodology. | MZD | Healthcare providers |

### 3.4 Shortcomings in Communication and Application of Informed Consent

The provision of health services, including care during childbirth, is only possible on the basis of free and informed consent.[181] This requirement is enshrined in several legal instruments, including constitutional ones. In addition to the Charter of Fundamental Rights and Freedoms, the Civil Code and the Health Services Act are key pieces of legislation for practical application. The latter incorporates the requirements of the Convention on Biomedicine,[182] a key international treaty to which the Czech Republic is bound. The Czech Republic ratified this important human rights document in 2001. The Convention introduced into Czech law not only the requirement that medical interventions in the field of healthcare be based on the free and informed consent of the person concerned, but also a comprehensive catalogue of other patient rights and, above all, fundamentally changed the view of the "doctor-patient" relationship.

However, high-quality legislation does not correspond to practice in the field of obstetrics. It took some time for the medical and healthcare professions in general to become accustomed to the requirements of the Convention on Biomedicine, including the obligation to obtain informed consent for the services provided.[183] Although this obligation is now common knowledge and practice among healthcare personnel, there are still fundamental and frequent shortcomings in the application of informed consent in prenatal, peripartal and postnatal care. This is evidenced in particular by feedback from care recipients, which has been mapped in detail by research (see Chapter 2.3 for more details), but also by investigations by the Public Defender of Rights and a large number of complaints and lawsuits (see Chapter 2.4 for more details).



References by women to interventions carried out without consent, prior information, or directly against the will of the mother occur across all research in the Czech context over the last almost twenty years. **Interventions without consent are among the most frequently mentioned experiences of women during childbirth**, even in the latest extensive research, i.e., that conducted between 2021 and 2024, *entitled The Quality of Prenatal and Perinatal Care from the Perspective of Czech Women* (for more details, see Chapter 2.3).[184] In addition to interventions without consent, the most frequently mentioned experiences of women during childbirth include lack of support, disrespect, manipulation, and obstetric violence.[185] However, these experiences are also directly related to non-compliance with the principles of free and informed consent and can be effectively prevented by proper implementation of this principle.

#### 3.4.1 Respect for Autonomy and Other Necessary Requirements

The introduction of informed consent into Czech law is part of the modernization of healthcare law[186] towards greater respect for patient autonomy (will). **Respecting the individuality of each patient** is **part of the legal definition** of what it means **to provide healthcare services at the appropriate professional level** (de lege artis).[187] *"This is not only about the individuality*

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[181] There are only a few legal exceptions to this rule in the interests of protecting third parties, public health, and the life and health of a specific person (emergency care), including situations where a patient is provided with emergency services and is required to undergo a professional medical examination under the Act on Protection against Harmful Effects of Addictive Substances. For the application of these exceptions in the provision of care in connection with childbirth, see Chapter 3.4.5.

[182] Full title: Council of Europe Convention on Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, promulgated under No. 96/2001 Coll.

[183] See, for example, Česká justice. The convention, which has been protecting patients' rights for twenty years, has also been implemented in the Czech Republic. Česká justice, 2017. Available at: https://www.ceska-justice.cz/2017/10/umluva-ktera-jiz-dvacet-let-chrani-prava-pacientu-se-prosadila-take-cesku/.

[184] The project is implemented with the support of the Ministry of Health and focuses on identifying key determinants that influence women's satisfaction with the care provided during early motherhood, with an emphasis on the subsequent practical application of these findings (for more details, see Chapter 2.3).

[185] Care provided without free and informed consent is also considered a form of obstetric violence (see Chapter 3.5 for more details).

[186] Conducted in connection with the ratification of the Convention on Biomedicine.

[187] Section 4(5) of the Health Services Act

*of the patient in relation to the unique characteristics of his or her organism, but also about taking into account the uniqueness of his or her personality, mental state, and needs, including religious, cultural, and other needs. ... While the doctor has expert knowledge and skills in the field of medicine, the patient is the best expert on his or her own life."*[188] The inclusion of the client's preferences, needs, and wishes in decisions about the method of treatment is also an integral part of evidence-based medicine and practice (see Chapter 3.1 for more details).

Healthcare professionals must inform each person in an understandable manner and allow them to ask additional questions about their health and the proposed healthcare services. The information must be provided to a sufficient extent, commensurate with the situation of the individual, their education, and intellectual capacity.[189] The information provided must not be formal, but genuinely informative—simply signing an informed consent form is not sufficient if the patient has not had a real opportunity to understand its content.[190]

Consent must not only be formally given, but also genuinely **informed and free**, i.e. **given on the basis of sufficient information** about the nature, consequences, risks, and alternatives of the proposed care, **without any coercion or manipulation**.



The patient has the right to refuse the proposed care,[191] even if it has negative effects on his/her health and life. He/she may also withdraw his/her consent to the provision of health services.[192]

Informed consent serves to balance the information deficit on the part of care recipients/service users. It thus compensates for their generally weaker position, given that they usually lack expertise in the field of medicine and often come to healthcare professionals in pain and fear. This asymmetry is particularly evident in the context of birth care and makes women more vulnerable to pressure and manipulation. These manifest themselves in particular medically unjustified intimidation of women, informing them about risks as facts that will occur (including fatal risks as a certain consequence of refusing the proposed procedure), imposing care under the threat of time pressure that does not actually exist (but could exist), creating a feeling that the situation cannot be changed, and other forms of verbal or time pressure. A specific example is telling a woman that if she does not remain lying on her back or undergo a certain procedure or examination, her child will die.[193] Such conduct is not only unethical, but also illegal. For healthcare professionals who engage in such conduct, there may be corresponding legal and liability consequences.

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[188] Health Services Act: Practical Commentary, Wolters Kluwer, ISBN: 978-80-7676-653-2.

[189] KOPSA TĚŠINOVÁ, Jolana, Tomáš DOLEŽAL and Radek POLICAR, 2019. *Medical Law.* 2nd edition. Prague: C.H. Beck. ISBN 978-80-7179-318-2, pp. 58-59.

[190] See Supreme Court Decision 25 Cdo 3100/2021, here on January 20, 2023. Available at https://zdravotnickepravo.info/wp-content/uploads/2023/04/NS_informovany-souhlas.pdf.

[191] Again, with the exception of a few situations specified by law, such as court-ordered protective treatment.

[192] Withdrawal of consent is not effective if the medical procedure has already begun and its interruption could cause serious damage to the patient's health or endanger their life.

[193] See, for example, the experience of a woman from the South Bohemian Region in 2023: *"The doctor took offense and scolded me, saying that he doesn't meddle in my profession. He said that he could use the monitor recording as a reason for hospitalization. And that if I signed the discharge form,* ***my child would die.*** *And that I shouldn't even try to sue him, because I wouldn't win, as pregnant women are considered legally incompetent in court. I was under psychological pressure because my babysitter for my older children was leaving, so I let them examine me."* The whole story is available at https://www.uz-dost.cz/tehotna-je-pred-soudem-brana-jako-nesvepravna/.

For further examples of coercion and manipulation, see, for example, Hrešanová E. Women who desire 'natural childbirth' in hospitals in a highly medicalized birth care system. Health Care Women Int. 2024 Sep 10:1-21. doi: 10.1080/07399332.2024.2397457. Epub ahead of print. PMID: 39255416. Available at: https://pubmed.ncbi.nlm.nih.gov/39255416/.

See also Daly, D., Sedlicka, N., Švanderlíková, K. *et al.* An online survey of women's views of respectful and disrespectful pregnancy and early labor care in the Czech Republic. *BMC Pregnancy Childbirth* **24,** 370 (2024). https://doi.org/10.1186/s12884-024-06448-5.

If a woman refuses the care offered, healthcare personnel have the option of explaining everything again in a factual and medically substantiated manner, and if the woman still does not change her mind, they have the right to provide protection through a negative reversal (see Chapter 3.4.5). This fulfills the legal obligation to provide information while respecting the woman's right to choose and maintaining the legal certainty of the healthcare professional.

### 3.4.2 (Ineffective) Communication

Adherence to the principles of free and informed consent requires communication skills. However, these skills are still often lacking in the Czech healthcare environment, or do not reach the required level.[194] They are not sufficiently developed even in the preparation for healthcare professions. Effective communication is a learnable skill, not an innate trait. Good communication is important not only for satisfaction with care and the fulfillment of the principles of informed consent, but also has a direct impact on the effectiveness of treatment.[195] Inadequate communication, on the other hand, increases the risk of error. According to foreign data, poor medical communication and the attitude of medical staff were the main reasons for litigation in 70 % of cases of medical malpractice lawsuits.[196] Good communication, on the other hand, contributes significantly to treatment compliance (adherence to treatment), i.e., the willingness of the patient to accept the proposed medical procedure. These factors are particularly pronounced and intensified during childbirth, which is often a dynamic and unpredictable process. This can lead to greater misunderstanding and frustration for both the mother and the medical staff.



### 3.4.3 Birth Plan as a Tool to Facilitate Communication

Out of concern that their wishes will not be respected and in an effort to avoid the communication shortcomings outlined above, some women, especially when planning a hospital birth, prepare **birth plans** (written birth wishes). They are also used by women who want to increase the likelihood of a positive birth experience and clarify their ideas about the course of the birth or how to deal with anticipated situations with their healthcare provider in advance. However, the practical application of these plans faces a number of obstacles in the Czech environment.

Firstly, healthcare staff do not always respond to the existence of a birth plan in the best way possible. Instead of seeing it as a useful tool to facilitate communication with the mother, they often approach it with a negative attitude or a lack of understanding.[197] This negative attitude is often justified by the fact that *“a birth plan is a concept that does not exist in law.”*[198] Although the birth plan is not explicitly defined in law and is often confused with previously expressed wishes (see Chapter 3.4.4 for more details), this does not mean that it is a legally irrelevant expression of will – quite the contrary. In this case, too, the Civil Code takes precedence, especially when it comes to protecting physical and mental integrity, but also the principle of informality of legal acts, which states that everyone *"has the right to choose any form for legal acts, unless the choice of form is restricted by agreement or law."*[199]

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[194] Communication with patients remains one of the biggest problems in Czech healthcare, see, for example, https://www.nzip.cz/clanek/481-zdravotnicky-personal-vs-pacient-stiznosti.

[195] PTÁČEK, Radek and Petr BARTŮNĚK, 2011. *Ethics and Communication in Medicine.* Grada. ISBN 978-80-247-7267-7. See also, for example, the professional conference of the patient forum *Cooperation between patients and healthcare professionals. Humanity matters* (May 17, 2023).

[196] Levinson W. (1994). Physician-patient communication. A key to malpractice prevention. *JAMA, 272(*20), 1619–1620; cited from PTÁČEK, Radek and Petr BARTŮNĚK, 2011. *Ethics and Communication in Medicine.* Grada. ISBN 978-80-247-7267-7.

[197] *“Quite often, healthcare providers who run maternity wards complain that expectant mothers come to them with a so-called birth plan, in which they reserve certain rights, certain healthcare services provided in a specific manner, and demand that their wishes be granted ... It is not advisable to comply with such requests, presented as a so-called birth plan."* Tempus Medicorum. Journal of the Czech Medical Chamber. Volume 32, 6/2023.

[198] Ibid

[199] Section 559 of the Civil Code

Some facilities are trying to adapt to this trend and publish on their websites a list *of permitted birth wishes* or *a list of prohibited wishes* that they refuse to fulfill in advance when providing care. Although this approach may be motivated by a desire to ensure that care is provided at an appropriate professional level, some of the care options that maternity hospitals seek to restrict in advance in their plans for expectant mothers are not necessarily contrary to evidence-based medicine. The list *of unacceptable requests* often includes organizational instructions that have no legal basis, such as making early discharge from the maternity hospital conditional on the presentation of written consent from a pediatrician to take the newborn into care. It is particularly serious and contrary to the law when hospitals make the admission of a mother into care conditional on these requirements. The Health Services Act lays down strict conditions for refusing to provide care**,** and **childbirth is one of the exceptions where admission to care cannot be refused**.[200]

Healthcare personnel play a key role in providing information about the proposed care in accordance with professional recommendations. **However,** the mother[201] **does not have the right to demand that healthcare personnel actively act contrary to recognized medical practices**. Birth plans can vary in form and content. Sometimes they contain unrealistic wishes, such as requests that are not in line with standard medical practice or the availability of care in a given hospital. The appropriate response is to treat these wishes with respect and discuss them openly, rather than rejecting them in advance without knowledge of specific medical history, including personal, family, and social history, or stigmatizing the woman on that basis. Healthcare professionals should be able to explain why certain requests may not be possible and offer alternatives that are safe and tailored to the woman's individual needs. This approach can help reduce frustration and promote better cooperation and, ultimately, the provision of quality healthcare services.



Several civic initiatives in the Czech Republic are striving to **improve communication** between mothers and healthcare professionals. They offer to help women draw up birth plans (wish lists) so that they are **fully informed**, have a clear overview, and ideally **have discussed their wishes in advance** with those who will be providing care during the birth.[202]

### 3.4.4 The Institution of Advance Directives in the Context of Childbirth

In practice, due to insufficient legal awareness, **birth plans** are often **confused with advance directives**,[203] both by mothers and healthcare professionals. While the law does not impose any specific requirements on the form of a birth plan, advance directives are a highly formalized institution, the form and **binding nature** of which are regulated in detail by law. It is used in cases where a person expects that in the future they will not be able to make decisions about their health and treatment on their own.[204] Mothers choose it, among other things, precisely because of its legally binding nature for healthcare professionals. However, *a* completely *"basic condition for the applicability of an advance directive is the current inability to give consent at the decisive moment."*[205] If a woman is "*competent to give consent* at *the given moment, her previously expressed wishes cannot be taken into account at all"*[206] and healthcare personnel are still obliged to obtain her informed consent or informed refusal (negative reversal) in accordance with general rules. A woman's previously expressed wishes are only activated when she is unable to make decisions about herself.

A woman **can prepare both a birth plan and an advance directive** (**or a combination of both**, thereby ensuring that all situations are covered) for the situation of childbirth. It is only

[200] § 48(3) of the Health Services Act
[201] Refusal of care is recorded by means of a so-called negative reversal (for more information on the refusal of health services and the responsibility of medical personnel in such situations, see Chapter 3.4.5).
[202] See, for example, https://www.porodni-prani.cz/info.
[203] Within the meaning of Section 36 of the Health Services Act.
[204] This institution is typically used, for example, in situations of terminal illness in the final stages, where the patient is not interested in maintenance treatment because they perceive such a situation as undignified.
[205] Health Services Act: Practical Commentary, Wolters Kluwer, ISBN: 978-80-7676-653-2.
[206] Ibid.

necessary that the previously expressed wishes are not used in situations where it is inappropriate and fundamentally impossible, because the woman is fully conscious, is not in intense pain, etc. In such a situation, it is necessary to communicate the proposed care and verify her consent.

### 3.4.5 Specifics of Consent to Care Provided During Childbirth and the Responsibility of Healthcare Personnel

Closely related to the provision of health services based on informed consent is the issue of responsibility for the services provided and any complications. The current legislation is based on a clear departure from the paternalistic approach, where healthcare personnel made decisions on behalf of patients (for more details, see Chapter 3.4.1). Today, the right to self-determination and personal autonomy is paramount.[207] This anthropocentric approach emphasizes the importance of respecting patients' individual decisions, even **if healthcare professionals may have a different opinion about their choice.** In the context of childbirth, it is also the duty of healthcare professionals to provide women with all the necessary information about the nature, risks, and alternatives of the proposed care and to enable them to make a free and informed decision.

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| The woman is responsible for her choice, and the medical staff is responsible for providing information and the quality of healthcare services. |

If a woman in labor refuses a procedure or part of a procedure, or wishes to use a method other than that indicated and recommended by the attending staff, her decision must be respected. **A procedure performed without valid informed consent or a valid legal reason is unlawful.** Healthcare professionals protect themselves from the consequences of refusing to provide the proposed care through the institution **of negative consent.**[208] This procedure is used when the attending staff believes that not providing care may endanger the health or life of the woman or the fetus. Although the law does not oblige a woman in labor to sign a negative reversal, from the point of view of protecting healthcare personnel, it is advisable that the reversal be signed not only by the attending physician, but above all by the mother, in order to prove that she has been repeatedly (i.e., at least twice) informed and has nevertheless consciously refused care. If the mother does not sign the waiver, healthcare providers have the option of documenting this fact by having a witness sign the waiver.[209] Healthcare professionals cannot be legally sanctioned for not providing healthcare services that a legally competent mother refuses.



The key responsibility of healthcare personnel is to provide healthcare at an appropriate professional level, while respecting the individuality of the mother and taking into account the specific conditions and objective possibilities.[210] If, despite fulfilling this obligation, healthcare does not lead to the expected result, this does not automatically give rise to a right to compensation. When assessing responsibility for an unsuccessful diagnostic or therapeutic procedure, it is crucial whether or not it was performed in a professionally correct manner. Childbirth is a dynamic process and *"biological processes in the human body cannot always be accurately predicted, so it is essentially impossible to guarantee a favorable outcome of treatment. This is one of the reasons why responsibility in connection with the provision of health services is primarily a responsibility for professionally correct procedure (lege artis) and not a responsibility for the outcome."*[211]

From the perspective of the above rights and obligations, childbirth is specific in that their application may occasionally lead to a conflict between a woman's right to self-determination

[207] See Article 2 of the Convention on Biomedicine: *"The interests and welfare of the human being shall prevail over the sole interest of society or of science."*
[208] Section 34(3) of the Health Services Act
[209] Section 34(5) of the Health Services Act
[210] Section 4(5) of the Health Services Act
[211] ŠUSTEK, P. – HOLČAPEK, T. 2016. Health Law. Prague: Wolters Kluwer.

and the protection of the unborn child.[212] In such situations, healthcare personnel must balance these two interests sensitively and cautiously. It is always the case that if there is no immediate threat to the life or health of the fetus, the woman's right to autonomy takes precedence and her decision must be respected. An exception allowing medical personnel to perform an intervention without the mother's consent may only be applied if it is clear that the intervention is absolutely necessary to protect life or prevent serious damage to the health of the fetus. However, this situation must be clearly demonstrated and must involve an **immediate, not merely hypothetical, risk.** At the same time, it is necessary that *"the measures taken [be] proportionate to the aim pursued, which is to save the life and health of the unborn child."*[213]

The development of defensive practices also plays an important role in maternity care in relation to liability. Defensive medicine, i.e., practices motivated more by fear of litigation than by clinical judgment, often leads to unnecessary interventions or excessive preventive measures that do not always correspond to actual needs.[214] This stems, among other things, from legal uncertainty, insufficient legal awareness among healthcare professionals, and their fear of potential disputes and sanctions (for more details, see also Chapter 2.4). *"This approach carries with it the risk of unnecessary burden on patients through these procedures and any complications arising from them, as well as the diversion of significant healthcare capacity and resources, and ultimately a deterioration in the availability of healthcare as such."*[215] One way to reduce defensive practices is to strictly adhere to the principles of free and informed consent.

### 3.4.6 Supervision, Intervision, and Psychotherapeutic Support for Healthcare Professionals



Working in such an emotionally, legally, and ethically demanding environment is often accompanied by stress and pressure to make decisions. It is therefore essential that healthcare professionals have regular access to supervision, intervision, and, if necessary, psychotherapeutic support. Without this support, there is a risk that unprocessed negative emotions from one challenging situation may unintentionally affect other clients, which can worsen the quality of care and the working environment and disrupt teamwork. Regular supervision and other forms of support not only reduce stress levels and the risk of burnout, but also ensure better compliance with clinical standards, increase the safety of care recipients, improve the performance of healthcare professionals, and contribute to their job satisfaction and, ultimately, to women's satisfaction with care.

### 3.4.7 Strategic Part and Task Part – Set of Measures No. 4

In response to the identified problems, the strategy proposes several interlinked measures, which are ultimately aimed at preventing procedures from being performed without informed consent. The first set of measures focuses on the systematic and targeted improvement of healthcare professionals' communication skills and, by extension, the quality of their communication with care recipients. The strategy emphasizes the integration of this training into regular education, the development of listening and empathy skills, and the acquisition of knowledge about the bio-psycho-social model of health services, the benefits of continuous care, and the principles of woman-centered care and family-centered care.

Another part of the measures focuses on the effective application of the principles of free and informed consent. Along with the methodological guidelines, an e-learning course will be developed that focuses specifically on the application of informed consent and the principles of evidence-based medicine in the context of childbirth. The course will include videos showing specific examples of situations from the Czech context, based on statements obtained in

[212] Široká L., Povolná M. 2017. The right of a woman in labor to refuse care versus the right of the child to life and health in light of the case law of the Constitutional Court and the European Court of Human Rights. Jurisprudence, 2017, 26(5), pp. 18-28.
[213] Constitutional Court ruling of March 2, 2015, ref. no. I. ÚS 1565/14
[214] Adamová, H. (2023). Liability for harm and quality of healthcare with regard to foreign experience. Journal of Health Law and Bioethics, 13(1), pp. 1–20.
[215] Ibid

surveys of women's satisfaction (or dissatisfaction) with care. In line with measures from other strategic objectives, the course will also include information on the prevention of obstetric violence. The proposed measures also include raising the legal awareness of healthcare professionals in order to improve their familiarity with the content of patient rights and their practical application in the context of maternity care.

An important condition for ensuring quality care and appropriate communication is psychosocial support for healthcare personnel. The strategy calls for the introduction of regular supervision and intervision, as well as additional psychotherapeutic support for healthcare professionals so that they can process emotionally and ethically demanding situations in a safe environment and not carry them over into their interactions with other clients. The proposed measures will contribute to improving the satisfaction of healthcare personnel, the quality of teamwork, reducing stress, and preventing burnout.

The strategy also focuses on raising public awareness of women's rights in relation to childbirth. Information on pregnancy, childbirth, and the postpartum period will be revised on the National Health Information Portal in line with the cross-cutting principles of this strategy, with a simultaneous emphasis on clarity and user-friendliness. The new content will be understandable, written in simpler language and tailored to the needs of women as the main target group. A separate tab with information on drawing up birth plans will also be created on the website.

Last but not least, the strategy provides for ongoing monitoring of the quality of services provided from the perspective of clients and the implementation of research and representative surveys of women's satisfaction with care in early motherhood.

## Breakdown of tasks for the chapter Shortcomings in communication and the application of informed consent

| **Strategic objective 4** | | **Improving the application of informed consent and communication between women and healthcare personnel** | | | | |
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| Specific objective | Measure | Description | Duration of measure / deadline for completion | Criteria for fulfillment | Responsible institution (manager) | Cooperating entities (co-manager) |
| **4.1 Improve the communication and interpersonal skills of healthcare personnel** | 4.1.1 Support the teaching of communication skills in the context of providing prenatal, delivery, and postnatal care | Systematically and purposefully improve the communication skills of current and future healthcare professionals involved in providing care during pregnancy, childbirth, and the postpartum period. Use interactive teaching methods and practical training in model communication situations with experienced role-players. Introduce respectful communication training into regular teaching. | July 1, 2025 – December 31, 2030 (ongoing) | Support is provided for teaching and training programs in communication as a basic clinical skill. | MZD, MŠMT, IPVZ NCO NZO | KVOP, relevant NGOs, schools, universities, and workplaces |
| | 4.1.2 Strengthen the presence of female representatives of care recipients and social science research in professional training courses for relevant healthcare professions | Strengthen the presence of female care recipients (e.g. through experience sharing, participation in discussions or evaluation of teaching) and social science research in professional training courses for relevant healthcare professions with the aim of improving communication and interpersonal skills, as well as listening and empathy skills. Familiarize healthcare professionals with the principles of the bio-psycho-social model of care. Include in teaching the key determinants of women's satisfaction with care during childbirth, the benefits of the continuous care model, and the principles of woman-centered care and family-centered care. | July 1, 2025 – December 31, 2030 (ongoing) | The presence of representatives of care recipients and social science research in teaching is supported. | MZD, MŠMT, IPVZ NCO NZO | KVOP, relevant NGOs, schools, universities, and workplaces |
| | 4.1.3 Support the use of recommended practices as a basis for communication with care recipients | In connection with measures 1.1.1 and 1.2.1, motivate healthcare personnel to actively use recommended practices and operational recommendations when communicating with clients, thereby improving clients' (patients') understanding of the proposed diagnostic and therapeutic procedures and increasing the possibility of active involvement of clients and their lay caregivers in the care process. | July 1, 2025 – December 31, 2030 (ongoing) | A simplified section in the recommended procedures containing simplified information for clients (patients) is actively used in communication with care recipients. | MZD, MŠMT, IPVZ NCO NZO | KVOP, relevant NGOs, schools, universities, and workplaces |
| **4.2 Improve methodological guidance, legal awareness, and psychosocial support for healthcare professionals** | 4.2.1 Develop an e-learning course on the application of informed consent and EBM/EBP in the context of childbirth | In line with the methodological guidelines currently being prepared on the correct and effective application of informed consent in accordance with human rights standards, create an e-learning course specifically aimed at improving the application of this principle in the context of childbirth. Include principles of respectful care that take into account the individual needs of women in labor and ensure their informed and active participation in decision-making processes during childbirth. Use specific examples of situations taken from research on (dis)satisfaction with care in the form of videos to illustrate all key components of informed consent (e.g., providing information in a comprehensible manner and to a | by July 1, 2026 | Existence of an e-learning course focused on the application of the principles of informed consent and EBM/EBP in the context of childbirth, developed in cooperation with NGOs defending the rights of care recipients and other relevant entities. | MZD, KVOP, ÚV ČR (Working Group on Obstetrics) | NGOs |

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| | | sufficient extent; allowing additional questions to be asked regarding health status and proposed health services; emphasizing that consent is considered free if it is given without any coercion). The course content should include relevant information on the application of EBM/EBP principles, the prevention of obstetric violence (in line with measure 5.2.3), and the responsibilities of healthcare professionals. The course should also take into account the needs of women with health or language disadvantages. Lawyers specializing in human rights and NGOs defending the rights of care recipients should be involved in the preparation of the course. | | | | |
| | 4.2.2 Support the education of healthcare professionals in the basics of healthcare law | Support continuing education for healthcare professionals in the basics of healthcare law to improve their knowledge of patient rights and their practical application in the context of maternity care, as well as the related rights and obligations of healthcare providers. Provide information on tools to increase the legal certainty of healthcare professionals and reduce the risk of potential disputes, with an emphasis on informing them about the undesirable effects of defensive medicine on the quality of care. Create a related educational module and consider including it as a mandatory part of pre-licensing education, as well as education prior to obtaining a license as a senior manager. | July 1, 2025 – December 31, 2030 (ongoing) | Support for educational programs in the fundamentals of medical law and the prevention of defensive medicine. | Ministry of Health, Ministry of Education, Youth and Sports, Institute for Postgraduate Medical Education | KVOP, relevant NGOs, schools, universities, and workplaces |
| | 4.2.3 Ensure regular supervision and intervision and increase the availability of psychosocial support for healthcare personnel | Provide financial and organizational support for regular supervision and intervision for healthcare professionals providing care in the areas of pregnancy, childbirth, and the postpartum period. Enable the processing of difficult emotional and ethical situations in a safe environment. Ensure the availability of psychotherapeutic support for staff to reduce stress and prevent burnout. Strengthen the quality of teamwork, including compliance with clinical and organizational standards, and thereby increase the satisfaction of staff and clients. | July 1, 2025 – December 31, 2030 (ongoing) | Financial and organizational support for regular supervision and intervision and peer support lines. Availability of psychosocial support. | MZD | IPVZ, NCO NZO, relevant schools, universities, and workplaces |
| **4.3 Raise public awareness of women's rights in the context of care provision during pregnancy, childbirth and the postpartum period** | 4.3.1 Support women in education and the preparation of informed birth plans (wishes) | Create a separate tab on the NZIP website on the topic of preparing birth plans. Support women in creating informed birth plans and DVP. Support NGOs that help women with this process and education, and ensure the availability of useful links they have created (e.g., https://www.porodni-prani.cz/info) on the NZIP portal and other relevant government platforms. | By August 1, 2025, include a tab on the NZIP with links to websites offering assistance with preparing birth plans, then continuously from July 1, 2025, to December 31, 2030 | The content of the NZIP website and other relevant government platforms is supplemented with relevant links. Ministry subsidy programs offer support for educational activities in the area of patient rights and birth preparation. | MZD, MPSV | NGOs |

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| | 4.3.2 Conduct a comprehensive review of the presentation on pregnancy, childbirth, and the postpartum period on the NZIP website | Conduct a comprehensive review and update of the presentation on pregnancy, childbirth, and the postpartum period on the National Health Information Portal (NZIP) to bring it into line with the content of this strategy and its cross-cutting principles. The review should be carried out following the NHS model (from the guide at https://www.nhs.uk/pregnancy/) and consistently applying the principles of HCD (human-centered design/user-centered design). I.e., in line with other measures in this strategy (3.1.1 and others), create comprehensive information materials that will inform women in a clear, objective, and non-judgmental manner about the key aspects of the life situation "Pregnancy, childbirth, and the postpartum period." Ensure a clear structure and adapt the language to the needs of care recipients as the target group (not the needs of healthcare providers). Involve care representatives in the preparation of new website content. | by July 1, 2026 | Presentation of the life situation "Pregnancy, childbirth and the postpartum period" on the ministry's web platform complies with HCD principles. | MZD, ÚV ČR (Working Group on Obstetrics) | NGO |
| **4.4. Continuously monitor the quality of services and women's satisfaction with care** | 4.4.1 Continuously monitor the quality of care from the perspective of clients | Support healthcare providers in the ongoing monitoring of the quality of care from the perspective of clients and in the operational improvement of services in response to their feedback. Use the methodologies and educational materials developed within the project *Quality of prenatal and perinatal care from the perspective of Czech women.* | July 1, 2025 – December 31, 2030 (ongoing) | Ongoing monitoring of the quality of care from the perspective of clients is supported and implemented. | MZD | Healthcare providers |
| | 4.4.2 Conduct regular representative surveys and qualitative research on women's satisfaction with care | Conduct regular representative surveys and qualitative research on women's satisfaction with care, reflecting key determinants of satisfaction and the specificity of care provided in early motherhood. Take into account the outputs and recommendations of the project *Quality of prenatal and perinatal care from the perspective of Czech women.* | July 1, 2025 – December 31, 2030 (ongoing) | A representative survey is conducted at least once every three years. | Ministry of Labor and Social Affairs, Czech Science and Research Agency | ÚV ČR (Working Group on Obstetrics), NGOs, relevant research institutions and entities |

## 3.5 Prevention of Disrespectful Care and Obstetric Violence

### 3.5.1 Definition and Main Causes

The term obstetric violence is not explicitly enshrined in Czech law. The term obstetric violence is used in professional literature and non-legally binding documents of international organizations to describe **physical or psychological violence** that occurs **during the provision of health services during pregnancy and especially during childbirth** and postpartum care. It includes practices such as performing procedures without informed consent, overuse of medically unjustified interventions, humiliation and disrespect for the needs of women in labor, abuse of power by healthcare personnel, and medically unjustified separation of mother and child. Obstetric violence has **a significant gender and institutional dimension.** It is not necessarily the intentional act of a specific person, but often the result of broader systemic settings in healthcare facilities and education, where healthcare professionals are influenced by established organizational practices and where routine and often excessive interventions are considered normal practice, leading to the dehumanization of care and a loss of respect for the individuality of women in labor. This practice is also closely linked to the historically unequal position of women in society. Its roots lie in patriarchal structures that shape not only the approach to care for women in labor, but also the very functioning of healthcare systems.[216]



Obstetric violence can be considered **a form of gender-based violence** that arises as a result of deep-rooted social inequalities and discrimination. It is *"also a consequence of inadequate education and training [of health professionals], as well as insufficient respect for women's equality and human rights*."[217]

Discrimination against women in this area stems from a historical tendency to pathologize women's bodies and their excessive medicalization. This tradition of medicine views the female body as fundamentally problematic and in need of intervention.[218] As a result, women have been subjected to medical authority for centuries, limiting their autonomy in matters of reproductive and sexual health.[219] This form of violence is exacerbated by other shortcomings in healthcare systems.[220] These include, for example, insufficient funding, inadequate staffing levels, poor working conditions, and hierarchies that systematically weaken the position of care recipients. These structural problems create a stressful environment for healthcare professionals, which can lead to violent behavior towards women, without healthcare staff always being fully aware of it.[221] This type of violence is not necessarily intentional, but is rooted in a system that supports and normalizes such practices as a routine part of care.

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[216] European Commission, Directorate-General for Justice and Consumers, Quattrocchi, P., Obstetric violence in the European Union – Situational analysis and policy recommendations, Publications Office of the European Union, 2024, available at https://data.europa.eu/doi/10.2838/440301.

[217] Šimonović, Dubravka. "A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence." New York: UN, July 11, 2019. Available at https://digitallibrary.un.org/record/3823698.

[218] See, for example, TINKOVÁ, Daniela, 2010. *Body, Science, State: The Birth of the Maternity Hospital in Enlightened Europe.* Prague: Argo. Everyday Life. ISBN 978-80-257-0223-9.

[219] *Obstetric and gynecological violence in the EU: Prevalence, legal frameworks and educational guidelines for prevention and elimination.* (2024, April). Directorate-General for Internal Policies. PE 761.478. Available at https://www.europarl.europa.eu/RegData/etudes/STUD/2024/761478/IPOL_STU(2024)761478_EN.pdf.

[220] Ibid. The text in question describes these connections in general terms, not as an assessment of the specific situation in the Czech Republic.

[221] Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Saraiva Coneglian, F., Diniz, A. L., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Medicine, 12(*6), e1001847. https://doi.org/10.1371/journal.pmed.1001847.

### 3.5.2 Types of Obstetric Violence

Types of obstetric violence can be broadly divided into eight categories:[222]

- Physical violence (including interventions without medical justification)
- Care provided without informed consent
- Disrespect for privacy and intimacy
- Degrading treatment and emotional violence
- Discrimination based on specific attributes of the client
- Refusal to provide healthcare (including refusal to provide pain relief)
- Detention in healthcare facilities
- Damage to the child's relationship with her mother

### 3.5.3 Terminological Pitfalls

Although the term *obstetric violence* is widely accepted and used not only in international scientific literature but also in official documents of the Council of Europe and the UN,[223] other terms are also used to describe this phenomenon, such as violence against women in obstetrics,[224] or less confrontational descriptions such as sub*standard and disrespectful care* in labor.[225]



These alternative terms are related, among other things, to the belief of some healthcare professionals and some of their professional organizations that the term obstetric violence implies that they act with the intention to harm, which in most cases is not true.[226] According to them, the word *violence* in everyday language evokes deliberate, aggressive acts intended to cause harm or injury. In a recent joint statement, three professional organizations therefore emphasized that most cases of inadequate or disrespectful care during childbirth are not based on an intention to harm, but rather on systemic problems and poor communication on the part of healthcare personnel. At the same time, they pointed out that the term obstetric violence also gives the impression that it only concerns obstetricians and maternity wards, neglecting other health professions that are also involved in the care of mothers and children. According to them, the use of the term obstetric violence contributes to a defensive atmosphere that discourages healthcare professionals from engaging in open dialogue about problems in the provision of care because they feel attacked, and they therefore propose that a different (more neutral) term be used.[227]

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[222] The strategy deliberately adopts a simplified classification system from the awareness campaign *Už dost!* (Enough is Enough! on obstetric violence), which is **available in Czech** and includes **examples of specific manifestations of each type of violence,** based on anonymized experiences of women who gave birth in Czech maternity hospitals. See https://www.uz-dost.cz/porodnicke-nasili/#co-je-nasili. For the origin of the classification, see also PAŠKOVÁ, Sandra, 2018. *The concept of "obstetric violence" in contemporary legal and medical discourse.* Diploma thesis. Faculty of Law, Masaryk University. Available at https://is.muni.cz/th/bcobf/Paskova_Sandra_Porodnicke_nasili_tisk_final.pdf.

[223] This term has also been adopted by the Czech government, which, in its resolution No. 269 of March 8, 2021, and subsequently in its resolution No. 682 of October 2, 2024, committed itself to addressing obstetric violence as part of the implementation of measures in the Health chapter of the Strategy for Gender Equality for 2021–2030.

[224] WHO Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth, World Health Organization; Geneva, Switzerland: 2015. The Czech translation, "Prevention and elimination of harm and disrespect during childbirth in healthcare facilities," is available at https://www.who.int/publications/i/item/WHO-RHR-14.23.

[225] European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour – because words matter, European Journal of Obstetrics & Gynecology and Reproductive Biology, Volume 296, 2024, Pages 205-207, ISSN 0301-2115, Available at https://www.ejog.org/article/S0301-2115(24)00107-6/fulltext.

[226] Ibid.

[227] Ibid.

The Council of Europe[228] and other human rights initiatives, on the other hand, emphasize the correctness and necessity of using the term obstetric violence, as it best captures its essence and connection to gender-based violence.[229] They reject the objection that the word *violence* necessarily implies intent to harm. They point out that violence can also be structural and systemic without involving direct intent. The use of the term obstetric violence makes it possible to clearly identify and address the problems caused by this phenomenon and to strengthen the position of women as care recipients.[230] They warn that the use of softer or more neutral terms, such as *disrespectful care* or *failure to provide care*, etc., can obscure the real causes and systemic problems, reduce awareness of the true impact of this phenomenon, and hinder necessary reforms. Inconsistent terminology and the concealment of the element of violence ultimately prevent effective judicial remedies and compensation, and thus women's access to justice.[231]

For the above reasons, this strategy also uses *obstetric violence* as an established term.

### 3.5.4 Negative Impacts of Obstetric Violence

Obstetric violence has a wide range of negative impacts on women's physical, mental, and social health. These include, in particular:

- **Psychological consequences**: Experiences of inappropriate behavior or violence during pregnancy and childbirth often lead to long-term psychological trauma. In addition to acute stress reactions, women may suffer from post-traumatic stress disorder or postpartum depression.
- **Restriction of autonomy with an impact on quality of life**: Violence of this type leads to a loss of autonomy and the ability to make decisions about one's own body and sexual health. This has a direct impact on the overall quality of life.
- **Social and family impacts**: Experiencing obstetric violence can negatively affect women's sexuality, cause problems in intimate relationships, and also affect relationships with children. In some cases, it also causes women to delay or refuse to have another child.
- **Avoidance of follow-up health care due to trauma**: Women who have experienced this violence often lose trust in the health care system and refuse follow-up gynecological or other medical care due to their traumatic experiences, which can lead to a deterioration in their overall health. The traumatic experience may also be a reason for choosing to give birth outside a healthcare facility in the future.



The individual impacts are subsequently reflected in the broader social and economic consequences of obstetric violence. In addition to increased healthcare and psychosocial support costs, this phenomenon also has a negative impact on the birth rate at the national level. No such survey has yet been conducted in the Czech Republic, but data from abroad show the seriousness of the problem. For example, a survey conducted in Italy on a

[228] See Resolution No. 2306 (2019) of the Parliamentary Assembly of the Council of Europe on obstetric violence, available at https://pace.coe.int/en/files/28236/html.

[229] A technical term used to describe and examine all acts of physical, sexual, psychological, economic, or other forms of violence directed against women because they are women, or against men because they are men, or acts of violence that disproportionately affect women or men. Although men are also victims of gender-based violence, women are clearly the predominant victims of these forms of violence.

[230] Quattrocchi, P., Schantz, C., van der Waal, R., Villarmea, S., & Rozée, V. (2024, October 2). Obstetric violence: Abuse during childbirth is widespread – but the first step to fighting it is naming it. The Conversation. Available at https://theconversation.com/obstetric-violence-abuse-during-childbirth-is-widespread-but-the-first-step-to-fighting-it-is-naming-it-235161.

[231] *Obstetric and gynaecological violence in the EU: Prevalence, legal frameworks and educational guidelines for prevention and elimination.* (2024, April). Directorate-General for Internal Policies. PE 761.478. Available at https://www.europarl.europa.eu/RegData/etudes/STUD/2024/761478/IPOL_STU(2024)761478_EN.pdf.

representative sample of women (mothers of children aged 0-14) showed that 11 % of mothers admit to having suffered trauma as a result of hospital care and therefore preferred to postpone their decision to have another child for many years. For 6 % of the total number of survey participants, the trauma of obstetric violence was so severe that they decided not to have more children.[232] The survey estimated that this results in 20,000 fewer births per year.[233]

### 3.5.5 Legal Regulation and Mechanisms for Prevention, Resolution, and Compensation

The term obstetric violence is not explicitly enshrined in Czech law. However, it has been introduced into the text of laws in other countries, particularly in South America.[234] Initiatives to enshrine this term in law are also underway in the European context. However, to date, this issue has only been explicitly addressed in EU Member States in legislation at regional and[235] not at national level. The creation of a better legal framework that explicitly recognizes obstetric violence as a form of gender-based violence and ensures better access to justice for victims is part of the 2024 recommendations addressed to the European Union institutions.[236]

At the international level, this type of violence is particularly addressed in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which in Article 12 requires governments to take measures to eliminate discrimination against women in the field of health care, including pregnancy and childbirth. Although the term obstetric violence is not explicitly mentioned in the Convention, in 2022, in response to a complaint lodged by a Spanish citizen, the UN Committee on the Elimination of Discrimination against Women found a violation of the Convention precisely because of obstetric violence as a form of gender-based violence. The Committee concluded that the domestic courts had uncritically accepted the statements of the hospital's medical staff instead of respecting the principle of informed consent, and that they had based their findings on gender stereotypes, failed to assess the complainant's claims fairly and at the same time trivialized her harm, thereby violating Articles 2(b), (c), (d) and (f), 3, 5 and 12 of the Convention.[237]

In response to the complaint, the Committee reiterated that States parties have an obligation to abolish laws and regulations, as well as customs and practices, that constitute discrimination against women. It stated that gender stereotypes negatively affect women's right to protection from gender-based violence, in this case obstetric violence, and that state authorities should take this into account consistently.[238] The Committee called on Spain to provide the complainant with adequate reparation, including financial compensation for the damage to her physical and mental health, and to take concrete steps to ensure respect for women's human rights in relation to pregnancy and reproductive health care. The Committee's



[232] OVOItalia. Doxa-OVOItalia Survey, 2017, for more details see https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/.
[233] Ibid.
[234] See https://respectfulcare.eu/laws/.
[235] For example The Valencian Community incorporated the concept of obstetric violence into its health law (*Ley 10/2014, de 29 de diciembre, de Salud de la Comunitat Valenciana,* available at https://www.boe.es/buscar/pdf/2015/BOE-A-2015-1239-consolidado.pdf), The Basque Autonomous Community enshrined the term in an amendment to the Law on Equality between Women and Men (*Law 1/2022, of March 3, second amendment to the Law on Equality between Women and Men,* available at https://www.boe.es/buscar/doc.php?id=BOE-A-2022-4849).
[236] See the recommendations from the above-mentioned study commissioned by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM) in April 2024 or the recommendations from the above-mentioned report for the European Commission. See also Summary: Case Studies on Obstetric Violence in the European Union, European Commission, Directorate-General for Justice and Consumers, Rozée, V., Schantz, C., van der Waal, R. et al., Case studies on obstetric violence – Experience, analysis, and responses, Publications Office of the European Union, 2024, available at https://op.europa.eu/en/publication-detail/-/publication/2c7bf1b8-0b64-11ef-a251-01aa75ed71a1/language-en.
[237] See CEDAW/C/75/D/138/2018, available at https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2f82%2fD%2f149%2f2019&Lang=en.
[238] In accordance with Article 7(3) of Optional Protocol No. 1 to CEDAW.

recommendations also include adequate training for medical personnel, courts, and state authorities that may deal with cases related to women's reproductive health.

In the Czech Republic, the need for a better legal and institutional framework that explicitly recognizes this form of violence and allows victims access to justice has been highlighted in particular by legal experts[239] and civil initiatives working to support women who have been victims of such violence.

In 2022, the Center for Victims of Obstetric Violence was established in Brno.[240] It is the first center of its kind in the Czech Republic that helps women resolve cases of violations of their rights during pregnancy, childbirth, and the postpartum period, using the means offered by existing legislation. The center assists women, for example, in filing complaints against healthcare providers and forwarding complaints to regional authorities or the public defender of rights.

The Czech government has also committed itself to strengthening mechanisms to prevent, consistently address, and compensate for obstetric violence, following the recommendations of the UN Special Rapporteur on violence against women (see Chapter 2.1.4) and the outputs of the DEVOTION CA118211 project[241].[242]

### 3.5.6 Strategic and Task-oriented Section – Set of Measures No. 5

In response to the problems, recommendations, and commitments described above, the strategy proposes the implementation of several interlinked measures aimed at raising awareness of obstetric violence among healthcare personnel, hospital ombudsmen, hospital management, care recipients, courts, and the general public. To support awareness-raising, a special tab will be created on the Ministry of Health's web platform, where important information on obstetric violence, options for addressing it, and the related rights of care recipients/service users will be collected, as well as information for victims on where to seek legal and psychosocial assistance. The strategy provides for support for further research into obstetric violence, its occurrence and impact in the context of the Czech Republic, as well as civic activities to promote awareness and create support structures for victims of obstetric violence, including legal advice and psychosocial support, so that women feel safe when reporting cases and have access to the necessary assistance and care.

To improve the methodological guidance of healthcare providers, separate methodological guidelines on the prevention and combating of obstetric violence will be developed. In addition to training activities for judges through the Judicial Academy, training materials will be developed and distributed directly to healthcare professionals. The strategy also provides for the amendment of qualification standards and decrees on the education and activities of relevant non-medical healthcare professions, amend decrees on education in relevant basic medical fields, and revise education requirements for specialization training and advanced fields so that info on obstetric violence, its causes, manifestations, and prevention becomes an integral part of training for healthcare professions that care for mothers and children in early motherhood.

The implementation of measures from other parts of the strategy will also contribute to the achievement of strategic objective No. 5, as the prevention and elimination of obstetric violence is closely linked to strengthening the variability of services in the area of prenatal, childbirth, and postnatal care, or diversifying them so that they better reflect the principle of women's



[239] HOŘEJŠÍ, Adéla, 2020. Obstetric violence. How (old) men decide about (young) women's bodies. In: KATEŘINA, Šimáčková, Havelková BARBARA and Špondrová PAVLA. *Men's rights: are legal rules neutral?* Prague: Wolters Kluwer, pp. 733-780. ISBN ISBN 978-80-7598-761-7.
[240] See https://porodnictvibeznasili.cz/.
[241] For more details, see the policy recommendations available at https://www.ca18211.eu/research-outputs/#1697205429571-9f9bd564-d375.
[242] See Government Resolution No. 269 of March 8, 2021, and subsequently Government Resolution No. 682 of October 2, 2024, approving the updated Strategy for Gender Equality for 2021–2030.

autonomy and offer them a real choice of place, manner, and circumstances of childbirth. In other words, support for individualized and continuous care by midwives, together with the development of birth centers and centers, has the potential to contribute to reducing the incidence of obstetric violence. Another factor that reduces the incidence of this type of violence is the promotion of evidence-based knowledge and practices among healthcare students, healthcare nd the general public. It is also essential to strictly adhere to the principles of free and informed consent.

The strategic objective also includes measures to consider specialized legislation to improve access to justice for victims of obstetric violence, streamline reporting mechanisms, and strengthen the protection of women's rights.

Other strategic documents at the government level should also contribute to the prevention of obstetric violence as a form of gender-based violence. These include, in particular, action plans to prevent domestic and gender-based violence, which contain measures to prevent various forms of gender-based violence and to assist its victims.

## Breakdown of tasks for the chapter Prevention of disrespectful care and obstetric violence

| **Strategic objective 5** | | **Prevention and combating obstetric violence** | | | | |
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| Specific objective | Measures | Description | Duration of measure / deadline for completion | Criteria for fulfillment | Responsible institution (manager) | Cooperating entities (co-manager) |
| **5.1 Raise awareness of obstetric violence, its causes and impacts** | 5.1.1 Inform the public through relevant government web platforms | Create a separate tab on the NZIP and other relevant government websites dedicated to health, health services, and the living and legal situations of Czech citizens on the topic of obstetric violence in order to inform the public about the manifestations, causes, and impacts of obstetric violence. In connection with measure 5.3.2, add contact details for support organizations to the website. | by July 1, 2026 | State administration web platforms, including NZIP, contain relevant information and contacts. | MZD, MPSV, MSp, KVOP | NGOs |
| | 5.1.2 Implement coordinated awareness-raising activities to support victims of obstetric violence | Implement coordinated awareness-raising activities to support victims of obstetric violence (e.g. on World Patient Safety Day or during the 16 Days of Activism Against Gender-Based Violence) through joint press releases, social media posts, press conferences, exhibitions, or through support for related activities by NGOs and associations of care recipients. | July 1, 2025 – December 31, 2030 (ongoing) | At least once a year, joint awareness-raising activities will be carried out. | MZD, ÚV ČR | NGOs, KVOP |
| | 5.1.3 Ensure educational activities for the legal community, court experts, hospital ombudsmen, courts, and administrative authorities | Ensure educational activities for the legal community, court experts, hospital ombudsmen and public administration on the specifics of obstetric violence so that they can better understand this issue and make effective decisions on related cases. | July 1, 2025 – December 31, 2030 (ongoing) | Existence of educational courses and seminars. | Ministry of Justice, Office of the Government of the Czech Republic, KVOP | NGOs, universities, and other research institutions |
| **5.2 Educate healthcare professionals about obstetric violence and tools for its prevention** | 5.2.1 Update qualification standards and amend decrees on the education and activities of relevant medical and non-medical healthcare professions | By amending/updating the relevant decrees and standards, adjust in an appropriate manner and at a general level the training requirements for relevant non-medical and medical healthcare personnel so that information on obstetric violence, its causes, manifestations, and prevention becomes an integral part of the training for healthcare professions that care for mothers and children in early motherhood. | by July 1, 2026 | Relevant regulations and standards include information on obstetric violence, its causes, manifestations, and prevention. | Ministry of Labor and Social Affairs, Ministry of Education, Youth and Sports | Government of the Czech Republic (Working Group on Obstetrics) |
| | 5.2.2 Create and distribute teaching materials on obstetric violence for secondary schools, higher vocational schools, universities, and continuing lifelong education | Create teaching materials for secondary schools, higher education institutions and continuing lifelong education to support the education of future and current healthcare professionals on the topic of obstetric violence. Use case studies from nationwide research and surveys on satisfaction with perinatal care in the Czech Republic. Ensure their distribution in an appropriate form to schools and other relevant workplaces. Create or adopt and subsequently publish informative educational videos on the topic on the ministry's web platform. | July 1, 2026 – December 31, 2027 | Creation and distribution of educational materials. Publication informative (educational) videos on the topic of obstetric violence. | MZD,ÚV ČR (Working Group on Obstetrics) | MZD, WHO, KVOP, NNO, IPVZ, NCO NZO, MŠMT, relevant professional institutions and entities, relevant schools and universities |

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|---|---|---|---|---|---|---|
| | 5.2.3 Create methodological guidelines for healthcare providers on the prevention and combating of obstetric violence | In order to improve the methodological guidance provided to healthcare providers, create separate methodological guidelines for the prevention and combating of obstetric violence. These guidelines should also take into account the role of hospital ombudsmen. Inform relevant entities, including hospital management, hospital ombudsmen, relevant professional associations of healthcare professionals, and healthcare service providers, about the existence of the guidelines and other government activities on the topic of obstetric violence by means of a letter from the Minister of Health and the Government Commissioner for Human Rights. | by March 31, 2026 | Publication of methodological guidelines in the MZD Bulletin. Informing the Association of Ombudsmen in healthcare and other entities about the existence of the guideline. | MZD, ÚV ČR (Working Group on Obstetrics) | KVOP |
| **5.3 Create and develop support structures for victims of obstetric violence** | 5.3.1 Ensure financial and other support for organizations specializing in providing legal advice and psychosocial support to victims of obstetric violence | Support the establishment and development of support structures for victims and their access to legal advice and psychosocial support. Support related awareness-raising activities by the civil sector aimed at making women feel safe when reporting cases and ensuring they have access to the necessary assistance and care. To this end, map appropriate grant schemes and propose their revision, if necessary, so that their funds can be used to support these activities. | July 1, 2025 – December 31, 2030 (ongoing) | Grant calls linked to the support of relevant activities. | MZD, MPSV (OPZ+), ÚV ČR | NGOs |
| | 5.3.2 Provide information on government websites about legal and psychosocial support options for victims of obstetric violence | Add information on legal and psychosocial support options for victims of obstetric violence, including contact details for support organizations, to government websites dedicated to health, health services, and the living and legal situations of Czech citizens. | July 1, 2025 – December 31, 2030 (ongoing) | State administration web platforms, including NZIP, contain relevant information and contacts. | MZD, MPSV, MSp, KVOP | NGOs |
| **5.4 Support the development of further mechanisms for the prevention of obstetric violence** | 5.4.1 Support further research into obstetric violence to improve understanding of its extent, nature, and possible solutions | Support further research into obstetric violence in order to improve understanding of its extent, nature and possible solutions, and respond to existing gaps in the system of protection against obstetric violence. | July 1, 2025 – December 31, 2030 (ongoing) | Grant and subsidy calls linked to the implementation of this strategy. | Ministry of Labor and Social Affairs, Ministry of Labor and Social Affairs (OPZ+), state grant agencies | AV ČR, universities and other research institutions, NGOs |
| | 5.4.2 Consider legislatively anchoring the definition of obstetric violence | In accordance with the recommendations of international organizations and their bodies, and following the recommendations arising from research on obstetric violence, prepare an analysis of the possible introduction of a uniform definition of obstetric violence into Czech law. | by July 1, 2026 | Prepare an analysis of the intention to introduce a definition of obstetric violence into law. | MZD, ÚV ČR (Working Group on Obstetrics) | KVOP |
| | | | | | | |

## 3.6 Perinatal Mental Health

### 3.6.1 Shortcomings in the Mental Health Care System for Women in the Perinatal Period

In addition to inappropriate communication and disrespectful treatment (see Chapter 3.4 for more details), which in the most serious cases leads to obstetric violence (see Chapter 3.5 for more details), other factors affect women's mental health in early motherhood, such as changes in social background, pressure to cope with the new role of motherhood, and lack of support from the child's father. These can contribute to the development of anxiety or postpartum depression. In the Czech Republic, almost one in five women experience symptoms of mental distress, depression, or anxiety during pregnancy or after childbirth, with three-quarters of them not seeking help.[243] In addition to the inadequate preparedness of the care system, access to adequate support is also hampered by (self-)stigmatization—in a related study conducted in the Czech Republic, 40% of women said they would be ashamed if their family knew they had sought professional help for mental health problems, 61% would be ashamed if their colleagues knew about it.[244]

Untreated mental health problems, especially perinatal depression, can have a number of negative effects. These include not only economic difficulties or relationship problems, but can also lead to complications in pregnancy and abnormal fetal or child development. Prenatal depression and anxiety in mothers can also have long-term effects on the child, including behavioral problems, poorer cognitive abilities, and social withdrawal.



There is currently no comprehensive system of perinatal mental health care in the Czech Republic, unlike in other European countries. Screening for mental health issues is only available on a pilot basis in selected hospitals and outpatient clinics. Only some women who screen positive receive follow-up care and peer support. There is a lack of infrastructure and a sufficient number of specialists focusing on women's mental health during pregnancy and after childbirth. There is also a lack of psychiatric facilities where women could be hospitalized with their children, resulting in their unjustified separation during treatment.

To date, the Perinatal project, implemented by the National Institute of Mental Health in cooperation with a patient organization, has been the main initiative focused on raising awareness, educating professionals, connecting women with peer consultants, and piloting other tools to address the issues outlined above.[245] The implementation and expansion of the project is an important basis for the development of systematic care in the future. In the fall of 2024, the Perinatal Mental Health Center was also opened in Prague as the first specialized facility of its kind in the Czech Republic.[246] Other regions still lack this type of specialized facility.

Midwives also play an important role in the early detection of problems and the provision of support. Thanks to their expertise and close contact with women, they are ideally placed to identify mental health problems at an early stage and refer women to the appropriate services. Abroad, there are midwives specializing in mental health who focus on preventive support, networking, and a trauma-informed approach, especially for women who have had a difficult birth experience or perinatal loss. A similar specialization is now developing in the Czech Republic.[247]

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[243] Sebela A., Byatt N., Formanek T., Winkler P. (2021). Prevalence of mental disorders and treatment gap among Czech women during paid maternity or parental leave. *Archives of Women's Mental Health,* 24(2), 335–338.
[244] Ibid.
[245] See https://www.perinatal.cz/.
[246] See https://www.cpdp.cz/.
[247] Through a certified course *entitled Midwife with Special Professional Qualifications in Perinatal Mental Health,* which was developed in cooperation with the National Institute of Mental Health. For more information, see https://www.zdravotnickydenik.cz/2025/04/prvni-porodni-asistentky-v-cesku-absolvovaly-novy-kurz-ziskaji-

### 3.6.2 The Role of Support Persons and Doulas

To ensure the emotional well-being of women in early motherhood and thus prevent mental health problems, it is also important to allow women to be accompanied during childbirth and to have loved ones present (provided that the woman herself wishes this and the person in question is willing to accompany her). Most often, women choose their partner (the child's father) as their companion, whose role is also crucial during pregnancy and after childbirth. The father's attitude toward pregnancy influences the woman's emotional state and behavior, and thus the subsequent development of the child, not only in the prenatal period.

Non-medical helping professions such as doulas play an important role in supporting women's mental health during the perinatal period.[248] Doulas provide a paid service[249] accompanying women and families during pregnancy, childbirth (birth doulas) and after childbirth (postpartum and some birth doulas).[250] They often also act as lactation consultants, whose services are covered by some health insurance companies from prevention funds. If doulas provide services of this nature, they are appropriately trained and certified and undergo ongoing recertification by the relevant organizations to ensure that their care and support are professional and safe.



The work of a doula complements the services provided by healthcare professionals to women during pregnancy, childbirth, and the postpartum period.[251] Thanks to the range of services provided, doula care is often continuous and allows for full use of knowledge of the individual situation of clients and the established relationship of trust, which significantly contributes to the quality and effectiveness of care. A doula provides women with continuous physical and emotional support, helping to alleviate their stress, fear, and tension. A doula's help in coping with pain and difficult emotional moments has a positive effect on the overall mental state of women throughout the perinatal period.

The use of doula services contributes to shorter labor, fewer complications and interventions (C-section, use of analgesia, operative delivery, premature birth), higher breastfeeding rates, reduced stress and incidence of postpartum depression and anxiety, and greater bonding between mother and baby.[252] Research also shows that the presence of a doula increases the mother's satisfaction with the birth and contributes to better health for the newborn.[253] The most beneficial effects of continuous support during childbirth were reported when the support was provided by a doula or another non-related person who was not part of the medical staff. In certain respects, the presence of a doula during childbirth can therefore yield better results

odbornost-v-peci-o-dusevni-zdravi/ and the list of accreditations granted and extended available at https://mzd.gov.cz/certifikovany-kurz/.

[248] See https://www.duly.cz/kdo-je-dula/.

[249] The profession of doula is not explicitly regulated in Czech law. Doulas provide psychosocial support during pregnancy, childbirth, and the postpartum period, and their activities fall under the category of independent professions and are not considered health services.

[250] According to a recent study by Wilhelmová et al. (unpublished), 3.2% of women surveyed used the services of a doula. Internal statistics and expert estimates from the Czech Association of Doulas indicate that this represents approximately 2% of all births (i.e., births where a doula is present as one of the accompanying persons from among non-medical staff). The study by Wilhelmová et al. also shows that 73% of women chose their partner as their companion (however, this figure may be negatively affected by the COVID-19 pandemic, and the actual proportion may be even higher).

[251] It is necessary to ensure a strict separation of medical and non-medical competences. As women are sometimes misled into believing that hiring a doula means paying for the services of a healthcare professional, professional doula organizations strive to establish clear rules. For example, the Czech Association of Doulas (ČAD) requires its members to comply with the ČAD Code of Ethics and to accompany women exclusively in the presence of medical personnel. Members are also required to undergo training and supervision.

[252] Sobczak, A., Taylor, L., Solomon, S., Ho, J., Kemper, S., Phillips, B., Jacobson, K., Castellano, C., Ring, A., Castellano, B., & Jacobs, R. J. (2023). The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. Cureus, 15(5), e39451. https://doi.org/10.7759/cureus.39451.

[253] Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6.

than the presence of another person, such as a partner, friend, or other family member.[254] A doula also makes the early stages of motherhood easier for women and supports them in their parenting skills.

### 3.6.3 Perinatal Loss

A specific issue that closely relates to women's mental health during the period covered by the strategy is perinatal loss.[255] For a woman (as well as for parents and the family), going through such a situation represents a very challenging time, which requires a sensitive and comprehensive approach from healthcare staff and the support of a palliative care team. Palliative teams provide interdisciplinary care that includes decision-making assistance, grief support, and creating space for a final farewell with the child. However, women and families who have experienced perinatal loss do not always have access to adequate support within perinatal palliative care. Although this is gradually developing in the Czech Republic,[256] it still faces a shortage of appropriately trained staff and facilities suitable for providing such care. Interdisciplinary cooperation in this area is also hampered by the absence of uniform standards.[257]

### 3.6.4 Strategic and Task-oriented Section – Set of Measures No. 6

The proposed measures aim to improve mental health care for women in early motherhood (and also in the event of perinatal loss). The strategy proposes to introduce universal screening for mental health problems and link it to a system of follow-up care. The strategy calls for the establishment of at least one specialized center in each region to provide comprehensive mental health support to women during pregnancy and after childbirth. EU funds can be used to provide the necessary infrastructure. The availability of this care will also be facilitated by its coverage by public health insurance. The measures also aim to ensure that the use of these centers or any psychiatric hospitalization does not result in the unnecessary separation of the child from the mother.



The proposed measures also include awareness-raising activities aimed at destigmatizing women with mental health issues, involving peer counselors, supporting non-medical birth companions (through doulas), and developing the practice of postpartum conversations.

The last part of the measures is specifically focused on perinatal palliative care and ensuring the availability of psychosocial support for women experiencing or at risk of perinatal loss.

[254] Ibid.
[255] The situation of fetal or neonatal death, stillbirth, or death of a child within 28 days of birth.
[256] Including support for healthcare and other personnel for whom providing this care may also be challenging (see, for example, https://www.perinatalniztrata.cz/sebepece/).
[257] Palliative Care Center. *Current status and possibilities for the development of perinatal palliative care in the Czech Republic.* Prague: Palliative Care Center, 2023. ISBN 978-80-906109-2-7.

# Breakdown of tasks for the chapter on perinatal mental health

| **Strategic objective 6** | | **Comprehensive mental health support for women in early motherhood and women experiencing perinatal loss** | | | | |
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| Specific objective | Measure | Description | Duration of measure / deadline for completion | Criteria for fulfillment | Responsible institution (manager) | Cooperating entities (co-manager) |
| **6.1 Introduce comprehensive screening for mental health issues during pregnancy and after childbirth and ensure the availability of follow-up psychosocial support** | 6.1.1 Introduce universal screening for mental health problems during pregnancy and after childbirth and link it to a multi-level care system | Introduce universal screening for mental health problems during pregnancy and after childbirth and, if mental disorders are detected or there is a risk of their development, ensure that women are referred to appropriate care systems according to the severity of their condition. Ensure that screening and follow-up health services are covered by public health insurance. | July 1, 2025 – December 31, 2030 (ongoing) | Existence of a comprehensive screening program covered by public health insurance and its connection to follow-up care. | MZD | NÚDZ, health insurance companies |
| | 6.1.2 Support the establishment and development of specialized facilities providing comprehensive mental health support during pregnancy and after childbirth | Support the establishment and development of specialized facilities (centers) providing comprehensive mental health support during pregnancy and after childbirth. Design the infrastructure and operation of the centers so that the use of their services does not result in unnecessary separation of the child from the mother. Ensure that these services are covered by public health insurance and are available in all regions of the Czech Republic. | July 1, 2025 – December 31, 2030 (ongoing) | By the end of 2030, a specialized center will exist in every region. | MZD, MMR, MPSV (OPZ+) | NÚDZ, health insurance companies |
| | 6.1.3 Prevent the unjustified separation of mothers and children during psychiatric hospitalization | Ensure that women requiring psychiatric hospitalization can be hospitalized together with their children. Support the development of appropriate infrastructure at specialized facilities. Seek funding for this infrastructure from EU funds and other financial mechanisms, or other sources if necessary. | July 1, 2025 – December 31, 2030 (ongoing) | Mothers and children are not separated during psychiatric hospitalization due to inadequate infrastructure. Support the publication of related calls for proposals within the available national, European, and other financial resources. | MZD, MMR | Healthcare providers |
| **6.2 Support other forms of education, prevention, and assistance** | 6.2.1 Implement awareness-raising, destigmatization, and peer activities | Ensure the implementation of awareness-raising activities aimed at preventing stigmatization and self-stigmatization of women with mental health issues during pregnancy and after childbirth. Involve peer consultants from among mothers of the same age who have personal experience with mental health issues and can offer support to women with similar problems in awareness-raising and related activities. When implementing these activities, avoid inappropriate commercial influences and ensure compliance with the International Code of Marketing of Breast-milk Substitutes. | July 1, 2025 – December 31, 2030 (ongoing) | Annual awareness-raising activities and ongoing peer support without undesirable commercial influences. | MZD, NÚDZ | NGO |

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| | 6.2.2 Support and evaluate the effectiveness of doulas and birth companions | If a woman is interested in non-medical support during childbirth, support the presence of a doula or other support person without unnecessary restrictions (e.g., at the expense of the presence of a loved one). Ensure that the presence of the support person requested by the woman is possible from the moment the woman is admitted until the first care of the newborn. At the same time, ensure that the mother is not forced to have a support person present and can decide at any time to refuse their presence or change her original decision. Expand the collection of data on childbirth to include information on support persons and enable the evaluation of the effectiveness of their presence (by pairing data on support persons with the level of interventions performed). | July 1, 2025 – December 31, 2030 (ongoing) | Cooperation with doulas is actively supported. The data collected on childbirth includes information on the mother's support, and the effectiveness of support is being evaluated (by pairing with the level of interventions performed). | MZD | ÚZIS ČR, professional organization of doulas |
| | 6.2.3 Develop the practice of postpartum interviews to reduce the impact of emotionally intense or traumatic experiences during childbirth | Support the practice of conducting postpartum interviews (supportive postnatal interviews) and enable mothers to discuss their experiences of childbirth directly in the hospital (or other facility or place of birth) with trained staff and people who were present at the birth. This will help reduce the impact of emotionally intense or traumatic experiences during childbirth and the stay in the maternity ward. | July 1, 2025 – December 31, 2030 (ongoing) | Expansion of the practice of conducting postpartum interviews. | MZD, NÚDZ | Healthcare providers |
| **6.3 Ensure adequate care for women experiencing perinatal loss** | 6.3.1 Strengthen education, interdisciplinary cooperation, and professional capacities in perinatal palliative care | Ensure awareness and education about perinatal palliative care across relevant disciplines and specializations (neonatology, gynecology and obstetrics, midwifery, psychology, social work, etc.) at the undergraduate and postgraduate levels and through lifelong learning. Expand professional capacity by creating certified courses and training programs that will improve the qualifications of healthcare personnel and their readiness to provide this specific type of care. Support interdisciplinary cooperation and the creation of specialized teams. Consider the development of uniform standards and procedures for the provision of perinatal palliative care to ensure effective and coordinated care for women and families experiencing or at risk of perinatal loss. | July 1, 2025 – December 31, 2030 (ongoing) | Professional capacities are strengthened and the standardization of procedures in perinatal palliative care is supported. | MZD, IPVZ NCO NZO, MPSV, MŠMT | NGO |
| | 6.3.2 Improve the availability and infrastructure of psychosocial support services | Support the creation and development of activities, including the operation of specialized telephone lines, for women and families experiencing or at risk of perinatal loss. Seek opportunities to draw on grant programs, EU funds, and other financial mechanisms for organizations specializing in the provision of psychosocial support, including support and infrastructure development (adequate space for such care, availability of special rooms for meetings with families in existing facilities, memory boxes, etc.). | July 1, 2025 – December 31, 2030 (ongoing) | Efforts to issue calls for proposals for grants to support relevant activities. Consideration of drawing on EU funds and other financial mechanisms or available national resources. | MZD, MMR, MPSV | NGOs |

# 4. Strategy Implementation

The Ministry of Health, in cooperation with the Government Commissioner for Human Rights or the Office of the Government of the Czech Republic, is the manager and central coordinator of the strategy implementation.

Tasks aimed at implementing the strategy will be assigned to the managers of individual measures by a government resolution and will thus be binding on the Office of the Government of the Czech Republic, ministries and their subordinate organizations.

Cooperating entities from the professional public, civil society, health insurance companies and, to some extent, international organizations will also play an important role in implementing the strategy. Although these are entities that the government cannot directly assign tasks to, the strategy counts on their cooperation and the active role of the Ministry of Health and other ministries as managers of individual measures in establishing and maintaining cooperation with representatives of these entities.

## 4.1 Action Plan

The strategy is prepared for the period 2025 to 2030, and the action plan is based on this setting. For each measure, the task sections of the chapters in the tables (logical frameworks) always specify the responsible institutions (managers) and cooperating entities, as well as the timetable for their implementation.

## 4.2 Time Schedule

As mentioned above, the expected time frame for the implementation of activities is from the approval of the strategy until the end of 2030. The timetable has the following key milestones:



- By November 15, 2024, approval of the draft task and analytical parts of the strategy by the Working Group on Obstetrics at the Government Council for Gender Equality and subsequent submission of the material for internal mandatory consultation as soon as possible
- By February 28, 2025, settlement of comments from the mandatory internal consultation process.
- By March 17, 2025, submission of the strategy for joint optional internal and external consultation
- By June 30, 2026, settlement of comments from the internal and external comment procedure and submission of a request for the strategy to be submitted to the government for discussion
- 2025–2030 implementation of the strategy measures and, in cooperation with the relevant advisory bodies, evaluation every two years in relation to the government
- By June 30, 2030, overall evaluation of the implementation of the strategy and proposal of measures for the period after its expiry (at least until 2040).

Given the medium-term scope of the strategy, no revision is planned in advance. However, if changes of such a fundamental nature are identified during its validity that require a revision of the strategy, a possible update will be proposed to the government together with an evaluation of its implementation for the relevant two-year period.

## 4.3 Budget and Sources of Funding

Ensuring consistent implementation of the strategy is a complex process that affects multiple levels. Although the implementation of relevant measures and tasks will be centralized at the state administration level, it is necessary to take into account that multiple actors will be involved in the implementation of tasks. In addition to state administration bodies, these include, in particular, healthcare providers, their founders, health insurance companies, but

also non-governmental non-profit organizations, international organizations, and other entities. This complexity is reflected in a multi-source financing system. The implementation of the strategy will be financed both from the national central level (state budget) and from EU funds or funds from international organizations and other entities.

In terms of financing, the individual measures can be divided into four basic types. The first type consists of measures without direct costs, which are to be implemented as part of the existing activities of the administrators (e.g., awareness-raising activities or the preparation of draft legislative changes).

The second type consists of measures already financed from the Employment Plus Operational Program (OPZ+) and measures for which it will be possible to seek funding from EU funds and EEA/Norway programs, depending on the outcome of future negotiations on new programming periods. EU funds may also be used to cover any personnel costs related to the implementation of the strategy.

The third type consists of funds from health insurance payers, or rather their use by health insurance companies to support the implementation of certain measures, such as strategies proposed in the form of incentives and bonuses for healthcare providers.

The last type are measures with a possible direct impact on the state budget – they concern the increase or modification of the focus of some existing subsidy programs of the Ministry of Health and other ministries. The last type of measures will be financed taking into account the current possibilities of the state budget.

### 4.4 System for Monitoring and Evaluating the Implementation of the Strategy

Given its complexity, the system for monitoring and evaluating the implementation of the strategy will operate at several levels.



The first level will be based on central data collection carried out on the basis of the existing legal obligation of healthcare providers to submit data to the National Health Information System (NZIS). Data collection enables regular reporting to the government and its working and advisory bodies, including the possibility of responding quickly to any problems and proposing measures to remedy them. The second level will be ensured through reimbursement bonuses and control mechanisms available to health insurance companies to verify that providers are meeting standards. The third level will concern the healthcare providers themselves and their professional organizations. The fourth level will include mechanisms for external and public control of the program's implementation, including with the support of the National Institute for Quality and Excellence in Healthcare (NIKEZ). The fifth level will concern reporting by the Czech Republic to international organizations.

The basic monitoring and evaluation cycle will be completed every two years by the government discussing a report on the implementation of the strategy, which will be prepared by the Ministry of Health in direct cooperation with the secretariat of the Working Group on Obstetrics at the Government Council for Gender Equality, using input from the relevant departments of the Ministry of Health, the Institute of Health Information and Care (ÚZIS ČR) and other stakeholders. The draft report on the implementation of the strategy will then be discussed with the Working Group on Obstetrics at the Government Council for Gender Equality. The next step will be to submit the report to the standard inter-ministerial consultation process and to the government.

## 5. Process of Strategy Development and Consultation

To be completed after the conclusion of the first consultation phase and the incorporation of comments.

## 6. List of References

To be completed after the conclusion of the first part of the consultation phase.