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Joint submission by the Center for Reproductive Rights, Občan, demokracia a zodpovednosť (Citizen, Democracy and Accountability), Ženské kruhy (Women's Circles), and TransFúzia (TransFusion)

The Center for Reproductive Rights, Občan, demokracia a zodpovednosť (Citizen, Democracy and Accountability), Ženské kruhy (Women's Circles), and TransFúzia (TransFusion) present this submission to the Committee on the Elimination of Discrimination against Women (CEDAW Committee) for its consideration in the context of its examination of Slovakia's fifth and sixth periodic reports on compliance with the Convention on the Elimination of All Forms of Discrimination Against Women (the Convention).

This submission highlights a range of concerns regarding Slovakia's compliance with the Convention in the area of reproductive health and rights. The submission reiterates many of the concerns which were outlined in the PSWG submission our organizations presented to the Committee in January 2015 (PSWG submission),[1] and which the state's replies to the List of Issues (LOIs) failed to sufficiently address or alieviate.

This submission complements and supplements a broader submission on a range of related issues which is being submitted separately to the Committee by three Slovak organizations (Občan, demokracia a zodpovednosť, Ženské kruhy, and TransFúzia).

Articles 2, 5, 10, 12, 14 and 16 of the Convention: Women's reproductive rights

The sub-sections below outline some of the ways in which Slovakia's laws and practices continue to undermine women's reproductive rights. The concerns highlighted include: (a) the lack of a comprehensive state policy on sexual and reproductive health and rights; (b) barriers in access to contraceptive services and information; (c) barriers in access to abortion services; (d) the inadequate regulation of conscience-based refusals of reproductive health care; (e) ill-treatment of women during facility-based childbirth, and (f) the lack of comprehensive data on sexual and reproductive health. A number of recommendations are outlined at the end of each sub-section.

a. Lack of a comprehensive state policy on sexual and reproductive health and rights

As previously outlined in the PSWG submission, Slovakia has not adopted a comprehensive policy on sexual and reproductive health and rights. Although there have been repeated attempts to adopt such a policy, the Slovak government has consistently failed to do so, primarily due to pressure from the Catholic Church hierarchy and other organizations opposing reproductive rights.

In 2007, the Ministry of Health proposed a draft program on sexual and reproductive health entitled "National Program on Protection of Sexual and Reproductive Health in the Slovak Republic".[2] The draft program was based, in part, on international human rights and medical standards. Among the program's goals was a decrease in unintended pregnancies and improving access to high-quality modern contraceptives by making them affordable for everyone.[3] The Catholic Church hierarchy and organizations opposing reproductive rights heavily criticized the program, claiming that it was "strongly liberal,"[4] against national interests,[5] and "anti-family," especially because it sought to improve access to contraception.[6] As a result, the government did not adopt the program, despite having acknowledged its importance,[7] and instead decided that the Ministry of Health should draft a new policy, which was renamed the "National Program on Care for Women, Safe Motherhood and Reproductive Health". The Ministry prepared a draft of this new program in 2009. The draft did not contain a set of measures to comprehensively deal with sexual and reproductive health issues; instead it incorporated proposals from conservative Catholic organizations.[8] However, due to continuing opposition from the Catholic Church hierarchy, which contested the new proposal,[9] the program was not adopted. Since 2009 the Ministry has not proposed a new draft.

In its response to the Committee's LOIs question on the status of the draft program the government states that "no professional consensus has been reached among the stakeholders in various aspects of the issue" and thus seeks to justify postponing its adoption.[10] It is unclear what the government means by "*professional* consensus"[11] as opposition to the initiative does not stem from healthcare professionals or sexual and reproductive health experts, but instead from religious and other organizations advocating against reproductive rights. The matter has been pending for over a decade.[12] Notably, the Ministry of Health has recently specified that the adoption of a reproductive health program has had to be postponed due to a lack of financial resources.[13]

Recommendations

- Adopt, without further delay, a comprehensive human rights compliant and evidence-based program on sexual and reproductive health and allocate adequate financial and human resources for its effective implementation. Ensure the active participation of women's rights and reproductive rights organizations in the drafting and implementation processes.

b. Barriers in access to contraceptive services and information

Although in principle contraceptives are available in Slovakia, contrary to the government's claim in its replies to the LOIs[14] they continue to be inaccessible in practice for many women.[15] According to the state's statistics, the use of modern contraceptives remains low and has been decreasing since 2007. In 2014, only 16.1% of women in reproductive age used hormonal contraception and 3.5% used IUDs.[16]

As outlined in the PSWG submission, the barriers faced by women and adolescent girls in access to contraceptive services and information include: (i) a widespread lack of knowledge and misperceptions about modern contraceptive methods, and (ii) the relatively high cost of contraceptives and general lack of subsidization.

i. <u>Information</u>

The lack of comprehensive and evidence-based information inhibits women's access to modern contraceptives in Slovakia. In many schools, sexuality education is inadequate, focusing primarily on reproductive organs and anatomy.[17] At the same time, the teenage birth rate continues to be high in Slovakia with 18 births per 1000.[18] The Catholic Church hierarchy actively advocates against the use of modern contraceptives and promotes traditional methods of family planning.[19] Many gynecologists do not provide women with adequate information to make informed choices, expect that women seeking

contraceptive methods should already have adequate information, and frequently do not take the initiative to inform women of their contraceptive options.[20] Moreover, due to poor communication by physicians and inadequate sexuality education in schools, women are often misinformed about the impact and side effects of hormonal contraceptives on their health.[21]

ii. Cost

In its response to the Committee's question in the LOIs regarding the extent to which public health insurance covers modern contraceptives, the government states that public health insurance in Slovakia does not cover health care that is not indicated for medical reasons but that where use of contraceptives is 'medically justified,' it may be covered on a case-by-case basis by a woman's public health insurance.[22] It is apparent that the state does not interpret the criteria of 'medical justification' to include the prevention of unintended pregnancies. As a result, public health insurance in Slovakia does not cover the use of contraceptives when they are used solely to prevent unintended pregnancies. Therefore, most women are left to cover the entire cost of contraception themselves. The relatively high price of contraceptives is prohibitive for some women and prevents others from using the method that they would prefer.[23]

Indeed, in 2011 the Slovak Parliament adopted a law that explicitly prohibits public health insurance coverage of "drugs intended [] *solely for the regulation of conception* (contraceptives),"[24] and coverage of medical devices that are "intended for the regulation of conception."[25] This means that where contraceptives are used exclusively to protect against unintended pregnancies they cannot be covered under public health insurance. Although the 2011 law did not alter the *status quo* in practice – since public health insurance coverage for contraceptives had never occurred (although it had been formally required by law until 2011) – it codified a discriminatory practice into law and made ensuring public funding for contraceptives much more difficult to achieve in the future.

Moreover, by adopting this law the state re-affirmed its long-term approach to contraceptives as "life-style drugs," and not essential medicines. This approach is also reflected in the government's replies to the LOIs which indicates that excluding contraceptive use for pregnancy prevention from public health insurance coverage ensures the "efficient use of public resources."[26] Such an approach contradicts World Health Organization (WHO) standards that define contraceptives as essential medicines. In 2012, the Committeee on Economic, Social and Cultural Rights (ESCR Committee) expressed concern over the 2011 coverage ban and urged Slovakia to expand public health insurance coverage to include modern contraceptives.[27] However, the government has not adopted any measures to implement this recommendation thus far.

On the contrary, the government continues to refuse to provide contraceptive coverage to the majority of women who are using contraceptives *solely* to prevent unintended pregnancies. Meanwhile, even where contraception use is indicated for other 'medical' reasons the discretion to grant individual coverage in such cases is left to the individual health insurance company. A woman's health insurance company will decide whether or not she qualifies for coverage following a written request for subsidization from an individual woman's health care provider.[28] As a result, in practice, it is very difficult for women to secure subsidization for contraceptives, even if they are being used primarily for purposes other than pregnancy prevention.

Recommendations

- Take effective measures to expand women's access in practice to affordable contraception, including through training and information programmes designed to improve public and health-care providers' levels of knowledge and evidence-based information on contraception.
- Repeal the 2011 prohibition on public health insurance coverage of contraception and ensure universal coverage of modern contraception under public health insurance.

c. Barriers in access to abortion services

Slovak abortion law permits abortion on request without restriction as to reason up to 12 weeks of pregnancy, and thereafter, if a woman's life is in danger or in cases of fetal impairment.[29] However, a range of barriers continue to undermine women's access to safe and legal abortion in practice.

Cost: Abortion on request is not covered by public health insurance.[30] It costs between 240-370 EUR, which represented approximately 35% to 54% of the median monthly income for women in Slovakia in 2014.[31] As a result, financial barriers often impede women's timely access to abortion services. Recognising the discriminatory financial burdens that the lack of insurance coverage can impose on women seeking abortion services and contraceptives this Committee has recently called on a state party to "ensure universal coverage of abortion and modern contraception within the . . . Health Insurance Fund."[32]

Mandatory waiting periods: In 2009 a legislative amendment to the Healthcare Act[33] was adopted by Parliament which introduced a mandatory waiting period prior to abortion into Slovak law for the first time. The new 48-hour mandatory waiting period applies to abortions on request.[34] Previously women seeking abortion on request did not have to observe a mandatory waiting period and as such, by imposing new preconditions and restrictions on women's access to reproductive health services, the new law represents a retrogressive measure which contravenes the principle of non-retrogression. Mandatory waiting periods regularly delay women's access to legal abortion services, contribute to women having abortions later in pregnancy[35] and often increase the financial burden on women accessing abortion services.[36] Meanwhile, as the WHO and the International Federation of Gynecology and Obstetrics have specified, mandatory waiting periods, "demean[] women as competent decision-makers"[37] and reflect a range of discriminatory assumptions and harmful gender stereotypes including that women make fickle, changeable and impulsive decisions that they later regret.[38] As a result, this Committee as well as Human Rights Committee have requested states to ensure women's access to safe abortion without subjecting them to mandatory waiting periods.[39]

Biased information requirements: The 2009 amendment also requires that women receive information outlining the: "physical and psychological risks," associated with abortion;[40] "the current development stage of the embryo or fetus," and "alternatives to abortion" such as adoption, and support in pregnancy from civic and religious organizations.[41] This information must be provided to all women during the informed consent process prior to abortion and they are not able to refuse this information.[42] These new requirements were introduced with the biased and directive goal of dissuading women from obtaining abortion services, "in favor of the life of an unborn child."[43] The government's replies to the LOIs omits to acknowledge that in compelling women to receive such information with the purpose of dissuading them from accessing legal abortion services, these new information requirements are biased and directive in nature.[44]

The principle of full and informed consent is an integral component of a range of human rights including the right to health.[45] Informed consent requires that a patient's medical decision-making be free of threat or inducement, and that a patient's consent to a medical procedure, including abortion, be given freely and voluntarily after receipt of understandable, adequate, accurate, and evidence-based information on the procedure.[46] It is implicit in the principle of informed consent that patients must also be entitled to refuse such information yet still undergo the requested procedure.[47] For example, the Special Rapporteur on the Right to Health has specified that "[j]ust as a patient has the right to receive information in giving consent, a patient has the right to refuse such information in giving consent, providing disclosure of such information has been appropriately offered."[48]

Biased information requirements contradict the principle of informed consent. First, by imposing certain information on women as a precondition to abortion, they implicitly contradict the necessity that individuals be entitled to refuse information related to their health and proceed to treatment without it. Second, when information and counselling requirements are biased, and require health professionals to seek to persuade women not to undergo abortion, including through the provision of medically inaccurate, misleading, or stigmatizing information, they contravene obligations to ensure that health-related information and counseling be relevant, accurate, evidence-based, and non-directive and that medical decision-making be free from inducement, coercion, or discrimination.[49]

Provision of biased information on abortion also promotes a series of harmful and discriminatory gender stereotypes about women. By seeking to persuade women to continue their pregnancies, biased information requirements reflect the view that the primary role of women in society is as mothers, and the related assumption that women are by their nature maternal. As a result, a woman's decision to have an abortion is assumed to be "counter" to her nature, and therefore irrational and harmful.[50] Biased counselling and information requirements often seek to pressure women into deciding against abortion by generating a sense of disapproval and shame and promoting a belief that women who terminate their pregnancies are doing something wrong. By generating and exacerbating stigma concerning abortion, biased and directive counselling and information can cause women trauma and suffering.[51]

Confidentiality concerns: The 2009 amendment also requires doctors to send a report to the National Health Information Centre confirming that each woman seeking abortion has received this information.[52] The Centre is responsible for receiving and evaluating these reports, as well as for overseeing compliance with the mandatory waiting period.[53] The required reports must contain a woman's personal details and must be submitted before an abortion is performed.[54] This gives rise to a range of confidentiality concerns. In 2012, the ESCR Committee urged Slovakia to "ensure that the personal data of patients undergoing abortion remain confidential."[55] However, the requirement on doctors to provide the personal details of women seeking abortions remains in effect.

Parental consent: In addition, the 2009 amendment extended parental consent requirements to include all adolescent girls under 18**.**[56] The relevant information provided by the government in its replies to the LOIs does not reflect this legislative change. In its replies the government states that girls between 16-18 are subject only to requirements that their parents be notified after they have undergone an abortion, and implies that parental consent requirements prior to abortion apply only to adolescents under 16. It refers to a provision on parental consent and notification requirements contained in the Abortion Act.[57] However, that provision became obsolete after the adoption of the 2009 amendment.

Recommendations

- Take effective measures to ensure women's access to safe and legal abortion services, including by repealing legislative provisions which subject them to mandatory waiting period and biased information requirements, and that breach women's and adolescent girls' entitlements to confidentiality and privacy in access to services. Ensure that health care providers provide women with medically accurate and non-stigmatizing information on abortion and guarantee women's and adolescent girls' confidentiality.
- Ensure universal coverage of abortion services within public health insurance.

d. Inadequate regulation of conscience-based refusals of reproductive health care

Despite the Committee's recommendation that Slovakia adequately regulate the extent to which health care providers can refuse to provide reproductive health care on grounds of personal conscience and ensure that such refusals do not undermine or jeopardize women's timely access to reproductive health care,[58] the government has not adopted measures to implement this recommendation.

In its replies to the LOIs the government indicates that the situation concerning conscience-based refusals of care has stabilized and that such refusals of care do not restrict women's access to services in practice. However, as the government itself acknowledges such statements are based on anecdotes.[59] Indeed, the number of hospitals and health practitioners refusing to provide abortions and contraception is unknown since the state does not monitor the situation or collect data on the prevalence of such refusals.

Conscience-based refusals of care have primarily occurred with regard to the provision of abortion and contraceptive services.[60] In addition to refusals by individual practitioners, a number of hospitals have sought to justify not providing abortions on request or other legal abortions by specifying that all relevant individual doctors working within their premises have objected to providing abortion services on grounds of conscience.[61] There are also reports of hostile and judgmental treatment on the part of some health care personnel towards women undergoing abortion on request.[62] Healthcare practitioners who do provide abortion services also face stigma, which often manifests in contemptuous and judgmental behavior from colleagues and peers who opt not to perform abortions.[63]

Conscience-based refusals of health care are regulated in the Act on Healthcare and the Code of Ethics of a Health Practitioner. Under the Act health care providers can refuse to provide certain health services, namely abortion, sterilization, and assisted reproduction, if the provision of those services "is impeded by a personal belief on the part of a health practitioner who is supposed to provide the service."[64] Since under Slovak law the term "health care provider" includes health facilities,[65] institutions and not only individuals, are allowed to refuse to provide reproductive health care on grounds of conscience. If a health care provider refuses to provide health care, the Act entitles the patient to file a complaint to a regional self-governing body which is responsible for reviewing the complaint and identifying a provider who will provide the service and who is not located too far away from the person's residence or work.[66]

Additionally, the Code of Ethics of a Health Practitioner allows individual health professionals to refuse to provide *any* medical service if performing the service "contradicts [their] conscience," except in situations posing an immediate threat to the life or health of a person. In such instances health professionals are required to inform their employer as well as their patients that they are refusing to provide particular medical care.[67] However, neither the Act nor the Code of Ethics impose an obligation on them to refer the patient to another practitioner who will provide care. As a result, the current legal framework places the burden on women who are refused abortion care, sterilization, and assisted reproduction to file a complaint with the regional self-governing body described above in order to obtain legal reproductive health services. No responsibility is placed on health care providers and state authorities to take effective and proactive measures to ensure women's prompt and easy access to those services.

As a result, the existing regulation of conscience-based refusals is flawed and inadequate and contradicts international human rights requirements. For example:

- It allows for institutional refusals to provide certain reproductive health services;
- It does not require health care providers to refer patients to alternative and easily accessible health care providers;
- It does not require health care institutions to ensure a sufficient number of employees are in place who are willing to provide relevant services;
- Effective mechanisms to oversee and monitor the practice are lacking. This means that the number of conscience-based refusals and their effect is unknown. It undermines the ability of the state to design effective measures to ensure that refusals of care do not jeopardize women's access to services in practice.

Recommendations

- Take effective measures to ensure that conscience-based refusals of care do not impede women's access to reproductive health care services, including by amending legislation and introducing legal provisions that would: i) explicitly prohibit institutions from adopting institutional refusal policies or practices; ii) guarantee that women are promptly referred to alternative and easily accessible health care providers; iii) establish a registry of health professionals who refuse to perform reproductive health care services for reasons of personal conscience; iv) ensure effective oversight and implementation.
- Establish effective monitoring systems and mechanisms to enable the collection of comprehensive data on the extent of conscience-based refusals of care and the impact of the practice on women's access to legal reproductive health services.

e. Ill-treatment of women during facility-based childbirth

The majority of childbirth in Slovakia takes place in hospitals and is conducted by doctors, with the assistance of midwives. This is because of various factors including the fact that the law does not recognize the possibility for midwives to work independently outside of hospital settings, limiting women's choices as to where to give birth.

The government does not monitor and collect data related to the treatment of women, or respect for their rights, in childbirth, and it has not adopted any policies on this matter.[68] Since 2013, Citizen, Democracy and Accountability and Women's Circles have conducted monitoring and research activities (hereinafter "research") concerning the treatment of women in maternity hospitals, with a primary focus on vaginal childbirth.[69] The research findings have been documented in a recently published report[70] (English summary attached) and they reveal very concerning violations of women's rights in the provision of obstetric care in Slovak health care facilities.

The practices identified by the research include: spatial arrangements and behavior of hospital staff that heavily impede women's privacy, intimacy and confidentiality of care;[71] regular verbal humiliation, ridiculing, harassment;[72] significant failures by medical staff to provide women with adequate information before, during and after childbirth and to guarantee their right to full and informed decision-making without coercion and other abuses of power;[73] practices preventing women from moving freely and choosing the birthing position;[74] practices that prevent women from eating and drinking during delivery;[75] the routine performance of medically unnecessary interventions (such as forced shaving of pubic hair, the application of oxytocin, or episiotomy), very often without women's consent, and sometimes also against their will;[76] the exertion of extreme physical pressure by healthcare personnel on women's abdomens during the pushing stage (known also as the Kristeller Maneuver);[77] suturing birth injuries without, or with insufficient, anesthesia;[78] separating new born babies from women against their will and without medical reasons, especially during the very first hours following birth.[79] These practices, which often contradict scientific evidence and international standards of care,[80] point to serious violations of women's human rights during childbirth in Slovakia including the right to freedom from cruel, inhuman or degrading treatment and the rights to privacy, highest attainable standard of health and personal integrity. Not only may women suffer physical and mental trauma and harm as a result of such practices but their autonomy and decision-making capacity is heavily undermined.

The research has also revealed that health professionals often disrespect, or misunderstand, the concept of free and informed decision-making. All of the women interviewed during the research were asked to sign informed consent forms upon arriving in maternity hospitals without being provided with information necessary to enable them understand what they were consenting to. The research demonstrates that many health professionals perceive informed consent to be a mere formality – a requirement simply to obtain a written signature that covers any intervention a health professional may

decide to perform. In addition, some obstetricians misinterpret legislation that allows them to perform interventions without prior informed consent in cases of emergency, in which case although informed consent cannot be obtained in advance it can be assumed,[81] and they erroneously treat childbirth as healthcare intervention that generally does not require prior free and informed consent.[82] The research has also revealed that pregnant women often face substantial difficulties in obtaining information about healthcare facilities in Slovakia.[83] This prevents women from freely choosing a provider and enables hospitals to retain a monopoly and exercise considerable power over women in childbirth.

The research findings on suturing of birth injuries are particularly disturbing. Many women reported that this procedure was extremely painful for them, for many it was the worst and most painful part of the birth.[84] The suturing was painful for 59% of women who responded to our internet survey on suturing experiences. 15% described it as "slightly painful", 21% as "painful", and 23% as "extremely painful."[85] In 14% of births that were followed by suturing no anesthesia was applied. Of the women who experienced suturing as painful, 28% verbalized that the suturing was painful, 25% moaned, cried or screamed of pain, 40% could not lay still because of the pain (moving up their pelvis/buttocks), and as many as 27% neither complained nor showed any sign of pain (multiple answers were possible).[86] Of those who complained, only 28% received additional anesthesia. This percentage was even lower when women were only showing signs of pain without making verbal complaints. These findings point to, *inter alia*, systemic deficiencies in knowledge and skills on the part of medical practitioners with regard to their ability to perform this intervention properly,[87] as well as to the normalization of this particular form of illtreatment.

In addition, some women feel compelled, against their wishes, to remain in hospital following childbirth for a number of days (usually 3 to 5). Although there is no legal obligation per se that requires a woman to stay in hospital for a certain amount of time following childbirth, Slovak legislation does contain certain provisions that in fact often compel women to remain in hospital until they are allowed to leave.[88] Moreover, the lack of provision of post-natal care in the home after birth is an additional factor that may compel women to stay in hospital for a number of days after giving birth.

Furthermore, although maternal mortality in Slovakia decreased significantly at the end of the 20th century, it has significantly risen in the last 10 years, as reported by leading Slovak experts in obstetrics and gynecology. The maternal mortality ratio in the Slovak Republic in 2007-2009 was 17.3 per 100 000 live births. This is one of the highest ratios among EU countries.[89]

Recommendations

- Take a series of effective measures to ensure that the human rights of women giving birth in Slovakia are respected and protected. These should include adequate training of current and future obstetricians and midwives, both on international medical standards and on human rights.
- Establish effective mechanisms, including those operating on an ex-officio basis, to monitor and oversee respect for women's rights in childbirth.

f. Lack of comprehensive data on sexual and reproductive health

As outlined in the PSWG submission, the state does not collect adequate or comprehensive data on sexual and reproductive health indicators, such as the number of unintended pregnancies, the unmet need for contraception, the prevalence of conscience-based refusals of reproductive health care, or data related to childbirth. In addition, it does not monitor compliance with rights protection in these fields. For example, the limited data that the state gathers on the prevalence of a few contraceptive methods—namely, hormonal contraception and intrauterine devices—is insufficient and inadequate to identify and explain the reasons behind the low use of contraception in Slovakia.[90] As a result of the deficits in adequate data collection, it is difficult to effectively identify measures that should be taken to meet the needs of women

and adolescent girls in the area of sexual and reproductive health. In addition, it enables the state to avoid accountability for failures to adequately address the health needs of women in Slovakia.

Recommendations

- Collect, on a systematic basis, comprehensive data related to sexual and reproductive health and rights, including data on unmet need for contraceptives and data related to women's rights in childbirth. Ensure that all data is disaggregated by relevant classifiers including sex, age, social status and other characteristics as necessary.

Annex: Citizen, Democracy and Accountability & Women's Circles, *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia* (2015, English summary)

[1] Center for Reproductive Rights, Citizen, Democracy and Accountability and Women's Circles, *Supplemental Information on Slovakia, Adoption of List of Issues by the Committee on the Elimination of Discrimination against Women During its Pre-Sessional Working Group Meeting*, March 9-13, 2015, *available at* http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/SVK/INT_CEDAW_NGO_SVK_19477_E.pdf.

[2] Ministry of Health, Návrh Národného programu ochrany sexuálneho a reprodukčného zdravia v SR [Draft National Program on Protection of Sexual and Reproductive Health in the Slovak Republic], point 8.1, Doc. No. UV-5302/2008 (*submitted* Mar. 26, 2008) (Slovk.) [hereinafter Draft Nat'l Program on Protection of Sexual & Repro. Hlth. in the SR (2008)]. *See also* Ministry of Health, Draft National Program on Protection of Sexual and Reproductive Health in the Slovak Republic, Doc. No. 22346-1/2007-OZSO (*submitted* Nov. 29, 2007) (Slovk.). The importance of adopting a National Program on the Protection of Reproductive Health was recognized by the Slovak Government as early as 2003. *See also* Resolution No. 278/2003 (Apr. 23, 2003) (Slovk.) [hereinafter Resolution No. 278/2003].

[3] Draft Nat'l Program on Protection of Sexual & Repro. Hlth. in the SR (2008), *supra* note 2.

[4] Civic Association, Fórum života: *Zásadné pripomienky k Národnému programu sexuálneho a reprodukčného zdravia v SR* [Forum of Life: *Substantial comments on the National Program of Sexual and Reproductive Health in the SR*] (2007), *available at* http://www.forumzivota.sk/index.php?page=32&type=news&id=34&method=main&art=124 (last visited Sept. 29, 2015) [hereinafter Civic Assoc., Forum of Life (2007)].

[5] *Konferencia vyšších rehoľných predstavených na Slovensku nesúhlasí s programom ochrany sexuálneho a reprodukčného zdravia [Conference of senior religious order superiors in Slovakia does not agree with the program on protection of sexual and reproductive health]* (Dec. 2007), *available at* http://www.tkkbs.sk/view.php?cisloclanku=20071213029.

[6] *Mobily vyzváňali na protest proti programu sexuálneho a reprodukčného zdravia* [*Mobiles rang on the protest against the program on sexual and reproductive health*], PRAVDA, Apr. 2, 2008, http://spravy.pravda.sk/mobily-vyzvanali-na-protest-proti-programu-sexualneho-a-reprodukcneho-zdravia-gdz-/sk_domace.asp?c=A080402_105743_sk_domace_p29 (last visited Sept. 29, 2015); *MZ SR trvá na Národnom programe ochrany sexuálneho zdravia* [*Ministry of Health of the SR continues the National program on the protection of sexual health*], 24HOD, Mar. 31, 2008, http://www.24hod.sk/mz-sr-trva-na-narodnom-programe-ochrany-sexualneho-zdravia-cl50675.html (last visited Sept. 29, 2015). *See also* Civic Assoc., Forum of Life (2007), *supra* note 4; Ladislav Bariak, ml., *Program sexuálneho zdravia mobilizuje aktivistov* [*Program on sexual health mobilizes the activists*], AKTUÁLNE, Apr. 2, 2008, http://aktualne.centrum.sk/domov/zdravie-skolstvo-spolocnost/clanek.phtml?id=1155478 (last visited Sept. 29, 2015).

[7] Resolution No. 278/2003, *supra* note 2, task C.22. In this resolution, the government mandated the Ministry of Health to create and submit a National Program on the Protection of Reproductive Health for governmental discussion. The resolution was adopted by the Slovak Government (2002–2006), but it failed to adopt the program. The following government (2006–2010) continued in the preparation of the program until it eventually cancelled the task in January 2009.

[8] Ministry of Health, Návrh Národného programu starostlivosti o ženy, bezpečné materstvo a reprodukčné zdravie [National Program on Care for Women, Safe Motherhood and Reproductive Health], Doc. No. 12568/2009 - OZS (May 14, 2009) (Slovk.); Resolution No. 56/2009 (Jan. 21, 2009) (Slovk.). For comments to the draft program by a group of human rights and feminist NGOs, *see* Center for Civil and Human Rights et al., *Hromadná pripomienka skupiny mimovládnych organizácií k návrhu Národného programu starostlivosti o ženy, bezpečné materstvo a reprodukčné zdravie, predloženého Ministerstvom zdravotníctva Slovenskej republiky (číslo materiálu 12568/2009 - OZS) [Collective comment of the group of non-governmental organizations on the draft of the National Program on Care for Women, Safe Motherhood and Reproductive Health submitted by the Ministry of Health of the Slovak Republic* (doc. no. 12568/2009 – OZS)] (2009), *available at* http://www.poradna-prava.sk/dok/HP%20MVO%20Nar%20program%20reprozdravie_MV_OaD_Poradna_QLF_270509.pdf.
[9] *Biskupi sa s Ficom nezhodli na programe starostlivosti o ženy* [*Bishops disagreed with Fico on the program on care for women*], Jul. 23, 2009, http://www.obroda.sk/clanok/63407/Biskupi-sa-s-Ficom-nezhodli-na-programe-starostlivosti-o-zeny/ (last visited Jan. 29, 2015). *See also* Civic Assoc., Forum of Life (2007), *supra* note 4.
[10] The adoption of the program was initially postponed to October 30, 2015. The Ministry of Health has requested further postponement from the Prime Minister. *See* Committee on the Elimination of Discrimination against Women (CEDAW Committee), *List of issues and questions in relation to the combined fifth and sixth periodic reports of Slovakia, Addendum - Replies of Slovakia*, para. 98, U.N. Doc. CEDAW/C/SVK/Q/5-6/Add.1 (2015), *available at* http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fSVK%2fQ%2f5-6%2fAdd.1&Lang=en [hereinafter CEDAW Committee: *Replies of Slovakia*]; Letter from the Ministry of Health of the Slovak Republic, Sept. 8, 2015, on the file with Citizen, Democracy and Accountability.
[11] Emphasis added.
[12] The importance of adopting a National Program on the Protection of Reproductive Health was recognized by the Slovak Government as early as 2003. Resolution No. 278/2003, *supra* note 2, task C.22. In this resolution, the government mandated the Ministry of Health to create and submit a National Program on the Protection of Reproductive Health for governmental discussion. *See also supra* note 7.
[13] Letter from the Ministry of Health of the Slovak Republic, Sept. 8, 2015, on the file with Citizen, Democracy and Accountability.
[14] CEDAW Committee: *Replies of Slovakia*, *supra* note 10, para. 105.
[15] *See* CENTER FOR REPRODUCTIVE RIGHTS ET AL., CALCULATED INJUSTICE, THE SLOVAK REPUBLIC'S FAILURE TO ENSURE ACCESS TO CONTRACEPTIVES 21 (2011), [hereinafter CALCULATED INJUSTICE] *available at* http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/calculated_injustice.pdf.
[16] NATIONAL HEALTH INFORMATION CENTER, ČINNOSŤ GYNEKOLOGICKÝCH AMBULANCIÍ V SR 2014 (2015), *available at* http://www.nczisk.sk/Documents/publikacie/2014/sp1502.pdf.
[17] *See* CALCULATED INJUSTICE, *supra* note 15, at 36.
[18] UNITED NATIONS CHILDREN'S FUND (UNICEF) OFFICE OF RESEARCH, CHILD WELL-BEING IN RICH COUNTRIES: A COMPARATIVE OVERVIEW 25 (UNICEF, *Innocenti Report Card 11*, 2013), *available at* http://www.unicef-irc.org/publications/pdf/rc11_eng.pdf.
[19] CALCULATED INJUSTICE, *supra* note 15, at 8.
[20] *Id*. at 38.
[21] *Id*.
[22] CEDAW Committee: *Replies of Slovakia*, *supra* note 10, para. 105.
[23] *See* CALCULATED INJUSTICE, *supra* note 15, at 27. Additionally, the Slovak government does not regulate the price of contraceptives, which means many of them are relatively expensive. *See* Zákon č. 363/2011 Z. z. o rozsahu a podmienkach úhrady liekov, zdravotníckych pomôcok a dietetických potravín na základe verejného zdravotného poistenia a o zmene a doplnení niektorých zákonov [Act No. 363/2011 Coll. of Laws on the Scope and Conditions of Drugs, Medical Devices and Dietetic Foods Coverage by Public Health Insurance and on Amending and Supplementing Certain Acts], sec. 22(3)(b) (Slovk.) [hereinafter Act No. 363/2011].
[24] Act No. 363/2011, *supra* note 23, art. I, sec. 16(4)(e)(1) [emphasis added].
[25] Act No. 363/2011, *supra* note 23, art. I, sec. 37(5)(c)(6).
[26] CEDAW Committee: *Replies of Slovakia*, *supra* note 10, para. 105.
[27] Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations*: *Slovakia*, para. 24, U.N. Doc. E/C.12/SVK/CO/2 (2012).
[28] *See* Act No. 363/2011, *supra* note 23, sec. 88(8). Under sec. 88(8), an insurance company may decide to cover a drug that is not included in the list of categorized drugs "in justified cases, in particular when the provision of the drug ... is the only appropriate option, taking into consideration the health condition of the insurer ..." *Id.*
[29] Zákon č. 73/1986 Zb. o umelom prerušení tehotenstva v znení zákona č. 419/1991 Zb. [Act No. 73/1986 Coll. on Artificial Termination of Pregnancy as amended by the Act No. 419/1991 Coll.] (1986), secs. 4–5 [hereinafter Act No. 73/1986 Coll.]; Vyhláška Ministerstva zdravotníctva SSR č. 74/1986 Zb., ktorou sa vykonáva zákon Slovenskej národnej rady č. 73/1986 Zb. o umelom prerušení tehotenstva, v znení neskorších zmien [Decree of the Ministry of Health of the SSR No. 74/1986 Coll., which exercises Act No. 73/1986 Coll. on Artificial Termination of Pregnancy, as amended], sec. 2 (Slovk.).

[30] Nariadenie vlády SR č. 777/2004 Z.z., ktorým sa vydáva Zoznam chorôb, pri ktorých sa zdravotné výkony čiastočne uhrádzajú alebo sa neuhrádzajú na základe verejného zdravotného poistenia [Order No. 777/2004 Coll. of Laws issuing the List of Diseases at which Medical Procedures Are Partially Covered or Not Covered Based on Public Health Insurance], Annex No. 2, point III (2004) (Slovk.).
[31] *Interrupcie nerobíme. Z technických príčin... [We do not perform abortions...For technical reasons]*, PRAVDA, Jan. 22, 2011, http://spravy.pravda.sk/interrupcie-nerobime-z-technickych-pricin-fju-/sk_domace.asp?c=A110122_173602_sk_domace_p29 (last visited Sept. 29, 2015); ŠTATISTICKÝ ÚRAD SR [STATISTICAL OFFICE OF THE SLOVAK REPUBLIC], ŠTRUKTÚRA MIEZD V SR 2014, 4 [STRUCTURE OF EARNINGS IN THE SR 2014] (2015).
[32] CEDAW Committee, *Concluding Observations: Croatia*, para. 31(b), U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015).
[33] Zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov v znení zákona č. 345/2009 Z.z. [Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts *as amended by* the Act No. 345/2009 Coll. of Laws] (Slovk.) [hereinafter Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009].
[34] *Id.* sec. 6(b)(3).
[35] *See* WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 96-97 (2nd ed. 2012) [hereinafter WHO, SAFE ABORTION GUIDANCE (2012)]; *see also* Theodore J. Joyce et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review*, GUTTMACHER INST. 15 (2009), *available at* http://www.guttmacher.org/pubs/MandatoryCounseling.pdf.
[36] CENTER FOR REPRODUCTIVE RIGHTS, MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE: RESTRICTING ACCESS TO ABORTION, UNDERMINING HUMAN RIGHTS, AND REINFORCING HARMFUL GENDER STEREOTYPES (Sept. 2015) [hereinafter MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE].
[37] WHO, SAFE ABORTION (2012), *supra* note 35, at 96.
[38] FIGO, ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY, HARMFUL STEREOTYPING OF WOMEN IN HEALTH CARE, page 30, para. 8 (2012), *available at* http://www.figo.org/sites/default/files/uploads/wg-publications/ethics/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf.
[39] CEDAW Committee, *Concluding Observations: Hungary*, para. 31(c), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); Human Rights Committee, *Concluding Observations: The Former Yugoslav Republic of Macedonia*, para. 11, U.N. Doc. CCPR/C/MKD/CO/3 (2015) (advance unedited version).
[40] *See* Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 33, sec. 6b; *see also* Vyhláška MZ SR č. 417/2009 Z. z., ktorou sa ustanovujú podrobnosti o informáciách poskytovaných žene a hlásenia o poskytnutí informácií, vzor písomných informácií a určuje sa organizácia zodpovedná za prijímanie a vyhodnocovanie hlásenia [Decree of the Ministry of Health of the Slovak Republic No. 417/2009 Coll. of Laws on Laying Down Details for Information Provided to a Woman, for Notification of the Provision of Information and the Model of Written Information, and Designating an Entity Responsible for the Receipt and Evaluation of Notifications] (Slovk.) [hereinafter Decree No. 417/2009]. Women seeking abortion on request must also be provided with the required information in writing. A model for this written information is provided by the Ministry of Health in a decree implementing the Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009. It suggests that written information on the risks of induced abortion should outline that "[t]he subsequent impaired ability or inability to become pregnant cannot be ruled out," and that "[f]ollowing the induced termination of pregnancy, a woman may experience feelings of anxiety, guilt, sadness and depression." This information provided should also include written information on the stage of fetal development, which the Ministry of Health specifies as information on "the result of the ultrasound examination, the length of pregnancy, and the development stage of the embryo or fetus." Decree No. 417/2009, *supra* note 40, Annex. Contrary to this decree, the Royal College of Obstetricians and Gynaecologists (United Kingdom) has recommended that "[w]omen should be informed that there are no proven associations between induced abortion and subsequent . . . infertility." ROYAL COLLEGE OF OBSTETRICIANS AND GYNEACOLOGISTS, THE CARE OF WOMEN REQUESTING INDUCED ABORTION: EVIDENCE-BASED CLINICAL GUIDELINE NUMBER 7 43-46 (2011), *available at* https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf. It has noted that "[p]ublished studies strongly suggest that infertility is not a consequence of uncomplicated induced abortion" performed in legal settings. *Id.* at 44 (citations omitted). With regard to psychological sequelae, the Royal College has recommended that "[w]omen with an unintended pregnancy should be informed that the evidence suggests that they are no more or less likely to suffer adverse psychological sequelae whether they have an abortion or continue with the pregnancy and have the baby" and that "[w]omen with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy." *Id.* at 45.
[41] *See* Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 33, sec. 6(b).
[42] Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 33, secs. 6(4), 6b; Decree No. 417/2009, *supra* note 40.
[43] *See* Dôvodová správa, tlač 1030 (2009) [Explanatory Report to the Act No. 345/2009] (Slovk.). "The purpose of the proposed amendment is to inform a woman requesting abortion on the alternatives in favor of the life of an unborn child." *Id.* part A. During a parliamentary debate about the bill, a member of the Slovak Parliament, one of the key supporters of the bill, explained that "[t]he aim of this amendment is to provide a woman who could be in a difficult life situation with the qualified information.

This information is directed for her to decide in favor of life […]. The state has no obligation to be neutral on this matter. The state has a right to say that it prefers life, prefers life before termination of life and offers a helping hand." (Daniel Lipšic, MP, Transcript from the debate on the Act No. 345/2009, print 1030, by the National Council of the Slovak Republic, 35th sess.) (Apr. 21, 2009), *transcript available at* http://www.psp.cz/eknih/2006nr/stenprot/035schuz/s035024.htm.

[44] *See* MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE, *supra* note 36.

[45] Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, paras. 18-19, U.N. Doc. A/64/272 (Aug. 10, 2009) [hereinafter *2009 Special Rapporteur on Health Report*]; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, (20th Sess., 1999), paras. 31(b), (e), U.N. Doc. A/54/38/Rev.1 (1999).

[46] *See* MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE, *supra* note 36.

[47] *See, e.g.*, Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, *adopted* Apr. 4, 1997, art. 10(2), C.E.T.S. No. 164 (*entered into force* Dec. 1, 1999); A Declaration on the Promotion of Patients' Rights in Europe: World Health Organization European Consultation on the Rights of Patients, para. 2.5, ICP/HLE 121 (June 28, 1994); *2009 Special Rapporteur on Health Report*, *supra* note 45, para. 15.

[48] *2009 Special Rapporteur on Health Report*, *supra* note 45, para. 15.

[49] MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE, *supra* note 36.

[50] MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE, *supra* note 36; *see also* Reva B. Siegel, Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1687 (2008).

[51] MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE, *supra* note 36; *see also* Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, para. 24, U.N. Doc. A/66/254 (Aug. 3, 2011); Anuradha Kumar et al., *Conceptualizing Abortion Stigma*, 11(6) CULTURE, HEALTH & SEXUALITY 625 (2009); Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, WOMEN'S HEALTH ISSUES 7 (2011) (authors ed.), *available at* http://www.guttmacher.org/pubs/journals/Abortion-Stigma.pdf; Rebecca J. Cook, *Stigmatized Meanings of Abortion Law*, *in* ABORTION LAW IN TRANSNATIONAL PERSPECTIVE: CASES AND CONTROVERSIES 347, 347 (Rebecca J. Cook, Joanna N. Erdman & Bernard M. Dickens eds., 2014); Bruce G. Link & Jo C. Phelan, *Stigma and its Public Health Implications*, 367 THE LANCET 528, 528-29 (2006); Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 ANN. REV. OF SOC. 363, 367-76 (2001).

[52] Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 33, sec. 6b(3); Decree No. 417/2009, *supra* note 40.

[53] Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 33, sec. 6c(1); Decree No. 417/2009, *supra* note 40.

[54] Decree No. 417/2009, *supra* note 40; National Health Information Center, *Hlásenie o poskytnutí informácii o umelom prerušení tehotenstva,* http://data.nczisk.sk/zdravotny_stav/Z9-99.pdf (last visited Oct. 2, 2015); Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 33, sec. 6b(3).

[55] ESCR Committee, *Concluding Observations*: *Slovakia*, para. 24, U.N. Doc. E/C.12/SVK/CO/2 (2012).

[56] Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 33, sec. 6b(4).

[57] Act No. 73/1986 Coll., *supra* note 29, sec. 6. Section 6 states: "(1) In the case of a woman who has not yet reached the age of 16, artificial interruption of pregnancy in accordance with Section 4 may be performed with the consent of her legal representative or of the person who has been assigned responsibility for bringing her up. (2) If artificial interruption of pregnancy in accordance with Section 4 has been performed on a woman between 16 and 18 years of age, the health facility shall notify her legal representative." *Id.*

[58] CEDAW Committee, *Concluding Observations: Slovakia*, paras. 42, 43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008).

[59] CEDAW Committee: *Replies of Slovakia*, *supra* note 10, para. 107.

[60] *See* CALCULATED INJUSTICE, *supra note* 15, at 39.

[61] *Štátne kliniky majú výhradu svedomia. Uhliarik mlčí, [State clinics apply conscientious objection.Uhliarik is silent.]*, PRAVDA, Jan. 22, 2011, *avaliable at* http://spravy.pravda.sk/statne-kliniky-maju-vyhradu-svedomia-uhliarik-mlci-fx7-/sk_domace.asp?c=A110121_194642_sk_domace_p29 (last visited Sept. 29, 2015); Iris Kopcsayová, *Mnoho štátnych nemocníc interrupcie nerobí, univerzitná v Bratislave bude [Many state hospitals do not perfom abortions, the University hospital in Bratislava will do it]*, PRAVDA, Jan. 27, 2011, http://spravy.pravda.sk/mnoho-statnych-nemocnic-interrupcie-nerobi-univerzitna-v-bratislave-bude-1tn-/sk_domace.asp?c=A110126_193530_sk_domace_p12 (last visited Sept. 29, 2015); Iris Kopcsayová, *Interrupcie nerobíme. Z technických príčin.... [We do not perform abortions...For technical reasons]*, PRAVDA, Jan. 22, 2011, http://spravy.pravda.sk/interrupcie-nerobime-z-technickych-pricin-fju-sk_domace.asp?c=A110122_173602_sk_domace_p29 (Sept. 29, 2015).

[62] *Potrat? Nerobíme! Choďte inam, hovoria lekári Slovenkám [Abortion? We do not perform! Go somewhere else, the doctors say to Slovak women]* TVNOVINY, 2010.

[63] *See, e.g., id.*

[64] Zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov v znení neskorších predpisov [Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts *as amended*] (Slovk.), secs. 12(2)(c), 12(3) [hereinafter Act 576/2004].
[65] Zákon č. 578/2004 Z. z. o poskytovateľoch zdravotnej starostlivosti, zdravotníckych pracovníkoch, stavovských organizáciách v zdravotníctve a o zmene a doplnení niektorých zákonov [Act No. 578/2004 Coll. of Laws on Healthcare Providers, Health Workers and Professional Medical Associations, and Amending and Supplementing Certain Acts, *as amended*], secs. 4, 11 [hereinafter Act 578/2004].
[66] Act 576/2004, *supra* note 64, sec. 12(5).
[67] Act 578/2004, *supra* note 65, Annex No. 4. (Deontology or medical ethics codes, while not legally binding, are highly persuasive authorities since the development of deontology codes are mandated by public health laws.) (Slovk.).
[68] *See* official response of the Ministry of Health of the Slovak Republic of 21 October 2014 to a request for information of 10 October 2014 filed by Citizen, Democracy and Accountability, both published in DEBRECÉNIOVÁ, J. (ED.), ŽENY – MATKY – TELÁ: ĽUDSKÉ PRÁVA ŽIEN PRI PÔRODNEJ STAROSTLIVOSTI V ZDRAVOTNÍCKYCH ZARIADENIACH NA SLOVENSKU [WOMEN – MOTHERS – BODIES: WOMEN'S HUMAN RIGHTS IN OBSTETRIC CARE IN HEALTHCARE FACILITIES IN SLOVAKIA] (2015), Občan, demokracia a zodpovednosť & Ženské kruhy, at 206-209 (English version), *available at* http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf (Slovk.); http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf (Engl.) [hereinafter ŽENY – MATKY – TELÁ].
[69] These activities included (a) in-depth interviews with women who have recently given birth, (b) filing requests for information and monitoring hospitals' and other websites, and (c) carrying out an internet survey on suturing of birth injuries. As for the in-depth interviews (point a), 15 women of 26 to 39 years of age had been interviewed. The majority of respondents were middle-class women with a higher-level education (secondary or university one). The respondents included no women from ethnic minorities. All but one of respondents had, at the time of delivery, male partners (the one respondent without a male partner was a single mother). All the births described in the interviews took place in Bratislava (the capital) and Trnava (50 km from the capital) districts. As for the information requests and monitoring of hospitals' websites (point b), letters and official requests for information were sent to all hospitals with maternity wards in Slovakia (54) and to the Ministry of Health. The monitoring of the websites involved all hospitals in Slovakia with maternity wards. As for the surveys (point c), the internet survey on suturing of birth injuries took place through questionnnaires available on the website of Women's Circles in the period of February 20, 2014 to March 20, 2014. 2279 questionnaires were completed, out of which 1946 described vaginal births experienced by 1474 women (those 1946 questionaires on vaginal birth were further processed and analysed). The monitoring and research also included carrying out in-depth interviews with obstetricians and midwives, and analysing legislation and other available documentation.
[70] *See* ŽENY – MATKY – TELÁ, *supra* note 68.
[71] *See* ŽENY – MATKY – TELÁ, *supra* note 68, at 94-110.
[72] There are many forms of humiliation, ridicule and harassment that take place. For example, women are often objectified by not being treated as equals in their communication with doctors and as persons with subjectivity, rights and entitlements but by being objects of interventions (for example, the hospital staff are often talking about them in their presence as if they were not present; the hospital staff are not introduced to them and do not usetheir names and surnames to address them but instead use the general term "mummy"). Birthing women are often belittled and their perceptions, feelings and impressions are often questioned. Women are often ridiculed if they formulate their own wishes connected to their childbirth, and are made subject of derision. Women often experience persuasion, manipulation and coercion ("your child will die, if you...; your child will have an egg-shaped head if you..."), or the fulfillment of their preferences and wishes is conditioned upon their "obedience". The medical staff are often forcing their will upon the labouring women at their expense, with the intention to make the work during the birth easier for the staff instead of taking the labouring women's wishes into account. Women are even being forced to undertake certain interventions with authoritarian commands. Women also reported a lack of encouragement from the hospital staff and feelings of failure and guilt. *See also* ŽENY – MATKY – TELÁ, *supra* note 68, at 110-120. A few women, especially those participating in the survey on suturing birth injuries, also reported sexism – performed as "jokes" of (male) doctors, formulated, for example, as questions to husbands present at suturing about the preferred width of the stitch. Women are also discouraged from making sounds and noises. Women may be shamed for natural body exposures related to birth – for example urine or faeces during pushing stage.
[73] *See, e.g.*, ŽENY – MATKY – TELÁ, *supra* note 68, at 60-75 & 85-94.
[74] Continual electronic fetal monitoring in the first stage of labor is a very frequent practice and is performed while women are laid on their back. Interviewed women often used words like, "I was stripped down for more than an hour. I could not move, which was extremely painful." The freedom of movement in the first stage is also often made impossible due to extremely limiting spatial arrangements available to women going through this stage. In the second (pushing) stage, women are, in grave majority of the cases, laying (or semi-laying) on their back, with legs in stirrups (often tied). The WHO classifies freedom in position and movement throughout labor and encouragement of non-supine position in labor as practices which are demonstrably useful and should be encouraged. At the same time, it classifies the routine use of the supine position during labor as practice which is clearly harmful or ineffective and should be eliminated. *See* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE 21, 27 & 35 (1996) [hereinafter WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996)], *available at* http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.24.pdf. *See also* ŽENY – MATKY – TELÁ, *supra* note 68, at 60-68.

[75] *See also* ŽENY – MATKY – TELÁ, *supra* note 68, at 81-82. In some instances, women are not allowed to eat or drink anything upon arrival in the hospital (this practice differs across hospitals). This may last until a baby is delivered and often even longer, especially in regards to eating, since hospitals often do not order a meal for a woman who is already in labor but not hospitalized yet in the postnatal unit. The WHO classifies restriction on food and fluids during labour as practices which are frequently used inappropriately. At the same time, it classifies offering oral fluids during labor and delivery as a practice which is demonstrably useful and should be encouraged. *See id.* at 9-10 & 34-35.

[76] *See also* ŽENY – MATKY – TELÁ, *supra* note 68, at 60-76. The WHO classifies "liberal or routine use of episiotomy" as a practice which is frequently used inappropriately. It argues that "there is no reliable evidence that liberal or routine use of episiotomy has a beneficial effect, but there is clear evidence that it may cause harm. The WHO recommends a restricted use of episiotomy, with 10% being a "good goal to pursue". *See* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 74, at 37 & 29. In Slovakia, the average episiotomy rate for all vaginal births that took place in 2012 was 65%, and there are even hospitals in the country where the average episiotomy rates exceed 90%. See Korbeľ M., Borovský M., Danko J., Nižňanská Z., Kaščák P., Krištúfková A., *Analýza materskej morbidity v Slovenskej republike v roku 2012*. 12 Gynekológia pre prax 1 (2014) 13 – 19.

[77] In course of the research undertaken by Citizen, Democracy and Accountability and Women's Circles, this practice was often mentioned by women interviewed but its occurence was denied by hospitals when asked about the use of this practice (*see also* ŽENY – MATKY – TELÁ, *supra* note 68, at 69-70, 153 and 190). Anecdotal evidence also indicates that this practice is usually not recorded in patients' medical records. The WHO notes that "the practice of fundal pressure [is common] during the second stage of labour []" and that "[a]part from the issue of increased maternal discomfort, there is suspicion that the practice may be harmful for the uterus, the perineum and the fetus, but no research data is available. The impression is that the method is at least used too often, with no evidence of its usefulness." *See* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 74, at 25-26. Several anecdotal reports also suggest that fundal pressure is associated with maternal and neonatal complications, for example: uterine rupture, neonatal fractures and brain damage. *See* Evelyn C. Verheijen, Joanna H. Raven, G. Justus Hofmeyr, *Fundal pressure during the second stage of labour*. *Cochrane Database of Systematic Reviews*, 4 COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2009), Issue 4. Art. No.: CD006067. DOI: 10.1002/14651858.CD006067.pub2. *available at* http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006067.pub2/abstract.

[78] *See, e.g.,* ŽENY – MATKY – TELÁ, *supra* note 68, at 75-76.

[79] *See, e.g.,* ŽENY – MATKY – TELÁ, *supra* note 68, at 76-79. The WHO classifies early skin-to-skin contact between mother and child and support for the initiation of breast-feeding within 1 hour postpartum (in accordance with the WHO guidelines on breastfeeding) as practice which is demonstrably useful and should be encouraged. *See* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 74, at 33 & 35. Also regulations of the Ministry of Health of the Slovak Republic stipulate that "[i]mmediate contact between a woman after childbirth and her infant shall be guaranteed in all rooms where delivery has taken place and is a condition for Mother- and Baby-Friendly Hospitals under the Mother and Baby Friendly Hospital Initiative (MBFHI)." *See* Odborné usmernenie Ministerstva zdravotníctva Slovenskej republiky č. 14422/2009 – OZS o podpore výživy dojčiat a batoliat dojčením, vydané dňa 15. 10. 2009.Vestník MZ SR 2009, čiastka 54-55, s. 402, čl. 7 (1) [Expert Guidelines of the Ministry of Health of the Slovak Republic on the support of nourishment of sucklings and toddlers by breastfeeding of 15 October 2009. Bulletin of the Ministry of Health of the Slovak Republic 2009, Unit 54-55, p 402, Art. 7 (1)] (Slovk.).

[80] *See, e.g.,* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 74; FIGO Safe Motherhood and Newborn Health (SMNH) Committee, *Management of the second stage of labor*, 119 INTL. J. GYN. & OBS. (2012) 111-116, *available at* www.odondevice.org/press/FIGO-second-stage.pdf [hereinafter FIGO, MANAGEMENT OF THE SECOND STAGE OF LABOR]; *Intrapartum Care*: *Cochrane Database of Systematic Reviews*, *available at* http://community.cochrane.org/cochrane-reviews/cochrane-database-systematic-reviews-numbers; NATIONAL COLLABORATING CENTRE FOR WOMEN'S AND CHILDREN'S HEALTH, INTRAPARTUM CARE: CARE OF HEALTHY WOMEN AND THEIR BABIES DURING CHILDBIRTH. CLINICAL GUIDELINE 190: METHODS, EVIDENCE AND RECOMMENDATIONS (2014), *available at* http://www.nice.org.uk/guidance/cg190/evidence/cg190-intrapartum-care-full-guideline3 [hereinafter NATIONAL COLLABORATING CENTRE FOR WOMEN'S AND CHILDREN'S HEALTH, INTRAPARTUM CARE: CARE OF HEALTHY WOMEN AND THEIR BABIES DURING CHILDBIRTH].

[81] *See* Healthcare Act, *supra* note 64, sec. 6(9)(a).

[82] This position has even been officially presented by a representative of the Health Care Surveillance Authority, at a public presentation of the report ŽENY – MATKY – TELÁ, *supra* note 68, that took place on April 29, 2015.

[83] *See* ŽENY – MATKY – TELÁ, *supra* note 68, at 127-168.

[84] *See id.* at 75-76.

[85] The total number of births examined with regard to the painfulness of suturing is 1814.

[86] The percentages do not add up to make 100 % since multiple answers were possible.

[87] According to FIGO, suturing should always be performed under adequate perineal anesthesia. *See* FIGO, MANAGEMENT OF THE SECOND STAGE OF LABOR, *supra* note 80, at 114. The clinical guidelines of the National Institute for Health and Care Excellence (United Kingdom) recommend with regard to suturing: "When carrying out perineal repair[,] ensure that tested effective analgesia is in place… If the woman reports inadequate pain relief at any point, address this immediately." *See* NATIONAL COLLABORATING CENTRE FOR WOMEN'S AND CHILDREN'S HEALTH, INTRAPARTUM CARE: CARE OF HEALTHY WOMEN AND THEIR BABIES DURING CHILDBIRTH, *supra* note 80, at 765.

[88] These include a statutory provision that conditions the payment of a state childbirth benefit on not leaving maternity hospital in a manner which conflicts with legal regulations concerning the release of patients from facility-based care. Under the law, healthcare providers are obliged to release a patient from health care facility when the patient requests. However, the wording of the relevant provisions and the lack of mechanisms guaranteeing that requests for release are handled by the hospital staff, create the impression that women must follow special procedures when they wish to leave a maternity hospital, or that they must fulfil special duties before leaving hospital. Such legal regulations give rise to situations of uncertainty and power imbalances that prevent women from deciding freely and voluntarily about the length of their stay in a maternity hospital after childbirth. Zákon č. 383/2013 Z. z o príspevku pri narodení dieťaťa [Act No. 383/2013 Coll. on Childbirth Allowance and on Allowance on More Concurrently Born Children], sec. 3 (4) (b), referring to zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej staroslivosti a o zmene a doplnení niektorých zákonov v znení neskorších predpisov [Act No. 576/2004 Coll. on Healthcare, Services Related to the Provision of Healthcare and on amending and supplementing certain acts, as amended], sec. 9(6)(c). Sec. 9(6)(c) of the Act No. 576/2004 Coll. reads as follows: "[A healthcare provider shall release a person from a facility-based care] upon her own request, or upon the request of her legal representative if she, despite an adequate amount of information received, refuses the facility-based care, unless the facility-based care is ordered by a court or unless a facility-based care the legality of which is decided upon by a court is at stake."

[89] Korbeľ M., Borovský M., Danko J., Krištúfková A., Nižňanská Z., Kaščák P., *Materská mortalita v Slovenskej republike* [*Maternal Mortality in the Slovak Republic*] 12 Gynekológia pre prax 1 (2014) 26 – 29. This data on all maternal and pregnancy-related deaths was collected by the Slovak Society of Gynecology and Obstetrics. Maternal deaths are well evidenced in obstetric departments, but are not always reported to the Ministry of Health. Reporting of maternal deaths from other then obstetric departments, of deaths in postpartum, and of accidental or incidental deaths is very weak.

[90] The last comprehensive research on contraceptive use among women in Slovakia is from January 1997, conducted privately by FOCUS Agency for Slovak Family Planning Association. *See* SLOVAK FAMILY PLANNING ASSOCIATION & FOCUS–SOCIAL AND MARKETING ANALYSIS CENTRE, REPRODUCTIVE PRACTICES OF SLOVAK WOMEN (1997), *available at* http://www.rodicovstvo.sk/reproductive_practices.htm.