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CALCULATED INJUSTICE

THE SLOVAK REPUBLIC'S FAILURE TO
ENSURE ACCESS TO CONTRACEPTIVES

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THE SLOVAK REPUBLIC'S FAILURE TO ENSURE ACCESS TO CONTRACEPTIVES

The ability of women to control their own fertility is absolutely fundamental to women's empowerment and equality. When a woman can plan her family, she can plan the rest of her life. When she is healthy, she can be more productive. And when her reproductive rights . . . are promoted and protected, she has freedom to participate more fully and equally in society. Reproductive rights are essential to women's advancement.

— **Thoraya A. Obaid, UNFPA Executive Director (2009)**

CENTER FOR REPRODUCTIVE RIGHTS' MISSION

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill.

FREEDOM OF CHOICE SLOVAKIA'S MISSION

Freedom of Choice Slovakia is a feminist nongovernmental organization that seeks to contribute to creating a society in which individuals have a real “freedom of choice” without restrictions determined by gender stereotypes, and in which gender equality, diversity and justice are key social values.

CITIZEN, DEMOCRACY AND ACCOUNTABILITY'S MISSION

Citizen, Democracy and Accountability is an independent civic association that promotes the values of open society based on civic responsibility and the accountability of public authorities. One of CDA's primary aims is to assert everyone's rights to human dignity and to protection from discrimination, as well as to assert the human rights of women.

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Contraceptives in Slovakia are not covered by public health insurance, making them inaccessible to many women and adolescent girls. The lack of accurate, unbiased and comprehensive information on modern contraceptives further inhibits their access.

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GLOSSARY AND COMMON ACRONYMS

Abstinence: Refraining from any kind of sexual activity. “Periodic abstinence” refers to refraining from sexual intercourse when the woman could become pregnant.

Beijing Declaration and Platform for Action: Consensus document adopted by states participating in the 1995 U.N. Fourth World Conference on Women.

Bishops’ Conference: In the Roman Catholic Church, the Conference of Bishops (or National Conference of Bishops) is an official assembly of all bishops of a given territory.

Catholic Church hierarchy: In the Catholic Church, “hierarchy” is used in a variety of ways, but it is literally defined as “holy government.” The hierarchal nature of the Church is considered to be of divine institution and essential to the Church itself.

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women. International treaty codifying states’ duties to eliminate discrimination against women.

CEDAW Committee: Committee on the Elimination of Discrimination against Women. U.N. body responsible for monitoring states’ compliance with CEDAW.

CEE: Central and Eastern Europe. Countries in the CEE region include Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, and Slovenia.

Children’s Rights Committee: U.N. body responsible for monitoring states’ compliance with the Convention on the Rights of the Child.

Civil and Political Rights Covenant: International Covenant on Civil and Political Rights. International treaty protecting individuals’ civil and political human rights.

Coitus interruptus/withdrawal: The practice of withdrawing the penis from the vagina and away from a woman’s external genitals before ejaculation in order to prevent pregnancy.

Convention on the Rights of the Child: International treaty upholding the human rights of children.

Council of Europe: Regional intergovernmental body consisting of 47 European Member States dedicated to promoting the human rights and fundamental freedoms of European citizens and residents.

Economic, Social and Cultural Rights Covenant: International Covenant on Economic, Social and Cultural Rights. International treaty protecting individuals’ economic, social, and cultural human rights.

Emergency contraception: Drugs that act to prevent ovulation and/or fertilization within the first few days after intercourse in order to prevent pregnancy.

ESCR Committee: Committee on Economic, Social and Cultural Rights. U.N. body responsible for monitoring states’ compliance with the Economic, Social and Cultural Rights Covenant.

EU: European Union. Regional body consisting of 27 Member States dedicated to promoting European integration. “Old(er) Member States” refers to the 15 countries that were part of the EU before its enlargements in 2004 and 2007: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom. “New(er) Member States” refers to the 12 countries that joined the EU in 2004 or 2007: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, and Slovenia.

European Committee of Social Rights: Committee responsible for monitoring states’ compliance with the European Social Charter and the Revised European Social Charter.

European Social Charter: Council of Europe treaty guaranteeing social and economic human rights. Reference includes the Revised European Social Charter.

Family planning: The ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved

through use of contraceptive methods and the treatment of involuntary infertility.

Hormonal contraceptives: Oral pills, injectables, hormone-releasing implants, skin patches, vaginal rings, and some IUDs.

Human Rights Committee: U.N. body responsible for monitoring states' compliance with the Civil and Political Rights Covenant.

International Conference on Population and Development: U.N. conference held in Cairo in 1994, where world leaders, high-ranking officials, representatives of NGOs, and U.N. agencies gathered to agree on a Programme of Action to address issues related to population and development.

IUD: Intrauterine device. A small device that is inserted into a woman's uterine cavity to prevent pregnancy and is effective for up to 12 years depending on the type used.

Modern contraceptives: Clinic and supply methods of contraception, including female and male sterilization; IUDs; hormonal methods, such as oral pills, injectables, hormone-releasing implants, skin patches, and vaginal rings; condoms; and vaginal barrier methods, such as the diaphragm, cervical cap, spermicidal foams, jellies, creams, and sponges.

NGO: Nongovernmental organization.

PACE: Parliamentary Assembly of the Council of Europe. Assembly consisting of 318 representatives from the 47 Council of Europe Member States. PACE meets four times a year to discuss topical issues and ask European governments to undertake initiatives on particular issues (such as human rights) and report back.

Pills or contraceptive pills: Oral hormonal contraceptives that contain either estrogen and progestin, or only progestin.

Programme of Action of the International Conference on Population and Development: Consensus document adopted by states participating in the International Conference on Population and Development.

Sexually transmitted infection: An infection that can be transferred from one person to another through sexual contact.

Sterilization: A permanent contraceptive method. Surgical sterilization involves an operation in which the fallopian tubes are cut or blocked in order to prevent fertilization.

Traditional methods of family planning: Non-supply methods of contraception, including rhythm, withdrawal, abstinence, and lactational amenorrhoea (a method based on the natural postpartum infertility that occurs when a woman is fully breastfeeding and not menstruating; women must be continuously and exclusively breastfeeding and less than six months postpartum).

Treaty monitoring bodies: U.N. committees that monitor governmental compliance with the major U.N. human rights treaties. These committees influence governments by issuing specific observations about states' progress and compliance with human rights obligations and, in some cases, consider individual complaints against governments.

U.N.: United Nations.

WHO: World Health Organization. U.N. agency devoted to researching and promoting public health worldwide.

EXECUTIVE SUMMARY

Women and adolescent girls in Slovakia face numerous barriers to accessing modern contraceptives and contraceptive information. Because contraceptives are not covered by public health insurance, their users must pay the full price out of pocket. Some women and adolescent girls—especially the most vulnerable ones, such as those with low incomes or in violent relationships—lack the means to do so. Others are forced by the high cost of hormonal contraceptives to resort to low-quality versions that may not be best suited for them or to unreliable traditional methods of family planning such as coitus interruptus (withdrawal). One month's supply of oral contraception ranges from 7 euros (€) to over €15; a one-time dose of emergency contraception costs about €22; and an intrauterine device costs about €158—prices that are out of reach for many women. The latest available figures, from 2009, put the median monthly income for women in Slovakia at €562.51. The poverty line for a one-person household was €283 per month, and up to 11.9% of women were at risk of poverty in 2009. For young women, the costs are also prohibitive. As one pharmacist noted, young women often cannot afford emergency contraception and instead opt to purchase a pregnancy test at less than one-fifth the cost.

The lack of accurate, unbiased, and comprehensive information on family planning methods further inhibits women's and adolescent girls' access to modern contraceptives. In many schools, sexuality education is either lacking altogether or inadequate, focusing only on reproductive organs and influenced by the religious views of teachers or administrators. The Catholic Church hierarchy, which plays an important role in Slovak politics and communities, actively advocates against the use of modern contraceptives and promotes traditional methods of family planning, such as periodic abstinence, which are often ineffective. Gynecologists frequently lack the time or will to appropriately discuss contraceptives with their patients. As a result, misinformation and myths about the side effects of contraceptives abound, undermining their use. It is not surprising, then, that use of hormonal contraceptives remains low, at 22.3%, while use of withdrawal as a family

planning method is at approximately 32%. These figures stand in stark contrast to those of other European Union countries, the majority of which subsidize contraceptives through public health insurance. In France, for example, 43.8% of women use the pill and only 3.1% rely on withdrawal; and in Germany, over 50% use the pill and only 0.5% rely on withdrawal.

The Slovak government's failure to address the multiple barriers that women and adolescent girls face in accessing contraception runs counter to its obligations under national, regional, and international law, and defies sound public policy considerations. At the national level, the Slovak Constitution guarantees the rights to health, to information, and to non-discrimination on the basis of sex. Domestic legislation further explicitly mandates the government to provide women with access to prescription contraceptives free of charge. However, these provisions are ignored.

Slovakia is also party to numerous regional and international human rights instruments that require states to ensure that women and adolescent girls have access to a full range of sexual and reproductive health services. This obligation entails making acceptable and affordable contraceptive methods available, as well as making accurate information on those methods available—including by requiring sexuality education in schools. At the regional level, the European Committee of Social Rights, for example, requires Member States to ensure that sexuality education is “provided throughout the entire period of schooling,” “forms part of the ordinary school curriculum,” that such education is “adequate in quantitative terms,” and that it is “objective, based on contemporary scientific evidence and does not involve censoring, withholding or intentionally misrepresenting information, for example as regards contraception and different means of maintaining sexual and reproductive health.” At the international level, binding human rights treaties such as the Convention on the Elimination of All Forms of Discrimination against Women require states to eliminate discrimination against women in all spheres of life, including access to healthcare.

In 2008, the Committee that monitors the Convention emphasized that family planning services in Slovakia, of which contraceptives form an integral part, fell short of what is required under international law. The Committee urged the government “to take measures to increase the access of women and adolescent girls to affordable . . . reproductive healthcare, and to increase access to information and affordable means of family planning. . . .” Slovakia is thus aware that human rights violations are occurring. Furthermore, the government may not use its own failure to collect adequate data on indicators such as the unmet need for family planning—which it is required to do under international law and which would enable it to develop effective policies—as a way to escape accountability.

Ensuring women’s access to acceptable and affordable contraceptives is not only required by law but also sound policy from an economic and public health perspective. An increase in contraceptive use reduces the number of unintended pregnancies, which, in turn, leads to savings in healthcare costs. Moreover, fewer unintended pregnancies benefit women’s health by lowering the number of induced abortions and reducing maternal morbidity and mortality. The World Health Organization recognized the health and cost benefits when it included contraceptives, including emergency contraception, in its list of essential drugs that states should make affordable to all. Also aware of these benefits, 18 of 27 European Union Member States agreed to fully or partially cover the cost of contraceptives through their public health insurance schemes. Yet, in Slovakia, with the exception of sterilization on health grounds, contraceptives for pregnancy prevention fall completely outside the scope of public health insurance.

Testimonies Collected*

The testimonies gathered during our fact finding highlighted the many barriers, described above, that women and adolescent girls in Slovakia face in accessing acceptable modern contraceptive methods. Our interviews with various stakeholders—women, healthcare providers, and others—revealed broad support for subsidizing contraceptives through public health insurance in order to enhance women’s empowerment and choice and prevent unintended pregnancies. Improving sexuality education was also seen as a positive step that the government should take to increase women’s access to contraceptives.

Recommendations

We urge the Slovak government to ensure that its national laws and policies comply with international human rights standards and World Health Organization recommendations calling on states to ensure access to a wide range of modern contraceptive methods by making them affordable to all. We call on the Slovak government to implement this recommendation through public health insurance coverage. In addition, we call on the government to address contraceptive information barriers by mandating comprehensive, evidence-based, non-discriminatory sexuality education in schools and developing policies that ensure that women and adolescent girls obtain comprehensive contraceptive information from their gynecologists. Finally, we call on regional and international human rights bodies to urge Slovakia to abide by its human rights obligations.

METHODOLOGY AND STRUCTURE OF THE REPORT

Methodology

This report is based on research and interviews conducted by the Center for Reproductive Rights; Citizen, Democracy and Accountability; and Freedom of Choice Slovakia in April and September 2010. Our in-depth interviews gathered the experiences of 29 women of reproductive age from different socioeconomic backgrounds from the Prešov and Košice regions of Eastern Slovakia. Some women were single, while others were married; some women did not have any children, while others had given birth up to 11 times; some women wanted more children, while others did not; some women were low income and relied on social benefits, while others were middle class; some women had not finished secondary school, while others had a university degree; some women came from towns, while others lived in smaller, more remote villages or Romani settlements. In addition, we interviewed 39 social workers, healthcare providers (including gynecologists and pharmacists), and representatives of nongovernmental organizations (NGOs) working with women. This report also draws on research of national, regional, and international laws and policies and on other articles and published materials relevant to women's and adolescent girls' right to affordable and acceptable contraceptive services and information.

The participants interviewed for the report were identified through national-level NGOs that work with women and adolescents, as well as through other contacts of Citizen, Democracy and Accountability and Freedom of Choice Slovakia.

To protect their privacy, the names of all women whose testimonies are used throughout this report have been changed. The names of other stakeholders whose experiences are presented have also been changed, except where explicit permission to use the individual's real name was received.

Scope and Structure of the Report

This report documents legal, political, and social factors that make the accessibility of modern contraception a formidable barrier to women and adolescent girls in Eastern Slovakia, negatively affecting their health and lives. The report focuses on the prevention of unintended pregnancies through the regular use of female-controlled contraception. To that end, the report primarily covers access to hormonal contraceptives available by prescription. However, it also addresses some concerns around emergency contraception, which is available without a prescription, and female sterilization, which is a surgical procedure. Given the scope of the report, the use of condoms is not addressed.¹

This report focuses primarily on the state's failure to ensure women's access to affordable contraceptives. It also addresses other structural and social barriers, such as the absence of mandatory, comprehensive, evidence-based sexuality education in schools and the limited information provided to women and adolescent girls during their visits to the gynecologist. The Catholic Church hierarchy's influence on laws and policies is also discussed.

The report opens with a general background that explains why access to contraceptive services and information is critical to the health and lives of women and adolescent girls. The next section provides a general overview of the situation in Slovakia, including a brief historical account of women's access to contraceptive services and information, and a discussion of several structural and social factors that adversely influence such access today. It also addresses the current financial crisis and its impact on reproductive rights. The following section contains the results of the interviews we conducted and focuses on the key barriers documented in this report: lack of affordability and lack of reliable information. It also discusses some of the effects of barriers to access and ways that interviewees believe the situation can be improved. The last section provides an overview of the legal and human rights standards of the rights violations identified. Recommendations to key stakeholders, based on input by those interviewed, are included at the end of the report.

It is evident from the results of the testimonies gathered that Slovakia must take action to ensure that (i) contraceptives are affordable and acceptable to all women and adolescent girls, and (ii) comprehensive, accurate, and reliable information on contraceptives specifically, and on sexual and reproductive health and rights issues generally, is provided both by healthcare providers and in schools.

The high price of contraceptives is prohibitive for some women and keeps others from using the method most suitable based on their health, personal circumstances or preferences.



INTRODUCTION

Slovakia was formed on January 1, 1993, after Czechoslovakia peacefully split into two separate states, the Czech Republic and the Slovak Republic. It is a country in Central Europe with a population of just over five million. Slovakia is a parliamentary democracy with a multi-party system. According to the last official census, the dominant religion, to which about 70% of the population adheres, is Roman Catholic.² Slovakia was among the first group of Central and Eastern European (CEE) countries to join the European Union (EU) in 2004. Because of its economic prosperity, Slovakia is currently one of only two CEE countries to be part of the Eurozone, the EU's monetary union.

Although Slovakia may have progressed economically since the fall of communism, as it strove to bridge the gap with older EU Member States, the country lags far behind others when it comes to reproductive rights, including access to contraceptives. While this report's interview findings are not meant to be representative of the population at large, they clearly show that some women and adolescent girls in Slovakia face serious challenges in accessing modern contraceptive methods and information.

Despite strong policy justifications, World Health Organization (WHO) guidelines, and clear international human rights obligations, the Slovak government has failed to ensure that all women and adolescent girls have access

WHO Model List of Essential Medicines

Since 1977, the World Health Organization has been publishing and regularly updating a Model List of Essential Medicines. Essential medicines are defined as “those that satisfy the priority healthcare needs of the population,” and that “are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford.” The list is meant to “guide the procurement and supply of medicines in the public sector,” including “schemes that reimburse medicine costs.”¹

The Model List of Essential Medicines consists of two tiers. A core list “presents [the] minimum medicine needs for a basic healthcare system, listing the most efficacious, safe and cost effective medicines for priority conditions.” Priority conditions “are selected on the basis of current and estimated future public health relevance, and potential for safe and cost effective treatment.”² A complementary list includes essential medicines that may have “consistent higher costs or less attractive cost-effectiveness.”³

Underscoring the health benefits and cost-effectiveness of ensuring access to affordable and acceptable contraceptives, the WHO includes contraceptives on its core list of essential drugs. The core list includes oral hormonal contraceptives, injectable hormonal contraceptives, intrauterine devices (IUDs), barrier methods and implantable contraceptives, and emergency contraception.⁴ The Committee on Economic, Social and Cultural Rights (ESCR Committee) has noted that access to drugs on this list is a core state obligation under the right to health.⁵ Thus, states must ensure that contraceptives are affordable for all women, whether rich or poor.

to a full range of affordable and acceptable contraceptive methods. The price of contraceptives is prohibitive for some women, while it keeps others from using the method that would be best suited for them. Some of the most vulnerable women, such as women in violent relationships or those scraping by on a low income, suffer the most from the lack of financial support for contraceptives. Slovakia has also failed to provide women and adolescents with access to comprehensive and reliable information on contraceptives, which also limits women's and adolescent girls' ability to make free and responsible decisions regarding their fertility. This is in large part because sexuality education in schools, if provided at all, is often inadequate, focusing only on anatomy or influenced by religious views. The absence of sexuality-related discussions in the home and a lack of information provided by gynecologists are other barriers that further impede access.

The Slovak government's failure to gather adequate data on contraceptive use and the unmet need for contraceptives leaves the precise scope of the problem in Slovakia unknown. This lack of data not only stands in the way of developing effective laws, policies, and programs but also enables Slovakia to escape accountability for neglecting to meet the health needs of its population. Existing relevant national and international laws and policies, including WHO guidelines on making contraceptives (including emergency contraception) affordable for all, are ignored, in part due to the influence of the Catholic Church hierarchy on the government. This is indicative of a prevailing negative attitude of public officials towards women's control over their own fertility and reproductive rights more generally.

In light of these circumstances, the aims of this report are twofold: (i) to point out the problems in access to contraceptive services and information through the testimonies of women, healthcare providers, and other professionals, and (ii) to call on the Slovak government to undertake immediate steps to ensure that all women and adolescent girls have access to affordable and acceptable contraceptives and to comprehensive, reliable contraceptive information. Until the situation changes, women and adolescent girls in Slovakia will continue to have their human rights violated.

The remainder of this section illustrates that access to contraceptives is a problem not only in Slovakia but also across the region and the globe. Written and published as the impact of the current financial crisis is being felt

across Europe, the report denounces supposed economic justifications for not covering contraceptives through national health insurance plans. Women's empowerment, equality, and human rights—including economic and social rights, such as the right to health—require that states invest in increasing access to affordable and acceptable modern contraceptive methods and in providing accurate and reliable information on those methods.

Access to Contraceptive Services and Information: A Global and Regional Problem

The lack of contraceptive availability, accessibility, and acceptability³ is a problem around the globe: one-third of diseases among women of reproductive age are the result of sexual and reproductive ill-health.⁴ Specifically, the unmet need for contraception often leads to abortion and unintended pregnancies, which in some countries contribute to high rates of maternal mortality and morbidity.⁵ The devastating impact of an unintended pregnancy on a woman's life also affects communities and societies in their efforts to reduce poverty.⁶ Marginalized women, such as low-income women and women subjected to sexual violence, are especially at risk of not being able to control their own fertility.⁷ [See box Marginalized Women Are Especially At-Risk, p. 23.] Financial accessibility is crucial to increasing contraceptive use and preventing unintended pregnancies and all their consequences.⁸ In addition, without appropriate education and counseling on the full range of contraceptive methods and pregnancy risks, women cannot make informed decisions regarding their use. Yet, while it is cheaper and easier for states to address contraceptive access rather than deal with the economic and societal costs of unintended pregnancies, many governments are loath to take action. In failing to do so, states violate their international human rights obligations requiring them to ensure women's access to affordable and acceptable contraceptive methods and to reliable and accurate information on those methods.

The governments of many CEE countries, including Slovakia, are no exception. CEE countries frequently lack proper legal and policy frameworks for the protection of reproductive rights, which include the right to acceptable and affordable contraceptives. Consequently, in many CEE countries, the contraceptives that are available are expensive and not covered by public health insurance, severely restricting women's access to them.⁹ In addition, information barriers

are a serious problem in Central and Eastern Europe and further inhibit contraceptive access. Doctors barely counsel their patients on the subject and sexuality education in schools is often inadequate or nonexistent.¹⁰ Official figures that would bring these issues to light—such as contraceptive prevalence, unmet need for family planning, and extent of knowledge on contraceptives—are largely unknown due to state failure in many CEE countries, including Slovakia, to consistently gather appropriate disaggregated data on these indicators.¹¹ This dearth of information is a formidable barrier to developing effective laws and policies that address the population’s health needs, and, moreover, enables public officials to remain unaccountable to the health needs of the people.¹²

The Right to Contraceptive Services and Information

International human rights law requires states to provide women with access to a full range of sexual and reproductive health services, which includes making

acceptable and affordable contraceptive methods available. It also includes providing sufficient and appropriate information on those methods. These obligations are grounded in numerous internationally recognized human rights, including the rights to equality and non-discrimination, the right to privacy, the right to decide the number and spacing of children, and the right to health.

The ESCR Committee has made clear that the right to health encompasses the right to sexual and reproductive health, which obligates states to ensure affordable access to contraceptives¹³ and family planning information.¹⁴ The Committee has explicitly stated that all drugs on the WHO Model List of Essential Medicines, which includes contraceptives and emergency contraception,¹⁵ should be made accessible to all.¹⁶ It has also expressed the view that lack of access to contraception and to sexuality education are violations of the right to health.¹⁷ States thus have an obligation to provide all women with access to affordable, acceptable, and good-quality contraceptives. At the regional level, the Parliamentary Assembly of the Council of Europe

The Right to Sexual Health

Sexuality is a characteristic of all human beings and a fundamental aspect of an individual’s identity.¹ The WHO’s working definition of sexuality recognizes that it is a central part of human life and

*encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.*²

Access to sexual healthcare is an important component of sexuality. Indeed, human rights standards recognize that the right to health includes the right to sexual health.³ The Programme of Action of the International Conference on Population and Development defines reproductive health as including care for “sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”⁴ The possibility of having pleasurable and safe sexual experiences free of discrimination is also reflected in the WHO’s and the U.N. Special Rapporteur on the Right to Health’s definitions of sexual health.⁵

While these definitions demonstrate that sexuality and the right to sexual health are far more than a matter of physiological or sexual activity, they are often expressed this way. Unfortunately, rather than enriching personal relationships, intimacy, and pleasure, the expression of sexuality is often a cause of distress, especially for women and adolescent girls who cannot afford contraception and face the possibility of an unintended pregnancy. The right to sexual health obligates states to ensure access to sexual and reproductive healthcare services, including contraceptives.

(PACE)—the representative body of Europe’s human rights system, the Council of Europe—adopted a resolution in 2008 urging states to make contraceptives accessible and affordable, as well as ensure sexuality education in schools in order to prevent unwanted pregnancies and avoidable abortions.¹⁸ Moreover, denying access to services that only women need violates their fundamental rights to equality and non-discrimination—hallmark principles of international human rights law enshrined in major regional and international treaties.¹⁹

Regional and international human rights standards pay special attention to marginalized women—for example, poor women, women in rural areas, and young women—regarding information on and access to contraceptives.²⁰ In addition, to ensure that states are fulfilling their human rights obligations, regional and international legal instruments underscore the importance of data collection on women’s status, health indicators, and education,

CEDAW Committee Recommendations to Slovakia, July 2008

. . . The Committee is also concerned at the persisting high rate of abortion, which is a consequence of the lack of information and access of women to family planning. The Committee is further concerned at the difficulties women belonging to vulnerable communities experience in accessing healthcare due to the cost of related services. Furthermore, the Committee expresses concern at the lack of a holistic and life-cycle approach to women’s health. . . .

The Committee urges the State party to take measures to increase the access of women and adolescent girls to affordable health-care services, including reproductive healthcare, and to increase access to information and affordable means of family planning for women and men. It calls upon the State party to increase its efforts to implement awareness-raising campaigns targeting women and men on the importance of family planning and related aspects of women’s health and reproductive rights.¹

disaggregated by relevant grounds, including gender, age, and ethnicity.²¹

Governments have clear international human rights obligations—as well as compelling economic, social, and public health reasons—to ensure women’s access to affordable and acceptable contraceptives and information and to collect data on the realization of those obligations. However, the Slovak government has largely ignored these obligations and policy justifications. The Committee on the Elimination of Discrimination against Women (CEDAW Committee) recognized this failure in 2008 when it emphasized that family planning services in Slovakia, of which contraceptives form an integral part, fell short of what is required under international law. The Committee urged the government “to take measures to increase the access of women and adolescent girls to affordable . . . reproductive healthcare, and to increase access to information and affordable means of family planning. . . .”²² The findings of this report bolster the CEDAW Committee’s observations and reveal that women in Slovakia face significant barriers to accessing contraceptives.

Policy Justifications for Access to Acceptable and Affordable Contraceptives

Besides being a component of the right to health, ensuring that women have information on and access to modern contraceptive methods is sound policy from both an economic and public health perspective. If the state has accurate data on contraceptive prevalence and the unmet need for family planning, it can develop effective laws and policies, which can result in increased contraceptive use and reduced numbers of unintended pregnancies—leading, in turn, to savings in healthcare costs.²³ In addition, fewer unintended pregnancies benefit women’s health.²⁴ When women are empowered with the information and the means to plan whether and when to have children, they are able to avoid frequent, unhealthy pregnancies and the complications that accompany them. Every year, modern contraceptives help prevent 215,000 pregnancy-related deaths and 2.7 million infant deaths worldwide.²⁵ Moreover, according to a WHO study, foreseeing the unmet need for family planning “has the potential to decrease 71% of unwanted pregnancies,” and lead to “22 million fewer unplanned births, 25 million fewer induced abortion[s] and 7 million fewer miscarriages.”²⁶

Guaranteeing access to contraception is fundamental to women's empowerment and equal participation in society. The use of contraceptives to avoid unintended pregnancies increases women's status and decision-making power, resulting in enhanced self-esteem and quality of life.²⁷ This allows them to advance their own economic security; improve the well-being of their families,²⁸ such as by spending more on basic needs such as adequate nutrition;²⁹ and contribute to the economic health of society.³⁰ When adolescents are faced with unintended pregnancies, they are often forced to abandon or delay their studies,³¹ which has a detrimental impact on their ability to play a full economic, social, and political role in their communities and is directly linked to increased poverty.³² In addition, when women have the information and means to decide whether and when to have children, they are better able to provide adequate care, nutrition, and education for their existing offspring.³³ A reduction in unintended pregnancies further leads to a reduced burden on the healthcare system.³⁴ Thus, states will be able to promote health more strategically and efficiently if they ensure reproductive health services and if contraceptives are affordable for all women.

BACKGROUND

Regional and Czechoslovak History

Many factors that affect women's reproductive rights in Central and Eastern Europe today can be traced to the communist era. High numbers of unintended pregnancies followed by abortions as the dominant method of fertility control; the lack of information and misinformation on contraceptives; pronatalist policies; and the absence of sexuality education have had an impact on women's access to affordable, acceptable contraceptives and contraceptive information. The situation in Czechoslovakia³⁵ was emblematic of what took place in most of Central and Eastern Europe during the communist period. As in most of the CEE region, where in the mid-1950s³⁶ abortion was legalized for numerous reasons, including public health and gender equality,³⁷ the regulation of abortion in Czechoslovakia was liberalized in 1957. However, again like in the rest of the region, modern contraceptives, after their introduction in Western Europe in the 1960s, were not widely available in the East.³⁸ CEE governments were not interested in their promotion, in part because governments did not want to expend hard currency on importing them.³⁹ Furthermore, throughout the region, international research on modern contraception was not publicized, and the majority of the public was misinformed on its health risks.⁴⁰

It is thus unsurprising that a 1965–66 survey of 293 young urban Czechoslovak couples revealed their limited knowledge about contraception and found the most common birth control method to be withdrawal.⁴¹ One decade later, in 1977, a survey indicating that only one-third of urban women and one-fifth of rural women in Czechoslovakia were fully informed about contraceptives showed that not much had changed.⁴² Because of the limited choice of pills and the fear of negative side effects, oral contraceptive use in the country and region remained low towards the end of the 1970s.⁴³ Consequently, the CEE region had—and continues to have—the highest abortion rates in the world.⁴⁴

In most of Central and Eastern Europe, sexuality education in schools, as a potential source of information on modern contraceptives, was a taboo subject during the first 15 to 20 years after World War II. It was widely believed that contraception promoted sexual promiscuity and that the family was more effective in addressing sexuality issues.⁴⁵ During the 1960s and 1970s, when demographic decline became a concern, some CEE countries developed sexuality education programs that were pronatalist in nature and included propaganda on the societal importance of childbearing.⁴⁶ During the 1970s, a public dialogue on “education for parenthood” emerged in Czechoslovakia,⁴⁷ which prompted the dissemination of information on sexual anatomy and physiology. Information on non-procreative sexual practices, however, was not widely available since the focus was on parental, rather than sexuality, education.⁴⁸ A late 1970s survey of young married couples revealed that over 25% of the men and 50% of the women either had not received sexuality education or thought that the sexuality education they received was insufficient or nonexistent.⁴⁹

Contraception in Slovakia: Unaffordability and Other Structural Barriers to Access

Equality between women and men is a fundamental right, a common value of the EU, and a necessary condition for the achievement of the EU objectives of growth, employment and social cohesion.

— European Commission, Division of Employment, Social Affairs and Equal Opportunities

Gender equality cannot be achieved without guaranteeing women's sexual and reproductive health and rights, and . . . expanding access to sexual and reproductive health information and health services are essential for achieving the Beijing Platform for Action, the Cairo Program of Action and the Millennium Development Goals.

— Declaration of the (EU) Conference of Ministers of Gender Equality, Luxembourg, February 2005

Although the availability and use of modern prevention methods in Slovakia has been on the rise during the last two decades,⁵⁰ contraceptive prevalence remains below the European average. This disparity may be explained in part by the significant structural and social barriers to access that exist in Slovakia and for which the state carries responsibility. This section, after first briefly addressing public health insurance coverage of contraceptives and low usage rates, discusses some of these barriers—most notably, the lack of affordable and acceptable methods, the lack of comprehensive data on reproductive health indicators, the lack of adequate sexuality education in schools, and the failure of some gynecologists to provide sufficient information on contraceptives to their patients.

The role of the Catholic Church hierarchy, which has increasingly influenced laws and government policy since the fall of communism, is raised as well. Where relevant, developments in the CEE region as a whole and comparisons between EU countries are made in order to situate Slovakia in a broader context.

Lack of Contraceptive Coverage

With the exception of emergency contraception, which is available over the counter, female hormonal contraception can be obtained only by prescription from a gynecologist, whom women may visit without a referral from a primary care physician. Such contraception includes pills, patches, injectables, vaginal rings, and implants. Slovakia's public

Access to Contraception in Slovakia

Accessing Contraceptive Prescriptions and Counseling

Aside from emergency contraception, all hormonal contraceptives are available only by prescription from a gynecologist. For contraceptive pills, a prescription is usually given for a one- or three-month period, after which time the woman must return to her gynecologist to renew the prescription. However, prescriptions enabling women to obtain contraceptives for longer periods of time without having to go back for a visit are given as well, at the discretion of the gynecologist. Gynecologists sometimes charge a fee of about €1 for issuing a prescription.

Women may visit gynecologists without a referral from a general practitioner.¹ They are free to choose their gynecologist, and there are no restrictions as to residency or workplace. Walk-in visits are generally free of charge, while scheduled appointments may cost as much as €7-10.

After a woman's first pregnancy, and for all women 18 years or older, contraceptive counseling should be provided as part of the annual gynecological examination covered by public health insurance.² Yet, there is no law requiring coverage for preventative gynecological check-ups for minors who have not been pregnant. Women under 18 are eligible for one preventative-care visit every two years provided by a pediatrician, but it is unclear if the visit includes contraceptive counseling.³

Accessing Emergency Contraception

Access to a full range of contraceptives should include access to emergency contraception. Emergency contraception, also known as the "morning-after pill," reduces a woman's chance of becoming pregnant by 60–90% when taken within five days after contraceptive failure or unprotected intercourse.⁴ In Slovakia, only one type of emergency contraception is available. While it is available over the counter, its approximate price of €22 per dose puts it out of reach for many women.⁵ The government should take measures to change this. Indeed, the CEDAW Committee has noted that states should provide for "a wide range of contraceptive measures, including emergency contraception. . . ."⁶

health insurance scheme, which is mandatory for the entire population, does not cover hormonal contraceptives, thus requiring women to pay for these items out of pocket.⁵¹ This policy exists despite the fact that Slovakia's abortion law seeks to prevent unintended pregnancy by requiring that prescription contraceptives "be provided to a woman free of charge."⁵² Furthermore, Slovakia's requirements for including a drug on the list of medicinal products covered by public health insurance include the drug's life-saving, curative, or preventative qualities.⁵³ The only insured contraceptive method is surgical sterilization, which is permanent and irreversible and covered only when there are health indications. Therefore, women to whom pregnancy poses a health risk are given no other option under health insurance besides sterilization. The state also does not subsidize emergency contraception in any way.

Low Contraceptive Use and Gaps Between European Union Countries

Contraceptive use in Slovakia has improved since the early 1990s, when only 2.2% of women of reproductive age were using hormonal contraception. In 2008, the percentage increased tenfold to 22.3%.⁵⁴ Yet, this figure remains low in comparison with other EU countries. In neighboring Czech Republic, 47.4% of women of reproductive age were using hormonal contraception in 2008.⁵⁵ In France, 43.8% of women were using the pill in 2009, and use of contraceptive pills in Germany is among the highest in the world, at over 50%.⁵⁶

Decrease in Abortions

The decrease in abortions in Slovakia over the last two decades has been attributed, in part, to an increase in modern contraceptive availability and use.¹ In 1995, shortly after the Slovak Republic was formed, 28,887 induced abortions were performed. In 2008, this number dropped to 10,869.² While this change is considered to be the most favorable recent trend in reproductive behavior in Slovakia,³ high abortion rates due to lack of information and access of women to family planning still remain a concern.⁴ It is important to keep in mind that access to legal abortion will always remain necessary as unintended pregnancies, albeit in reduced numbers, will continue to occur even with widespread access to contraceptives.⁵

The Cost of Contraceptives in Slovakia¹

Type	Price (€)	Period of use/quantity
Condoms	0.70 to 3.00	3 condoms
Vaginal cream	6.50	72 grams
Pills	7.23 to 15.38	1 month
Emergency contraception	22.91	1 time
Hormonal vaginal ring	45	3 months
IUD	158.21	1 time
Skin implant	220	3 years

When comparing overall data from the new EU Member States of Central and Eastern Europe to that of older EU Member States, serious gaps emerge. Prevalence of modern methods (including not just hormonal contraceptives, but also IUDs, female sterilization, and male condoms) stands at 36% in some countries of the CEE region—namely, Bulgaria, Czech Republic, Hungary, Poland, Romania, and Slovakia, which are all new EU Member States. This is nearly twice as low as in Western European countries, where the prevalence is on average 71%.⁵⁷ For example, 28% of women in Poland and 40% of women in Bulgaria are using modern contraceptives, compared to 77% and 82% of women in France and the United Kingdom, respectively.⁵⁸ This disparity indicates that contraceptive use is an issue worthy of attention across Europe.

Lack of Comprehensive Data on Reproductive Health Indicators

Like many other governments in the CEE region,⁵⁹ the Slovak government does not gather comprehensive data on reproductive health indicators, such as unintended pregnancies, contraceptive use, and the unmet need for contraception. The limited data that the state gathers on the prevalence of just a few contraceptive methods—namely, hormonal contraception and IUDs—is insufficient for understanding the reasons behind low usage rates in Slovakia.⁶⁰ As a result, it is difficult to effectively identify measures that should be taken to meet the contraceptive needs of women and adolescent girls. Furthermore, public officials are able to remain unaccountable for neglecting to adequately address the health needs of the public due to their own failure to collect adequate and reliable data.

Subsidization of Sterilization

In Slovakia, the only contraceptive method covered by public health insurance for prevention of pregnancy is sterilization for health reasons.¹ Women for whom pregnancy poses a risk to their health are left without a choice, for the only contraception covered is an irreversible procedure. In addition, those who decide not to be sterilized and who cannot afford to pay for other contraception are exposed to the risk of having unwanted pregnancies and possibly undergoing unnecessary abortions. The government should focus on funding preventative healthcare services that cover all contraceptive methods, including sterilization, to enable women to make free reproductive choices.

Unaffordability of Contraceptives

The transition to a market economy after the fall of communism brought about profound political, economic, and social changes in Slovakia. In the health context, these changes included the reorganization of the healthcare system, the establishment of health insurance companies, and the appearance of private health facilities and pharmacies. Such developments have resulted in an increased variety of available contraceptive methods, providing for more possibilities in reproductive decision making today than during the communist period. Yet, for many women and adolescents, their preferred contraceptives remain inaccessible due to their high price. This is because contraceptives for prevention of unintended pregnancy—with the exception of sterilization on health grounds—are not covered by public health insurance. Moreover, contraceptives fall outside the price regulation system, meaning that the government does not control their maximum price and enabling drug companies to keep contraceptive prices relatively high. The state's failure to adopt measures to ensure the affordability of contraceptives further limits women's access to modern contraceptive methods.⁶¹

While recognizing the need to improve access to contraceptive services,⁶² the Slovak government has failed to reign in their high costs. In 2007, the Ministry of Health introduced a long-awaited comprehensive draft program on sexual and reproductive health⁶³ that was based, in part, on international human rights and medical standards.

Among the program's goals were ensuring a decrease in unintended pregnancies and improving access to high-quality modern contraceptives by making them affordable for everyone, including marginalized women.⁶⁴ The Catholic Church hierarchy and anti-choice groups heavily criticized the program, claiming that it was "strongly liberal,"⁶⁵ against national interests,⁶⁶ and "anti-family," especially by aiming to improve access to contraception.⁶⁷ As a result, the government failed to adopt the program, despite having acknowledged its importance.⁶⁸ Instead, the Ministry of Health drafted a new policy, which, apparently to appease the Catholic Church hierarchy, was renamed the "National Program on Care for Women, Safe Motherhood and Reproductive Health" and which incorporated proposals from conservative Catholic groups.⁶⁹ However, due to continuing opposition from the Catholic Church hierarchy, which considered even this policy to be contrary to its convictions,⁷⁰ the new program was not adopted.

Comparing European Countries' Subsidizations and Their Justifications

Slovakia is not the only EU country in which the high price of contraceptives is a barrier to access; in other new Member States, it is a problem as well. To effectively deal with this issue, state subsidization of reproductive healthcare services in the form of basic public health insurance is widely considered an appropriate measure. Of the twenty-seven EU Member States, eighteen include contraceptives in their public health insurance package as a means to prevent pregnancy without there having to be an underlying health condition. Those states either fully or partially subsidize some hormonal contraceptive methods for all women, for low-income women, or for women under a certain age.⁷¹ However, the remaining nine EU Member States do not provide subsidies for hormonal contraceptives, despite their inclusion on the WHO's essential medicines list.⁷² All but one of these nine countries are new Member States, among them Slovakia.⁷³ Some of those same countries, including Slovakia, also either do not have national strategies for ensuring access to reproductive healthcare services or do not have effective strategies for making contraceptives affordable.⁷⁴

EU Member States that subsidize contraceptives do so on public health grounds or to uphold fundamental rights. The Slovenian government, for example, considers family planning a fundamental human right guaranteed by the Constitution, which grants all citizens the right to determine whether to bear children.⁷⁵ In Poland, while the Ombudsman for Human Rights found the withdrawal of

The Financial Crisis Hits Reproductive Healthcare

Gender equality should be a key principle in any policy response [to today's economic downturn].

— European Parliament Report on Gender Aspects of the Economic Downturn and Financial Crisis¹

Spending on health is not just a cost, it is an investment. Health expenditure can be seen as an economic burden, but the real cost to society are the direct and indirect costs linked to ill-health as well as a lack of sufficient investment in relevant health areas. . . . Healthcare spending should be accompanied by investment in prevention, protecting and improving the population's overall physical and mental health.

— Commission of the European Communities, White Paper: Together for Health: A Strategic Approach for the EU 2008–13²

In Europe, the gender inequalities that women confront in obtaining healthcare, particularly reproductive health services and affordable contraceptives, are exacerbated by the recent financial crisis and resulting economic crisis.³ Faced with difficult financial decisions, misguided governments are cutting healthcare expenditures, resulting in women paying out of pocket for a greater part of their reproductive health needs.⁴ A recent European Parliament report noted that public spending cuts are negatively affecting preventative services in the area of women's sexual and reproductive health.⁵ In many European countries, the situation was already untenable before the crisis due to the long-existing absence of effective gender mainstreaming in health policies, especially gender budgeting.⁶ As a result, many countries failed to allocate budgetary resources for health in a fair and efficient way for women.⁷

Slovakia's National Strategy for Gender Equality for 2009–2013,⁸ for which the Ministry of Labor, Social Affairs and Family is responsible, provides one such example. The strategy identifies gender-specific health services, including protection of sexual and reproductive health, as one of the areas that should be focused and elaborated on in specific action plans on gender equality.⁹ However, to date, despite this commitment, the national action plan adopted to implement the strategy's goals does not address sexual and reproductive health issues.¹⁰

The worsening of women's reproductive healthcare due to the financial crisis is occurring not only in Europe but around the globe. The United Nations Population Fund recently recognized as much, noting that in a time of crisis, funding for women's health issues takes a particular hit: “. . . sexual and reproductive health, gender equality and prevention of HIV, unwanted pregnancies and preventative care in general, are often first to be discontinued.”¹¹

In times of crises, it is even more important and in the best interest of economic recovery that governments ensure women's human rights. Yet European administrations and the EU are paying little attention to the financial crisis's social impact¹² and impact on gender equality.¹³ This is troubling because women in Europe, like women everywhere, are already more likely than men to live in poverty¹⁴ and “generally have less access to resources and/or private health coverage.”¹⁵ In the EU, almost 17% of women are categorized as living in poverty.¹⁶ Women facing multiple marginalization, such as women subjected to male violence are especially affected. A recent study revealed increasing numbers of victims of domestic violence in Europe as economic stress places pressures on families, creating conditions for abuse.¹⁷

Governments should employ a long-term strategy for healthcare investment, particularly in the area of reproductive health services, realizing that every Euro spent on reproductive health is an investment that contributes not only to women's equality but also to economic recovery¹⁸ and may ultimately lead to a reduction in healthcare costs.¹⁹

Marginalized Women Are Especially At-Risk

For marginalized women, accessing contraceptive information and services can be very challenging. Low-income women, Romani women, and women subjected to male violence are some examples of women in Europe who are particularly affected by government failure to ensure the accessibility and affordability of contraceptives.¹ Despite the importance of ensuring access to healthcare for all, in some European countries, including Slovakia, basic health services such as contraceptives are not covered by public health insurance,² leaving the most vulnerable women with few resources to cover their relatively high cost.

Low-Income Women

While the EU is one of the wealthiest regions in the world, poverty remains an issue. On average, based on household income, 16% of the EU's population is at risk of poverty.³ In Slovakia, up to 11.9% of women were at risk of poverty in 2009.⁴ As with many other social and economic indicators where women are frequently found lagging behind men,⁵ poverty is no exception: women experience poverty at a higher rate than their male counterparts.⁶ Poverty can have a negative impact on all aspects of a person's life, including their health, making it all the more important that states provide universal coverage of basic healthcare needs, including contraceptives.

Romani Women

Romani women use healthcare services less than the majority population, partly due to the discrimination they face when accessing such services.⁷ Prevalent ethnic and gender stereotypes regarding Romani women's ability to regulate their fertility shape some healthcare providers' views and, consequently, their provision of services to Romani women.⁸ Language and other barriers also restrict Romani women's access to healthcare, including to contraceptive information and services.⁹ The discrimination they face has led to the denial of full reproductive healthcare information, including comprehensive and understandable information on prevention of pregnancy—and has even led to forced sterilization.¹⁰

Women in Violent Relationships

Male violence against women¹¹ and its impact on women's health constitutes a significant barrier to the achievement of gender equality and women's enjoyment of their human rights.¹² The health consequences are devastating for society and, moreover, for women's mental and physical well-being. Across Europe, more than one in ten women are victims of sexual violence.¹³ In Slovakia, one in five women experiences some form of violence from her partner.¹⁴ Unintended pregnancy and sexually transmitted infections are consequences that women survivors experience in cases of rape both in and outside a domestic setting.¹⁵ Numerous factors may affect some women's ability to control their fertility when they are subjected to intimate partner violence, including the inability to negotiate contraceptive use, because their partner may use pregnancy or potential pregnancy as a controlling mechanism.¹⁶ Also, women's economic dependence on men may prevent them from accessing household resources to buy contraceptives without their partner's knowledge.¹⁷ By making contraceptives affordable for women through public health insurance schemes, states can help prevent the harm that women survivors of violence might experience when faced with an unintended pregnancy.

Strong Public Support for Women's Reproductive Rights and Sexuality Education

There is broad public support in Slovakia for reproductive health services and information in schools, as well as for women's right to decide on the number and spacing of their children. A 2003 survey conducted by the Institute for Public Affairs, a Slovak NGO, found that "an overwhelming majority of women and men (86% and 84%, respectively) believed that '... society should focus on sex education and prevention of unwanted pregnancies.'"¹ Another survey, held among students, also noted a high demand for comprehensive sexuality education in schools, without parental involvement.² Other surveys have also shown strong public support for women's reproductive choice.³

subsidies for contraceptives to constitute discrimination on the ground of sex,⁷⁶ the government has failed to reinstate their subsidization. The Belgian Constitutional Court, in addressing the constitutionality of the law on pricing for pharmaceuticals, stated generally that the pricing scheme aims to improve access to drugs that promote public health and social benefits. The Court noted that contraceptives are a type of drug that must be accessible to the public at an affordable price. It explained that providing access to them is justifiable on the grounds of public health and social protection in order to reduce the number of unwanted pregnancies.⁷⁷ Similarly, the Danish government considers family planning services, including subsidization of contraception, "an integral part of the national health service."⁷⁸ In France, research conducted by public authorities on the use of various oral contraceptives indicated that contraceptive subsidies "present an interest in terms of public health."⁷⁹ Also espousing the public health argument, the United Kingdom's National Health Service Act mandates that contraceptives be available free of charge to "cut down the number of unwanted pregnancies and . . . decrease the number of abortions."⁸⁰

Lack of Information and Sexuality Education

Women and adolescent girls in Slovakia not only lack access to contraceptives covered by public health insurance but also suffer from serious barriers to information on

contraceptives, which may contribute to the country's low usage rates. Knowledge of modern prevention methods is generally poor; doctors seldom counsel patients sufficiently on the subject;⁸¹ sexuality education in schools is frequently inadequate or absent; and the Catholic Church hierarchy consistently tries to impose its traditional and often discriminatory views on politicians and the public.⁸²

In addition, in February 2010, Catholic conservative parliamentarians⁸³ introduced a bill that would require health professionals to wrongly inform patients that hormonal contraceptives are abortifacients. The bill also proposed to place this inaccurate information on contraceptive packaging.⁸⁴ It further included an informed-consent provision that imposed a duty on health professionals to provide women with information on the "potential physical and psychological risks" of hormonal contraception and on resources about alternatives to hormonal contraception provided by civil society groups and religious associations.⁸⁵ While the bill did not pass,⁸⁶ the number of parliamentarians who voted in favor of it or abstained is alarming⁸⁷ and points to, among other things, a lack of knowledge of sexual and reproductive health issues and growing opposition to reproductive rights issues among elected representatives across the political spectrum.

The government has also failed to adopt policies and programs to promote reproductive health and rights in the field of education. In Slovakia, sexuality education is not a mandatory classroom subject, and if it is provided, it is not a separate subject in school; rather, it is taught during biology, ethics, or religious classes.⁸⁸ The quality and comprehensiveness of such education depends to a high degree on individual teachers and the course subject.⁸⁹ Moreover, discussions on sexual and reproductive health and rights and on contraception are rare.⁹⁰ In 2007, in an attempt to help remedy this, a new textbook was prepared by a multidisciplinary team of experts in cooperation with the Slovak Family Planning Association and submitted to the Ministry of Education for accreditation.⁹¹ In an open letter sent to the Minister of Education, the Slovak Bishops' Conference successfully called for rejection of the textbook, accusing it of being "a technical propagation of sex."⁹² After this intervention, the Ministry, without explanation, refused to accredit the book.⁹³ Current official textbooks on sexuality education, called "Education for Marriage and Parenthood," promote gender stereotypes and lack comprehensive information on sexual and reproductive health.⁹⁴

Inadequate Regulation of Conscientious Objection

Access to reproductive health services, in particular to abortion and contraception, is further undermined by the use of conscientious objection. Under their code of ethics, health professionals are permitted to refuse to provide any reproductive health service if performing the service “contradicts [their] conscience,” except in situations posing an immediate threat to the life or health of a person.⁹⁵ Although public perception is that conscientious objection, often grounded in religious beliefs, is used primarily with respect to abortion services, the interviews conducted for this report confirm that it is also invoked to refuse to prescribe or sell contraceptives.⁹⁶

Existing regulation of conscientious objection is inadequate, as it does not properly balance practitioners’ option to refuse to provide certain medical services with their professional duties and the rights of the patient to lawful and timely medical care.⁹⁷ For example, while objecting practitioners are required to inform their employer as well as their patients that they are exercising conscientious objection to a particular service, the state has failed to enact regulations setting forth other essential duties such as referral of a patient to an appropriate non-objecting healthcare provider and information on the procedure being objected to.⁹⁸ Effective oversight and control mechanisms of the practice are also lacking, making the precise numbers of objectors unknown. The state is responsible for ensuring that patients’ right to access lawful and timely healthcare is respected, protected, and fulfilled, and that healthcare providers comply with their professional responsibilities.⁹⁹

Influence of the Catholic Church Hierarchy

The Slovak government is responsible for ensuring that women and adolescent girls have access to contraceptive services and information, and it should be held to account

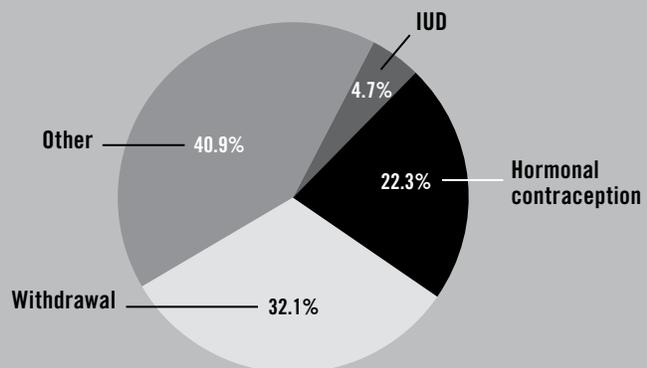
Religion Should Not Influence Laws

The World Health Organization makes clear that signatories of the Programme of Action of the International Conference on Population and Development should not be guided by religious principles in dealing with reproductive health issues and must formulate and advance laws that serve their populations’ best interest.¹

for its failure to do so. It is evident that in neglecting to fulfill the need for sexual and reproductive health services and information, the government is countenanced by the Catholic Church hierarchy, which has assumed a growing influence on Slovak laws and policies. As noted above, the hierarchy successfully opposed both the adoption of a policy seeking to make contraceptives affordable to everyone and the introduction of textbooks containing comprehensive sexual and reproductive health information. With regard to reproductive rights issues, particularly contraception, the hierarchy has been more successful in shaping decisions taken by the government¹⁰⁰ than in changing the behavior of individual adherents of the Catholic faith or society at large.¹⁰¹ Aware of its limited influence on people’s sexual and reproductive behavior, the hierarchy has been trying to impose its views through formal and informal dealings with politicians, oftentimes successfully influencing legislation and policy.¹⁰²

The hierarchy’s powerful role in politics is not unique to Slovakia. Its efforts to limit women’s and adolescents’ reproductive rights, including access to contraceptive services and information, present a challenge to other CEE countries as well.¹⁰³ For example, it was successful

Family Planning Methods Used in Slovakia¹



in transforming Poland's abortion law into one of the most restrictive in Europe.¹⁰⁴ In the area of educational policy, the Catholic Church hierarchy's influence has led governments throughout the region to incorporate programs into school curricula that promote abstinence until marriage and sex only within marriage. These programs provide inaccurate information to students on the ability of contraceptives to prevent pregnancy and of condoms to prevent transmission of sexually transmitted infections; they also promote gender stereotypes such as the belief that a woman's primary role is as a mother.¹⁰⁵ Such programs have been proven ineffective and harmful to youth.¹⁰⁶ Governments in the region must ensure that religious beliefs that undermine women's human rights and jeopardize women's and adolescents' health, autonomy, and well-being have no place in political decision making.

PERSONAL ACCOUNTS OF BARRIERS TO ACCESS

Not having access to acceptable and affordable contraceptives can have far-reaching consequences for women's lives and well-being. Despite legal obligations and strong public policy justifications that ought to prevent this from happening, the Slovak government has remained idle, and women's access to contraceptives in the country has been considerably impeded.

This section is based on the experiences of women and other stakeholders whom we interviewed during the fact finding.¹⁰⁷ After briefly discussing reliance on traditional family planning methods, the section focuses on the most significant structural barriers that women and adolescents face in accessing modern contraceptives in Slovakia, beginning with lack of affordability. The testimonies show that the high price of contraceptives is prohibitive for some women and keeps others from using the method that would be most suitable based on their health, personal circumstances, or preferences. Other structural barriers, most notably to comprehensive and accurate information—such as inadequate sexuality education, parental consent requirements for minors who want to use contraceptives, and insufficient information provided by some gynecologists—further limit women's and adolescent girls' ability to make unconstrained decisions regarding their fertility. Several social barriers, such as community pressure in rural areas and a lack of male involvement, were also consistently raised by our interviewees.

The state has an obligation not only to enact and implement laws and regulations that address existing structural barriers but also to develop policies that aim to increase women's equality and autonomy and to encourage male involvement and responsibility regarding family planning, which can help counteract the structures that underlie social barriers.¹⁰⁸

As a result of the barriers to access, some women and adolescent girls may use contraceptives that are not well suited for them or may not use any contraception at all, exposing themselves to unintended pregnancy and health risks that could negatively affect the rest of their lives.

Reliance on Traditional Family Planning Methods

Unable to use suitable modern contraceptives because of their high price, personal religious beliefs, or fear of side effects due to a lack of awareness and misinformation, many women resort to unreliable traditional family planning methods, such as withdrawal or periodic abstinence.¹⁰⁹ A 2005 study reported that 32.1% of couples in Slovakia use withdrawal as a family planning method.¹¹⁰ In comparison, only 3.1% of women in France and 0.5% of women in Germany rely on withdrawal as a family planning method.¹¹¹

The testimonies gathered for this report illustrate that traditional family planning methods are indeed widely relied on in Slovakia. While a majority of women interviewed had some experience with modern contraceptives,¹¹² most commonly with the pill,¹¹³ half of the sexually active women who did not want to become pregnant relied on traditional methods, particularly withdrawal, which was sometimes described as “being careful” or having the “husband take care of it.”¹¹⁴ Such methods expose women to a high risk of unintended pregnancy.¹¹⁵ Moreover, traditional methods require a partner's cooperation, which may be difficult for women to negotiate, especially when coercion or violence is involved.¹¹⁶

The account of Irena, a 32-year-old mother of two, is typical. She confided that she does not use contraception to avoid getting pregnant:

*I rely on my husband for that, it is interrupted intercourse. I haven't taken contraception. I was afraid when I read of the side effects—about high risk of breast cancer, feeling sick, and other health problems. These things can happen, so I refuse to use them.*¹¹⁷

Many others echoed Irena's fear of using modern contraceptives. Only two women interviewed for this report had used hormonal contraception for an extended period of time.¹¹⁸ The others had all stopped after several months



Emergency contraception is prohibitively expensive for young women, particularly students. A pharmacist noted that when some of her customers see the price of emergency contraception, they realize they cannot afford it and purchase a pregnancy test instead.

because a lack of accurate information made them afraid of the health risks and negative effects of hormones in the body; many women falsely believed, for example, that extended use of contraceptive pills results in infertility.¹¹⁹

The use of non-hormonal methods of modern contraceptives is also low. For example, only about a third of the women interviewed who had experience with modern contraception mentioned that their partner uses condoms. Yet, not unlike their experiences with other modern methods, most women interviewed noted that their partner's use of condoms is inconsistent.¹²⁰ Some interviewees said that they find condoms uncomfortable and that men may not want to use them¹²¹—making it all the more important that women have access to additional female-controlled methods of contraception to prevent pregnancy.

The experience of Ms. Lucia Vargová, who has been a pharmacist for six years, underlined that exposure to unintended pregnancies from inconsistent use of modern contraception is a problem:

*I am very surprised how often emergency contraceptives are sold. . . . Very often, very often—especially girls from universities, usually girls at the age who should have done differently already, 18- or 19-year-old girls. . . . I think girls like that should think about it. . . . I am surprised.*¹²²

Reliance on traditional family planning methods, or not using any contraceptive method at all, may have a great impact on women's lives. Almost everyone interviewed for this report, including the adolescents, knew of women or girls who had had unintended pregnancies.¹²³ Some carried their pregnancy to term, while others opted for abortion. The stories of unintended pregnancies are telling, especially since participants remarked that women are often reluctant to admit that a pregnancy is unintended. They underscore the importance of access to modern contraceptives.

Unintended pregnancies may affect women's financial and educational situations. Raising more children than intended may be economically challenging for those with limited means. In addition, a single woman who is unexpectedly experiencing her first pregnancy may be expected to marry.¹²⁴ In the words of Renáta, a 36-year-old mother of one, who talked about women from her community, "You mostly find out it is [an] unwanted pregnancy when it is the first pregnancy. . . . [Pregnancy] before marriage," which is

then "solved" by the woman getting married.¹²⁵ In addition, when young women have to deal with an unintended pregnancy, they sometimes interrupt their studies or drop out altogether, shortchanging their futures.

Jarmila, a 17-year-old Roma, was coerced to drop out of school when she was seven months pregnant. Viera, her mother, recounted that she went to her daughter's school to inform the headmaster of Jarmila's pregnancy. The headmaster told Viera that he wanted Jarmila to stay at home because he was worried that something might happen to her and the "child" (the pregnancy). As a result, he expelled her from school. Viera mentioned that in some Romani communities, girls who leave school due to pregnancy return when their child is a few years old. However, in her community, she added, girls who drop out never go back to finish.¹²⁶

Unaffordability

Modern contraceptives, including emergency contraception, are listed on the WHO Model List of Essential Medicines, meaning that they should be accessible and affordable to all. Moreover, the WHO's list is recognized by the ESCR Committee as a core component of the right to health.¹²⁷ Similarly, under Slovakia's abortion law, prescription contraceptives "shall be provided to a woman free of charge."¹²⁸

Yet, despite various legal obligations, affordable contraceptives remain scarce in Slovakia. The figures from 2009 put the median monthly income for women in Slovakia at €562.51.¹²⁹ According to figures from 2009, the poverty line for a one-person household was €283 per month and up to 11.9% of women were at risk of poverty.¹³⁰ The price of oral contraception ranges from €7 to over €15 a month, and an IUD costs about €158. In addition, a one-time dose of emergency contraception costs approximately €22. Public health insurance does not cover any portion of these costs.¹³¹ Accordingly, many women are unable to use the contraceptives that would be most suitable for them based on their health or personal preferences, while some women cannot afford any modern method at all. It is troubling that the price of contraceptives is a main—if not *the* main—determinant of the kinds of contraceptives that women use. Dr. Zora Debnárová, a practicing gynecologist for 35 years, did not hesitate when asked what most influences contraceptive decisions for women with limited means: "Price, price, definitely price."¹³²

Price Is a Barrier to Preferred or Quality Modern Contraceptive Methods

Dr. Debnárová's response is indicative of the experiences shared during our interviews. Almost everyone identified the price of contraceptives as one of the main barriers to access.¹³³ Several participants knew of women and adolescents who were not using contraceptives because they are too expensive or for whom price had been a factor in deciding what kind of contraception to use.¹³⁴ In the case of emergency contraception, which is available over the counter, price is also an issue—especially for students. One pharmacist noted that students, upon seeing the prohibitive price of emergency contraception, often opt instead to buy a pregnancy test, as it costs about one-fifth the price.¹³⁵

Some women can afford only lower quality contraceptives. Not surprisingly, such contraceptives are not suitable for everyone and may negatively affect women's health. However, aware that the affordability of contraceptives is an issue for their patients, medical professionals offer these drugs. Often, gynecologists' first consideration when women come to them for contraception is how much the women can afford to spend. Price—and not health or personal preference—sets the parameters for contraceptive use for many women.

When asked whether she offers patients different contraceptive options, Dr. Elena Molnárová, a gynecologist, responded,

*I tell [a woman] about the possibilities and she tells me her financial limit. I tell her what I think is the best and most suitable for her, but the crucial thing is what she can afford. It has happened to me that a patient wanted to take more expensive contraception and she didn't buy it because she couldn't afford it, and she got pregnant.*¹³⁶

For Livia, a 23-year-old woman with one child, price played a central role when choosing an oral contraceptive. She recounted,

*Price was a concern for me and my friends. [The] doctor's first question to me when I asked for contraceptive pills was what I think the cost was and how much I was prepared to pay. . . . I decided on price and asked whether price had anything to do with effectiveness. The [doctor] recommended me the "student" contraception [an inexpensive form on contraception].*¹³⁷

According to Dr. Anton Novák, a practicing gynecologist for 19 years, the high price of some contraceptives leads many women to resort to low-quality options:

*Money plays an important role [in women's decision making on contraception]. I see many of them [who] would prefer the patches, as they are put on only once a week, but many of them can't afford them. After considering the high price, they go to basic tablets. . . . There are many other means that are better, but they don't have enough money to buy them.*¹³⁸

The situation of Iveta, a 39-year-old mother of two, illustrates Dr. Novák's point. Iveta's doctor told her that the contraceptive pill Iveta uses has three kinds of hormones and is quite harmful to her health. However, she is single and unemployed and cannot afford another contraceptive option.¹³⁹

Ms. Vargová, the pharmacist described above, further remarked that pharmaceutical companies exacerbate the problem by regularly raising the price of some contraceptives, even though their content remains the same. They are able to do this because the government, which regulates the prices of other essential drugs, has chosen not to regulate the price of contraceptives.¹⁴⁰ If the situation does not change, quality contraceptives will become too expensive for an ever-increasing group of women.

For the Most Vulnerable Women, Price Prohibits the Use of Any Modern Contraceptive Method

For some women, any kind of modern contraception is out of reach. More than one-third of the women we interviewed for this report were unable to afford contraceptives or knew of others in that situation.¹⁴¹ These are women who, for various reasons, either have a low personal income or have no access to the family income.

Low-Income Women

Our interviewees consistently said that contraception is difficult to afford for low-income women—for example, women who have to survive on only one income, have many children, or are unemployed.¹⁴² According to them, it is simply not possible to afford contraceptives while living on social benefits.¹⁴³ Even working women can find contraceptives difficult to afford: a divorced pharmacy assistant with two children said that paying for contraceptive pills would be difficult because they are too expensive;¹⁴⁴ likewise, a divorced social-work student with part-time

employment said that contraceptive pills and patches are too expensive for her, so she does not use them;¹⁴⁵ and a married Romani woman was able to afford contraception now, but said that she may not be able to if either she or her husband loses their job.¹⁴⁶ Other women knew of similar stories.

Beáta, a 40-year-old mother of two, noted that of her approximately 30 female acquaintances, only one is using modern contraception. She explained why this figure is so low:

*I think the main reason is first and foremost financial, that they cannot afford it. Simply in the case of some of my acquaintances or friends it's either that she doesn't work or her husband doesn't work, they have two to three children, it is a problem to [get by], you understand. So I think it is a financial problem.*¹⁴⁷

Dr. Debnárová related how the high price of contraceptives affects her patients:

*[When some poor women have an unintended pregnancy, they would like to] go for abortion and they would like to use IUDs, but they don't have money.*¹⁴⁸

Ingrida, a mother of 11 who lives on social support, noted that her ideal number of children would have been five or six but that she could not afford contraception. She characterized the price of an IUD as “abnormally expensive.” For her, the options were clear: “I cannot take food from my children’s mouth. Are they going to starve and I am going to have an IUD? I cannot do that!” She wished that her daughters had access to affordable contraception, so as not to have as many children as she did.¹⁴⁹

Contraception for pregnancy prevention is not covered by public health insurance, even if a pregnancy could pose a risk to a woman’s health (with the exception of sterilization); abortions, however, are covered for health reasons. Dr. Debnárová stated,

*Yes, [abortions for health reasons] [are] subsidized by the insurance company. But some of my patients would rather use [an IUD] if they had money. . . .*¹⁵⁰

Women in Violent Relationships

One group of women in a particularly vulnerable situation consists of those who are subjected to coercion or sexual

violence. These women are often unable to refuse sex and may not want to get pregnant. At the same time, their partners may be using conception as a means of controlling them; the more children a woman has, the more dependent she becomes on her partner and the less likely she is to leave the relationship.¹⁵¹ Even if these women have money of their own, they may be unable to buy contraceptives as their partner may control all of the finances.¹⁵²

Ms. Apolónia Sejková, director of the NGO, MYMAMY, which provides support to women subjected to male violence, explained the following:

*Abused women have complained about [their husbands not giving them money for] contraception. It is on the list of things that they do not have buying power after the abuse starts. . . . It is true that abusing men often use conception of more and more children for stronger control and for restricting the partner. In the socioeconomic situation most of our clients are in, and in general most of the average population of Eastern Slovakia, it is difficult to [come up with] any solution. If you have four or five children, no income, live in the house that belongs to the husband or his family, . . . [it is] difficult to leave the husband. Many women therefore stay in violent relationships because they take it as at least they have basic living needs covered and they rather stand to be hit or humiliated . . . they feel that it is the only way for their survival.*¹⁵³

Partner’s Lack of Contribution to Contraceptive Costs

Even women in stable relationships are not always able to rely on their partners to share the cost burden of contraception. Although some couples do share the cost of contraceptives,¹⁵⁴ and it is not uncommon to discuss their use with a partner,¹⁵⁵ many of the women we interviewed explained that preventing pregnancy is usually seen as the woman’s responsibility. Despite their belief that preventing unwanted pregnancies should be a shared responsibility,¹⁵⁶ the reality is different.¹⁵⁷ Some men see pregnancy and contraception as a woman’s issue or their partner giving birth as a sign of their manhood.¹⁵⁸

Iveta, the 39-year-old mother of two, related,

[I]n my relationships I am used to rely[ing] on myself. . . . If I left it up to the partner, . . . a man considers giving birth to a child to be a sign of his

*manhood and he does not have a problem with it at all, you [a woman] have a problem. . . .*¹⁵⁹

Zuzana, a 27-year-old mother of three, commented that while it would be better if both partners would agree on preventing pregnancies, in reality there are men who do not care about what the woman wants. Therefore, preventing an unintended pregnancy is the woman's responsibility. Zuzana said that having many children is tough on women and gives them a lot of worries.¹⁶⁰

Some young women shared the view that taking care of contraception is their responsibility alone.¹⁶¹ Barbora, a 21-year-old woman, is one of them. When asked whether she spoke with her partner about who is going to pay for contraceptives, she responded,

*Hm. I know we spoke about it that it is quite expensive, but about who is going to pay for it, no. I think it's really up to me, it's my matter. . . . I don't think boys would be interested in contributing to contraception for girls. Boys buy condoms for themselves and girls buy contraception—although it is much more expensive.*¹⁶²

According to Ms. Monika Bosá, a university professor and president of the NGO EsFem, when men do take responsibility, it is usually under the influence of their partner. She believed that preventing unintended pregnancies “really comes down to women's involvement.”¹⁶³

Other Structural Barriers to Access

Aside from affordability concerns, other structural barriers—most notably those limiting women's and girls' access to information—stand in the way of modern contraceptive use as well. In order to be able to make responsible decisions regarding fertility and protection, women and adolescents need accurate, unbiased, and comprehensive information on contraception. However, as our interviews show, despite clear legal obligations and the many benefits to women's lives and well-being, there is a dearth of sound information on contraceptives in Slovakia. This is caused in part by the influence of religion and rural surroundings. Sexual issues are still largely taboo in rural areas, and the Catholic Church hierarchy professes that the use of modern contraception is a sin. In addition, in contravention of numerous international legal obligations, Slovakia has failed to implement adequate sexuality education in schools, causing the CEDAW

Committee to express concern at the insufficient access to sexuality education in the country.¹⁶⁴

Other structural barriers are also at play. For example, even though the CEDAW Committee has called on Slovakia to regulate conscientious objection so that it does not thwart women's right to sexual and reproductive health services,¹⁶⁵ the practice remains insufficiently regulated and its invocation by healthcare providers continues to limit women's access to contraceptives.¹⁶⁶

All of these factors significantly inhibit women's and adolescent girls' access to modern contraceptives.

Role of the Catholic Church Hierarchy

The Catholic Church hierarchy, which considers the use of modern contraceptives a sin,¹⁶⁷ plays an active role in Slovakia. Our interviewees noted that conservative Catholic groups have more time, space, and resources than secular organizations to organize activities and disseminate their views on contraceptives, and that Catholic groups systematically promote their views through schools, lectures, pre-marital education, and politics.¹⁶⁸

Dr. Molnárová recounted her visit to a public secondary school to give a lecture on health issues to first-year students who were 15 years old:

*A biology teacher came up to me and said, “You know, there is a priest teaching sexuality education here and I would like to ask you to lead the lecture in [such a way that it shows the students] they should not have sexual intercourse and should avoid it. [Teach them] how dangerous it is.” I don't [give such lectures] anymore. . . . It is too much to organize [and] then you feel like you are intruding.*¹⁶⁹

Klaudia, a 36-year-old mother of one, said that daughters of her Catholic friends go to meetings with Salesians, a Roman Catholic religious order,¹⁷⁰ where they also receive information on contraception. However, the information provided is one sided, focusing on natural family planning and the negative side effects of hormonal contraception.¹⁷¹

Speaking about the Catholic Church hierarchy's influence on women's contraceptive use, Iveta, mentioned above, observed with apparent sarcasm:

The church gives [women] a great option: don't use withdrawal, don't use contraception, bring up

*your child on your own, and don't go for abortion. And that is really great, really great.*¹⁷²

According to Ms. Olga Pietruchová, executive director of the Slovak Family Planning Association, access to contraception is impeded by conservative Catholic groups and individuals who spread half-truths and demonize contraception:

*Ideologically-based groups . . . have a big influence on power, either through the Catholic Church hierarchy or through some political parties. . . These groups, which include some NGOs and doctors, run negative campaigns, primarily against hormonal contraception by pointing to its negative side effects. But the information [they provide] is partial; they say one thing but don't say the rest. They always talk about negatives [and] this dominates the public discussion.*¹⁷³

Dr. Júlia Naďová, a practicing gynecologist, shared the following experience from her practice:

*[A] patient [with cancer] to whom I prescribed [an IUD due to her health condition] told me that her priest told her not to use it because [using] any contraception is sin. I told the priest that if he was taking responsibility for her health, he should come and talk to me about it. She was quite ill; she got [the IUD] inserted after few months.*¹⁷⁴

Although religion may influence some women's decision making on contraceptive use,¹⁷⁵ it is not a decisive factor for everyone. Notably, while almost all women interviewed during the fact finding said they were Catholic, many of them still had some experience with modern methods of contraception.¹⁷⁶

Jana, a 35-year-old mother of one, thought that while religion certainly plays a role in women's use of contraceptives, its influence is handled differently by everyone. She talked about the Catholic Church and contraceptives:

The church deals with [contraception] quite a lot. . . I think they should deal with other things because they can do lots of mischief and they interfere with the things that they do not need to [interfere with]. Moreover, I have a strong connection to God although I don't go to church regularly. God . . . could not prohibit me from taking contraceptives. I think he created us all the

*same, we are all the same, but there are people who make mistakes, who do this and that. I would not say that God is going to be angry because I take contraceptives.*¹⁷⁷

Rural Areas

Surroundings also matter when it comes to women's use of contraceptives. Our interviews suggest that there are important differences for women and adolescents who live in towns and cities and for those who live in smaller, more remote areas—both in their ability to access contraceptives and in their level of information.¹⁷⁸ The difficulties faced by women and adolescents in villages stem from the Catholic Church hierarchy's strong influence in rural areas and from various forms of social pressure and control. It may be a challenge, for example, to obtain a contraceptive prescription in a small community because of doctors' conscientious objection. Further, there may be only one gynecologist or pharmacy in the area, which a woman may be reluctant to visit for fear of her family and friends discovering that she is using contraceptives.¹⁷⁹

Renáta, described above, said that while hormonal contraception and condoms are accessible in towns and cities, there is a problem in villages. She shared the story of her sisters-in-law, who live in a village: "My husband is from the village and his sisters have a big problem with [accessing contraception], and basically both of them had to get married." She giggled and continued: "It was a big problem for them to either buy contraceptives or have them prescribed." Renáta ascribed this to "everybody know[ing] everybody" in the village; there being only one doctor for the whole community; and the strong influence of religion, "so everyone pretends that sex is [only] after the wedding."¹⁸⁰

According to Mária, described below, people in her village do what they are told in church, where the use of modern contraceptives is not condoned: "[The people] just simply submit to it, because they don't want those old ladies to give them an evil eye."¹⁸¹

According to Ms. Sejková, the NGO representative described above, girls in rural areas have problems admitting that they use contraceptives or would like to use them. She believed that this is also due to the strong influence of religion in those areas and the prevailing view that sex should be postponed until after marriage. Even though young men and women might have opinions of their own, they must deal with strong pressure and control from their surroundings, which can make them feel like they have to conform.¹⁸²

Barriers Young Women Face¹

Unaffordability

The average age of first sexual intercourse among young people in Slovakia is 17 years old.² Since young women often do not have their own income, coming up with enough money for contraceptives can be difficult or even impossible. The majority of young women interviewed for this report who were using prescription contraceptives or had done so in the past said their parents paid for them. In addition, a few young women mentioned using their pocket money for contraceptives.³ Some young women also said that without parental support, they would not be able to use contraceptives.⁴

Miroslava, an 18-year-old, captured the situation of many adolescents:

I think that adolescents face a lot of financial barriers to access. . . . Students who do not work have problems to buy contraceptives if their parents don't support them financially. For me, it is financially possible to choose because my parents are helping to pay for it. . . . Prices make access more difficult, especially for young girls if their parents don't want to support them. They end up looking for other solutions that don't end up very well.⁵

Young women are thus dependent on their parents for being able to use contraceptives, which is problematic if the women do not have an open relationship with their parents or if their parents simply cannot afford contraceptives.⁶

When Mária, a 19-year-old student, was asked if she would consider using contraceptives, she explained that she would like to use them “right now.” The only reason holding her back is money—she cannot afford contraceptives and her parents do not help her buy them.⁷ She further explained, “The money restricts the most. There is no freedom. Because if there was freedom, then I could choose, either this or that. . . . But if there is no money, then I have only one option: that I will not take [contraceptives].”

18-year-old Nina said that, among her friends, price is the main problem with using contraceptives. She noted that prices have “certainly” been going up. Nina has “a friend who stopped taking contraceptives just because of the price.”⁸

Ms. Vargová, a pharmacist, has noted that emergency contraception is prohibitively expensive (€22) for young women, particularly students, who lack income. She noted that when some of her customers see the price of emergency contraception, they realize that they cannot afford it and purchase a pregnancy test instead.⁹

Parental Consent

Having to go to the gynecologist is also a barrier for girls under 18 who may be unable to obtain the necessary parental consent¹⁰—for example, when they do not have a good relationship with their parents.¹¹ Some of the young women interviewed for this report have friends who cannot use contraceptives because of parental consent or who take contraception prescribed for someone else.¹² Women did not agree with the parental consent requirement, arguing that girls are able to think for themselves and take responsibility for their own lives.¹³ Moreover, they said that contraception is preferable to an unintended pregnancy, and all its consequences.¹⁴

Alexandra, a 20-year-old, felt that the government should devote more attention to the problems of girls and young women:

*For example, [some girls] are afraid to go to their parents to get parental consent, [and the state should] find better solutions for this problem, because the girls don't realize what the danger can be to their lives [if they become pregnant].*¹⁵

Kamila, a 19-year-old, viewed the parental consent requirement as bad policy. She said that if a girl thinks in a normal and sensible way, there is no reason to require a parent's consent for contraceptive prescriptions. Instead, girls should be allowed to take responsibility for themselves.¹⁶

Lack of Communication with Parents

One of the Catholic Church hierarchy's arguments against sexuality education in schools is that such education should be left to the parents.¹⁷ However, as the testimonies gathered for this report showed, parents rarely have open discussions about contraception with their children,¹⁸ making sexuality education in schools all the more important. This is also reflected in General Comment 4 of the Committee on the Rights of the Child (Children's Rights Committee), which states that adolescents should have access to sexual and reproductive health information regardless of their parents' consent.¹⁹ The young women we interviewed felt hesitant to bring up contraception with their mothers, who grew up at a time when sexual issues were even more taboo in Slovakia than they are today. At the same time, some parents—feeling uncomfortable with the subject, lacking accurate information themselves, or against contraceptives for religious reasons—pretend that there is nothing to talk about.²⁰

When talking about communication between parents and children on contraception, Lívía, a 23-year-old woman with one child, said the following:

*[The] parents of [my] friends did not speak to them about [contraceptives] when they were younger, and now when my friends are older, their parents do not consider there is a need anymore to talk to them about contraception. . . .*²¹

Impact on Other Rights

Failing to provide adolescent girls with adequate contraceptive services and information not only constitutes a human rights violation in and of itself but also affects other rights, such as the right to education. The Human Rights Committee, Children's Rights Committee, and ESCR Committee have all noted that unintended pregnancies, which may be caused by a lack of family planning services and sexuality education, should not interfere with girls' ability to exercise their right to education.²²

Sexuality Education and Information on Contraception

Accurate, unbiased, and comprehensive education on sexual and reproductive health is vital to women's and girls' abilities to make informed decisions on contraceptive use.¹⁸³ The interviews conducted for this report show that despite international standards and recommendations from international bodies, sexuality education in Slovakia, particularly concerning different methods of contraception, remains wholly inadequate. It is important to note that while international human rights laws and standards support a general right of adolescents to receive sexuality education, the discussion below is limited to the specific right of adolescents to receive sexuality education in schools.

School Is Not a Main Source of Information on Contraception

The women and adolescents interviewed reported that their most common sources for gathering information are friends,¹⁸⁴ family members,¹⁸⁵ gynecologists,¹⁸⁶ magazines,¹⁸⁷ and the internet.¹⁸⁸ Notably, while the doctor or gynecologist was cited as the most trustworthy source,¹⁸⁹ other women came in as a close second.¹⁹⁰ Painfully missing among most common and trusted sources of information is the school, which ought to be a primary source of reliable and comprehensive information on contraceptives for everyone.

Inadequacy of Sexuality Education in Schools

Our interviews demonstrate that sexuality education in Slovak schools is very minimal, and sometimes nonexistent. Moreover, each school exercises discretion regarding the specific content of this education. Consequently, whether and how sexuality education is taught depends on the views of individual teachers and school administration—and sometimes influenced by the Catholic Church hierarchy.¹⁹¹

According to Dr. Molnárová, the lack of access to contraceptives has to do with the way schools provide sexuality education:

*[N]owadays, at many secondary schools there is sexual education, which is taught by catechists, or people who are from different parishes, and [their] explanation of this area is pronouncedly one-sided. . . . We still have a problem [establishing] sexual education within the framework of classes at school. It's still more or less up to biology teachers. In fact, it depends on the professor's view in what direction it all goes.*¹⁹²

Ms. Pietruchová of the Slovak Family Planning Association also cited lack of adequate sexuality education as a problem:

*Sex education—that is, “Education for Marriage and Parenthood”—is not a mandatory subject, but if the school chooses to teach it, it should do it according to [official school] guidelines [set by the Ministry of Education]. However, these guidelines are very general; anything can be included under the topics addressed. Moreover, the name of the subject itself—“Education for Marriage and Parenthood”—is sick.*¹⁹³

Ms. Eva Sopková, director of the NGO Pro Familia, lamented:

*Now [after the fall of communism], because of the church, many are afraid to even touch upon sexuality education.*¹⁹⁴

Mária recalled that a classmate's father, who was a pastor, objected to a lesson on contraceptives being given at school. As a result, the school cancelled the lesson.¹⁹⁵

Professor Bosá, described above, shared her experience in developing a program that integrated sexuality education into existing curricula but that was never implemented:

*I was a teacher and responsible for coordinating a sexuality program at a primary school in 2002. The whole task was to make a timetable and plans on that subject, and to fit it into other subjects that were relevant to sex education. . . . It was very hard work; I had to take the teaching plans of every teacher and find the right space to fit in information on sexuality. Once I finished, the deputy took the plan and put it in her drawer—she just wanted it in case of an inspection. If the inspector came and he would see we're not teaching sexuality education, we would have an excuse: we are not teaching it today, but we have it in a plan, we do teach it. . . .*¹⁹⁶

While most women reported having received some sexuality education in school, it usually included only basic information on biological aspects, menstruation, and reproductive organs. Almost no one had been given any information on pregnancy prevention or contraceptives.¹⁹⁷ Moreover, Professor Bosá, who also has experience working at secondary schools, said that when the subject is discussed, the information given to students focuses disproportionately on the negative effects of contraception.¹⁹⁸ However, sometimes students are blatantly misinformed.



Sexuality education in Slovakia is frequently inadequate or absent. Whether and how sexuality education is taught depends on the views of individual teachers and the school administration—and sometimes influenced by the Catholic Church hierarchy.

Professor Bosá recounted such an incident and its adverse consequences:

I had one case at a primary school where I taught for a bit. A student came to me; she was 15 years old and had become pregnant, and was afraid to tell her parents. I told her to tell them and I will be with her and so on. She was very unhappy; she honestly didn't know how it could have happened. I asked her if she didn't learn about sex and pregnancy in biology. Her answer was, "Yes, but I had bleached hair." I really didn't understand why she was saying that, and then I thought about the religion teacher; he told the girls that if they colored their hair, they wouldn't get pregnant. So, [this girl] she . . . [had] believed she was protected.¹⁹⁹

Misinformation

Outside of schools misinformation on contraceptives is widespread as well, posing a significant barrier to access. Our interviews reveal that many women have distorted information on contraceptives; often, they believe that contraceptives damage their health and have an exaggerated understanding of the side effects.²⁰⁰ Indeed, almost all of the women we interviewed had heard disconcerting stories about the side effects of contraceptives.²⁰¹ Aside from accounts of weight gain, hair loss, headaches, depression, and general poor health,²⁰² common contraceptive myths included having an increased risk of breast cancer²⁰³ and being unable to conceive after using the pill.²⁰⁴ Women are also afraid that hormonal contraception would significantly harm their body's hormonal balance.²⁰⁵ For some, the fear of side effects is so strong that it keeps them from using contraceptives.²⁰⁶ In this regard, several women mentioned that the information leaflets attached to contraceptive packages include so many side effects as to be frightening.²⁰⁷

Beáta, described above, holds ideas about contraceptives that have kept her from even discussing the option with her doctor. To her knowledge, women must be closely monitored and undergo liver tests when using contraception. She recognized that her ideas might be a bit old-fashioned, but still thought that there are serious side effects from modern contraceptives—thus keeping her from using them.²⁰⁸

Due to the lack of adequate sexuality education in schools, misinformation about the effects of contraceptives also

abounds among young women and may have detrimental effects for their health and well-being. For example, Barbora, described above, who uses the pill, believes that it also protects against sexually transmitted infections.²⁰⁹ And, Daniela, an 18-year-old who had used contraceptive pills in the past, stopped using them and seemed unsure of what to do after her psychologist told her about a woman who went mad after using contraceptives and her homeopath told her that pills are bad for the ovaries.²¹⁰

Communication and Accessibility Issues with Gynecologists

In order to access hormonal contraceptives (with the exception of emergency contraception), women in Slovakia need a prescription from a gynecologist, whom they may visit without a referral from a primary care physician. Gynecologists, who specialize in reproductive issues and are the gateway to women's access to contraceptives, are well positioned to be a steady, reliable source of information on contraceptives. However, the testimonies gathered for this report show that time constraints, provider attitudes, and the costs involved with visiting a doctor's office may all work to inhibit women's and girls' access to contraceptive information—and to contraception itself.

Lack of Communication with Gynecologists

Although many women reported that the gynecologist is or would be their most trusted source of information on contraception, they pointed to several issues that prevent this from being the case. For one, interviewees noted that gynecologists by and large do not inform their patients about contraceptives on their own initiative. Women reported having to ask for information themselves²¹¹—and when they do, they are not always satisfied with the response. They complained that gynecologists do not explain everything they want to know, are not communicative, expect them to already know everything, and do not present contraceptive options to choose from.²¹² Romani women, because of negative stereotypes, noted that they are sometimes treated especially poorly, even with hostility, by doctors.²¹³

Some gynecologists themselves mentioned not having a lot of time with each patient,²¹⁴ which may explain why they do not initiate conversations on their own. According to the pharmacist Ms. Vargová, whether or not women receive enough information depends on the gynecologist:

There are some gynecologists who have a lot on their plate. Some, I can say specifically, . . . they check you, say everything is ok, give [you] a

*prescription, and tell [you] to read the instruction leaflet and goodbye. And there are some who explain and speak to you about it and so on. . . It depends on the gynecologist; especially some older gynecologists do not talk much about [contraception] and can't explain much about it.*²¹⁵

These time-related concerns were echoed by Dr. Molnárová, who recognized that not all women have sound information on contraceptives. She would like to provide the women she sees in her practice with reliable and comprehensive information on contraceptives. However, she said that she has very little time with each patient, making it difficult to always do so.²¹⁶

Conscientious Objection Inhibits Access to Contraception

Catholicism also influences access to contraceptives through conscientious objection. Some of our interviewees reported healthcare professionals invoking conscientious objection to refuse to prescribe contraceptives or fill a prescription.¹

Ms. Zdena Horvátová, who has worked as a pharmacist for over ten years, called it “shocking” that certain pharmacies do not sell contraceptives. She gave some examples:

*One pharmacy that is in our chain [doesn't sell contraception] because the head of the pharmacy is very religious and she doesn't [want to] sell it. She has control over what kind of pills she has in her pharmacy, so she doesn't have to order contraceptives. She tells people who come in, “We don't have pills.” . . . So I said, “She should have studied to become a nun, not a pharmacist.” . . . I [also] have a colleague who does not give out contraception, she always asks a colleague to do it so that she doesn't have to touch it.*²

Dr. Michal Kliment, a practicing gynecologist for 37 years and president of the Slovak Family Planning Association, explained that the state's failure to properly regulate conscientious objection enables the practice to stand in the way of women's access to contraceptives:

. . . in Slovakia, access to contraception is limited [by] conscientious objection of doctors whose actions are not regulated; there is no referral when a doctor refuses to prescribe contraception; in Slovakia the basic relations and rules on this matter are not defined.

Dr. Kliment also said that he personally knows of gynecologists who invoke conscientious objection to refuse to provide contraceptive services:

*Of course I do. There are doctors who refuse not only [to perform] an abortion, but also [to prescribe contraception as a [matter of] principle. But this is against the basic ethical principles of the International Federation of Gynecology and Obstetrics [FIGO]. One of the basic principles of FIGO is not to give preference to your religious views over your duty to patients. You cannot do it.*³

To Nina, 18-years old, it seemed only natural that gynecologists should not be allowed to use conscientious objection to impede women's access to contraceptives:

*I think this couldn't be a gynecologist, since they encounter [women wanting to use contraception] every day in work.*⁴

Beáta has never used any hormonal contraception:

*I don't have any experience with contraception. I have a gynecologist who never explained to me or never offered me, basically any possibility of contraception, or any forms. . . . Because I didn't have [any] option[s], [because he did not] explain to me this and that, . . . I don't know generally anything about it, yes, so it is basically for this reason I didn't use it.*²¹⁷

Ms. Vanda Durbáková, an attorney with Center for Civil and Human Rights (Poradňa), a human rights NGO, told us about the harsh reality that Romani women face. She knows of some doctors who “say they do not prescribe [contraception] to Romani women because you have to be regular [with it] and they think they will not [be capable of] us[ing] it regularly.”²¹⁸

Linda, a 33-year-old Romani woman with one child, expressed her frustration with the only gynecologist in her town:

I am not satisfied with the gynecologist from [my town], but what to do, Prešov is far away, I would

*have to travel there all the time. The gynecologist never explains what is wrong, he only makes jokes, writes something into the files, and that's it. He thinks that if we are Roma he doesn't have to inform us or treat us well.*²¹⁹

Lack of Access to Gynecologists

Time constraints and other factors, therefore, may undermine the functioning of gynecologists as easily accessible sources of information. In terms of actual access to contraceptives, gynecologists act as gatekeepers since, with the exception of emergency contraception, female hormonal contraception is available only by prescription. Because gynecologists usually write prescriptions for just three months at a time,²²⁰ women confront the difficulty of having to make repeated visits to the gynecologist.²²¹ Moreover, Romani women, some of whom are treated discriminatorily by healthcare personnel, including gynecologists, may be particularly hesitant to visit their offices for services or advice.²²²

While going to the gynecologist for a prescription is not a problem in and of itself, a visit may involve a significant time

Human Rights Require Regulating Conscientious Objection

International and regional human rights law requires states to ensure that health professionals' refusal to provide certain care or products based on their conscience does not unduly limit women's right to access medical services that they are legally entitled to receive.¹ The CEDAW Committee has recently raised this as a problem in Slovakia in its most recent recommendations to the state:

*While noting the measures taken by the State party to facilitate women's access to health care, including reproductive health, the Committee is deeply concerned about the insufficient regulation of the exercise of conscientious objection by health professionals with regard to sexual and reproductive health. . . . The Committee recommends that the State party adequately regulate the invocation of conscientious objection by health professionals so as to ensure that women's access to health and reproductive health is not limited. The Committee calls the attention of the State party to its general recommendation No. 24, which states that it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women.*²

In *Pichon and Sajous v. France*, the European Court of Human Rights explicitly addressed conscientious objection in the context of access to contraceptives. The Court stated that “as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products.”³ It thus made clear that health professionals' option to invoke the practice based on their right to freedom of thought, conscience, and religion is not unlimited and may not keep women from being able to access contraceptives.⁴

commitment, as women sometimes have to wait for hours before being seen. Making an appointment to avoid the long wait usually requires paying a fee in advance that can be as high as €7-10, which is too expensive for some women.²²³

Opinions on How to Improve the Situation

Our interviews with women, healthcare providers, NGO representatives, and other professionals bring to light the many barriers that women and adolescents in Slovakia face in accessing contraceptives. For some women, quality modern contraceptives are prohibitively expensive, while others cannot afford any kind of female-controlled contraceptive at all. Moreover, there is a lack of awareness surrounding modern contraception, fueled by conservative religious and societal pressures. Recognizing these problems, our interviewees offered possible solutions. It is telling that nearly everyone believed that the situation could be improved by two things: (i) public health insurance coverage of contraceptives and/or (ii) improved sexuality education in schools.

Include Contraceptives in Health Insurance Coverage

Almost everyone we interviewed believed that there should be at least partial health insurance coverage of certain kinds of contraceptives, citing various reasons.²²⁴ Some participants emphasized that women should be free to make decisions regarding their fertility and the use of modern contraceptives—and that women’s limited economic means should not be the deciding factor.²²⁵ Ms. Horvátová, described above, said that it is discriminatory for the government not to include contraceptives in its health insurance scheme “because the state is supposed to help its citizens, at least by subsidizing half of it. If we want to be a free state . . . mothers should be able to make free decisions.”²²⁶ Ms. Sejková also viewed the state’s failure to subsidize contraceptives as discrimination:

[The state not subsidizing contraceptives] is of course . . . discrimination against women because it puts them in a position where they have no choice. On the other hand, [by not subsidizing contraceptives, the state] is supporting the rural-religious view in all areas of human sexuality. . . The state pretends that “Yes, we support young, beautiful, happy and healthy families,” but at the same time it closes its eyes to the issue of safe sex. . . . So I think it is not only discrimination against women but also against young men who

*can have stress from it. . . . [Because] from my point of view, part of a normal life is also to have sex with somebody without being forced to have a family. So I think it is discrimination on part of the state.*²²⁷

Others remarked that including contraceptives in public health insurance is good policy because it is preferable to women having unwanted pregnancies.²²⁸ Further, several medical professionals noted that contraceptive coverage through public health insurance makes sense from an economic perspective, as unintended pregnancies cost the state more money than an insurance subsidy would.²²⁹

Svetlana, a 29-year-old mother of one, supported public funding for contraceptives. She said that one of the main reasons women don’t use contraceptives is because they are expensive, which leads to a lot of “unwanted pregnancies, abortions, and children put aside.” Subsidization would help prevent that.²³⁰

Ms. Henrieta Novotná, a social worker, suggested that public funding for contraceptives could help young girls who are ashamed to ask their parents for money for contraceptives: “Some may say that we [would be] giving them space for free sex, but if [the girl] is protected, she is taking responsibility. I don’t think we can stop them from having sex.”²³¹

Many of the participants who favored some form of public funding for contraceptives believed that coverage should be for *all* women,²³² explaining that it would be discriminatory to subsidize contraceptives only for certain women, such as Romani or low-income women.²³³ Moreover, basing coverage on income level could lead to administrative problems, as several medical professionals noted, and could fail to reach those who may be most in need, such as women in abusive relationships who have sufficient family income to afford contraception but cannot access that income.²³⁴

Ms. Sejková supported contraceptive coverage through public health insurance but thought that it was a bad idea to devise a scheme based on women’s income. She explained that, legally, her clients, who are survivors of violence, are considered to have access to their husbands’ income. If contraceptive subsidization were based on income and her clients’ husbands earned more than the threshold set by the state, these women would not be eligible for a subsidy when they in fact may not have access to the family income at all. That is why, she felt, it would be better for the state to provide a fixed discount on the price of contraceptives.²³⁵

Improve Sexuality Education in Schools

In addition, nearly all participants felt that schools and the public education system should bear responsibility for disseminating information on contraception.²³⁶ They believed that schools should provide information on contraception starting at an early age,²³⁷ that sexuality education should be firmly established in the curriculum, and that information should be given in a systematic way.²³⁸ Some professionals also thought it would be good if trained healthcare providers gave presentations on contraception, since the “people who lead these classes [now] are amateurs.”²³⁹

Dr. Molnárová told us that most of her patients with unintended pregnancies are 15 to 19 years old:

*It's a pity. It's already late when they come and that's why I think that the only form of prevention is to give more the education to schools, but not in the form of a [short] presentation, . . . as is often the case [now]. . . . It must be systematic. If there is no system and systematic work, it is useless.*²⁴⁰

Dr. Kliment, described above, recognized lack of access to contraception as a complex problem whose resolution requires efforts in several areas, including improved access to health services and sexuality education:

*First of all, children should have accurate education so they can protect themselves . . . against sexual abuse and sexual violence, [and] against unintended pregnancies. . . . So sexual education . . . is important.*²⁴¹

Klaudia, described above, thought that the state should help women prevent unwanted pregnancies through education in schools. Families have different social and religious backgrounds, and some may not speak about sexuality and contraception in the home—making the school an important place for ensuring that all children receive information.²⁴²

Almost all of the adolescents and young women who spoke on this topic believed that sexuality education in schools should be provided in a manner different from the current method. It should be more informal, more interesting with real life experiences, and no longer treated as taboo.²⁴³

Gabriela, a 19-year-old, spoke about sexuality education in school and how she thinks access to contraception can be improved:

*Generally, I think that . . . I don't know how to say it . . . the sexual education is strange, children take it more as taboo or that it is very funny. I think it would need reform, or to set it firmly into the curriculum. [To improve access to contraception I would] mainly introduce sexual education in schools; it is stupid to say that it must be like this, but it is needed.*²⁴⁴

Daniela, described above, also felt that sexuality education should be treated differently. She recounted:

*Yes, [I had sexuality education]. I remember that they took all the boys away and it was one lesson. And they told us about genitals and they explained how a woman gets pregnant and it was something they could have told us in year five [when we were 10 or 11 years old]. [Instead, this lesson was in year nine, when students are 14 or 15 years old.] We were free to ask about things, but there was nothing to ask about, it was a very embarrassing situation. I think if they gave it in an informal, different way, students would understand it differently, even in high school. Although in high school is too late, it should be done in primary school.*²⁴⁵

HUMAN RIGHTS VIOLATIONS IN THE CONTEXT OF CONTRACEPTIVE SERVICES AND INFORMATION

National, Regional, and International Law and Policy

The findings of this report reveal violations of fundamental human rights that are protected under national, regional, and international law. The Slovak government is obligated to guarantee the rights to equality and non-discrimination, the right to health, the right to information, and the right to privacy. The violations described in this report demonstrate that Slovakia is not implementing its domestic and international obligations to respect, protect, and fulfill these rights.

At the national level, numerous laws and policies require the state to guarantee contraceptive services and information. Slovakia has also ratified regional human rights treaties such as the European Convention for the Protection of Human Rights and Fundamental Freedoms and the Revised European Social Charter.²⁴⁶ At the international level, Slovakia has signed on to all major international human rights treaties, including the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant), the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child. Under the Slovak Constitution, international human rights treaties ratified by the state have priority over national laws.²⁴⁷ Furthermore, Slovakia has committed itself to international consensus documents such as the Beijing Declaration and Platform for Action and the Programme of Action of the International Conference on Population and Development.²⁴⁸

These national, regional, and international instruments require Slovakia to ensure that women and adolescent girls have access to a full range of affordable and acceptable contraceptive services and information. However, despite clear legal obligations, Slovakia does not provide coverage of contraceptives through its public health insurance scheme, making the cost of acceptable pregnancy prevention

methods prohibitive for many women. Slovakia also does not provide access to accurate, comprehensive information on family planning, which further undermines the use of contraceptives and harms the health and well-being of women and girls.

National Law and Policy

The Constitution

Several human rights and fundamental freedoms related to sexual and reproductive health in general, and contraceptives in particular, are set forth in the Slovak Constitution. They include the right to life,²⁴⁹ the right to health,²⁵⁰ the right to information,²⁵¹ the right to be free from inhuman and degrading treatment,²⁵² the right to privacy,²⁵³ and the right to freedom of thought, conscience, religion, and belief.²⁵⁴ The Constitution guarantees all fundamental rights to everyone regardless of sex; ethnic, national, or social origin; property; belief; religion; or any other status. In addition, it grants that “[p]eople are free and equal in dignity and in rights.”²⁵⁵

Healthcare and Health Insurance

Under the Constitution, everyone is entitled to the protection of his or her health.²⁵⁶ Moreover, citizens and residents have a right to free healthcare through medical insurance, under the terms set forth by law.²⁵⁷ As such, all are covered by the obligatory public health insurance system, which is based on the principle of solidarity.²⁵⁸ In addition, individual private health insurance, which is supplementary to the mandatory public health insurance coverage, is available.²⁵⁹

Conditions related to the provision of healthcare, its subsidization, health insurance, and the status of health professionals are regulated by several healthcare laws. One such law is the Act on Health Care, which guarantees everyone the right to healthcare in accordance with principles of equal treatment and non-discrimination.²⁶⁰ It prohibits discrimination on numerous grounds, including sex, gender, age, ethnic group affiliation, social origin, property, and religion.²⁶¹ Accordingly, the government must

ensure that women and adolescent girls can access health services on the basis of equal treatment.

The Act on Health Care also sets out patients' rights and informed consent requirements. Under the law, health professionals must inform their patients "on [the] purpose, nature, impacts and risks of health care provision, on options of proposed procedures, and on risks of rejecting health care."²⁶² In the case of minors, parental consent is required before services may be performed. However, a minor should "participate in decision making to the highest extent allowed by [his or] her abilities."²⁶³

Abortion Law

Under Slovakia's abortion law and its implementing regulation, abortion is permitted on request during the first 12 weeks of pregnancy, and thereafter if the woman's life is in danger or in cases of fetal impairment.²⁶⁴ To obtain an abortion, a woman must submit a written request to a gynecologist, who then must provide the woman with information on the purpose, nature, course, and consequences of the procedure, alternatives, and the current developmental stage of the fetus.²⁶⁵ If the gynecologist believes that the conditions allowing a woman to terminate her pregnancy are satisfied, she or he should approve the request.²⁶⁶ A 48-hour waiting period applies to abortion on request, starting from when the gynecologist sends the report on the provision of the mandated information to the relevant state institution.²⁶⁷ In case a woman's request for an abortion is denied, she has the right to appeal.²⁶⁸ Minors need the written informed consent of their legal guardian before they may undergo an abortion.²⁶⁹

Aside from regulating access to abortion, Slovakia's abortion law also focuses explicitly on the prevention of unintended pregnancies.²⁷⁰ Under the law, unintended pregnancies are to be prevented by education on "planned and responsible parenthood" and by the use of contraceptives, and prescription contraceptives "shall be provided to a woman free of charge."²⁷¹ Yet, according to practice, the user pays for contraception in full. The only exception is sterilization, which is covered by public health insurance when there is a medical indication for a high-risk pregnancy. [See box Subsidization of Sterilization, p. 21.]

Drug Regulations and Insurance Coverage

Even though the abortion law provision mandating the state to provide prescription contraception free of charge remains formally valid, a subsequent legal regulation on public health

insurance coverage for drugs is followed, rendering the provision obsolete.

The coverage of drugs by public health insurance is determined by the categorization process,²⁷² which is the procedure used to decide whether a drug is covered by public health insurance and to what extent. To be eligible for coverage, several criteria must be met. A drug must possess, among other things, life-saving, curative, or preventative qualities;²⁷³ and its effectiveness, contribution to the reduction of morbidity and mortality, indications and contraindications, and prevalence of adverse effects must also be taken into account.²⁷⁴ An appointed categorization commission reviews the list of subsidized drugs on a regular basis, with the Ministry of Health having the final say on what medicines to include.²⁷⁵ Because contraceptives are excluded—despite being on the WHO Model List of Essential Medicines—users must pay full price for them. Because contraceptives also do not fall under Slovakia's price regulation system, their price is governed by the market, which keeps many of them relatively expensive.²⁷⁶ [See box WHO Model List of Essential Medicines, p. 13; Lack of Contraceptive Coverage, p. 19.]

Ministry Policies Related to Sexual and Reproductive Health

In Slovakia, there is no one comprehensive state policy addressing sexual and reproductive health and rights issues. Instead, several ministries—the Ministry of Labor, Social Affairs and Family; the Ministry of Health; and the Ministry of Education, Science, Research and Sport—carry part of this responsibility, resulting in a limited and piecemeal approach that fails to provide women and adolescent girls with access to a full range of affordable and acceptable contraceptive services and information.

Ministry of Labor, Social Affairs and Family

The Ministry of Labor, Social Affairs and Family is responsible for the National Strategy for Gender Equality for 2009–2013.²⁷⁷ The strategy identifies gender-specific healthcare services, including protection of sexual and reproductive health, as one of the focus areas for specific action plans on gender equality.²⁷⁸ However, to date, the national action plan that was adopted to implement the strategy's goals does not address sexual and reproductive health issues.²⁷⁹

Ministry of Health

The Ministry of Health is responsible for designing and implementing policies related to sexual and reproductive

health and information. Health has been recognized by the state as key to society's and individuals' development. In addition, accessibility and equality in access to healthcare are considered fundamental values of the healthcare system.²⁸⁰ Accordingly, the objectives of Slovakia's current health policy include improving the affordability of healthcare by focusing on prevention and using the available financial resources in such a way that everyone has an equal opportunity to access effective health services.²⁸¹ However, while there have been several proposals to give voice to these objectives—for instance, in the 2007 draft program on sexual and reproductive health—the Ministry has failed to translate them into practice, leaving many women unable to afford contraceptives of their choice. [See Unaffordability of Contraceptives, p. 21.]

Ministry of Education, Science, Research and Sport

The Ministry of Education, Science, Research and Sport concerns itself with matters related to sexual and reproductive health information, such as the content of sexuality education in schools. In 2008, it was tasked with proposing legislative amendments to “upgrade school curricula on Education for Marriage and Parenthood and . . . support education on sexual and reproductive health, family planning, prevention of sexually transmitted diseases (use of condoms), [and] sexual abuse of children and youth. . . .”²⁸² This task is also meant to ensure that sexuality education reaches students in the lower grades of elementary school, when they are seven to ten years old.²⁸³ [See Lack of Information and Sexuality Education, p. 24.]

Regional and International Standards

The Rights to Equality and Non-Discrimination

The rights to equality and non-discrimination are fundamental rights found in every major regional and international human rights instrument. The equality and non-discrimination provisions in these instruments focus on equality between men and women and include sex or gender as a prohibited ground for discrimination. The lack of access to contraceptives and contraceptive information discriminates against women and adolescent girls because it relates to healthcare services that, due to biological, social and cultural factors, primarily affect women and whose absence have a far greater impact on women's lives than on men's lives.²⁸⁴ In so disregarding women's reproductive health needs, states are violating the rights to equality and non-discrimination.

CEDAW, which is of particular importance when it comes to gender equality,²⁸⁵ recognizes that women's “role in procreation” exposes them to discrimination.²⁸⁶ The treaty acknowledges that despite efforts to eliminate discriminatory laws and practices, women “. . . continue to suffer from various forms of discrimination because they are women.”²⁸⁷ This recognition is particularly important in the context of access to reproductive healthcare; the CEDAW Committee has stressed that the obligation of non-discrimination requires that states parties not only treat men and women identically when their interests are the same but also acknowledge and address biological—as well as socially and culturally constructed—differences.²⁸⁸

In order to achieve gender equality and non-discrimination, CEDAW requires that states adopt measures “towards a real transformation of opportunities, institutions and systems so that they are no longer grounded in historically determined male paradigms of power and life patterns.”²⁸⁹ For example, the Committee has addressed women's existing inequalities in the family as they relate to decisions on the number and spacing of children, noting that “the responsibilities that women have to bear and raise children affect their right of access to education [and] employment[. . .] impose inequitable burdens of work on women. . . . and also affect their physical and mental health.”²⁹⁰ To effectively end the

Slovakia Should Promote Male Involvement in Family Planning

Although men and women should share responsibility for contraception and family planning, male involvement is often lacking in practice. On several occasions, the CEDAW Committee has expressed concern over countries in which family planning, including “contraception[,] . . . appears to be regarded as the sole responsibility of women”¹ and has urged governments to adopt programs and policies that “increase knowledge of and access to contraceptive methods”² and “stress the shared responsibilities of women and men in this regard.”³

In addition, the Children's Rights Committee has called on states to promote male acceptance of the use of contraceptives through education, health policies, and counseling,⁴ and to include men in programs on reproductive health.⁵

discrimination that women suffer in deciding whether and when to have children and the multiple inequalities that such discrimination fosters, CEDAW obligates states to ensure women’s access to “health care services, including those related to family planning,” as well as to information on such services.²⁹¹

The CEDAW Committee’s most recent recommendations to Slovakia specifically urge the state to “take measures to increase the access of women and adolescent girls to affordable health-care services, including reproductive health care, and to increase access to information and affordable means of family planning for women and men.”²⁹²

Discriminatory practices that affect the human rights related to contraceptive access and information are also fueled in part by pervasive gender stereotypes that exist in some societies. Under CEDAW, states are required to counter such stereotypical conceptions of women, which,

as the CEDAW Committee has time and again observed, may be propagated by inappropriate education, perpetuate discrimination against women, and stand in the way of women’s equality and advancement.²⁹³ As recent as 2008, the Committee recognized that Slovakia should do more to deal with this problem, expressing concern “about the persistence of traditional stereotypes regarding the roles and tasks of women and men in the family and in society at large, including in specific areas, such as . . . the health sector [and] academia and politics, that are strongly conditioned by traditional views.” It also expressed “concern at the persistence of gender stereotypes prevailing in school textbooks” and recommended “that policies be developed and programmes implemented to ensure the eradication of traditional sex role stereotypes in the family, labour market, the health sector, academia, politics and society at large.”²⁹⁴

The rights to equality and non-discrimination also mean that states cannot use religion or other social and cultural

EU Law and Policy on Gender Equality and Healthcare

Gender Equality

Gender equality is a fundamental right¹ recognized as central to achieving the EU’s objectives of growth, employment, and social cohesion.² As recognized by both EU and international bodies, the ability to control one’s fertility, which requires the availability and accessibility of modern contraceptive information and services is fundamental to reducing gender inequality.³ [See Regional and International Standards, p. 45.] While the EU admits to the persistence of gender inequality among Member States, it has paid little attention to women’s reproductive healthcare needs, including their need for improved access to quality modern contraceptives and contraceptive information.⁴

Healthcare

EU treaties also guarantee a “high level of human health protection” for all and the right to access preventative healthcare.⁵ As stated by EU health ministers and endorsed by the European Council, the overarching values of universality, solidarity, and equity underpin the health systems of Member States, which aim “to reduce the gap in health inequalities” across the EU.⁶ However, existing research on women’s health in Europe indicates persistent gender inequalities in health status and access to healthcare, both within and between Member States.⁷ This is a result of many disparities that women face as compared to men, such as unequal pay, greater responsibility in childrearing and other unpaid work, male violence against women, and discrimination based on gender stereotypes.⁸ The EU—despite its limited competence in healthcare policy—can act as facilitator and coordinator of health indicators and best practices across Member States;⁹ as of yet, however, it has failed to do so in the reproductive health field.

The EU should promote sexual and reproductive health and rights between and within Member States as an integral component of achieving gender equality, or else face failure in achieving this common value.

attitudes to perpetuate discriminatory and unequal treatment, including where it concerns women's right to family planning services and information. The Human Rights Committee has specifically urged states to "ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law. . . ."295

The Right to the Highest Attainable Standard of Health

Under article 12(1) of the Economic, Social and Cultural Rights Covenant, everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.²⁹⁶ The ESCR Committee has emphasized that this right entails an obligation on the part of states to ensure that health facilities, goods, and services are available, accessible, and acceptable to all without discrimination.²⁹⁷ Accessibility has an economic component, meaning that healthcare must be "affordable for all, including socially disadvantaged groups." It moreover includes the right of everyone "to seek, receive and impart information and ideas concerning health issues."²⁹⁸ In addition to being acceptable—that is, responsive to the needs and personal circumstances of women—all healthcare must also be medically appropriate and of good quality.²⁹⁹

The ESCR Committee has interpreted the right to health to encompass the right to sexual and reproductive health. Furthermore, it has stated that governments should ensure that all drugs on the WHO Model List of Essential Medicines, which include a range of contraceptives, be made accessible.³⁰⁰ The CEDAW Committee has also stated that the right to affordable contraception falls under the right to access healthcare, which is a basic human right under CEDAW.³⁰¹

In Slovakia, both the accessibility and acceptability of contraceptives are an issue. While contraceptives are available, they are inaccessible to many women, especially marginalized ones, due to their relatively high price. The ESCR Committee has made clear that health goods, including contraceptives, "must be affordable for all . . . whether privately or publicly provided."³⁰² In addition, "[e]quity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."³⁰³ Failing to ensure the affordability of contraception is a violation of the right to health, which, in the words of the ESCR Committee, can occur when there is "insufficient expenditure or misallocation of public resources [on health goods and

services] which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized."³⁰⁴

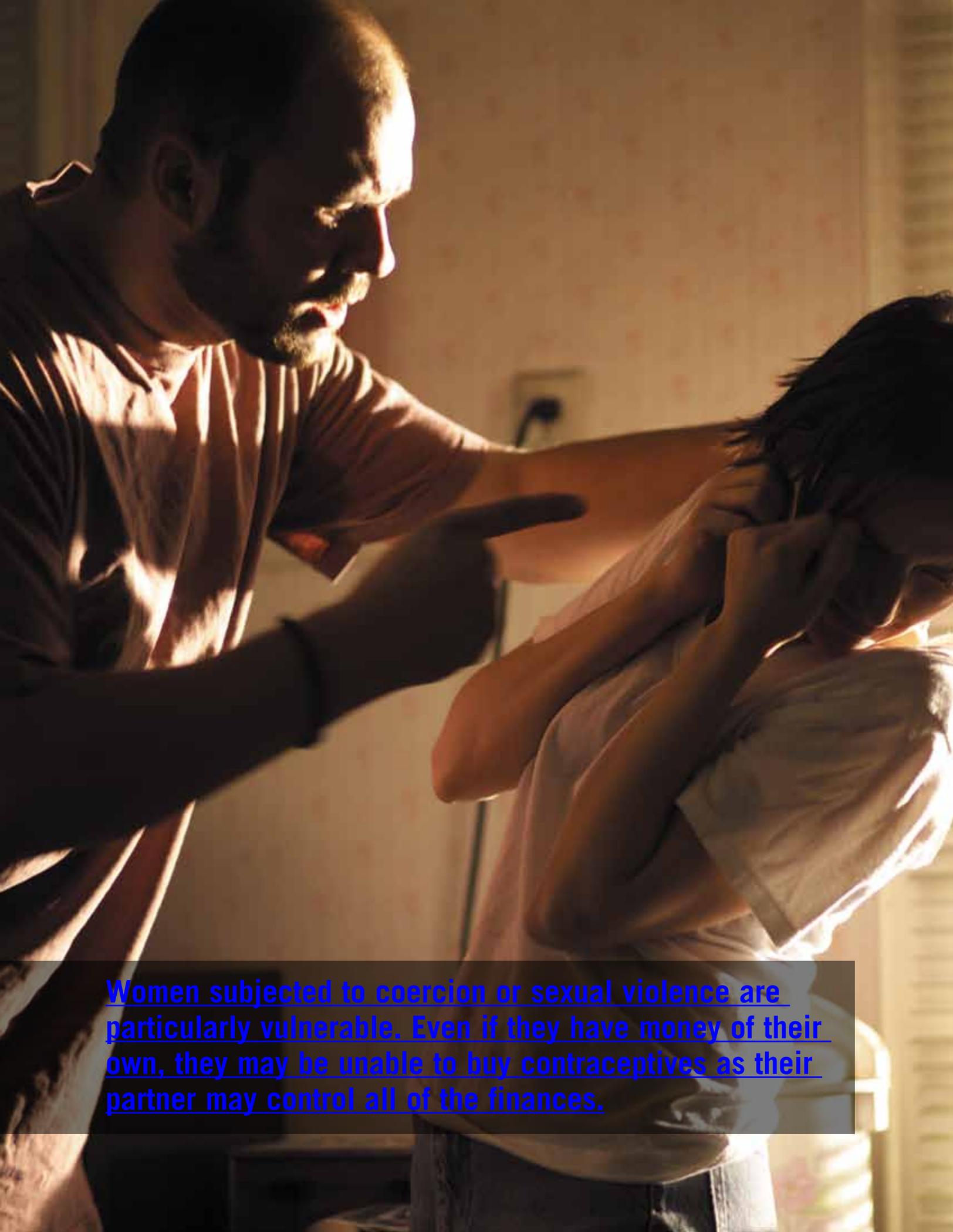
Regarding the acceptability of contraceptives, the ESCR Committee requires that health goods and services be "scientifically and medically appropriate and of good quality."³⁰⁵ Moreover, states must provide for "appropriate training of doctors and other medical personnel."³⁰⁶ However, in Slovakia, the high prices of certain contraceptive methods lead many women to resort to low-quality alternatives that may not be well suited for them based on their health or personal circumstances. Furthermore, some doctors may provide women with inaccurate information on contraception because they are not properly trained by the state.³⁰⁷ These shortcomings, which highlight Slovakia's disregard for the health needs of large parts of its population, are discriminatory and may negatively affect women's lives and well-being.

Access to a Full Range of Family Planning Methods

United Nations Treaty Monitoring Bodies

The CEDAW Committee,³⁰⁸ the ESCR Committee,³⁰⁹ and the Children's Rights Committee³¹⁰ have interpreted the right to health to require that states guarantee women's and adolescents' access to a full range of family planning services, including contraceptives (which encompass emergency contraception). This right gives women the ability to choose between different safe and effective contraceptive methods. Providing women with access to only one option, such as state-subsidized sterilization, or allowing barriers to access that force women to rely on traditional methods, such as periodic abstinence or withdrawal, is a violation of this right.

On several occasions, the CEDAW Committee has emphasized states' obligation to guarantee women's right to affordable contraceptives, recognizing that women may seek access to unsafe medical procedures, such as illegal abortion, due to a lack of means to appropriately control their own fertility.³¹¹ Moreover, the Committee has noted that access to family planning increases women's choice and empowers them.³¹² Consequently, it has frequently expressed concern over women's lack of access to and their low use of contraceptives³¹³ and has urged governments to improve access to prevention methods through increased insurance coverage³¹⁴ and greater attention to contraceptive costs.³¹⁵ In addition, the ESCR Committee has stated that governments have a core obligation to ensure the availability



Women subjected to coercion or sexual violence are particularly vulnerable. Even if they have money of their own, they may be unable to buy contraceptives as their partner may control all of the finances.

Marginalized Women and the Right to Access to Contraceptives

Recognizing that some women are particularly vulnerable, human rights standards frequently underscore the need for special efforts to accommodate marginalized women and their need for contraceptive and family planning services.

Adolescents

Although adolescents have the same right to access to contraceptives as adults, their lack of autonomy and physical vulnerability poses an additional barrier to exercising that right. States should thus take particular care to ensure that they fulfill their legal obligations with respect to adolescents. Providing adolescents with access to reproductive health services, including contraception, is important for helping reduce unintended pregnancies, unsafe abortions, and the spread of sexually transmitted infections.¹ Consequently, the Children’s Rights Committee has emphasized that governments have a duty to ensure that adolescents have access to such health services² and has encouraged states to offer contraceptives for free or at a low cost.³

If adolescents are to have access to affordable and acceptable contraceptives, it is paramount that they also have access to confidential reproductive health services. Parental consent or notification requirements may deter adolescents from seeking access to and advice on contraception, which could harm their health and well-being.⁴ The Children’s Rights Committee, in its General Comment 4, encourages states parties “to respect strictly [adolescents’] right to privacy and confidentiality, including with respect to advice and counselling on health matters.” The Committee further notes that “[h]ealth-care providers have an obligation to keep confidential medical information concerning adolescents. . . . Such information may only be disclosed with the consent of the adolescent.”⁵ In addition, the Committee has also asked states to remove parental consent requirements for contraception.⁶

Survivors of Violence

The Beijing Declaration and Platform for Action recognizes that many women have limited power in their relationships, which prevents them from making decisions regarding their sexual and reproductive health and inhibits their ability to decide freely and responsibly on the number and spacing of their children.⁷ As noted by the CEDAW Committee in its General Recommendation 24, these women and girls, who may be controlled by their partners and could be in violent relationships, “are often unable to refuse sex or insist on safe and responsible sex practices.”⁸ States are required to take measures against violence against women and safeguard the right to health of women in violent situations according to several treaty monitoring bodies, including the CEDAW Committee, the Human Rights Committee, and the ESCR Committee. Women should not be forced to bear the children of a violent partner, and women’s fertility should not be used as a means to control them. It is therefore of particular importance that states fulfill their obligation to ensure that even the most vulnerable women and girls, who may be victims of domestic and sexual violence and who may be economically dependent on their partners, have access to sexual and reproductive health services, including contraceptives.

Women in Rural Areas

Women and girls in rural or resource-poor areas require special attention when it comes to safeguarding their reproductive rights, including the right to contraceptives services and information. Their status, health, and economic power may be weak compared to that of their urban counterparts.⁹ Article 14 of CEDAW is dedicated to the protection of rural women’s right to health and requires states parties to take all appropriate measures to eliminate discrimination against women in rural areas regarding access to healthcare, including information, counseling, and family planning services.¹⁰ In addition, the ESCR Committee has noted in its General Comment 14 that “[p]ublic health infrastructures should provide for sexual and reproductive health services . . . particularly in rural areas.”¹¹

of all drugs on the WHO Model List of Essential Medicines, which includes contraceptives.³¹⁶

Council of Europe

Regional bodies also recognize that women must have access to family planning services, including affordable contraceptives. PACE has noted that access to affordable contraceptives must be part of Member States' policies on sexual and reproductive health and that Member States should appropriate money for contraceptives in their national budgets.³¹⁷ PACE reaffirmed the importance of ensuring access to affordable contraceptives in Resolution 1607, in which it called on Member States to "ensure that women and men have access to contraception and advice on contraception at a reasonable cost, of a suitable nature for them and chosen by them."³¹⁸ Moreover, the right to health in the European Social Charter, a binding instrument to which Slovakia is a party, requires states parties to ensure access to family planning services, which includes ensuring access to contraceptives.³¹⁹ In addition, the European Committee of Social Rights, which monitors compliance with the Charter, has made clear that healthcare must be accessible to everyone, even if it means that states must carry some of the financial costs that would otherwise fall on patients.³²⁰ The Committee has saluted states for improving access to family planning to reduce the number of unwanted pregnancies³²¹ and for providing access to contraception free of charge.³²²

International Consensus Documents

International consensus documents to which Slovakia has committed itself recognize the right to sexual and reproductive health. In discussing this right, these documents call on governments to ensure women's access to contraceptives. The Programme of Action of the International Conference on Population and Development, for example, recommends the provision of universal access to reproductive health services, urging countries to strive for universal access to a full range of safe and reliable family planning methods.³²³ Similarly, the Beijing Declaration and Platform for Action calls on governments to ensure a reliable, continuous supply of high-quality contraceptives.³²⁴

The Right to Decide on the Number and Spacing of Children

United Nations Treaty Monitoring Bodies

Article 16(1)(e) of CEDAW requires states parties to ensure that women, on an equal basis with men, have the right "to decide freely and responsibly on the number and spacing of their children and . . . have access to the information,

education and means to enable them to exercise these rights."³²⁵ In its General Recommendation 24, the CEDAW Committee links women's right to decide the number and spacing of their children to the right to health and emphasizes states' obligation to take appropriate "budgetary, economic and other measures to the maximum extent of their available resources" to ensure that women are able to exercise and enjoy these rights.³²⁶

International Consensus Documents

International consensus documents also recognize the right to decide on the number and spacing of children.³²⁷ For example, the Beijing Declaration and Platform for Action states that women's reproductive rights include "decid[ing] freely and responsibly the number, spacing and timing of their children. . . ."³²⁸ At the same time, the Declaration emphasizes that social realities, such as "inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services" and "the limited power many women and girls have over their sexual and reproductive lives" stand in the way of the realization of this right.³²⁹

The Rights to Family Planning Information and Sexuality Education

United Nations Treaty Monitoring Bodies

Article 10(h) of CEDAW requires states parties to ensure women's access, on an equal basis with men, to "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."³³⁰ The CEDAW Committee has encouraged countries to "continue . . . efforts to ensure women, particularly poor women, [have] access to family planning programs and related information to increase women's choice and as a means of empowerment."³³¹

As noted by the Special Rapporteur on the Right to Education, "[i]nternational human rights standards clearly establish the human right to comprehensive sexual education, which is indivisible from the right to education and is key to the effective enjoyment of the right to life, health, information and non-discrimination, among others."³³² The CEDAW Committee, ESCR Committee, and Children's Rights Committee have, for example, referred to sexuality education as a means to guarantee the right to health because such education contributes to reducing maternal mortality and morbidity, abortion, teen pregnancies, and HIV/AIDS.³³³ They have urged states to provide sexuality education in a systematic way³³⁴ and make it a mandatory part of the school curriculum,³³⁵ meaning

that parents should not be able to opt out on behalf of their children.³³⁶ The Human Rights Committee has linked sexuality education to the right to life, noting the importance of “ensur[ing] that schools include accurate and objective sexual education in their curricula.”³³⁷ Furthermore, the ESCR Committee and Children’s Rights Committee have

stated that the rights to health and information require states to refrain from “censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information.”³³⁸

Obligation to Gather Data

In order to monitor the implementation of states’ obligations under international human rights law, it is important that states collect data on a wide variety of issues broken down by different grounds, including age, gender, and ethnicity. Such gathering of data is essential if states are to develop effective strategies for the realization of human rights.¹ It is also key to promoting transparency and ensuring accountability, which “is one of the most important features of human rights . . . [and] includes the monitoring of conduct, performance and outcomes.”²

In context of the right to contraceptives and contraceptive information, the collection of data with respect to health, education, and the status of women are of particular importance. The WHO has emphasized that a well-functioning health system “ensures the production, analysis, dissemination and use of reliable and timely information on health determinants . . . and health status.”³ Likewise, the Special Rapporteur on the Right to the Highest Attainable Standard of Health has made clear that the right to health includes the requirement to collect “appropriately disaggregated data.”⁴ More specifically, the ESCR Committee has stated that the “disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.”⁵

Regional bodies have also recognized the importance of collecting disaggregated data on health and gender. For example, the Committee of Ministers of the Council of Europe has recommended that all Member States systematically collect appropriate sex-disaggregated data to combat gender inequalities in healthcare.⁶

Without reliable information on the number of women using contraceptives, the unmet need for family planning, or the number and spread of conscientious objectors, to name a few indicators, it is difficult to devise targeted policies to increase access to contraceptives. Governments can further use the lack of official figures as a shield when confronted with claims that they are failing to address barriers to access.

Slovakia’s lack of data collection, including in areas relevant to the right to access contraceptives, has long been recognized by treaty monitoring bodies as a problem that should be addressed. For example, in 2003, the Human Rights Committee stressed “the importance of data to assess the situation [on minorities and women] in the State party and to address possible inequalities and patterns of discrimination.” The Committee furthermore expressed concern “at the large discrepancy between official census figures and data provided by NGOs,” and urged Slovakia “to take steps to gather, through methods compatible with principles of data protection, statistical data reflecting the current . . . position of minorities and women in society.”⁷

A.S. v. Hungary (CEDAW Committee, 2006)¹

While undergoing surgery in connection with a miscarriage in a public hospital in Hungary, A.S., a Hungarian woman of Romani origin, was asked to sign a statement of consent to a cesarean section. The statement contained a barely legible note using the Latin word for sterilization. Only after she was sterilized did A.S. discover that she had agreed to a procedure that would make her permanently infertile.

In August 2006, the CEDAW Committee found Hungary in violation of CEDAW for the government's failure to protect A.S.'s reproductive rights. The decision establishes that the failure to provide reproductive health information and to ensure that women provide their full and informed consent to be sterilized violates women's most basic human rights, including the right to information on family planning services guaranteed under article 10(h) of CEDAW.² It marks the first time an international human rights tribunal has held a government accountable for failing to provide necessary information to a woman to enable her to give informed consent to a reproductive health procedure.

Council of Europe

In addition to encouraging Council of Europe Member States to provide women with access to affordable contraception, PACE also calls on states to ensure "women and men have access to . . . advice on contraception..."³³⁹ It also recommends that states

*adopt evidence-based appropriate sexual and reproductive health and rights strategies and policies, ensuring continued improvements and expansion of non-judgmental sex and relationships information and education, as well as contraceptive services, through increased investments from the national budgets into improving health systems, reproductive health supplies and information.*³⁴⁰

The European Committee of Social Rights has saluted governments for providing family planning advice free of charge in health centers.³⁴¹ The Committee has further held that states are required to ensure that sexuality education is "provided throughout the entire period of schooling", "forms part of the ordinary school curriculum," is "adequate in quantitative terms," and is "objective, based on contemporary scientific evidence and does not involve censoring, withholding or intentionally misrepresenting information, for example as regards contraception and different means of maintaining sexual and reproductive health."³⁴²

The Right to Privacy

The Human Rights Committee and other regional and international bodies have stated that decisions concerning whether and when to found a family are intricately linked to the right to privacy.³⁴³ The Committee has interpreted this right to include a state obligation to prohibit all interference with an individual's right to privacy by both public and private actors; to accomplish this, states should implement legislative frameworks and other measures protecting individual privacy.³⁴⁴ The ESCR Committee has also articulated on the right to privacy, declaring it an integral component of the right to health.³⁴⁵ In its General Comment 14, the Committee maintains that the freedoms encompassed by the right to health include "the right to control one's health and body, including sexual and reproductive freedom. . . ."³⁴⁶

The Right to Life

The Human Rights Committee, in addition to discussing reproductive rights in the context of privacy, has also recognized that access to contraceptives protects women's lives,³⁴⁷ particularly by preventing unintended pregnancies that may lead to unsafe, life-threatening abortions.³⁴⁸ It has therefore stated more than once that women should be ensured access to affordable contraceptives, which may require states to set up programs addressing financial barriers impeding access.³⁴⁹

CONCLUSION

Access to a full range of affordable and acceptable contraceptive methods and information is essential to women's and adolescent girls' equality, autonomy, health, and well-being. As such, it is recognized as a component of human rights at the national, regional, and international levels.

However, despite legal obligations and strong public policy justifications to protect this right, Slovakia continues to deny women and girls access to contraceptive services and information. Although the state's failure to collect ample, disaggregated data on relevant indicators stands in the way of determining the precise scope of the problem, this does not absolve the state from responsibility. It is evident from the interviews conducted for this report that action is needed.

The testimonies that we collected show that the absence of coverage for modern contraceptives through public health insurance forces some women to resort to contraceptives that are not well suited for them based on their health or personal circumstances. For the most vulnerable groups, any female-controlled method is out of reach.

By allowing this situation to persist, Slovakia has failed to implement national laws and policies and is violating numerous human rights, including women's rights to equality and non-discrimination, the right to decide freely and responsibly on the number and spacing of their children, and the right to health, which have been interpreted by the international and regional human rights bodies as requiring states to provide women with access to a full range of family planning methods, including contraceptives.

The testimonies further reveal that women's access to contraceptives is also impeded by the lack of available reliable information on family planning methods. Participants noted that in many schools, sexuality education is inadequate or absent, focusing only on reproductive

organs and influenced by religious views. It is clear that in neglecting to fulfill its obligations in this regard, the state is swayed by the Catholic Church hierarchy, which has had a growing impact on law and policy since the fall of communism and whose strong influence was revealed during our interviews. The hierarchy not only promotes ineffective traditional family planning methods but also actively advocates against the use of modern contraceptives. In addition, gynecologists frequently lack the time or will to appropriately discuss contraceptives with their patients. Consequently, misinformation and myths about the side effects of contraceptives abound.

By failing to provide women and girls with sound and comprehensive information on family planning, including contraceptives, Slovakia is violating their right to information on family planning guaranteed under CEDAW. It is also violating their right to sexuality education, which has been recognized by the Special Rapporteur on the Right to Education and several treaty monitoring bodies as vital to and grounded in the rights to health, life, information, and non-discrimination.

Our interviewees voiced broad support for subsidizing contraceptives through public health insurance in order to enhance women's empowerment and prevent them from having to deal with the consequences of unintended pregnancies. Improving sexuality education was also seen as a positive step that the government could take to increase women's access to contraceptives. The state should give heed to these views and address the public's health needs more seriously.

In times of economic crises, which often have a greater impact on women than men, it is especially important that governments do not shortchange human rights in the name of economic prudence or necessity. Slovakia must correct its failure to provide women and girls with access to the contraceptive services and information they are entitled to receive.

RECOMMENDATIONS

The following recommendations are based upon the findings of this report. They do not exhaustively list the actions required of the Slovak government and parliament to comply with its international legal obligations, but instead target some of the key rights violations that we encountered during our investigation. The government must ensure a comprehensive and coordinated approach to the legislative, policy, and budgetary changes needed to ensure women's and adolescent girls' access to a full range of affordable and acceptable contraceptive services and information. In addition, these recommendations should be implemented in close consultation with civil society.

To the Government of the Slovak Republic and its Ministries

- Ensure effective implementation of international obligations in the field of sexual and reproductive health, including the CEDAW Committee's 2008 concluding observations on Slovakia.
- Incorporate gender analysis and gender budgeting into all governmental policies and programs, including those on health and reproductive health, to ensure equality in practice.
- Adopt a comprehensive program on sexual and reproductive health based on international human rights and WHO standards. In addition, ensure that action plans on gender equality include measures related to the enhancement of reproductive health and rights, including the promotion of contraceptive services and accurate information. Ensure sufficient financial support for these policies and measures, as well as effective monitoring mechanisms for their implementation.
- Ensure access to all modern contraceptive methods for women of all socioeconomic classes and age groups by fully covering them through public health insurance.
- Organize and support awareness-raising campaigns on contraception that provide accurate and non-judgmental information on use and effectiveness.

- Organize systematic training of health professionals on new contraceptive services and information, in particular, and on sexual and reproductive rights and other human rights, in general.
- Collect, on a systematic basis, comprehensive data related to sexual and reproductive health and rights, including data on contraceptive use and unmet need for contraceptives. Ensure that all collected data are disaggregated by sex, age and other characteristics as necessary.
- Undertake comprehensive research on access to contraception in Slovakia, which should result in the design and adoption of measures that would lead to the elimination of existing barriers. Such research should be undertaken on a regular basis to ensure that individuals' contraceptive needs, especially those of women and adolescents, are fully met.
- Establish sexuality education as a mandatory subject in primary and secondary schools and revise textbooks and other teaching materials to ensure comprehensive, evidence-based sexuality education free of stereotypes. Sexuality education must be taught by teachers properly trained in this area.
- Ensure that access to contraceptive and other reproductive health services is not limited by health professionals' exercise of conscientious objection. Amend existing regulations in order to appropriately balance the exercise of conscientious objection with professional responsibility and the patient's right to access lawful healthcare services in a timely manner.

To the National Council of the Slovak Republic (Parliament)

- Explicitly include the right of every person to access sexual and reproductive health services in the Constitution of the Slovak Republic and in legislation.
- Incorporate gender analyses and gender budgeting into all relevant stages of the legislative processes.

To the Council of Europe

- Support Slovakia's implementation of PACE Resolution 1607 on access to safe and legal abortion in Europe (2008), particularly to adopt sexual and reproductive health and rights strategies and policies; ensure that women and men have access to contraception and advice on contraception at a reasonable cost, of a suitable nature, and chosen by them; and introduce compulsory sexuality education in schools to avoid unintended pregnancies.
- Monitor and support the implementation of the Recommendation of the Committee of Ministers on the inclusion of gender differences in health policy to Member States (2008). In particular, take the following actions:
 - Prioritize gender in the area of health through policies and strategies that address the specific health needs of men and women and that incorporate gender mainstreaming.
 - Systemically collect sex-disaggregated data.
 - Establish monitoring and evaluation frameworks on gender mainstreaming in health policies.
 - Implement measures presented in the appendix of the Recommendation.
- Support Slovakia's development of guidelines for gender budgeting in accordance with PACE Recommendation 1739 on gender budgeting (2006), particularly in ensuring the presence of gender analysis in the preparation, implementation, audit, and evaluation of government budgets.

To the European Union

- Recognize that sexual and reproductive rights are fundamental to the achievement of gender equality in EU Member States, without which the EU objectives of growth, employment, and social cohesion will not be achieved.
- Support Slovakia's implementation of European Parliament Resolution of 17 June 2010 on gender aspects of the economic downturn and financial crisis (2009/2204 [INI]).
- The European Commission should, under its authority in the Lisbon Treaty (article 168), organize the "exchange of best practices" or undertake initiatives aiming at the "establishment of guidelines and indicators" in the fields of sexual and reproductive health, particularly access to contraceptive services and sexuality education.

To U.N. Treaty Monitoring Bodies

- Monitor Slovakia's compliance with the treaty monitoring bodies' concluding observations on access to sexual and reproductive healthcare services.
- Use Slovakia's periodic reporting to issue strong concluding observations and recommendations to reinforce Slovakia's obligation to ensure access to quality contraceptive services and information. In particular, urge Slovakia to include contraceptives in public health insurance schemes; eliminate structural barriers that undermine access; ensure mandatory, comprehensive, evidence-based sexuality education in schools; and gather sex-disaggregated data.

- * Note: all interviews were translated by the Center for Reproductive Rights; Citizen, Democracy and Accountability; and Freedom of Choice Slovakia.
- 1 While condoms are easily accessible in Slovakia and are important in preventing pregnancy and sexually transmitted infections, including HIV, some women and adolescent girls (for example, those in violent relationships) may not be able to negotiate their use. *See, e.g.*, ANN M. MOORE, LORI FROHWIRTH, AND ELIZABETH MILLER, MALE REPRODUCTIVE CONTROL OF WOMEN WHO HAVE EXPERIENCED INTIMATE PARTNER VIOLENCE IN THE UNITED STATES (2010). In addition, human rights law specifically obligates states to make a *full range* of family planning methods available to women and adolescent girls so as to enhance their autonomy and meet their needs.
 - 2 Statistical Office of the Slovak Republic, *Chart 13 – Bývajúce obyvateľstvo podľa pohlavia a náboženského vyznania – 2001* [Official Census 2001], http://portal.statistics.sk/files/Sekcie/sek_600/Demografia/SODB/Tabulky/tab13.pdf (last visited Aug. 23, 2010).
 - 3 The Committee on Economic, Social and Cultural Rights defines availability, accessibility, and acceptability in the context of health. Availability means that “functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.” Accessibility means that “[h]ealth facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party.” The four prongs of accessibility are non-discrimination, physical accessibility, economic accessibility (i.e., affordability), and information accessibility. Acceptability means that health facilities must respect individuals’ cultures and confidentiality, as well as be sensitive to individuals’ gender and lifestyle. Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The right to the highest attainable standard of health*, (22nd Sess., 2000), paras. 12(a)–(c), U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *General Comment No. 14*].
 - 4 SUSHEELA SINGH ET AL., ADDING IT UP: THE BENEFITS OF INVESTING IN SEXUAL AND REPRODUCTIVE HEALTHCARE, Executive Summary (2004) [hereinafter ADDING IT UP (2004)]. *Id.* at 24–25.
 - 5 *Id.* at 5, 6, 25.
 - 7 *See* Rob Stephenson et al., *Domestic Violence, Contraceptive Use, and Unwanted Pregnancy in Rural India*, 39(3) STUDIES IN FAMILY PLANNING, 177, 183–184 (2008); Interview with Apolónia Sejková, in Prešov (Apr. 14, 2010); Interview with Ida, in Humenné (Apr. 15, 2010); Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, in Humenné (Apr. 15, 2010); Interview with Klaudia, in Prešov (Apr. 16, 2010); Interview with Dr. Galina Kováčová, in Prešov (Apr. 16, 2010); Interview with Xénia Vránska, in Košice (Apr. 19, 2010); Interview with Iveta and Alena, in Michalovce (Apr. 20, 2010); Interview with Henrieta Novotná and Božidara Balážová, in Michalovce (Apr. 20, 2010).
 - 8 UNITED NATIONS POPULATION FUND (UNFPA) AND UNITED NATIONS DEVELOPMENT FUND FOR WOMEN (UNIFEM), GENDER RESPONSIVE BUDGETING AND WOMEN’S REPRODUCTIVE RIGHTS: A RESOURCE PACK 28–33 (2006), available at <http://www.uneca.org/adfvi/documents/UNIFEM-GRbudgeting.pdf> [hereinafter GENDER RESPONSIVE BUDGETING AND WOMEN’S REPRODUCTIVE RIGHTS]; SUSHEELA SINGH ET AL., ADDING IT UP: THE COSTS AND BENEFITS OF INVESTING IN FAMILY PLANNING AND MATERNAL AND NEWBORN HEALTH 4–8 (2009), available at <http://www.gutmacher.org/pubs/AddingItUp2009.pdf>; GUTTMACHER INSTITUTE (GI), *Benefits of Meeting the Contraceptive Needs of Ethiopian Women*, 1 IN BRIEF 5–7 (2010), available at <http://www.gutmacher.org/pubs/IB-Contraceptive-Needs-Ethiopia.pdf> [hereinafter *Benefits of Meeting the Contraceptive Needs of Ethiopian Women*]; CENTER FOR REPRODUCTIVE RIGHTS ET AL., IMPOSING MISERY: THE IMPACT OF MANILA’S BAN ON CONTRACEPTION (2007).
 - 9 ASTRA NETWORK, REPRODUCTIVE HEALTH SUPPLIES IN THE CENTRAL AND EASTERN EUROPE 7 (2007), available at http://www.astra.org.pl/CEE_RH%20Supplies.pdf [hereinafter REPRODUCTIVE HEALTH SUPPLIES IN THE CENTRAL AND EASTERN EUROPE].
 - 10 *Id.* at 6; INTERRIGHTS v. Croatia, Complaint No. 45/2007, para. 47, Eur. Comm. Soc. Rts. (2009) [hereinafter INTERRIGHTS v. Croatia].
 - 11 REPRODUCTIVE HEALTH SUPPLIES IN THE CENTRAL AND EASTERN EUROPE, *supra* note 9, at 4; ASTRA NETWORK, LEGAL COMMITMENTS TO GENDER EQUALITY AND SRHR ISSUES IN ALBANIA, MACEDONIA, GEORGIA, POLAND AND UKRAINE 9 (2009), <http://www.astra.org.pl/PAI%20astra%20report%202009.pdf> [hereinafter LEGAL COMMITMENTS TO GENDER EQUALITY AND SRHR ISSUES IN ALBANIA, MACEDONIA, GEORGIA, POLAND AND UKRAINE]; U.N. ECON. COMM’N FOR EUR., THE MDGS IN EUROPE AND CENTRAL ASIA: ACHIEVEMENTS, CHALLENGES AND THE WAY FORWARD (2010), available at http://www.unecce.org/commission/MDGs/2010_MDG_Optimized.pdf [hereinafter THE MDGS IN EUROPE AND CENTRAL ASIA].
 - 12 The Special Rapporteur on the Right to Health (SRRH), Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, paras. 31, 40, 51, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008) [hereinafter SRRH, Paul Hunt (2008)].
 - 13 *See, e.g.*, CESCR, *Concluding Observations: Armenia*, para. 15, U.N. Doc. E/C.12/1/Add.39 (1999); *Poland*, para. 28, U.N. Doc. E/C.12/1/Add.82 (2002); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998).
 - 14 *See, e.g.*, CESCR, *Concluding Observations: Algeria*, para. 37, U.N. Doc. E/C.12/1/Add.71 (2001); *Armenia*, para. 15, U.N. Doc. E/C.12/1/Add.39 (1999); *Benin*, para. 23, U.N. Doc. E/C.12/1/Add.78 (2002); *Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); *Chile*, para. 54, U.N. Doc. E/C.12/1/Add.105 (2004); *Dominican Republic*, para. 15, U.N. Doc. E/C.12/1/Add.16 (1997); *Dominican Republic*, para. 22, U.N. Doc. E/C.12/1/Add.6 (1996); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Lithuania*, para. 50, U.N. Doc. E/C.12/1/Add.96 (2004); *Malta*, para. 24, U.N. Doc. E/C.12/1/Add.101 (2004); *Paraguay*, para. 16, U.N. Doc. E/C.12/1/Add.1 (1996); *Poland*, para. 28, U.N. Doc. E/C.12/1/Add.82 (2002); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998); *Saint Vincent and the Grenadines*, para. 12, U.N. Doc. E/C.12/1/Add.21 (1997).
 - 15 *See* CESCR, *General Comment No. 14, supra* note 3, para. 11.
 - 16 *Id.* paras. 12, 43.
 - 17 *See* CESCR, *Concluding Observations: Poland*, para. 27, U.N. Doc. E/C.12/POL/CO/5 (2009); *Lithuania*, para. 50, U.N. Doc. E/C.12/1/Add.96 (2004); *Republic of Moldova*, paras. 48–49, U.N. Doc. E/C.12/1/Add.91 (2003); *Russian Federation*, paras. 62–63, U.N. Doc. E/C.12/1/Add.94 (2003).
 - 18 *Report: Access to Safe and Legal Abortion in Europe*, EUR. PARL. ASSEMB. Doc. No. 11537 (2008), available at <http://assembly.coe.int/main.asp?Link=/documents/workingdocs/doc08/edoc11537.htm>.
 - 19 *See* Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, arts. 10(h), 12(1), 14(2)(b), 16(1)(e), G.A. Res. 34/189, UN GAOR (34th Sess.), Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (entered into force Sept. 3, 1981) (ratified by Slovakia Nov. 17, 2000) [hereinafter CEDAW].
 - 20 *Id.* art. 14; Committee on the Rights of the Child (CRC), *General Comment No. 4: Adolescent health and development* (33rd Sess.), paras. 28, 30, 31, U.N. Doc. CRC/GC/2003/4 (2003), General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 296 (2003) [hereinafter CRC, *General Comment No. 4*]; CEDAW Committee, *General Recommendation No. 24: Women and health* (20th Sess.), U.N. Doc. A/54/38, at 5 (1999), reprinted in Compilation of General Comments and General Recommendations

- Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6, at 271 (2003) [hereinafter CEDAW Committee, *General Recommendation No. 24*]; Res. on Sexual and Reproductive Health and Rights, Eur. Parl. Res. No. 2001/2128 (INI) (2002).
- 21 See SRRH, Paul Hunt (2008), *supra* note 12, paras. 31, 40, 51; COUNCIL OF EUR., Recommendation CM/Rec(2008)1 of the Committee of Ministers to member states on the inclusion of gender differences in health policy (2008), <https://wcd.coe.int/ViewDoc.jsp?id=1241743> (last visited Nov. 29, 2010); CESCR, *General Comment No. 14*, *supra* note 3, para. 20.
- 22 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Slovakia*, para. 43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008) [hereinafter CEDAW Committee, *Concluding Observations: Slovakia* (2008)].
- 23 UNFPA, HOW UNIVERSAL IS ACCESS TO REPRODUCTIVE HEALTH? 10 (2010), available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf; see generally GENDER RESPONSIVE BUDGETING AND WOMEN'S REPRODUCTIVE RIGHTS, *supra* note 8, at 28–33; Center for Reproductive Rights (CRR), *Factsheet: European Standards on Subsidizing Contraceptives*, 2–3 (2008), <http://reproductiverights.org/en/document/slovakia-european-standards-on-subsidizing-contraceptives> (last visited Nov. 29, 2010); *Benefits of Meeting the Contraceptive Needs of Ethiopian Women*, *supra* note 8.
- 24 HOW UNIVERSAL IS ACCESS TO REPRODUCTIVE HEALTH?, *supra* note 23, at 10; see generally GENDER RESPONSIVE BUDGETING AND WOMEN'S REPRODUCTIVE RIGHTS, *supra* note 8, at 28–33; *Benefits of Meeting the Contraceptive Needs of Ethiopian Women*, *supra* note 8.
- 25 GI AND UNFPA, *Contraception: An Investment in Lives, Health and Development 5 IN BRIEF 1* (2008), available at http://www.guttmacher.org/pubs/2008/11/18/IB_contraception.pdf. See also UK ALL PARTY PARLIAMENTARY GROUP ON POPULATION, DEVELOPMENT AND REPRODUCTIVE HEALTH, BETTER OFF DEAD? A REPORT ON MATERNAL MORTALITY 45 (2009), available at <http://www.health-e.org.za/uploaded/2abf4f8cc84c760af51ea81585badf01.pdf>. (A 2009 study indicated that in Nepal, maternal mortality has been reduced significantly—from 539 deaths per 100,000 live births between 1989 and 1995 to 281 deaths per 100,000 live births between 1999 and 2005—and that increased use of contraceptives has been a contributing factor to this decline.)
- 26 WORLD HEALTH ORGANIZATION (WHO), PACKAGES OF INTERVENTION FOR FAMILY PLANNING, SAFE ABORTION CARE, MATERNAL, NEWBORN AND CHILD HEALTH (2010), available at http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf.
- 27 See generally ADDING IT UP (2004), *supra* note 4.
- 28 See FAMILY HEALTH INTERNATIONAL, WOMEN'S VOICES, WOMEN'S LIVES: THE IMPACT OF FAMILY PLANNING, *Benefits to Women* (1998), available at <http://www.fhi.org/en/RH/Pubs/wsp/synthesis/index.htm>.
- 29 See ADDING IT UP (2004), *supra* note 4, at 26, 28.
- 30 See *id.* at 24–25.
- 31 *Id.* at 23.
- 32 *Id.* at 5, 22–23; INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF), DEATH AND DENIAL: UNSAFE ABORTION AND POVERTY 3 (2006), available at http://www.ippf.org/NR/rdonlyres/8D4783F5-D516-47D3-8B34-61F6D510202A/0/Death_Denial_unsafe_abortion_poverty.pdf [hereinafter IPPF, DEATH AND DENIAL].
- 33 ADDING IT UP (2004), *supra* note 4, at 26, 28.
- 34 See *id.* at 24–25.
- 35 The Slovak Republic (Slovakia) was formed on January 1, 1993, after Czechoslovakia was peacefully split into two separate states: the Czech Republic and Slovak Republic.
- 36 FROM ABORTION TO CONTRACEPTION: A RESOURCE TO PUBLIC POLICIES AND REPRODUCTIVE BEHAVIOR IN CENTRAL AND EASTERN EUROPE 8 (Henry P. David, ed., Greenwood Press, 1999) [hereinafter FROM ABORTION TO CONTRACEPTION]. However, in a few countries, such as Romania, experiences ranged from permissive to repressive. Thomas Frejka, *Birth Regulation in Europe: Completing the Contraceptive Revolution*, 19(5) *Demographic Research* 73, 75 (2008), <http://www.demographic-research.org/Volumes/Vol19/5/19-5.pdf> (last visited Nov. 29, 2010).
- 37 FROM ABORTION TO CONTRACEPTION, *supra* note 36, at 8.
- 38 REPRODUCING GENDER: POLITICS, PUBLICS AND EVERYDAY LIFE AFTER SOCIALISM 59 (Susan Gal and Gail Kligman, eds., Princeton University Press 2000).
- 39 FROM ABORTION TO CONTRACEPTION, *supra* note 36, at 8, 24.
- 40 *Id.* at 106.
- 41 *Id.* at 107.
- 42 *Id.*
- 43 *Id.*
- 44 GI, *Facts on Induced Abortion*, IN BRIEF (2009), available at http://www.guttmacher.org/pubs/fb_IAW.html.
- 45 FROM ABORTION TO CONTRACEPTION, *supra* note 36, at 28.
- 46 *Id.*
- 47 *Id.* at 116.
- 48 *Id.* at 117.
- 49 *Id.*
- 50 NATIONAL HEALTH INFORMATION CENTER, STAROSTLIVOSŤ O ŽENU V SR 2008 [CARE FOR A WOMAN IN THE SR 2008], ZŠ-14/2009, 9 2009, available at <http://data.nczisk.sk/publikacie/zs0914.pdf> [hereinafter NAT'L HEALTH INFO. CTR., STAROSTLIVOSŤ O ŽENU V SR 2008 [CARE FOR A WOMAN IN THE SR 2008]]; Zora Bútorová and Jarmila Filadelfiová, *Women, Men and the Increasing Diversity of Life*, in SHE AND HE IN SLOVAKIA: GENDER AND AGE IN THE PERIOD OF TRANSITION 45-72, 61 (Bútorová, Z. et al., 2008).
- 51 Zákon č. 580/2004 Z.z. o zdravotnom poistení a o zmene a doplnení zákona č. 95/2002 Z. z. o poisťovníctve a o zmene a doplnení niektorých zákonov [Act No. 580/2004 Coll. of Laws on Health Insurance and Amending and Supplementing Act No. 95/2002 Coll. of Laws on the Insurance Industry, and Amending and Supplementing Certain Acts, *as amended*] (2004) [hereinafter Health Insurance Act, No. 580/2004 Coll. of Laws]. In addition, people can take out individual private health insurance, which is supplementary to the mandatory public health insurance coverage but which also does not cover contraceptives. Zákon č. 577/2004 Z.z. o rozsahu zdravotnej starostlivosti uhrádzanej na základe verejného zdravotného poistenia a o úhradách za služby súvisiace s poskytovaním zdravotnej starostlivosti [Act No. 577/2004 Coll. of Laws on the Scope of Healthcare Covered by Public Health Insurance and on the Reimbursement of Healthcare-related Services, *as amended.*] (2004) [hereinafter Health Insurance Coverage Act, No. 577/2004 Coll. of Laws]. The hormonal contraception IUD Mirena is partially covered by public health insurance in cases of specific health indications. However, these indications do not include prevention of risky pregnancy. Email from Lucia Vargová, pharmacist (Oct. 22, 2010) (on the file with the Center for Reproductive Rights).
- 52 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.] secs. 2, 3 (1986) [hereinafter Abortion Act].
- 53 Health Insurance Coverage Act, No. 577/2004 Coll. of Laws, *supra* note 51, sec. 12 (1).
- 54 NAT'L HEALTH INFO. CTR., STAROSTLIVOSŤ O ŽENU V SR 2008 [CARE FOR A WOMAN IN THE SR 2008], *supra* note 50, at 9. See also NATIONAL HEALTH INFORMATION CENTER, HEALTH STATISTIC YEARBOOK OF THE SLOVAK REPUBLIC 2008 39 (2009), available at http://www.nczisk.sk/buxus/generate_page.php?page_id=594.
- 55 INSTITUTE OF HEALTH INFORMATION AND STATISTICS OF THE CZECH REPUBLIC, POTRATY ČR 2008 [ABORTIONS CR 2008] 85 (2009), available at <http://www.uzis.cz/en/publications/abortions-2008>.
- 56 U.N. Dept. of Econ. and Soc. Affairs Pop. Div., *World Contraceptive Use 2009*, available at <http://www.un.org/esa/population/publications/contraceptive2009/contraceptive2009.htm> [hereinafter *World Contraceptive Use 2009*].
- 57 UNFPA, State of World Population 2004, Monitoring ICPD Goals – Selected Indicators, <http://www.unfpa.org/swp/2004/presskit/docs/indicator1.pdf> (last visited Nov. 29, 2010).
- 58 SAVE THE CHILDREN, WOMEN ON THE FRONT LINES OF HEALTHCARE: STATE OF THE WORLD'S MOTHERS 2010 at 37 (2010).
- 59 REPRODUCTIVE HEALTH SUPPLIES IN THE CENTRAL AND EASTERN EUROPE, *supra* note 9, at 4–7; LEGAL COMMITMENTS TO GENDER EQUALITY AND SRHR ISSUES IN ALBANIA, MACEDO-

- nia, Georgia, Poland and Ukraine, *supra* note 11, at 9; THE MDGs IN EUROPE AND CENTRAL ASIA, *supra* note 11.
- 60 The last comprehensive research on contraceptive use and knowledge among women in Slovakia is from January 1997, conducted privately by FOCUS Agency for Slovak Family Planning Association. See SLOVAK FAMILY PLANNING ASSOCIATION AND FOCUS—SOCIAL AND MARKETING ANALYSIS CENTRE, REPRODUCTIVE PRACTICES OF SLOVAK WOMEN (1997), available at http://www.rodicovstvo.sk/reproductive_practices.htm [hereinafter REPRODUCTIVE PRACTICES OF SLOVAK WOMEN]. In December 2009, international survey society Synovate, along with Bayer Schering Pharma, conducted a survey on women's attitudes about hormonal contraception. See Prieskum: Majú slovenské ženy predsudky voči hormonálnej antikoncepcii? [Survey: Do Slovak women have prejudices against hormonal contraception?] Feb. 24, 2010, <http://tvnoviny.sk/zeny/top-tema/prieskum-maju-slovenske-zeny-predsudky-voci-hormonalnej-antikoncepcii.html> (last visited Oct. 28, 2010) [hereinafter Survey: Do Slovak women have prejudices against hormonal contraception?].
- 61 Interview with Lucia Vargová, in Košice (Apr. 14, 2010).
- 62 Ministry of Health, Draft Program on Protection of Sexual and Reproductive Health in the SR, Doc. No. UV-5302/2008 (submitted to the government session Mar. 26, 2008) (Slovak Republic), point 8.1 [hereinafter Draft Program on Protection of Sexual and Reproductive Health in the SR].
- 63 *Id.* See also Ministry of Health, Draft Program on Protection of Sexual and Reproductive Health in the SR, Doc. No. 22346-1/2007-OZSO (submitted to the inter-ministerial commentary process Nov. 29, 2007) (Slovak Republic). 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 (Apr. 23, 2003) (Government of the Slovak Republic).
- 64 Draft Program on Protection of Sexual and Reproductive Health in the SR, *supra* note 62, point 8.1.
- 65 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), <http://www.forumzivota.sk/index.php?page=32&ndtype=newsandid=34&method=main&dart=124> (last visited Jul. 10, 2010).
- 66 Konferencia vyšších rehoľných predstaviteľov na Slovensku súhlasí s programom ochrany sexuálneho a reprodukčného zdravia [Conférence of senior religious order superiors in Slovakia does not agree with the program on protection of sexual and reproductive health] (Dec. 13, 2007), <http://www.tkkbs.sk/view.php?cislocianku=20071213029> (last visited Jul. 23, 2010).
- 67 *Mobily vyzváňali na protest proti programu sexuálneho a reprodukčného zdravia* [Mobiles rang on the protest against the program on sexual and reproductive health], Apr. 2, 2008, available at http://spravy.pravda.sk/mobily-vyzvanali-na-protest-proti-programu-sexualneho-a-reprodukneho-zdravia-gdz-sk_domace.asp?c=A080402_105743_sk_domace_p29;MZ_SR_trva_na_Narodnom_programe_ochrany_sexualneho_zdravia [Ministry of Health of the SR continues the National program on the protection of sexual health], Mar. 31, 2008, <http://www.24hod.sk/mz-sr-trva-na-narodnom-programe-ochrany-sexualneho-zdravia-cl50675.html>. See also Civic Association, Fórum života: *Zásadné pripomienky k Národnému programu sexuálneho a reprodukčného zdravia v SR*, *supra* note 65; *Program sexuálneho zdravia mobilizuje aktivistov* [Program on sexual health mobilizes the activists], Apr. 1, 2008, <http://aktualne.centrum.sk/domov/zdravie-skolstvo-spolocnost/clanek.phtml?id=1155478> (last visited Jul. 10, 2010).
- 68 Resolution No. 278/2003 (Apr. 23, 2003) (Government of the Slovak Republic), 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.
- 69 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) (Slovak Republic); Resolution No. 56/2009 (Jan. 21, 2009) (Government of the Slovak Republic). For comments to the draft program by a group of human rights and feminist NGOs, see Center for Civil and Human Rights, Citizen and Democracy, Queer Leaders Forum, and ProChoice Slovakia, *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)] (May 27, 2009), available at http://www.poradnarska.sk/dok/HP%20MVO%20Nar%20program%20reprozdravie_MV_OaD_Poradna_QLF_270509.pdf (last visited Aug. 24, 2010).
- 70 *Biskupi sa s Ficcom nezhodli na programe starostlivosti o ženy* [Bishops disagreed with Fico on the program on care for women], Jul. 23, 2009, <http://www.fmg.sk/clanky/biskupi-sa-s-ficom-nezhodli-na-programe-starostlivosti-o-zeny-10182.html>. See also Fórum života, *Zásadné pripomienky k Národnému programu starostlivosti o ženy, bezpečné materstvo a reprodukčné zdravie (ďalej aj „Program“)* [Forum of Life: *Substantial comments on the National Program on Care for Women, Safe Motherhood and Reproductive Health (hereinafter “Program”)*], May 21, 2009, <http://www.peticia.sk/bezpecne-materstvo-a-reprodukne-zdravie> (last visited Aug. 25, 2010).
- 71 Center for Reproductive Rights, *Factsheet: European Standards on Subsidizing Contraceptives* (2009); SRRH, Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Mission to Poland*, para. 27, U.N. Doc. A/HRC/14/20 (May 20, 2010) [hereinafter SRRH, Anand Grover (2010)].
- 72 See WHO, MODEL LIST OF ESSENTIAL MEDICINES (16th ed., updated) (Mar. 2010), <http://www.who.int/medicines/publications/essentialmedicines/en/index.html>.
- 73 In addition to Slovakia, these countries are Austria, Bulgaria, Cyprus, Czech Republic, Latvia, Lithuania, Malta, and Poland.
- 74 See, e.g., Romania in UNFPA, *Review of Existing Reproductive Health Commodity Security Systems, Budgeting and National Capacities, and Progress Achieved with Family Planning Service Provision in the Eastern Europe and Central Asia Region 5* (2009) (unpublished source).
- 75 See Constitution of the Republic of Slovenia, art. 55.
- 76 See CENTER FOR REPRODUCTIVE RIGHTS, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES EAST CENTRAL EUROPE 108–109 (2003); Polish Federation for Women and Family Planning, *Independent Report submitted to the U.N. Human Rights Committee on Gender Discrimination* (1999), http://www.federa.org.pl/index.php?option=com_content&view=article&id=227&Itemid=138 (last visited Nov. 23, 2010).
- 77 See Merck, Sharp and Dohme BV contre État belge [Merck, Sharp and Dohme BV v. Belgium, No. C-245/03 (2006) (Belgium)]; see also loi due 27 avril 2005 relative à la maîtrise du budget des soins de santé [Law of Apr. 27, 2005 with respect to the control of the health case budget], as printed in *Moniteur Belge* (2005) (Belgium); Constitution of Belgium, available at <http://www.fed-parl.be/gwuk0002.htm>.
- 78 See Abortion Policy, Denmark, <http://www.un.org/esa/population/publications/abortion/doc/denmar1.doc> (last visited Jul. 4, 2008).
- 79 Avis de la Commission de la Transparence-Cycleane [Report of the Transparency Commission on Cycleane] (Jul. 10, 2002), <http://www.has-sante.fr/portail/upload/docs/application/pdf/ct021097.pdf> (last visited Jul. 4, 2008).

- 80 *Free Contraceptives in Great Britain*, 223(12) JAMA 1402 (1973).
- 81 REPRODUCTIVE HEALTH SUPPLIES IN THE CENTRAL AND EASTERN EUROPE, *supra* note 9, at 5. Interview with Livia, in Košice (Apr. 13, 2010); Interview with Lucia Vargová, *supra* note 61; Interview with Zoja, in Sabinov (Apr. 14, 2010); Interview with Irena, in Sabinov (Apr. 14, 2010); Interview with Anežka, in Humenné (Apr. 15, 2010); Interview with Jarmila, Slávka and Viera, in Rošovce (Apr. 17, 2010); Interview with Kamila, in Košice (Apr. 19, 2010); Interview with Beáta, in Michalovce (Apr. 20, 2010); Interview with Henrieta Novotná and Božidara Balázová, *supra* note 7; Interview with Svetlana, in Michalovce (Apr. 20, 2010); Interview with Jana, in Michalovce (Apr. 20, 2010); Interview with Iveta and Alena, *supra* note 7.
- 82 See, e.g., *Shadow Report to the Committee on the Elimination of Discrimination against Women for the Slovak Republic*, submitted by Alliance of Women in Slovakia et al., (2008) [hereinafter *Shadow Report to the CEDAW Committee for the Slovak Republic* (2008)]; Letter of Mons. František Tondra, chair of the Slovak Bishops' Conference, Otvorený list predsedu KBS ministromi školstva SR [Open Letter of the Chair of SBC to the Minister of Education of the SR], (Aug. 31, 2007), <http://www.tkkbs.sk/view.php?cislocikanku=20070831016> (last visited Jul. 12, 2010) [hereinafter Letter of Mons. František Tondra (2007)]; Slovak Bishops' Conference, Pastiersky list KBS na 3. pôstnu nedeľu [Pastoral Letter of Slovak Bishops' Conference on 3rd Lenten Sunday], Feb. 23, 2008, available at: <http://www.tkkbs.sk/view.php?cislocikanku=20080223001> (last visited Oct. 13, 2010) [hereinafter Pastoral Letter of Slovak Bishops' Conference on 3rd Lenten Sunday].
- 83 Návrh poslancov Národnej rady Slovenskej republiky Pavla Minárika a Rudolfa Bauera, ktorým sa mení a dopĺňa zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov a zákon č. 140/1998 Z. z. o liekoch a zdravotníckych pomôckach, o zmene zákona č. 455/1991 Zb. o živnostenskom podnikaní (živnostenský zákon) v znení neskorších predpisov a o zmene a doplnení zákona Národnej rady Slovenskej republiky č. 220/1996 Z. z. o reklame, parl. tlač 1437 [Proposal of members of the National Council of the Slovak Republic Pavol Minárik and Rudolf Bauer, amending and supplementing Act. No. 576/2004 Coll. on Healthcare, Healthcare-related Services and Amending and Supplementing Certain Acts and Act no. 140/1998 Coll. (on drugs and medical devices, amending Act no. 455/1991 Coll. on Trade Licensing (Trade Licensing Act) as amended and on amending and supplementing the Act of the National Council of Slovak Republic No. 220/1996 Coll. on Advertising), parl. press 1437, parl. sess. 48 (Feb. 2010)].
- 84 *Id.* art. II.
- 85 *Id.* art. I, point 3.
- 86 Parliament voted to move the bill to the second reading of the legislative process.
- 87 Parl. Sess. No. 48, Voting No. 164 (Hlasovanie č. 164), parl. press 1437, (Feb. 9, 2010) (Slovak Republic). Of 132 parliamentarians present, 54 voted for the bill to be moved to the second reading of the legislative process, 32 were against the move, 44 abstained, and 2 did not vote.
- 88 Under the current school reform, even the limited sexuality education (officially called "Education for Marriage and Parenthood") that existed has ceased to be a part of the mandatory subjects. Its incorporation into the teaching curricula is now at the discretion of each school. Email from Olga Pietruchová, Slovak Family Planning Association (Nov. 29, 2010).
- 89 IPPF EUROPEAN NETWORK, A REFERENCE GUIDE TO POLICIES AND PRACTICES: SEXUALITY EDUCATION IN EUROPE 74 (2006), available at <http://www.ippfen.org/en/Resources/Publications/Sexuality+Education+in+Europe.htm>.
- 90 SLOVAK FAMILY PLANNING ASSOCIATION, VEDOMOSTNÁ ÚROVEŇ V OBLASTI SEXUÁLNEHO A REPRODUKČNÉHO ZDRAVIA NA ZÁKLADNÝCH ŠKOLÁCH NA SLOVENSKU. KVALITATÍVNA A KVANTITATÍVNA ANALÝZA [LEVEL OF KNOWLEDGE ON SEXUAL AND REPRODUCTIVE HEALTH AT PRIMARY SCHOOLS IN SLOVAKIA. QUALITATIVE AND QUANTITATIVE ANALYSIS] (2005).
- 91 *Shadow Report to the CEDAW Committee for the Slovak Republic* (2008), *supra* note 82, para.108.
- 92 Letter of Mons. František Tondra (2007), *supra* note 82.
- 93 Olga Pietruchová, *Fakty o postojoch katolíckej cirkvi k sexualite* [Facts on the Catholic Church's Stance on Sexuality] (Nov. 23, 2007), <http://rodicovstvo.wordpress.com/2007/12/23/fakty-o-postojach-katolíckej-cirkvi-k-sexualite> (last visited Jul. 23, 2010).
- 94 See, e.g., Monika Bosá, *Vzťah rodových stereotypov k zodpovednosti v sexuálnom živote* [Relationship of gender stereotypes to responsibility in sexual life] in UPGRADE PRE SEXUÁLNU VÝCHOVU. ZBORNÍK Z KONFERENCIE, ALTERNATÍVY ZODPOVEDNEJ SEXUÁLNEJ VÝCHOVY" [UPGRADE FOR SEXUALITY EDUCATION, VOLUME FROM THE CONFERENCE, ALTERNATIVES OF RESPONSIBLE SEXUALITY EDUCATION] 28–30 (Bianchi, G. ed., 2001), available at <http://www.kvsbk.sav.sk/upgrade-sex-vychova/bosa.htm>; *Shadow Report to the CEDAW Committee for the Slovak Republic* (2008), *supra* note 82, paras. 28, 29, 107.
- 95 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], Annex No. 4, [hereinafter Healthcare Providers Act, No. 578/2004 Coll. of Laws]. 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.
- 96 See, e.g., *Shadow Report to the CEDAW Committee for the Slovak Republic* (2008), *supra* note 82, para. 89. A recent newspaper article reported that only one out of five public hospitals in Bratislava, the capital of Slovakia, performs abortions due to the insufficiently regulated practice of conscientious objection. *Potrat? Nerobíme! Chod'te inam, hovoria lekári Slovenkám* [Abortion? We do not perform! Go somewhere else, the doctors say to Slovak women], Jul. 30, 2010, <http://tvnoviny.sk/zeny/top-tema/potrat-nerobime-chodte-inam-hovoria-lekari-slovenkam.html> (last visited Aug. 13, 2010); see also *Potraty odmieta väčšina lekárov* [Most doctors refuse abortions], SME, Sept. 2, 2010, <http://www.sme.sk/c/5530004/potraty-odmieta-vacsina-lekarov.html> (last visited Sep. 15, 2010).
- 97 Draft resolution *Women's access to lawful medical care: the problem of unregulated use of conscientious objection*, PARL. ASSEMB. EUR. Doc. 12347 (Jul. 20, 2010). In 2005, the Slovak Ministry of Justice introduced a draft treaty entitled "Treaty between the Slovak Republic and Holy See on the Right to Exercise Objections of Conscience." If adopted, this treaty would have made the existing situation worse by providing for a very broad scope of areas and activities in which conscientious objection would be allowed, including healthcare and education, and would have further threatened women's access to reproductive health services by favoring the objector's interest over the right to access lawful reproductive healthcare services. The treaty was not adopted, but it again became a subject of debate during 2010 election period. After heavy criticism, primarily from civil society, the treaty was ultimately not included in the tasks of the newly elected government. For an analysis of the draft treaty, see, e.g., EU Network of Independent Experts on Fundamental Rights, Opinion No. 4-2005: *The right to conscientious objection and the conclusion by EU Member States of concordats with the Holy See*, Doc. CFR-CDF Opinion 4-2005 (Dec. 14, 2005).
- 98 International Federation of Gynecology and Obstetrics (FIGO), *Resolution on "Conscientious Objection," adopted by FIGO Gen. Assem.* (Nov. 7, 2006), <http://www.figo.org/projects/conscientious>.
- 99 Draft resolution *Women's access to lawful medical care: the problem of unregulated use of conscientious objection*, *supra* note 97. See also International Federation of Gynecology and Obstetrics (FIGO), Committee for the Ethical Aspects of Human Reproduction and Women's Health, *Ethical Guidelines on Conscientious Objection* (Aug. 2005); FIGO, *Resolution on "Conscientious Objection," supra* note 98.
- 100 This is happening despite the fact that, according to the Slovak Constitution, "[t]he Slovak Republic . . . is not bound to any ideology or religion." Constitution of the Slovak Republic, 460/1992 Coll. as amended, art. 1(1).
- 101 The fact that many Catholics do not follow

- the Catholic Church hierarchy's view on contraception was also recognized in the Pastoral Plan of the Catholic Church in Slovakia 2007–2013, according to which as many as 53.9% of Catholics consider hormonal contraception an appropriate form of pregnancy prevention, and 23.6% of those consider it to be a very appropriate form. SLOVAK BISHOPS' CONFERENCE, PASTORAČNÝ PLÁN KATOLICKEJ CIRKVI NA SLOVENSKU 2007–2010 [PASTORAL PLAN OF CATHOLIC CHURCH IN SLOVAKIA 2007–2010] (2007). *available at* <http://www.kbs.sk/documents/pdf/pep/pep2007.pdf> [hereinafter PASTORAL PLAN OF CATHOLIC CHURCH IN SLOVAKIA 2007–2010].
- 102 *See, e.g.,* Mária Kopcsay, *Scenzurovaný asexuálny program vlády* [Censored asexual government program], PRAVDA, May 18, 2009, http://nazory.pravda.sk/scenzurovany-asexuálny-program-vlady-dh6/-sk-nkom.asp?c=A090517_213033_sk-nkom_p29 (last visited Nov. 29, 2010); *Raši sa nepúšťa proti biskupom* [Raši does not go against bishops], SME, May 19, 2009, <http://www.sme.sk/c/4848745/rasi-sa-nepusta-proti-biskupom.html> (last visited Nov. 29, 2010); *Fico sa zhodol s biskupmi. Sexuálne zdravie bude inak* [Fico concurred with the bishops. Sexual health will be done otherwise], Nov. 6, 2008, <http://aktualne.centrum.sk/domov/zdravie-skolstvo-spolocnost/clanek.phtml?id=1168217> (last visited Nov. 4, 2010).
- 103 Catholics for Choice, “Religion and Politics in the New Europe,” Washington, DC, USA, 2008. <http://www.catholicsforchoice.org/topics/international/documents/EuropeanReportFINAL.pdf> (last visited Nov. 29, 2010); Supplementary Information on Lithuania, Scheduled for Review during the 41st Session of the CEDAW Committee submitted by the Family Planning and Sexual Health Association and the Center for Reproductive Rights (Jun. 8, 2008), http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/sr_lith_0600_eng_crr.pdf (last visited Dec. 2, 2010).
- 104 Center for Reproductive Rights, *The World's Abortion Laws 2007 Map* (Jul. 2007), *available at* http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/Abortion%20Map_FA.pdf; Center for Reproductive Rights, *Fact-sheet: The World's Abortion Laws*, May 2008, *available at* http://reproductiverights.org/sites/crr.civicaactions.net/files/pub_fac_abortionlaws2008.pdf; In Poland, the influence of the Catholic Church hierarchy has moreover lead to limits on state subsidization of contraceptives. SRRH, Anand Grover (2010), *supra* note 71; ASTRA NETWORK, *REPORT ON REPRODUCTIVE HEALTH SUPPLIES IN ASTRA COUNTRIES 3–12* (2008), *available at* <http://www.astra.org.pl/ASTRAreport2008%5B1%5D.pdf>; LEGAL COMMITMENTS TO GENDER EQUALITY AND SRHR ISSUES IN ALBANIA, MACEDONIA, GEORGIA, POLAND AND UKRAINE, *supra* note 11, at 13; Polish Federation for Women and Family Planning, *Independent Report submitted to the U.N. Human rights Committee* (2004), *available at* http://www.federa.org.pl/index.php?option=com_contentandview=articleandid=224andItemid=141.
- 105 REPRODUCTIVE HEALTH SUPPLIES IN THE CENTRAL AND EASTERN EUROPE, *supra* note 9, at 6. INTERRIGHTS v. Croatia, *supra* note 10, at 12–13, 18. Natasa Bijelic, *Sex Education in Croatia: Tensions between Secular and Religious Discourses*, 15 Eur. J. of Women's Studies 329 (2008).
- 106 For example, recent research from the United States on sexuality education programs that emphasize abstinence-only and do not cover contraception shows that such strategies may deter contraceptive use among sexually active teens, increasing the risk of unintended pregnancies and sexually transmitted infections. Douglas B. Kirby, *The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior*, 5(3) Sexuality Research and Soc. Policy, Sept. 2008, at 18; GI, *Facts on Sex Education in the United States*, IN BRIEF (2006), *available at* http://www.guttmacher.org/pubs/fb_sexEd2006.html#30a (last visited Jul. 16, 2010).
- 107 To protect their confidentiality, the names of all women and other stakeholders interviewed during the fact finding have been changed, except where explicit permission to use a person's real name was received.
- 108 *See, e.g.,* CEDAW Committee, *Concluding Observations: Slovakia* (2008), *supra* note 22, paras. 32–33. “[T]he Committee is concerned about the persistence of traditional stereotypes regarding the roles and tasks of women and men in the family and in society at large, including in specific areas, such as...the health sector. . . . The Committee expresses concern at the persistence of gender stereotypes prevailing in school textbooks. . . . The Committee is also concerned at the insufficient access to sex education in schools, which does not seem to meet the needs of girls and boys or to contribute to the fulfilment of the State party's responsibilities in that regard.”
- 109 IPPF, *DEATH AND DENIAL*, *supra* note 32, at 7; GI, *Improving Reproductive Health in the Philippines*, RESEARCH IN BRIEF NO. 1, 6–7 (2003), *available at* <http://www.guttmacher.org/pubs/rib/rib1-03.pdf>.
- 110 Akbar Aghajanian et al, *Continuing Use of Withdrawal as a Contraceptive Method in Iran*, 34 CANADIAN STUDIES IN POPULATION 179, 182 (2007). *See also* REPRODUCTIVE PRACTICES OF SLOVAK WOMEN, *supra* note 60.
- 111 *World Contraceptive Use 2009*, *supra* note 56.
- 112 Interview with Livia, *supra* note 81; Interview with Zuzana, in Sabinov (Apr. 14, 2010); Interview with Ida, *supra* note 7; Interview with Renáta, in Prešov (Apr. 16, 2010); Interview with Klaudia, *supra* note 7; Interview with Stela and Angela, in Vilcuna (Apr. 16, 2010); Interview with Alexandra, in Prešov (Apr. 16, 2010); Interview with Gabriela, in Košice (Apr. 19, 2010); Interview with Nina, in Košice (Apr. 19, 2010); Interview with Barbora, in Košice (Apr. 19, 2010); Interview with Sidónia, in Košice (Apr. 19, 2010); Interview with Daniela, in Košice (Apr. 19, 2010); Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, in Michalovce (Apr. 20, 2010); Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81; Interview with Mária, in Michalovce (Apr. 20, 2010).
- 113 Interview with Zuzana, *supra* note 112; Interview with Ida, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7; Interview with Nina, *supra* note 112; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Iveta and Alena, *supra* note 7.
- 114 Interview with Livia, *supra* note 81; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Klaudia, *supra* note 7; Interview with Stela and Angela, *supra* note 112; Interview with Ingrida, in Hájik (Apr. 16, 2010); Interview with Jarmila, Slávka and Viera, *supra* note 81; Interview with Oskar Balog, in Roškovce (Apr. 17, 2010); Interview with Nina, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Dominika, in Michalovce (Apr. 20, 2010); Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81.
- 115 Source4Women, *Birth Control* (Contraceptives): Traditional, http://www.uhc.com/source4women/womens_health_topics/birth_control.htm (last visited Nov. 18, 2010).
- 116 Rob Stephenson et al., *supra* note 7, at 2–3.
- 117 Interview with Irena, *supra* note 81.
- 118 Interview with Svetlana, *supra* note 81; Interview with Iveta and Alena, *supra* note 7.
- 119 Interview with Zuzana, *supra* note 112; Interview with Ida, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7; Interview with Nina, *supra* note 112; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; WHO, DEPT. OF REPRO. HEALTH AND RESEARCH ET AL., *FAMILY PLANNING: A GLOBAL HANDBOOK FOR PROVIDERS 3* (2007), *available at* global-handbook/handbook.pdf.
- 120 Interview with Livia, *supra* note 81; Interview with Ida, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Gabriela, *supra* note 112; Interview with Nina, *supra* note 112; Interview with Dominika, *supra* note 114; Interview with Svetlana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81; Interview with Mária, *supra* note 112.

- 121 Interview with Miroslava, in Košice (Apr. 13, 2010); Interview with Alexandra, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Beáta, *supra* note 81; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7.
- 122 Interview with Lucia Vargová, *supra* note 61.
- 123 Interview with Dr. Elena Molnárová, in Košice (Apr. 13, 2010); Interview with Apolónia Sejková, *supra* note 7; Interview with Zuzana, *supra* note 112; Interview with Ida, *supra* note 7; Interview with Vlasta, in Humenné (Apr. 15, 2010); Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7; Interview with Dr. Galina Kováčová, *supra* note 7; Interview with Libuša Lukáčová and Valentína Lacková, in Spišská Nová Ves (Apr. 16, 2010); Interview with Dr. Anton Novák, in Spišská Nová Ves (Apr. 16, 2010); Interview with Jarmila, Slávka and Viera, *supra* note 81; Interview with Gabriela, *supra* note 112; Interview with Nina, *supra* note 112; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Dominika, *supra* note 114; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81; Interview with Mária, *supra* note 112; Interview with Olga Pietruchová, in Bratislava (Sept. 29, 2010).
- 124 REPRODUCTIVE PRACTICES OF SLOVAK WOMEN, *supra* note 60. In a 1997 study 73% of single women with an unwanted pregnancy “resolved” the situation by getting married, “partly as a result of the pressure of prevailing social standards of behavior.” A study from 2008 notes that “[t]he share of children born out of wedlock in the total number of newborn children grew significantly, from 7.6% in 1990 to 27.6% in 2006.” Zora Bútorová and Jarmila Filadelfiová, *supra* note 50, at 47.
- 125 Interview with Renáta, *supra* note 112.
- 126 Interview with Jarmila, Slávka and Viera, *supra* note 81.
- 127 The core list includes oral hormonal contraceptives, injectable hormonal contraceptives, intrauterine devices, barrier methods such as condoms and diaphragms. See WHO, ESSENTIAL MEDICINES, WHO MODEL LIST (REV. 2005) (14th ed., 2005), http://whqlibdoc.who.int/hq/2005/a87017_eng.pdf; CESC, *General Comment No. 14*, *supra* note 3, paras. 12(b), 43.
- 128 Abortion Act, *supra* note 52, sec. 3.
- 129 Statistical Office of the Slovak Republic, Structure of Earnings in the SR 2009 (Jun. 2010), <http://portal.statistics.sk/showdoc.do?docid=25367> (last visited Dec. 6, 2010).
- 130 Statistical Office of the Slovak Republic, Zisťovanie o príjmoch a životných podmienkach EU SILC 2009 [Statistics on Income and Living Conditions EU SILC 2009] (2010), <http://portal.statistics.sk/showdoc.do?docid=25503> (last visited Nov. 11, 2010).
- 131 The hormonal contraception IUD Mirena is partially covered by public health insurance in case of specific health indications. However, these indications do not include prevention of risky pregnancy. Email from Lucia Vargová, *supra* note 51.
- 132 Interview with Dr. Zora Debnárová, in Košice (Apr. 14, 2010).
- 133 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Lívia, *supra* note 81; Interview with Miroslava, *supra* note 121; Interview with Dr. Júlia Naďová, in Prešov (Apr. 14, 2010); Interview with Dr. Zora Debnárová, *supra* note 132; Interview with Apolónia Sejková, *supra* note 7; Interview with Lucia Vargová, *supra* note 61; Interview with Zita Šimková, in Prešov (Apr. 14, 2010); Interview with Irena, *supra* note 81; Interview with Matilda Ružičková, in Sabinov (Apr. 14, 2010); Interview with Zuzana, *supra* note 112; Interview with Linda, in Sabinov (Apr. 14, 2010); Interview with Ida, *supra* note 7; Interview with Vlasta, *supra* note 123; Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7; Interview with Edita Bačová, in Prešov (Apr. 16, 2010); Interview with Dr. Galina Kováčová, *supra* note 7; Interview with Vanda Durbáková, in Prešov (Apr. 16, 2010); Interview with Libuša Lukáčová and Valentína Lacková, *supra* note 123; Interview with Stela and Angela, *supra* note 112; Interview with Ingrida, *supra* note 114; Interview with Dr. Anton Novák, *supra* note 123; Interview with Anastázia Gajdošová, in Spišská Nová Ves (Apr. 16, 2010); Interview with Zdena Horvátová, in Prešov (Apr. 16, 2010); Interview with Nina, *supra* note 112; Interview with Barbora, *supra* note 112; Interview with Xénia Vránka, *supra* note 7; Interview with Daniela, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81; Interview with Mária, *supra* note 112; Interview with Olga Pietruchová, *supra* note 123.
- 134 Interview with Miroslava, *supra* note 121; Interview with Zuzana, *supra* note 112; Interview with Nina, *supra* note 112; Interview with Xénia Vránka, *supra* note 7; Interview with Svetlana, *supra* note 81; Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Dr. Anton Novák, *supra* note 123; Interview with Olga Pietruchová, *supra* note 123.
- 135 Email from Lucia Vargová, *supra* note 51.
- 136 Interview with Dr. Elena Molnárová, *supra* note 123.
- 137 Interview with Lívia, *supra* note 81.
- 138 Interview with Dr. Anton Novák, *supra* note 123.
- 139 Interview with Iveta and Alena, *supra* note 7.
- 140 Interview with Lucia Vargová, *supra* note 61.
- 141 Interview with Dr. Zora Debnárová, *supra* note 132; Interview with Apolónia Sejková, *supra* note 7; Interview with Zuzana, *supra* note 112; Interview with Stela and Angela, *supra* note 112; Interview with Ingrida, *supra* note 114; Interview with Nina, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Beáta, *supra* note 81; Interview with Mária, *supra* note 112.
- 142 Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7; Interview with Klaudia, *supra* note 7; Interview with Dr. Galina Kováčová, *supra* note 7; Interview with Xénia Vránka, *supra* note 7; Interview with Iveta and Alena, *supra* note 7; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7.
- 143 Interview with Vlasta, *supra* note 123; Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7.
- 144 Interview with Ida, *supra* note 7.
- 145 Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112.
- 146 Interview with Zuzana, *supra* note 112.
- 147 Interview with Beáta, *supra* note 81.
- 148 Interview with Dr. Zora Debnárová, *supra* note 132.
- 149 Interview with Ingrida, *supra* note 114.
- 150 Interview with Dr. Zora Debnárová, *supra* note 132.
- 151 Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7; Interview with Iveta and Alena, *supra* note 7; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7.
- 152 Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7.
- 153 Interview with Apolónia Sejková, *supra* note 7.
- 154 Interview with Lívia, *supra* note 81; Interview with Renáta, *supra* note 112; Interview with Alexandra, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Beáta, *supra* note 81.
- 155 Interview with Lívia, *supra* note 81; Interview with Miroslava, *supra* note 121; Interview with Renáta, *supra* note 112; Interview with Dr. Anton Novák, *supra* note 123; Interview with Gabriela, *supra* note 112; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Beáta, *supra* note 81.
- 156 Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Ida, *supra* note 7; Interview with Anastázia Gajdošová, *supra* note 133; Interview with Alexandra, *supra* note 112; Interview with Mária, *supra* note 112.

- 157 Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Ida, *supra* note 7; Interview with Anastázia Gajdošová, *supra* note 133; Interview with Alexandra, *supra* note 112; Interview with Mária, *supra* note 112.
- 158 Interview with Zoja, *supra* note 81; Interview with Matilda Ružičková, *supra* note 133; Interview with Zuzana, *supra* note 112; Interview with Stela and Angela, *supra* note 112; Interview with Anastázia Gajdošová, *supra* note 133; Interview with Monika Bosá, in Prešov (Apr. 17, 2010); Interview with Alexandra, *supra* note 112; Interview with Xénia Vránka, *supra* note 7; Interview with Sidónia, *supra* note 112; Interview with Iveta and Alena, *supra* note 7; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7.
- 159 Interview with Iveta and Alena, *supra* note 7.
- 160 Interview with Zuzana, *supra* note 112.
- 161 Interview with Nina, *supra* note 112; Interview with Tatiana, in Košice (Apr. 19, 2010); Interview with Barbora, *supra* note 112.
- 162 Interview with Barbora, *supra* note 112.
- 163 Interview with Monika Bosá, *supra* note 158.
- 164 CEDAW Committee, *Concluding Observations: Slovakia* (2008), *supra* note 22, para. 32. *See also*, CEDAW Committee, *Concluding Observations: Slovakia*, para. 92, U.N. Doc. A/53/38 (1998).
- 165 CEDAW Committee, *Concluding Observations: Slovakia*, *supra* note 22, paras. 42-43.
- 166 *See* Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Dr. Galina Kováčová, *supra* note 7; Interview with Dr. Anton Novák, *supra* note 123; Interview with Zdena Horvátová, *supra* note 133; Interview with Dr. Michal Kliment, in Bratislava (Sept. 27, 2010); Interview with Dr. Vladimír Cupaník, in Bratislava (Sept. 28, 2010).
- 167 CATHOLICS FOR CHOICE, TRUTH AND CONSEQUENCE: A LOOK BEHIND THE VATICAN'S BAN ON CONTRACEPTION, 3 (2008), available at <http://www.catholicsforchoice.org/topics/reform/documents/TruthConsequencesFINAL.pdf>; Interview with Monika Bosá, *supra* note 158; Catholic Answers, Birth Control, http://www.catholic.com/library/Birth_Control.asp (last visited Aug. 9, 2010). *See also* Pastoral Letter of Slovak Bishops' Conference on 3rd Lenten Sunday, *supra* note 82.
- 168 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Miroslava, *supra* note 121; Interview with Dr. Júlia Naďová, *supra* note 133; Interview with Lucia Vargová, *supra* note 61; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Matilda Ružičková, *supra* note 133; Interview with Vlasta, *supra* note 123; Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7; Interview with Klaudia, *supra* note 7; Interview with Edita Bačová, *supra* note 133; Interview with Gabriela, *supra* note 112; Interview with Nina, *supra* note 112; Interview with Kamila, *supra* note 81; Interview with Dominika, *supra* note 114; Interview with Iveta and Alena, *supra* note 7; Interview with Mária, *supra* note 112; Interview with Olga Pietruchová, *supra* note 123.
- 169 Interview with Dr. Elena Molnárová, *supra* note 123.
- 170 Salesians of Don Bosco is a Roman Catholic religious order founded in the late 19th century by Saint John Bosco. Its mission is described as “the Christian perfection of its associates obtained by the exercise of spiritual and corporal works of charity towards the young, especially the poor, and the education of boys to the priesthood.” Catholic Encyclopedia, The Salesian Society, <http://www.newadvent.org/cathen/13398b.htm> (last visited Nov. 29, 2010).
- 171 Interview with Klaudia, *supra* note 7.
- 172 Interview with Iveta and Alena, *supra* note 7.
- 173 Interview with Olga Pietruchová, *supra* note 123.
- 174 Interview with Dr. Júlia Naďová, *supra* note 133.
- 175 *Id.*
- 176 Interview with Livia, *supra* note 81; Interview with Zuzana, *supra* note 112; Interview with Ida, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7; Interview with Stela and Angela, *supra* note 112; Interview with Alexandra, *supra* note 112; Interview with Gabriela, *supra* note 112; Interview with Nina, *supra* note 112; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81; Interview with Mária, *supra* note 112. PASTORAL PLAN OF CATHOLIC CHURCH IN SLOVAKIA 2007–2010, *supra* note 101.
- 177 Interview with Jana, *supra* note 81.
- 178 Interview with Livia, *supra* note 81; Interview with Apolónia Sejková, *supra* note 7; Interview with Lucia Vargová, *supra* note 61; Interview with Vanda Durbáková, *supra* note 133; Interview with Svetlana, *supra* note 81; Interview with Iveta and Alena, *supra* note 7; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7; Interview with Mária, *supra* note 112.
- 179 Interview with Apolónia Sejková, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Iveta and Alena, *supra* note 7; Interview with Mária, *supra* note 112.
- 180 Interview with Renáta, *supra* note 112.
- 181 Interview with Mária, *supra* note 112.
- 182 Interview with Apolónia Sejková, *supra* note 7.
- 183 U.N., *Report of the United Nations Special Rapporteur on the right to education*, U.N. Doc. A/65/162 (2010); *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5–13, 1994, paras. 7.3, 7.5(a)–(b), U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].
- 184 Interview with Livia, *supra* note 81; Interview with Miroslava, *supra* note 121; Interview with Matilda Ružičková, *supra* note 133; Interview with Zuzana, *supra* note 112; Interview with Linda, *supra* note 133; Interview with Renáta, *supra* note 112; Interview with Edita Bačová, *supra* note 133; Interview with Vanda Durbáková, *supra* note 133; Interview with Libuša Lukáčová and Valentína Lacková, *supra* note 133; Interview with Anastázia Gajdošová, *supra* note 133; Interview with Anabela, Vanesa, Romana and Sofia, in Roškovec (Apr. 17, 2010); Interview with Jarmila, Slávka and Viera, *supra* note 81; Interview with Gabriela, *supra* note 112; Interview with Kamila, *supra* note 81; Interview with Sidónia, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Jana, *supra* note 81; Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81.
- 185 Interview with Livia, *supra* note 81; Interview with Miroslava, *supra* note 121; Interview with Linda, *supra* note 133; Interview with Renáta, *supra* note 112; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Svetlana, *supra* note 81.
- 186 Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Matilda Ružičková, *supra* note 133; Interview with Renáta, *supra* note 112; Interview with Edita Bačová, *supra* note 133; Interview with Nina, *supra* note 112; Interview with Tatiana, *supra* note 161; Interview with Xénia Vránka, *supra* note 7; Interview with Sidónia, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Mária, *supra* note 112.
- 187 Interview with Livia, *supra* note 81; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Matilda Ružičková, *supra* note 133; Interview with Ida, *supra* note 7; Interview with Edita Bačová, *supra* note 133; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112.
- 188 Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Ida, *supra* note 7; Interview with Edita Bačová, *supra* note 133; Interview with Alexandra, *supra* note 112; Interview with Nina, *supra* note 112; Interview with Kamila, *supra* note 81; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Iveta and Alena, *supra* note 7; Interview with Mária, *supra* note 112.
- 189 Interview with Livia, *supra* note 81; Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Zuzana, *supra* note 112; Interview with Alexandra, *supra* note 112; Interview with Tatiana, *supra* note 161; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview

- with Beáta, *supra* note 81.
- 190 Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Gabriela, *supra* note 112; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Jana, *supra* note 81.
- 191 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Monika Bosá, *supra* note 158; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7; Interview with Dr. Michal Kliment, *supra* note 166; Interview with Dr. Vladimír Cupaník, *supra* note 166; Interview with Olga Pietruchová, *supra* note 123.
- 192 Interview with Dr. Elena Molnárová, *supra* note 123.
- 193 Interview with Olga Pietruchová, *supra* note 123.
- 194 Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7.
- 195 Interview with Mária, *supra* note 112.
- 196 Interview with Monika Bosá, *supra* note 158.
- 197 Interview with Lívia, *supra* note 81; Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7; Interview with Ingrida, *supra* note 114; Interview with Jarmila, Slávka and Viera, *supra* note 81; Interview with Alexandra, *supra* note 112; Interview with Zdena Horvátová, *supra* note 133; Interview with Gabriela, *supra* note 112; Interview with Nina, *supra* note 112; Interview with Tatiana, *supra* note 161; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Jana, *supra* note 81; Interview with Mária, *supra* note 112.
- 198 Interview with Monika Bosá, *supra* note 158.
- 199 *Id.*
- 200 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Dr. Júlia Naďová, *supra* note 133; Interview with Lucia Vargová, *supra* note 61; Interview with Vanda Durbáková, *supra* note 133; Interview with Dr. Anton Novák, *supra* note 123; Interview with Monika Bosá, *supra* note 158; Interview with Dr. Michal Kliment, *supra* note 166; Interview with Dr. Vladimír Cupaník, *supra* note 166.
- 201 Interview with Miroslava, *supra* note 121; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Linda, *supra* note 133; Interview with Ida, *supra* note 7; Interview with Klaudia, *supra* note 7; Interview with Ingrida, *supra* note 114; Interview with Barbora, *supra* note 112; Interview with Sidónia, *supra* note 112; Interview with Daniela, *supra* note 112; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Beáta, *supra* note 81; Interview with Mária, *supra* note 112.
- 202 Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Linda, *supra* note 133; Interview with Ida, *supra* note 7; Interview with Stela and Angela, *supra* note 112; Interview with Ingrida, *supra* note 114; Interview with Gabriela, *supra* note 112; Interview with Jana, *supra* note 81; Interview with Beáta, *supra* note 81.
- 203 Interview with Lucia Vargová, *supra* note 61; Interview with Irena, *supra* note 81; Interview with Renáta, *supra* note 112; Interview with Jarmila, Slávka and Viera, *supra* note 81.
- 204 Interview with Lívia, *supra* note 81; Interview with Zoja, *supra* note 81; Interview with Ida, *supra* note 7; Interview with Vlasta, *supra* note 123; Interview with Sidónia, *supra* note 112; Interview with Mária, *supra* note 112.
- 205 Interview with Klaudia, *supra* note 7; Interview with Vanda Durbáková, *supra* note 133.
- 206 Interview with Lívia, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Ida, *supra* note 7; Interview with Jarmila, Slávka and Viera, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112.
- 207 Interview with Lívia, *supra* note 81; Interview with Miroslava, *supra* note 121; Interview with Zuzana, *supra* note 112; Interview with Xénia Vránka, *supra* note 7; Interview with Jana, *supra* note 81.
- 208 Interview with Beáta, *supra* note 81.
- 209 Interview with Barbora, *supra* note 112.
- 210 Interview with Daniela, *supra* note 112.
- 211 Interview with Lívia, *supra* note 81; Interview with Lucia Vargová, *supra* note 61; Interview with Zoja, *supra* note 81; Interview with Irena, *supra* note 81; Interview with Anežka, *supra* note 81; Interview with Jarmila, Slávka and Viera, *supra* note 81; Interview with Kamila, *supra* note 81; Interview with Svetlana, *supra* note 81; Interview with Beáta, *supra* note 81; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7.
- 212 Interview with Lívia, *supra* note 81; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Iveta and Alena, *supra* note 7.
- 213 Interview with Zita Šimková, *supra* note 133; Interview with Zuzana, *supra* note 112; Interview with Linda, *supra* note 133; Interview with Vanda Durbáková, *supra* note 133; Interview with Ingrida, *supra* note 114; Interview with Dr. Anton Novák, *supra* note 123.
- 214 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Dr. Júlia Naďová, *supra* note 133.
- 215 Interview with Lucia Vargová, *supra* note 61.
- 216 Interview with Dr. Elena Molnárová, *supra* note 123.
- 217 Interview with Beáta, *supra* note 81.
- 218 Interview with Vanda Durbáková, *supra* note 133.
- 219 Interview with Linda, *supra* note 133.
- 220 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7;
- Interview with Vanda Durbáková, *supra* note 133; Interview with Dr. Anton Novák, *supra* note 123; Interview with Iveta and Alena, *supra* note 7; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7; Interview with Mária, *supra* note 112.
- 221 *See Survey: Do Slovak women have prejudices against hormonal contraception?, supra* note 60.
- 222 Interview with Zuzana, *supra* note 112; Interview with Linda, *supra* note 133; Interview with Vanda Durbáková, *supra* note 133; Interview with Stela and Angela, *supra* note 112.
- 223 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Ida, *supra* note 7; Interview with Vanda Durbáková, *supra* note 133; Interview with Alexandra, *supra* note 112; Interview with Iveta and Alena, *supra* note 7.
- 224 Interview with Miroslava, *supra* note 121; Interview with Dr. Júlia Naďová, *supra* note 133; Interview with Dr. Zora Debnárová, *supra* note 132; Interview with Apolónia Sejková, *supra* note 7; Interview with Lucia Vargová, *supra* note 61; Interview with Irena, *supra* note 81; Interview with Matilda Ružičková, *supra* note 133; Interview with Zuzana, *supra* note 112; Interview with Linda, *supra* note 133; Interview with Vlasta, *supra* note 123; Interview with Eva Sopková, Viktória Farkašová, and Štefánia Holubová, *supra* note 7; Interview with Renáta, *supra* note 112; Interview with Klaudia, *supra* note 7; Interview with Edita Bačová, *supra* note 133; Interview with Dr. Galina Kováčová, *supra* note 7; Interview with Vanda Durbáková, *supra* note 133; Interview with Libuša Lukáčová and Valentína Lacková, *supra* note 123; Interview with Stela and Angela, *supra* note 112; Interview with Ingrida, *supra* note 114; Interview with Dr. Anton Novák, *supra* note 123; Interview with Monika Bosá, *supra* note 158; Interview with Alexandra, *supra* note 112; Interview with Zdena Horvátová, *supra* note 133; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Iveta and Alena, *supra* note 7; Interview with Beáta, *supra* note 81; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7; Interview with Mária, *supra* note 112; Interview with Dr. Michal Kliment, *supra* note 166; Interview with Dr. Vladimír Cupaník, *supra* note 166.
- 225 Interview with Matilda Ružičková, *supra* note 133; Interview with Renáta, *supra* note 112; Interview with Vanda Durbáková, *supra* note 133; Interview with Zdena Horvátová, *supra* note 133.
- 226 Interview with Zdena Horvátová, *supra* note 133.
- 227 Interview with Apolónia Sejková, *supra* note 7.
- 228 Interview with Svetlana, *supra* note 81; Interview with Jana, *supra* note 81.
- 229 Interview with Lucia Vargová, *supra* note 61; Interview with Dr. Gizela Kremnická, in

- Prešov (Apr. 16, 2010).
- 230 Interview with Svetlana, *supra* note 81.
- 231 Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7.
- 232 Interview with Dr. Júlia Naďová, *supra* note 133; Interview with Apolónia Sejková, *supra* note 7; Interview with Lucia Vargová, *supra* note 61; Interview with Libuša Lukáčová and Valentína Lacková, *supra* note 123; Interview with Dr. Anton Novák, *supra* note 123; Interview with Monika Bosá, *supra* note 158; Interview with Alexandra, *supra* note 112; Interview with Zdena Horvátová, *supra* note 133; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Jana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Beáta, *supra* note 81; Interview with Mária, *supra* note 112.
- 233 Interview with Dr. Zora Debnárová, *supra* note 132; Interview with Dr. Galina Kováčová, *supra* note 7; Interview with Libuša Lukáčová and Valentína Lacková, *supra* note 123; Interview with Dr. Anton Novák, *supra* note 123; Interview with Alexandra, *supra* note 112; Interview with Gabriela, *supra* note 112; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112.
- 234 Interview with Apolónia Sejková, *supra* note 7.
- 235 *Id.*
- 236 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Apolónia Sejková, *supra* note 7; Interview with Lucia Vargová, *supra* note 61; Interview with Ida, *supra* note 7; Interview with Vlasta, *supra* note 123; Interview with Edit Bačová, *supra* note 133; Interview with Dr. Galina Kováčová, *supra* note 7; Interview with Libuša Lukáčová and Valentína Lacková, *supra* note 123; Interview with Stela and Angela, *supra* note 112; Interview with Gabriela, *supra* note 112; Interview with Tatiana, *supra* note 161; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Xénia Vránska, *supra* note 7; Interview with Daniela, *supra* note 112; Interview with Dominika, *supra* note 114; Interview with Svetlana, *supra* note 81; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 7; Interview with Dr. Michal Kliment, *supra* note 166; Interview with Olga Pietruchová, *supra* note 123.
- 237 Interview with Stela and Angela, *supra* note 112; Interview with Xénia Vránska, *supra* note 7; Interview with Sabína Králiková and Aurélia Adamcová, *supra* note 112.
- 238 Interview with Dr. Elena Molnárová, *supra* note 123; Interview with Gabriela, *supra* note 112.
- 239 Interview with Edit Bačová, *supra* note 133; Interview with Dr. Galina Kováčová, *supra* note 7.
- 240 Interview with Dr. Elena Molnárová, *supra* note 123.
- 241 Interview with Dr. Michal Kliment, *supra* note 166.
- 242 Interview with Klaudia, *supra* note 7.
- 243 Interview with Gabriela, *supra* note 112; Interview with Kamila, *supra* note 81; Interview with Barbora, *supra* note 112; Interview with Daniela, *supra* note 112.
- 244 Interview with Gabriela, *supra* note 112.
- 245 Interview with Daniela, *supra* note 112.
- 246 Convention for the Protection of Human Rights and Fundamental Freedoms, Europ. T.S. No. 5, 213 U.N.T.S. 222 (*entered into force* Sept. 3, 1953, *as amended* by Protocols Nos. 3, 5, 8, 11, *which entered into force* Sept. 21 1970, Dec. 20, 1971, Jan. 1, 1990, *and* Nov. 1, 1998) (*succeeded to by Slovakia*, Jan. 1, 1993); European Social Charter, Europ. T.S. 35, 529 U.N.T.S. 89 (*entered into force* Feb. 26, 1965) (*ratified by Slovakia*, Jun. 22, 1998) [hereinafter European Social Charter]; Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine, Apr. 4, 1997, Europ. T.S. 164, (*entered into force* Dec. 1, 1999) (*ratified by Slovakia* Jan. 15, 1998).
- 247 International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR (21st Sess.), Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (*succeeded to by Slovakia* May 28, 1993); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) (*succeeded to by Slovakia* May 28, 1993) [hereinafter International Covenant on ESCR]; CEDAW, *supra* note 19; Convention on the Rights of the Child, *adopted* Dec. 18, 1979, G.A. Res. 44/25, annex, U.N. GAOR (44th Sess.), Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) (*succeeded to by Slovakia* May 28, 1993); Constitution of the Slovak Republic, *supra* note 100, arts. 7(5) and 154c(1).
- 248 Beijing Declaration and the Platform for Action, Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995, U.N. Doc. A/CONF.177/20 (1996) [hereinafter Beijing Declaration and the Platform for Action]; ICPD Programme of Action, *supra* note 183.
- 249 Constitution of the Slovak Republic, *supra* note 100, art. 15(1).
- 250 *Id.* art. 40.
- 251 *Id.* art. 26(1).
- 252 *Id.* art. 16(2).
- 253 *Id.* arts. 16(1), 19.
- 254 *Id.* arts. 24(1)–(4).
- 255 *Id.* art. 12(1–2).
- 256 *Id.* art. 40.
- 257 *Id.*; Health Insurance Act, No. 580/2004 Coll. of Laws, *supra* note 51, Health Insurance Coverage Act, No. 577/2004 Coll. of Laws, *supra* note 51.
- 258 Health Insurance Act, No. 580/2004 Coll. of Laws, *supra* note 51, secs. 3–5.
- 259 *Id.* sec. 2(1). Zákon č. 40/1964 Zb.
- Občiansky zákonník v znení neskorších predpisov [Act No. 40/1964 Coll. Civil Code *as amended*] secs. 788–791.
- 260 Zákon č. 576/2004 Z.z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov [Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts *as amended*.] sec. 11(1)–(2) (2004) [hereinafter Healthcare Act, No. 576/2004 Coll. of Laws].
- 261 *Id.* sec. 11(2); Zákon č. 365/2004 Z.z. o rovnakom zaobchádzaní v niektorých oblastiach a o ochrane pred diskrimináciou a o zmene a doplnení niektorých zákonov (antidiskriminačný zákon) [Act No. 365/2004 Coll. of Laws on Equal Treatment in Certain Areas and Protection against Discrimination, and on Amending and Supplementing Certain Acts (Antidiscrimination Act)] *as amended* secs. 2(1), 5 (2004).
- 262 Healthcare Act, No. 576/2004 Coll. of Laws, *supra* note 260, sec. 6(1).
- 263 *Id.* sec. 6(6).
- 264 Abortion Act, *supra* note 52, secs. 4–5. *See also* 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 [Ordinance 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 [hereinafter Artificial Termination of Pregnancy Ordinance, No. 74/1986 Coll.].
- 265 Healthcare Act, No. 576/2004 Coll. of Laws, *supra* note 260, sec. 6b(1)(2).
- 266 Abortion Act, *supra* note 52, sec. 7; Artificial Termination of Pregnancy Ordinance, No. 74/1986 Coll., *supra* note 264, secs. 4–5.
- 267 Healthcare Act, No. 576/2004 Coll. of Laws, *supra* note 260, sec. 6b(3).
- 268 Abortion Act, *supra* note 52, sec. 8.
- 269 Healthcare Act, No. 576/2004 Coll. of Laws, *supra* note 260, sec. 6b(4). (The parental consent requirement applies to persons under 18 years of age, excepting those who achieved majority earlier by getting married).
- 270 Abortion Act, *supra* note 52, secs. 2, 3.
- 271 *Id.*
- 272 Health Insurance Coverage Act, No. 577/2004 Coll. of Laws, *supra* note 51, secs. 11–19 and secs. 39–47; Odborné usmernenie Ministerstva zdravotníctva Slovenskej republiky, ktorým sa mení a dopĺňa odborné usmernenie Ministerstva zdravotníctva Slovenskej republiky č. 16652/2009-OKCLP zo dňa 22. júla 2009 o postupe pri podávaní žiadosti o zaradenie lieku alebo vyradenie lieku do alebo zo zoznamu liečiv a liekov plne uhrádzaných alebo čiastočne uhrádzaných na základe verejného zdravotného poistenia a cenových návrhov na liek [Special Guideline of the Ministry of Health on the Procedure for Applying for the Inclusion or Exclusion of a Drug to or from the List of Medicinal Prod-

- ucts and Drugs Fully or Partially Covered on Basis of Public Health Insurance and on Submitting Price Proposals on a Drug] (Dec. 7, 2009) (Slovak Republic).
- 273 Health Insurance Coverage Act, No. 577/2004 Coll. of Laws, *supra* note 51, sec. 12(1).
- 274 *Id.* sec. 12(3).
- 275 *Id.* secs. 11(1)(2), 16, 17. *See also* Ministry of Health (Slovak Republic), *Statute of the Categorization Commission for Medicinal Products*, <http://www.health.gov.sk/?statuty-6> (last visited Nov. 29, 2010). The Ministry of Health issues the list of subsidized medicinal products in a ministerial measure. *See* Health Insurance Coverage Act, No. 577/2004 Coll. of Laws, *supra* note 51, sec. 4(3).
- 276 Interview with Lucia Vargová, in Košice (Sept. 16, 2010). *See also* Opatrenie Ministerstva zdravotníctva č. 07045-33/2010-OL, ktorým sa mení opatrenie Ministerstva zdravotníctva č. 07045/2003-OAP, ktorým sa ustanovuje rozsah regulácie cien v oblasti zdravotníctva v znení neskorších predpisov [Measure of the Ministry of Health No. 07045-33/2010-OL (Sept. 8, 2010) (Slovak Republic), *amending* Measure of the Ministry of Health No. 07045/2003-OAP (Dec. 30, 2003) (Slovak Republic), *establishing* the Scope of Price Regulation in the Health-care Sector, *as amended*].
- 277 Národná stratégia rodovej rovnosti na roky 2009–2013 [National Strategy for Gender Equality for the Years 2009–2013], Resolution No. 272/2009 (Apr. 8, 2009) (Government of the Slovak Republic).
- 278 *Id.* at 15.
- 279 Národný akčný plán rodovej rovnosti na roky 2010–2013 [National Action Plan for Gender Equality 2010–2013], Resolution No. 316/2010 (May 12, 2010) (Government of the Slovak Republic).
- 280 PROGRAMOVÉ VYHLÁSENIE VLÁDY SLOVENSKEJ REPUBLIKY NA OBDOBIE ROKOV 2010–2014 [SLOVAK GOVERNMENT PROGRAMMATIC MANIFESTO 2010–2014] 29 (2010), *available at* <http://www.vlada.gov.sk/data/files/6257.pdf>; Koncepcia štátnej politiky zdravia Slovenskej republiky [State Health Policy Concept of the Slovak Republic], Resolution No. 11/2008, point 4 (Jan. 9, 2008) (Government of the Slovak Republic), *available at* http://www.uvzsr.sk/docs/kspz/koncepcia_SP_zdravia_SR_EN.pdf.
- 281 State Health Policy Concept of the Slovak Republic, *supra* note 280. Moreover, the National Program on Protection of Sexual and Reproductive Health, which has not yet been adopted, is among the programs mentioned as being related to some extent to state health policy priorities. *See* State Health Policy Concept of the Slovak Republic, *supra* note 280, point 4.1.
- 282 Národný program starostlivosti o deti a dorast v Slovenskej republike na roky 2008–2015 [National Program on Care for Children and Adolescents in the Slovak Republic for the Years 2008–2015], Resolution No. 192/2008, para. 6.3 (Mar. 26, 2008) (Government of the Slovak Republic).
- 283 *Id.*
- 284 CEDAW Committee, *General Recommendation No. 21: Equality in Marriage and Family Relations* (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 21, U.N. Doc. HRI/GEN/rev.5 [hereinafter CEDAW Committee, *General Recommendation No. 21*].
- 285 Simone Cusack and Rebecca J. Cook, *Combating Discrimination Based on Sex and Gender*, in *INTERNATIONAL PROTECTION OF HUMAN RIGHTS* 205, 206 (Catarina Krause and Martin Scheinin eds., 2009).
- 286 *Id.* at 206; CEDAW, *supra* note 19, Preamble.
- 287 CEDAW Committee, *General Recommendation No. 25: Temporary special measures* (30th Sess.), para. 5, U.N. Doc. HRI/GEN/1/Rev.7 at 282 (2004) [hereinafter CEDAW Committee, *General Recommendation No. 25*]; *see also* CEDAW, *supra* note 19.
- 288 Simone Cusack and Rebecca J. Cook, *supra* note 285, at 206.
- 289 CEDAW Committee, *General Recommendation No. 25, supra* note 287, para. 10.
- 290 CEDAW Committee, *General Recommendation No. 21, supra* note 284, para. 21.
- 291 CEDAW, *supra* note 19, arts. 10(h), 12.1.
- 292 CEDAW Committee, *Concluding Observations: Slovakia* (2008), *supra* note 22, para. 43.
- 293 CEDAW Committee, *General Recommendation No. 3: Education and public information campaigns* (Sixth Sess.), U.N. Doc. A/42/38, at 78 (1987), *reprinted in* *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6, at 231 (2003); CEDAW Committee, *General Recommendation No.19: Violence against women* (11th Sess.), para. 11, U.N. Doc. A/47/38, at 1 (1993), *reprinted in* *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6, at 243 (2003); CEDAW Committee, *General Recommendation No. 23: Political and public life* (16th Sess.), paras. 12, 20(c), 44, U.N. Doc. A/52/38/Rev.1, at 61 (1997), *reprinted in* *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6, at 260 (2003).
- 294 CEDAW Committee, *Concluding Observations: Slovakia* (2008), *supra* note 22, paras. 32–33.
- 295 *See* Human Rights Committee, *General Comment No. 28: Equality of rights between men and women* (68th Sess.), para. 5, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), *reprinted in* *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6, at 179 (2003) [hereinafter HRC, *General Comment No. 28*].
- 296 International Covenant on ESCR, *supra* note 247, at 49, art. 12.
- 297 CESCR, *General Comment No. 14, supra* note 3, para. 12.
- 298 *Id.* para. 12(b).
- 299 *Id.* para. 12(c).
- 300 *Id.* paras. 12(a), 43(d), 44(a).
- 301 *See* CEDAW Committee, *General Recommendation No. 24, supra* note 20, paras. 1, 17.
- 302 CESCR, *General Comment No. 14, supra* note 3, para. 12(b).
- 303 *Id.*
- 304 *Id.* para. 52.
- 305 *Id.* para. 12(d).
- 306 *Id.* para. 36.
- 307 Interview with Dr. Vladimír Cupaník, *supra* note 166.
- 308 CEDAW, *supra* note 19, art. 12.1; *see, e.g.*, CEDAW Committee, *Concluding Observations: Mexico*, paras. 32–33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).
- 309 CESCR, *General Comment No. 14, supra* note 3, para. 11.
- 310 *See* CRC, *General Comment No. 4, supra* note 20, paras. 31–32.
- 311 *See, e.g.*, CEDAW Committee, *Concluding Observations: Chile*, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); *Bosnia and Herzegovina*, para. 35, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); *Estonia*, para. 111, U.N. Doc. A/57/38 (2002); *Georgia*, para. 111, U.N. Doc. A/54/38 (1999); *Greece*, para. 207, U.N. Doc. A/54/38 (1999); *Hungary*, para. 260, U.N. Doc. A/51/38 (1996); *Kazakhstan*, paras. 105–06, U.N. Doc. A/56/38 (2001); *Kyrgyzstan*, paras. 136–37, U.N. Doc. A/54/38 (1999); *Lithuania*, para. 158, U.N. Doc. A/55/38 (2000); *Luxembourg*, paras. 210, 221, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Mongolia*, para. 273, U.N. Doc. A/56/38 (2001); *Romania*, para. 314, U.N. Doc. A/55/38 (2000); *Slovakia*, paras. 91–92, U.N. Doc. A/53/38/Rev.1 (1998); *Slovenia*, paras. 107, 119, U.N. Doc. A/52/38/Rev.1 (1997).
- 312 CEDAW Committee, *Concluding Observations: South Africa*, para. 134, U.N. Doc. No. A/53/38/Rev.1 (1998).
- 313 *See, e.g.*, CEDAW Committee, *Concluding Observations: Greece*, para. 207, U.N. Doc. A/54/38 (1999); *Hungary*, para. 254, U.N. Doc. A/51/38 (1996); *Ireland*, para. 186, U.N. Doc. A/54/38 (1999); *Lithuania*, para. 158, U.N. Doc. A/55/38 (2000); *Mongolia*, para. 273, U.N. Doc. A/56/38 (2001).
- 314 CEDAW Committee, *Concluding Observations: Luxembourg*, para. 221, U.N. Doc. A/52/38/Rev.1, Part II (1997).
- 315 *See, e.g.*, CEDAW Committee, *Concluding Observations: Belarus*, para. 374, U.N. Doc. A/55/38 (2000); *Croatia*, para. 117, U.N. Doc. A/53/38 (1998); *Estonia*, para. 112, U.N. Doc. A/57/38 (2002); *Greece*, para. 207, U.N. Doc. A/54/38 (1999); *Hungary*, para. 260, U.N. Doc. A/51/38 (1996); *Israel*, para. 181, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Mongolia*, para. 274, U.N. Doc. A/56/38 (2001); *Slovakia*, para. 92, U.N. Doc. A/53/38/Rev.1 (1998).
- 316 CESCR, *General Comment No. 14, supra* note 3, paras. 12(a), 43(d).
- 317 *See* EUR. PARL. ASS., *Resolution 1399: European Strategy for the Promotion of Sexual and Reproductive Health and Rights*, paras. 11(i)(f), 11(iv), 12(iv) (Oct. 5, 2004), *avail-*

- able at <http://assembly.coe.int/Documents/AdoptedText/ta04/ERES1399.htm>.
- 318 EUR. PARL. ASSEMB., *Resolution 1607: Access to Safe and Legal Abortion in Europe*, para. 7.6 (Apr. 16, 2008), available at <http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta08/ERES1607.htm> [hereinafter *Resolution 1607: Access to Safe and Legal Abortion in Europe*].
- 319 See European Social Charter, *supra* note 246, arts. 11, 16.
- 320 Eur. Comm. Soc. Rts., *Conclusions I: Statement of Interpretation of Article 11, 59* (1961 Charter) (May 31, 1969); Eur. Comm. Soc. Rts., *Addendum to Conclusions XV-2: Cyprus*, art. 11.1 (1961 Charter); see also Eur. Comm. Soc. Rts., *Conclusions XVII-2 vol. 2: Portugal*, art. 11.1 (1961 Charter) (Jun. 30, 2005); Eur. Comm. Soc. Rts., *Conclusions 2007 vol. 1: Albania*, art. 11.1 (Oct. 31, 2007).
- 321 See Eur. Comm. Soc. Rts., *Conclusions 2005 vol. 2: Romania*, art. 11.1 (Sept. 3, 2005).
- 322 Eur. Comm. Soc. Rts., *Conclusions XVI-1 vol. 2: Portugal*, art. 16 (1961 Charter) (May 30, 2003); Eur. Comm. Soc. Rts., *Conclusions XVI-1 vol. 2: Turkey*, art. 16 (1961 Charter) (May 30, 2003).
- 323 ICPD Programme of Action, *supra* note 183, paras. 1.12, 7.16.
- 324 Beijing Declaration and the Platform for Action, *supra* note 248, para. 106(u).
- 325 CEDAW, *supra* note 19, art. 16.1(e).
- 326 CEDAW Committee, *General Recommendation No. 24*, *supra* note 20, para. 17.
- 327 The World Population Plan of Action, United Nations World Population Conference, Bucharest, Romania, Aug. 19–30, 1974, 6, 28–29, 57 U.N. ECOSOC, U.N. Doc. E/5585 (1974); Beijing Declaration and the Platform for Action, *supra* note 248, para. 95; ICPD Programme of Action, *supra* note 183, para. 7.3.
- 328 Beijing Declaration and the Platform for Action, *supra* note 248, para. 95.
- 329 *Id.*
- 330 CEDAW, *supra* note 19, art. 10(h).
- 331 CEDAW Committee, *Concluding Observations: South Africa*, para. 134, U.N. Doc. A/53/38/Rev.1 (1998).
- 332 CEDAW Committee, *Concluding Observations: South Africa*, para. 134, U.N. Doc. A/53/38/Rev.1 (1998). The treaties that protect the rights to life, health, non-discrimination, education, and information include the Economic, Social and Cultural Rights Covenant, the Civil and Political Rights Covenant, CEDAW, the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Rights of the Child, the International Convention on the Rights of Migrant Workers and Members of their Families, and the Convention on the Rights of Persons with Disabilities.
- 333 See, e.g., CEDAW Committee, *Concluding Observations: Belize*, paras. 56, 57, U.N. Doc. A/54/38 (1999); *Burundi*, para. 62, U.N. Doc. A/56/38 (2001); *Chile*, paras. 226–227, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 349, U.N. Doc. A/53/38 (1998); *Lithuania*, para. 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); *Nigeria*, para. 33, U.N. Doc. CEDAW/C/NGA/CO/6 (2008); CRC, *Concluding Observations: Cambodia*, para. 52, U.N. Doc. CRC/C/15/Add.128 (2000); *Colombia*, para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Dominican Republic*, para. 37, U.N. Doc. CRC/C/15/Add.150 (2001); *Ethiopia*, para. 61, U.N. Doc. CRC/C/15/Add.144 (2001); CESCR, *Concluding Observations: Bolivia*, para. 43, U.N. Doc. E/C.12/1/Add.60 (2001); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Libyan Arab Jamahiriya*, para. 36, U.N. Doc. E/C.12/LYB/CO/2 (2006); *Senegal*, para. 47, U.N. Doc. E/C.12/1/Add.62 (2001); *Ukraine*, para. 31, U.N. Doc. E/C.12/1/Add.65 (2001).
- 334 CEDAW Committee, *Concluding Observations: Republic of Moldova*, para. 31, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); see also CEDAW Committee, *Concluding Observations: Lithuania*, para. 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); *Turkmenistan*, para. 31, U.N. Doc. CEDAW/C/TKM/CO/2 (2006).
- 335 See, e.g., CEDAW Committee, *Concluding Observations: Lithuania*, para. 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).
- 336 CRC, *Concluding Observations: Ireland*, para. 52, U.N. Doc. CRC/C/IRL/CO/2 (2006).
- 337 Human Rights Committee, *Concluding Observations: Poland*, para. 9, U.N. Doc. CCPR/CO/82/POL (2004).
- 338 CESCR, *General Comment No. 14*, *supra* note 3, para. 34; CRC, *General Comment No. 3: HIV/AIDS and the rights of the child* (32nd Sess.), para. 16, U.N. Doc. CRC/GC/2003/3 (2003), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6, at 296 (2003).
- 339 *Resolution 1607: Access to Safe and Legal Abortion in Europe*, *supra* note 318, para. 7.6.
- 340 *Id.* para. 7.5.
- 341 Eur. Comm. Soc. Rts., *Conclusions XVI-1 vol. 2: Portugal*, art. 16 (1961 Charter) (May 30, 2003); Eur. Comm. Soc. Rts., *Conclusions XVI-1 vol. 2: Turkey*, art. 16 (1961 Charter) (May 30, 2003).
- 342 INTERIGHTS v. Croatia, *supra* note 10, paras. 45, 47.
- 343 See HRC, *General Comment No. 28*, *supra* note 295, para. 20; Human Rights Committee, *K.L. v. Peru*, Communication No. 1153/2003, para. 6.4 (2005); *Tysiąc v. Poland*, Application No. 5410/03, Eur. Ct. H.R., 106–107 (Mar. 20, 2007).
- 344 See HRC, *General Comment No. 28*, *supra* note 295, para. 20.
- 345 CESCR, *General Comment No. 14*, *supra* note 3, para. 3.
- 346 *Id.* para. 8.
- 347 See, e.g., Human Rights Committee, *Concluding Observations: Hungary*, para. 11, U.N. Doc. CCPR/CO/74/HUN (2002); *Paraguay*, para. 10, U.N. Doc. CCPR/C/PRY/CO/2, (2006).
- 348 See, e.g., Human Rights Committee, *Concluding Observations: Vietnam*, para. 15, U.N. Doc. No. CCPR/CO/75/VNM (2002); *Mongolia*, para. 8(b), U.N. Doc. CCPR/C/79/Add.120 (2000); see also *Georgia*, para. 239, U.N. Doc. CCPR/C/79/Add.75 (2000).
- 349 See Human Rights Committee, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000).

Endnotes for Boxes WHO Model List of Essential Medicines

- 1 WORLD HEALTH ORGANIZATION (WHO), ESSENTIAL MEDICINES, http://www.who.int/medicines/services/essmedicines_def/en/index.html (last visited Aug. 11, 2010).
- 2 See WHO, MODEL LIST OF ESSENTIAL MEDICINES (16th ed., updated) (Mar. 2010), <http://www.who.int/medicines/publications/essentialmedicines/en/index.html>. See also INTERAGENCY LIST OF ESSENTIAL MEDICINES FOR REPRODUCTIVE HEALTH (2006), WHO DEPT. OF REPRO. HEALTH AND RESEARCH, available at http://www.who.int/reproductivehealth/publications/general/RHR_2006_1/en/.
- 3 WHO, MODEL LIST OF ESSENTIAL MEDICINES, *supra* note 2.
- 4 See *id.* See also INTERAGENCY LIST OF ESSENTIAL MEDICINES FOR REPRODUCTIVE HEALTH, *supra* note 2; *Declaration of Alma-Ata, International Conference on Primary Healthcare*, Alma-Ata, USSR, sec. VII(3) (1978), available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.
- 5 Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, (22nd Sess., 2000), para. 43, U.N. Doc. E/C.12/2000/4 (2000).

The Right to Sexual Health

- 1 The Special Rapporteur on the Right to Health (SRRH), Paul Hunt, *Report of the Special Rapporteur, on Economic, Social and Cultural Rights: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, para. 54, U.N. Doc. E/CN.4/2004/49 (Feb. 16, 2004) [hereinafter SRRH, Paul Hunt (2004)].
- 2 WORLD HEALTH ORGANIZATION (WHO), DEFINING SEXUAL HEALTH: REPORT OF A TECHNICAL CONSULTATION ON SEXUAL HEALTH 28-31 JANUARY 2002, GENEVA 5 (2006) [hereinafter WHO, DEFINING SEXUAL HEALTH].
- 3 SRRH, Paul Hunt (2004), *supra* note 1, para. 54.
- 4 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995).
- 5 WHO, DEFINING SEXUAL HEALTH, *supra* note 2, at 5; SRRH, Paul Hunt (2004), *supra* note 1, para. 53.

CEDAW Committee Recommendations

to Slovakia, July 2008

- 1 CEDAW Committee, *Concluding Observations: Slovakia*, paras. 42–43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008).

Access to Contraception in Slovakia

- 1 Zákon č. 576/2004 Z.z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov [Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts, as amended] sec. 12(14)(a) (2004).
- 2 Zákon č. 577/2004 Z.z. o rozsahu zdravotnej starostlivosti uhrádzanej na základe verejného zdravotného poistenia a o úhradách za služby súvisiace s poskytovaním zdravotnej starostlivosti [Act No. 577/2004 Coll. of Laws on the Scope of Healthcare Covered by Public Health Insurance and on the Reimbursement of Healthcare-related Services, as amended] sec. 2(1)(h), Annex No. 2 (2004).
- 3 *Id.* sec. 2(1)(c).
- 4 WORLD HEALTH ORGANIZATION, Emergency Contraception (Rev. Oct. 2005), <http://www.who.int/mediacentre/factsheets/fs244/en/> (last visited Nov. 4, 2010).
- 5 Email from Lucia Vargová, pharmacist (Oct. 22, 2010) (on file with the Center for Reproductive Rights).
- 6 CEDAW Committee, *Concluding Observations: Mexico*, para. 33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).

Decrease in Abortions

- 1 Zora Bútorová and Jarmila Filadelfiová, *Women, Men and the Increasing Diversity of Life*, in SHE AND HE IN SLOVAKIA: GENDER AND AGE IN THE PERIOD OF TRANSITION 45–72, 61 (Bútorová, Z. et al., 2008); NATIONAL HEALTH INFORMATION CENTER, *Starostlivosť o ženu v SR 2008* [Care for a Woman in the SR 2008] 9 (2008).
- 2 NATIONAL HEALTH INFORMATION CENTER, *Potravy SR 2009/Abortions in the Slovak Republic 2009*, ZŠ-7/2010, 11 (2010).
- 3 Zora Bútorová and Jarmila Filadelfiová, *supra* note 1, at 61.
- 4 CEDAW Committee, *Concluding Observation: Slovakia*, para. 28, U.N. Doc. CEDAW/C/SVK/CO/4 (2008). The Committee is also concerned at the persisting high rate of abortion which is a consequence of the lack of information and access of women to family planning.
- 5 David A Grimes et al., *Unsafe abortion: the preventable pandemic*, 368 THE LANCET 1908, 1915 (2006).

The Cost of Contraceptives in Slovakia

- 1 Email from Lucia Vargová, pharmacist (prices as of Sept. 2010) (on file with the Center for Reproductive Rights).

Subsidization of Sterilization

- 1 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 [Decree 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 IV (2004) (Government of the Slovak Republic).

The Financial Crisis Hits Reproductive Healthcare

- 1 Report on Gender Aspects of the Economic Downturn and Financial Crisis, Explanatory Statement, EUR. PARL. DOC. 2009/2204(INI) (2010) [hereinafter Rep. on Gender Aspects of the Economic Downturn and Financial Crisis].
- 2 *Commission White Paper on Together for Health: A Strategic Approach for the EU 2008–2013*, at 5, COM (2007) 630 final (Oct. 23, 2007) [hereinafter *Commission White Paper on Together for Health: A Strategic Approach for the EU 2008–2013*].
- 3 Eur. Women's Lobby Position Paper, *Women's Health in the European Union* 1, 13 (2010), available at http://www.womenlobby.org/IMG/pdf/EWL_Position-Paper_on_Women_and_health_EN.pdf [hereinafter Position Paper, *Women's Health in the European Union*].
- 4 UNITED NATIONS POPULATION FUND (UNFPA), Review of Existing Reproductive Health Commodity Security Systems, Budgeting and National Capacities, and Progress Achieved with Family Planning Service Provision in the Eastern Europe and Central Asia Region, at 14 (2009) (unpublished paper, on file with the Center for Reproductive Rights).
- 5 *See also* Rep. on Gender Aspects of the Economic Downturn and Financial Crisis, *supra* note 1, para. T.10. In the Netherlands in 2010, for example, the need for budgetary cuts as a result of the financial crisis led the Health Insurance Advisory Board to recommend that the government remove coverage of any kind of contraceptives, whether for pregnancy prevention or medical reasons, from the basic health insurance scheme. While the government is free to ignore the Board's advice, in practice it is almost always followed. The Health Insurance Advisory Board (the Netherlands), *Samenvatting Voorbehoeden van zwangerschap en Anticonceptiva in de Zorgverzekeringswet* [Summary of Pregnancy Prevention and Contraception under the Health Insurance Law] (2010), available at http://www.cvz.nl/binaries/live/CVZ_Internet/hst_content/nl/documenten/rapporten/2010/rpt1004+pakketaadvies+2010+-+anticonceptie.pdf.
- 6 Rec. on the Inclusion of Gender Differences in Health Policy, COUNCIL OF EUR. COMM.

- OF MINISTERS TO MEMBER STATES DOC. CM/Rec (2008) 1 (adopted Jan. 30, 2008), available at <https://wcd.coe.int/ViewDoc.jsp?id=1241743>; Gender Budgeting, PARL. ASSEMB. REC. 1739 (2006), available at <http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta06/erec1739.htm>. “Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality.” Gender budgeting as a tool for safeguarding women's health, PARL. ASSEMB. DOC. 12231 (2010), available at <http://assembly.coe.int/Main.asp?link=/Documents/WorkingDocs/Doc10/EDOC12231.htm>.
- 7 Rec. on the Inclusion of Gender Differences in Health Policy, *supra* note 6; Gender Budgeting, *supra* note 6.
 - 8 NATIONAL STRATEGY FOR GENDER EQUALITY FOR THE YEARS 2009–2013, RES. OF THE GOV'T OF THE SLOVAK REPUBLIC NO. 272/2009 (Apr. 8, 2009).
 - 9 *Id.* at 15.
 - 10 *Národný akčný plán rodovej rovnosti na roky 2010–2013* [National Action Plan for Gender Equality 2010–2013], Res. of the Gov't of the Slovak Republic No. 316/2010 (May 12, 2010).
 - 11 UNFPA, *Factsheet: ICPD issues and the Financial Crisis* (2009), available at <http://www.unfpa.org/wpd/2009/resources.html>.
 - 12 Press Release, World Bank, Global Crisis Pushing Almost 35 Million People Back into Poverty In Europe and Central Asia (Oct. 3, 2009), available at <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22338267~pagePK:64257043~piPK:437376~theSitePK:4607,00.html>; Rep. on Gender Aspects of the Economic Downturn and Financial Crisis, *supra* note 1, para. T.10.
 - 13 “[W]omen were more likely to say that in the past six months it had become somewhat or much more difficult to afford general healthcare (32% vs. 26% of men), childcare (14% vs. 11%) and long-term care services (26% vs. 21%).” MONITORING THE SOCIAL IMPACT OF THE CRISIS: PUBLIC PERCEPTIONS IN THE EUROPEAN UNION: ANALYTICAL REPORT, Eur. Commission Flash EB No. 276 27 (2010); Rep. on Gender Aspects of the Economic Downturn and Financial Crisis, *supra* note 1, para. T.10.
 - 14 Thomas Hammarberg, *Human Rights in Europe: Growing Gaps*, COUNCIL OF EUR. COMM'R FOR H.R. (Apr. 2010).
 - 15 Position Paper, *Women's Health in the European Union*, *supra* note 3, at 1, 13.
 - 16 EUR. WOMEN'S LOBBY AND OXFAM, WOMEN'S POVERTY AND SOCIAL EXCLUSION IN THE EUROPEAN UNION AT A TIME OF RECESSION AN INVISIBLE CRISIS? 4 (2010), available at http://www.oxfam.org.uk/resources/policy/economic_crisis/downloads/tr_gec_an_invisible_crisis_240310.pdf.
 - 17 *Id.* at 5; *see also* Rep. on Gender Aspects of the Economic Downturn and Financial Crisis, *supra* note 1, para. S.

- 18 See generally Rep. on Gender Aspects of the Economic Downturn and Financial Crisis, *supra* note 1.
- 19 Commission White Paper on Together for Health: A Strategic Approach for the EU 2008–2013, *supra* note 2, at 5; Benefits of Meeting the Contraceptive Needs of Ethiopian Women, ALAN GUTTMACHER INSTITUTE (2010), <http://www.guttmacher.org/pubs/IB-Contraceptive-Needs-Ethiopia.pdf>. The Swedish Government considers contraceptive subsidies a means of avoiding the higher costs associated with unplanned pregnancies—both the costs related to healthcare for pregnancies carried to term and those associated with subsidized abortions, which are guaranteed in the abortion law (1974:595). SOCIALSTYRELSEN, SKILLNADER, I KOSTNADER MELLAN OLIKA TYPER AV PREVENTIVMEDEL [DIFFERENCE IN COSTS BETWEEN VARIOUS PREVENTATIVE METHODS] 36 (2006).

Marginalized Women Are Especially At-Risk

- 1 Young women are another vulnerable group; they are discussed in a separate text box.
- 2 Eur. Women’s Lobby, Position Paper, *Women’s Health in the European Union* 12 (2010), available at http://www.womenlobby.org/IMG/pdf/EWL_PositionPaper_on_Women_and_health_EN.pdf [hereinafter Position Paper, *Women’s Health in the European Union*]; ASTRA NETWORK, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE, REPORT TO THE EUR. UNION (2006), available at <http://www.astra.org.pl/srhrEU.pdf>.
- 3 EUR. FOUND. FOR THE IMPROVEMENT OF LIVING AND WORKING CONDITIONS, INCOME POVERTY IN THE EUROPEAN UNION 2 (2007), available at <http://www.eurofound.europa.eu/ewco/surveyreports/EU0703019D/EU0703019D.htm> [hereinafter INCOME POVERTY IN THE EUROPEAN UNION].
- 4 Statistical Office of the Slovak Republic, Zisťovanie o príjmoch a životných podmienkach EU SILC 2009 [Statistics on Income and Living Conditions EU SILC 2009] (2010), <http://portal.statistics.sk/showdoc.do?docid=25503> (last visited Nov. 11, 2010) [hereinafter STATISTICS ON INCOME AND LIVING CONDITIONS EU SILC 2009]. Out of all the EU countries, Slovakia, together with Ireland and Spain, has the highest percentage of people living at risk of poverty, 21%. INCOME POVERTY IN THE EUROPEAN UNION, *supra* note 3, at 5.
- 5 Position Paper, *Women’s Health in the European Union*, *supra* note 2, at 13.
- 6 Commission Staff Working Document, *Joint Report on Social Protection and Social Inclusion*, at 10, SEC(2007) 329 (Mar. 2007), available at http://ec.europa.eu/employment_social/social_inclusion/docs/2007/joint_report/sec_2007_329_en.pdf. STATISTICS ON INCOME AND LIVING CONDITIONS EU SILC 2009, *supra* note 4.
- 7 EUR. ROMA RIGHTS CENTRE, AMBULANCE NOT ON THE WAY: THE DISGRACE OF HEALTHCARE

FOR ROMA IN EUROPE (2006), available at http://www.soros.org/initiatives/health/focus/roma/articles_publications/publications/ambulance_20061004. See also Savelina Danova/Russinova, *Undiagnosed: The Impact of Racial Discrimination on Roma Health*, Roma Rights Journal (2004), <http://www.errc.org/cikk.php?cikk=2062> (last visited Nov. 29, 2010); Center for Civil and Human Rights and People in Need Slovakia, Written Comments concerning the Third Periodic Report of the Slovak Republic under the International Covenant on Civil and Political Rights (2010), <http://www.poradna-prava.sk/dok/NGO%20Written%20comments%20HRC%20ICCPR.pdf?PHPSESSID=88258c98e6276138b0129c3e73ac8d8b> (last visited Nov. 29, 2010).

- 8 CENTER FOR REPRODUCTIVE RIGHTS AND CENTRE FOR CIVIL AND HUMAN RIGHTS OR PORADŇA, BODY AND SOUL: FORCED STERILIZATION AND OTHER ASSAULTS ON ROMA REPRODUCTIVE FREEDOM IN SLOVAKIA 54, 73–74 (2003) [hereinafter BODY AND SOUL]; Rec. Concerning Certain Aspects of Law and Practice Relating to Sterilization of Women in the Slovak Republic, COUNCIL OF EUR., COMMISS’R FOR H.R. (2003), <https://wcd.coe.int/ViewDoc.jsp?id=979625andSite=COE> (last visited Nov. 29, 2010).
- 9 Centre for Civil and Human Rights and International Federation for Human Rights, *Shadow Report to the CEDAW Committee for the Slovak Republic* (41st Sess., 2008), available at <http://www.poradna-prava.sk/dok/CEDAW%20Shadow%20%20report%20Poradna%20and%20FIDH%202008.pdf>; Alliance of Women in Slovakia, Center for Civil and Human Rights, Centre on Housing Rights and Evictions, Cultural Association of Roma in Slovakia, EsFem, Fenestra, Milan Šimečka Foundation & Pro Choice Slovakia, *Shadow Report to the CEDAW Committee for the Slovak Republic*, paras. 138–161 (2008); BODY AND SOUL, *supra* note 8, at 61–62; CORSI, M, ET AL., ETHNIC MINORITY AND ROMA WOMEN IN EUROPE: A CASE STUDY FOR GENDER EQUALITY? 111–115 (2010).
- 10 KH and Others v Slovakia, App. No. 32881/04, Eur. Ct. H.R. (2009); Rec. Concerning Certain Aspects of Law and Practice Relating to Sterilization of Women in the Slovak Republic, *supra* note 8; Center for Civil and Human Rights and People in Need Slovakia, *supra* note 7.
- 11 The CEDAW Committee defines gender-based violence as “violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.” Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 19: Violence against women*, (11th Sess., 1992), para. 6, U.N. Doc. A/47/38 (1993) [hereinafter CEDAW Committee, *General Recommendation No. 19*].
- 12 Position Paper, *Women’s Health in the European Union*, *supra* note 2, at 9.

- 13 COUNCIL OF EUR., COMBATTING VIOLENCE AGAINST WOMEN: STOCKTAKING STUDY ON THE MEASURES AND ACTIONS TAKEN IN COUNCIL OF EUROPE MEMBER STATES 7 (2006).
- 14 INST. FOR LABOUR AND FAMILY RESEARCH, REPRESENTATIVE RESEARCH ON PREVALENCE AND EXPERIENCE OF WOMEN WITH VIOLENCE AGAINST WOMEN (VAW) IN SLOVAKIA, Final Report No. 2224 15 (2008). This research shows that “exactly 21,2 % of grown women in Slovakia aged 18 to 64 having a partner during the survey experienced violence committed by him (in 6 % it was acute violence, i.e. often repeated physical and sexual violence and almost permanently present psychological, social or economic violence)”.
- 15 United Nations Population Fund, Gender Equality, *Ending Widespread Violence Against Women*, <http://www.unfpa.org/gender/violence.htm> (last visited Nov. 29, 2010).
- 16 Melissa Moore, *Reproductive Health and Intimate Partner Violence*, 31(6) Family Planning Perspectives (1999), available at <http://www.guttmacher.org/pubs/journals/3130299.html>; Guttmacher Institute, Roundtable discussion, *The Intersection of Domestic Violence and Sexual and Reproductive Health* (Sept. 23, 2008), available at <http://www.guttmacher.org/media/exchange/2008/09/23/GE2008.09.23.html>; Interview with Apolónia Sejková, in Prešov (Apr. 14, 2010).
- 17 Position Paper, *Women’s Health in the European Union*, *supra* note 2, at 10. See also CEDAW Committee, *General Recommendation No. 19*, *supra* note 11, para. 23.

Strong Public Support for Women’s Reproductive Rights and Sexuality Education

- 1 Zora Bútorová & Jarmila Filadelfiová, *Women, Men and the Increasing Diversity of Life*, in SHE AND HE IN SLOVAKIA: GENDER AND AGE IN THE PERIOD OF TRANSITION 63–64 (Bútorová, Z. et al., 2008); Bútorová, Z. et al., *Public Opinion in Slovakia 2003: A Global Report on the State of Society* (Kollár, M. and Mesežnikov, G. eds., 2004).
- 2 SLOVAK FAMILY PLANNING ASSOCIATION, VEDOMOSTNÁ ÚROVEŇ V OBLASTI SEXUÁLNEHO A REPRODUKČNÉHO ZDRAVIA NA ZÁKLADNÝCH ŠKOLÁCH NA SLOVENSKU. KVALITATÍVNA A KVANTITATÍVNA ANALÝZA [LEVEL OF KNOWLEDGE ON SEXUAL AND REPRODUCTIVE HEALTH AT PRIMARY SCHOOLS IN SLOVAKIA: QUALITATIVE AND QUANTITATIVE ANALYSIS] (2005).
- 3 Zora Bútorová and Jarmila Filadelfiová, *supra* note 1, at 62. According to a survey carried out by the Institute for Public Affairs, during which respondents were asked about their opinion on the permissive abortion law as valid in 2007, “. . . only 16% of respondents (20% of women and 11% of men) viewed the [. . .] abortion law as too lenient in November 2007. On the other hand, 64% of women and 57% of men advocated either preserving the *status quo* (43% of women and 41% of men) or further liberalization to increase availability

of abortions (21% of women and 16% of men).” See also SLOVAK FAMILY PLANNING ASSOCIATION AND FOCUS—SOCIAL AND MARKETING ANALYSIS CENTRE, REPRODUCTIVE PRACTICES OF SLOVAK WOMEN (1997), available at http://www.rodicovstvo.sk/reproductive_practices.htm.

Religion Should Not Influence Laws

- 1 REBECCA J. COOK AND BERNARD M. DICKENS, CONSIDERATIONS FOR FORMULATING REPRODUCTIVE HEALTH LAWS (World Health Organization, 2nd Ed., 2000).

Family Planning Methods Used in Slovakia

- 1 NATIONAL HEALTH INFORMATION CENTER, HEALTH STATISTICS YEARBOOK OF THE SLOVAK REPUBLIC 2008 at 39 (2009), available at http://data.nczisk.sk/rocniky/rocnika_2008.pdf; Akbar Aghajanian et al, *Continuing Use of Withdrawal as a Contraceptive Method in Iran*, 34 CANADIAN STUDIES IN POPULATION 179, 182 (2007). Data on use of hormonal contraception and IUD are from 2008; data on withdrawal are from 2005. See also SLOVAK FAMILY PLANNING ASSOCIATION AND FOCUS—SOCIAL AND MARKETING ANALYSIS CENTRE, REPRODUCTIVE PRACTICES OF SLOVAK WOMEN (1997), available at http://www.rodicovstvo.sk/reproductive_practices.htm.

Barriers Young Women Face

- 1 Young women are women between the ages of 10 and 24. Adolescents are women between the ages of 10 and 19. In this report, “minor” refers to women under the age of 18, the age of majority in Slovakia.
- 2 Bianchi, G., Lukšik, I., *Niektoré údaje o sexualite mládeže na Slovensku v 1. polovici 90. rokov [Some Data on Youth Sexuality in Slovakia in the 1st Half of the 1990s]* in VÝCHOVA K RODIČOVSTVU, MANŽELSTVU A ETIKE INTÍMNYCH VZŤAHOV. [EDUCATION FOR PARENTHOOD, MARRIAGE AND ETHICS OF INTIMATE RELATIONSHIPS] (Poliaková, E., Konečný, P., Ondrová, J. eds.); Nitra, European Union, International Planned Parenthood Federation, Slov. spol. pre plánov. rodičovstvo a vých. k rodič., Pdf VŠP, SlovDidac, v rámci projektu EÚ č. ZZ9408-LIEN 95- 0833.00 Phare [Slovak family Planning Association, Pdf VŠP, SlovDidac, EU project No. ZZ9408-LIEN 95- 0833.00 Phare], 19–26 (1996); Máthé, R., Ritomský, A., *Špecifická prvého pohlavného styku na Slovensku [Specifics of the First Sexual Intercourse in Slovakia]*, 1 *Sexuológia* 20–29 (2005).
- 3 Interview with Livia, in Košice (Apr. 13, 2010); Interview with Miroslava, in Košice (Apr. 13, 2010); Interview with Alexandra, in Prešov (Apr. 16, 2010); Interview with Sidónia, in Košice (Apr. 19, 2010); Interview with Daniela, in Košice (Apr. 19, 2010).
- 4 Interview with Miroslava, *supra* note 3; Interview with Sidónia, *supra* note 3.
- 5 Interview with Miroslava, *supra* note 3.

- 6 Interview with Lucia Vargová, in Košice (Apr. 14, 2010).
- 7 Interview with Mária, in Michalovce (Apr. 20, 2010).
- 8 Interview with Nina, in Košice (Apr. 19, 2010).
- 9 Email from Lucia Vargová, the pharmacist (Oct. 22, 2010) (on the file with the Center for Reproductive Rights).
- 10 Act No. 576/2004, Coll. of Laws on Healthcare, Healthcare-related Services and Amending and Supplementing Certain Acts, *as amended*, sec. 6 (6).
- 11 Interview with Dr. Elena Molnárová, in Košice (Apr. 13, 2010); Interview with Klaudia, in Prešov (Apr. 16, 2010); Interview with Edita Bačová, in Prešov (Apr. 16, 2010); Interview with Vanda Durbáková, in Prešov (Apr. 16, 2010); Interview with Alexandra, *supra* note 3; Interview with Nina, *supra* note 8; Interview with Kamila, in Košice (Apr. 19, 2010); Interview with Daniela, *supra* note 3; Interview with Henrieta Novotná and Božidara Balážová, in Michalovce (Apr. 20, 2010); Interview with Mária, *supra* note 7.
- 12 Interview with Miroslava, *supra* note 3; Interview with Nina, *supra* note 8; Interview with Kamila, *supra* note 11.
- 13 Interview with Kamila, *supra* note 11; Interview with Daniela, *supra* note 3.
- 14 Interview with Dr. Galina Kováčová, in Prešov (Apr. 16, 2010); Interview with Jarmila, Slávka and Viera, in Roškovce (Apr. 17, 2010); Interview with Alexandra, *supra* note 3; Interview with Nina, *supra* note 8.
- 15 Interview with Alexandra, *supra* note 3.
- 16 Interview with Kamila, *supra* note 11.
- 17 See e.g. Letter of Mons. František Tondra, chair of the Slovak Conference of Bishops (SBC), *Otvorený list predsedu KBS ministrom školstva SR [Open Letter of the Chair of SBC to the Minister of Education of the SR]* (Aug. 31, 2007), available at <http://www.tkkbs.sk/view.php?cislocclanku=20070831016> (last visited Oct. 11, 2010). See also Olga Pietruchová, *Fakty o postojoch katolíckej cirkvi k sexualite [Facts on the Catholic Church’s Stance on Sexuality]* (Nov. 23, 2007), <http://rodicovstvo.wordpress.com/2007/12/23/fakty-o-postojoch-katolickej-cirkvi-k-sexualite> (last visited Jul. 23, 2010).
- 18 Interview with Dr. Elena Molnárová, *supra* note 11; Interview with Livia, *supra* note 3; Interview with Lucia Vargová, *supra* note 6; Interview with Zita Šimková, in Prešov (Apr. 14, 2010); Interview with Linda, in Sabinov (Apr. 14, 2010); Interview with Vanda Durbáková, *supra* note 11; Interview with Oskar Balog, in Roškovce (Apr. 17, 2010); Interview with Svetlana, in Michalovce (Apr. 20, 2010); Interview with Sabina Králiková and Aurélia Adamcová, in Michalovce (Apr. 20, 2010); Interview with Henrieta Novotná and Božidara Balážová, *supra* note 11; Interview with Olga Pietruchová, in Bratislava (Sept. 29, 2010).
- 19 Committee on the Rights of the Child (CRC), *General Comment 4: Adolescent health and development in the context of the*

Convention on the Rights of the Child, para. 28, U.N. Doc. CRC/GC/2003/4 (2003).

- 20 Interview with Dr. Elena Molnárová, *supra* note 11; Interview with Livia, *supra* note 3; Interview with Miroslava, *supra* note 3; Interview with Zita Šimková, *supra* note 18; Interview with Klaudia, *supra* note 11; Interview with Vanda Durbáková, *supra* note 11; Interview with Henrieta Novotná and Božidara Balážová, *supra* note 11.
- 21 Interview with Livia, *supra* note 3.
- 22 See, e.g., Human Rights Committee, *Concluding Observations: Zambia*, para. 17, U.N. Doc. CCPR/C/79/Add.62 (1996); Committee on Economic, Social and Cultural Rights, *Concluding Observations, Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 2001; *Jamaica*, para. 17, U.N. Doc. E/C.12/1/Add.75 (2001); *Saint Vincent and the Grenadines*, para. 26, U.N. Doc. E/C.12/1/Add.21 (1997); CRC, *Concluding Observations, Kingdom of the Netherlands (Netherlands Antilles)*, para. 53, U.N. Doc. CRC/C/15/Add.186 (2002).

Conscientious Objection Inhibits Access to Contraception

- 1 Interview with Dr. Elena Molnárová, in Košice (Apr. 13, 2010); Interview with Dr. Galina Kováčová, in Prešov (Apr. 16, 2010); Interview with Dr. Anton Novák, in Spišská Nová Ves (Apr. 16, 2010); Interview with Zdena Horvátová, in Prešov (Apr. 16, 2010); Interview with Dr. Michal Kliment, in Bratislava (Sept. 27, 2010); Interview with Dr. Vladimír Cupaník, in Bratislava (Sept. 28, 2010).
- 2 Interview with Zdena Horvátová, *supra* note 1.
- 3 Interview with Dr. Michal Kliment, *supra* note 1.
- 4 Interview with Nina, in Košice (Apr. 19, 2010).

Human Rights Require Regulating Conscientious Objection

- 1 Report of the Committee on the Elimination of Discrimination against Women (40th and 41st Sess., 2008), para. 43, U.N. Doc. A/63/38(SUPP) (2008). See also Human Rights Committee, *Concluding Observations: Poland*, para. 9, U.N. Doc. CCPR/CO/82/POL (2004); CEDAW Committee, *Concluding Observations: Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007); *Croatia*, para. 109, U.N. Doc. A/53/38 (1998).
- 2 CEDAW Committee, *Concluding Observations: Slovakia*, paras. 42–43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008).
- 3 See Pichon and Sajous v. France, App. No. 49853/99 EUR. Ct. H.R. (2001).
- 4 Adriana Lamačková, *Conscientious Objection in Reproductive Healthcare: Analysis of Pichon and Sajous v. France*, 15 EUR. J. HEALTH LAW (2008).

Slovakia Should Promote Male Involvement in Family Planning

- 1 See, e.g., CEDAW Committee, *Concluding Observations: India*, para. 78, U.N. Doc. A/55/38 (2000); *Trinidad and Tobago*, para. 159, U.N. Doc. A/57/38, Part I (2002); *Viet Nam*, para. 266, U.N. Doc. A/56/38 (2001); *Bosnia and Herzegovina*, para. 36, CEDAW/C/BIH/CO/3 (2006); *Greece*, para. 199, U.N. Doc. A/54/38 (1999); *Belarus*, para. 374, U.N. Doc. A/55/38 (2000); *Slovenia*, para. 119, U.N. Doc. A/52/38/Rev.1 (1997); *United Kingdom of Great Britain and Northern Ireland*, para. 310, U.N. Doc. A/54/38 (1999).
- 2 CEDAW Committee, *Concluding Observations: Bosnia and Herzegovina*, para. 36, CEDAW/C/BIH/CO/3 (2006).
- 3 CEDAW Committee, *Concluding Observations: Greece*, para. 199, U.N. Doc. A/54/38 (1999).
- 4 See, e.g., Committee on the Rights of the Child (CRC), *Concluding Observations: Georgia*, para. 47, U.N. Doc. CRC/C/15/Add.124 (2000); *Grenada*, para. 22, U.N. Doc. CRC/C/15/Add.121 (2000); *Saint Kitts and Nevis*, para. 26, U.N. Doc. CRC/C/15/Add.104 (1999); *United Kingdom of Great Britain and Northern Ireland—Overseas Territories*, para. 38, U.N. Doc. CRC/C/15/Add.135 (2000).
- 5 See, e.g., CRC, *Concluding Observations: Benin*, para. 25, U.N. Doc. CRC/C/15/Add.106 (1999); *Georgia*, para. 47, U.N. Doc. CRC/C/15/Add.124 (2000); *Lesotho*, para. 46, U.N. Doc. CRC/C/15/Add.147 (2001); *Marshall Islands*, para. 51, U.N. Doc. CRC/C/15/Add.139 (2000); *Suriname*, para. 46, U.N. Doc. CRC/C/15/Add.130 (2000); *Vanuatu*, para. 20, U.N. Doc. CRC/C/15/Add.111 (1999).

EU Law and Policy on Gender Equality and Healthcare

- 1 EUR. COMM'N, EMPLOYMENT, SOCIAL AFFAIRS AND EQUAL OPPORTUNITIES, Gender Equality, <http://ec.europa.eu/social/main.jsp?catId=418> (last visited Nov. 16, 2010).
- 2 *Id.*
- 3 Equality between women and men is a fundamental right, a common value of the EU, and a necessary condition for the achievement of the EU objectives of growth, employment and social cohesion. EUR. COMM'N, EMPLOYMENT, SOCIAL AFFAIRS AND EQUAL OPPORTUNITIES, *supra* note 1. "... [G]ender equality can not be achieved without guaranteeing women's sexual and reproductive health and rights ... that expanding access to sexual and reproductive health information and health services are essential for achieving the Beijing Platform for Action, the Cairo Programme of Action and the Millennium Development Goals." *Ministerial Declaration of the Conference of Ministers of Gender Equality*, Luxembourg, Feb. 4, 2005 (EU Working Doc., 2005), http://www.eu2005.lu/en/actualites/documents_travail/2005/02/04pekin-decl-min/index.html.
- 4 Eur. Women's Lobby, Position Paper, *Women's Health in the European Union* 1–2 (2010); ASTRA NETWORK, CLOSING THE

- GAP ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE ENLARGED EUROPEAN UNION, available at <http://www.astra.org.pl/Gap%20on%20SRHR%20in%20UE.pdf>; ASTRA NETWORK, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE, REPORT TO THE EUROPEAN UNION (2006), available at <http://www.astra.org.pl/srhrEU.pdf>.
- 5 Treaty on the Functioning of the European Union, tit. XIV Public Health, art. 168 (art. 152 TEC), Doc. C 115/122 (2008); Charter of Fundamental Rights of the European Union, ch. IV, art. 35, Doc. C 364/16 (2000).
- 6 See *Council Conclusions on Common values and principles in European Union Health Systems* (2006/C 146/01), (Jun. 22, 2006), available at http://eur-lex.europa.eu/LexUriServ/site/en/oj/2006/c_146/c_14620060622en00010003.pdf (last visited Jul. 16, 2010).
- 7 EUR. INST. OF WOMEN'S HEALTH, WOMEN'S HEALTH IN EUROPE, FACTS AND FIGURES ACROSS THE EUROPEAN UNION iv, ix, (2006), available at http://www.eurohealth.ie/pdf/WomensHealthinEurope_prelims_FINAL.pdf; Eur. Women's Lobby, Position Paper, *Women's Health in the European Union* 1–2 (2010).
- 8 Eur. Women's Lobby, *supra* note 5, at 1–2. Generally, see Rebecca J. Cook et al., *Unethical Female Stereotyping in Reproductive Health*, 109(3) INT'L J. OF GYNECOLOGY AND OBSTETRICS 255, 255 (2010); REBECCA J. COOK AND SIMONE CUSACK, GENDER STEREOTYPING: TRANSNATIONAL LEGAL PERSPECTIVES (University of Pennsylvania Press) (2010).
- 9 See Commission White Paper, Together for Health: A Strategic Approach for the EU 2008–2013, COM (2007) 630 final (Oct. 23, 2007), available at http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf. See also of Treaty of Lisbon Amending the Treaty on European Union and the Treaty Establishing the European Community, art. 168(1) (2), Dec. 17, 2007, O.J. (C 306), available at <http://www.consilium.europa.eu/showPage.aspx?id=1296&lang=en>.

Marginalized Women and the Right to Access to Contraceptives

- 1 Sexuality Information and Education Council of the United States (SIECUS), *Fact Sheet: Comprehensive Sexuality Education is HIV Prevention!*, available at http://www.siecus.org/_data/global/images/FS_Women-HIV-AIDS.pdf.
- 2 See Committee on the Rights of the Child (CRC), *General Comment No. 3, HIV/AIDS and the right of the child*, para. 30, U.N. Doc. CRC/GC/2003/3 (2003).
- 3 *Id.* para. 20.
- 4 See CENTER FOR REPRODUCTIVE RIGHTS, STATE OF DENIAL: ADOLESCENT REPRODUCTIVE RIGHTS IN ZIMBABWE 54–58 (2002).
- 5 CRC, *General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, para. 11, U.N. Doc. CRC/GC/2003/4 (2003).
- 6 See, e.g., *id.* paras. 9, 28, 31–33.

- 7 *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4–15, 1995, para. 94, U.N. Doc. A/CONF.177/20 (1995).
- 8 See Committee on the Elimination of Discrimination Against Women (CEDAW Committee), *General Recommendation 24: Women and health*, (20th Sess.), para. 18, U.N. Doc. A/54/38 (1999).
- 9 See, e.g., CEDAW Committee, *Concluding Observations: Bangladesh*, para. 438, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Burkina Faso*, para. 274, U.N. Doc. A/55/38 (2000); *Cape Verde*, para. 30, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); *Colombia*, para. 396, U.N. Doc. A/54/38 (1999); *Eritrea*, para. 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Mali*, para. 33, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); *Lithuania*, para. 159, U.N. Doc. A/55/38 (2000); *Paraguay*, para. 123, U.N. Doc. A/51/38 (1996); *Peru*, para. 341, U.N. Doc. A/53/38/Rev.1 (1998); *South Africa*, para. 36, U.N. Doc. A/53/38/Rev.1 (1998); *Togo*, para. 28, U.N. Doc. CEDAW/C/TGO/CO/5 (2006); *Ukraine*, para. 287, U.N. Doc. A/51/38 (1996).
- 10 Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, art. 14, G.A. Res. 34/189, UN GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (entered into force Sept. 3, 1981).
- 11 Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, (22nd Sess., 2000), para. 36, U.N. Doc. E/C.12/2000/4 (2000).

Obligation to Gather Data

- 1 The Special Rapporteur on the Right to Health (SRRH), Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, paras. 31, 40, 51, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008) [hereinafter SRRH, Paul Hunt (2008)].
- 2 *Id.* para. 65.
- 3 World Health Organization, Health Systems Topics, <http://www.who.int/healthsystems/topics/en/> (last visited Nov. 21, 2010). See also UNITED NATIONS POPULATION FUND, HOW UNIVERSAL IS ACCESS TO REPRODUCTIVE HEALTH? A REVIEW OF THE EVIDENCE 10 (2010), available at <http://www.unfpa.org/public/home/publications/pid/6532>.
- 4 SRRH, Paul Hunt (2008), *supra* note 1, para. 71.
- 5 Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, (22nd Sess., 2000), para. 20, U.N. Doc. E/C.12/2000/4 (2000).
- 6 COUNCIL OF EUR., Recommendation CM/Rec(2008)1 of the Committee of Ministers to member states on the inclusion of gender differences in health policy (2008), <https://wcd.coe.int/ViewDoc.jsp?id=1241743>.
- 7 Human Rights Committee, *Concluding Observations: Slovakia*, para. 19 U.N. Doc. CCPR/CO/78/SVK (2003).

**A.S. v. Hungary (CEDAW
Committee, 2006)**

- 1 A.S. v. Hungary, Communication No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).
- 2 *Id.* paras. 11.2-4.

Mária, a 19-year-old student, would like to use contraception “right now.” The only reason holding her back is money: “The money restricts the most. There is no freedom. Because if there was freedom, then I would choose...But if there is no money then I only have one option: that I will not take contraceptives.”

Calculated Injustice documents the numerous barriers that women and adolescent girls in Slovakia face to accessing modern contraceptives and contraceptive information. Based on testimonies of women, healthcare providers, and others, this report illustrates that state failure to ensure both contraceptive coverage through public health insurance and accurate, unbiased, and comprehensive sexuality education in schools inhibits women's and adolescents' access to modern contraceptives and violates their human rights. Lack of ample data on relevant indicators and the influence of the Catholic Church hierarchy are but two factors standing in the way of effective laws and policies in this area.

Calculated Injustice demonstrates how Slovakia's failure to address these barriers runs counter to its obligations under national, regional, and international law, and defies sound public policy and economic considerations. It calls on the government and other key stakeholders to ensure that all women and adolescent girls have access to affordable and acceptable modern contraceptives and contraceptive information.