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Joint submission by: Citizen, Democracy and Accountability, the Center for Civil and Human Rights – Poradňa, Women's Circles and the Center for Reproductive Rights

Citizen, Democracy and Accountability, the *Center for Civil and Human Rights – Poradňa*, *Women's Circles* and the *Center for Reproductive Rights* present this submission to the Human Rights Committee for its consideration in the context of its examination of Slovakia's fourth periodic report on compliance with the International Covenant on Civil and Political Rights (the Covenant).

The submission outlines a number of concerns regarding women's enjoyment of Articles 2, 3, 7, 17 and 26 of the Covenant as a result of Slovak laws and practices concerning reproductive rights. As highlighted in Sections (i) – (iv) below these include: (i) discrimination against Roma women in reproductive health contexts; (ii) discrimination and abuse in the course of childbirth; (iii) barriers in access to abortion services; (iv) deficient regulation of medical practitioners' refusals of care on grounds of conscience. A number of recommendations for changes to Slovak law and practice are outlined at the end of each Section.

i. Discrimination against Roma Women in Reproductive Health Contexts (Articles 2, 3, 7, 17 and 26 of the Covenant)

Throughout Slovakia Roma women continue to face serious forms of discrimination in the context of reproductive health care. Despite repeated recommendations and expressions of concern from international human rights mechanisms and judgements of the European Court of Human Rights, Roma women who were subjected to forced and coercive sterilization in the past are still awaiting effective remedies and reparation and the Slovak Government has persistently failed to ensure their access to justice. Meanwhile the State has failed to establish monitoring mechanisms that would oversee implementation of current legislation on informed consent in the context of sterilization.

Failure to ensure effective remedies and reparation for survivors of forced and coercive sterilization

The widespread practice of forced and coercive sterilization of Roma women in Slovakia was exposed in a report *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia* published by Poradňa and the Center for Reproductive Rights

in 2003.[1] The report indicated that there was evidence to suggest that significant proportions of Roma women in Slovakia had been subject to forced and coercive sterilization.[2] Since then the practice has been the subject of repated condemnation by international human rights mechanisms and in judgements of the European Court of Human Rights (ECtHR).[3] Time and again the Slovak Government has been called upon to provide effective remedies, including reparation, for the human rights violations involved.[4] However, the State has continuously failed to conduct an effective investigation, to establish an accessible and appropriate reparations programme, to provide compensation and satisfaction to the survivors, including through an apology and acknowledgment of responsibility.

In January 2003 Slovak authorities initiated a criminal investigation into alledged practices of forced and coercive sterilization of Roma women. In October 2003 the investigation was discontinued with the authorities finding that the alleged events underlying the investigation had not occurred and that nothing indicated that any offence had occurred. Subsequently, following repeated complaints from Roma women who had been affected by forced and coercive sterilization, the investigation was eventually reopened in February 2007. Once again, in December 2007, the investigation was terminated and Slovak authorities concluded that no crimes had been committed. Since then no other official investigation has been initiated. Nor has the State established a reparations scheme or acknowledged any responsibility for the violations suffered. Detailed information on the serious shortcomings in the investigations were outlined in Poradňa's submission to the Committee in 2010 concerning Slovakia's third periodic report under the Covenant.[5]

As a result of Slovakia's failure to conduct an effective investigation and establish an accessible and appropriate reparations programme, Roma women seeking remedies and recognition of harm suffered have had no other option but to initiate and pursue individual civil claims. However, the deficiencies of such claims as an effective and appropriate avenue to justice is exemplified by the small number of claims filed by Roma women relative to the very large numbers of women effected by forced sterilization. Since 2003, 8 civil complaints have been filed by Roma women who were subjected to forced and coercive sterilization. Poradňa represented these women in court and throughout the legal proceedings. Although in a small number of these cases Slovak courts have found violations of the women's rights under Slovak law and awarded financial compensation to the survivors, in large part these proceedings have not resulted in effective remedies. Often the length of the proceedings, which in some cases have spanned 11 years, renders the process ineffective. For example, two cases filed in 2005 are still pending before domestic courts. In some cases domestic courts have failed to find a substantive violation in accordance with international human rights law and international medical standards, finding instead that a sterilization was performed as a life saving procedure, which is medically inaccurate. In a number of cases domestic courts have dismissed financial compensation due to 3-years statute of limitation. Meanwhile, even in cases where domestic courts have found violations of Roma women's rights, they have often awarded very low compensation amounts (max. 1500 Euros).[6] There is only one example of a case in which a domestic court, referring to

the jurisprudence of the ECtHR, awarded an appropriate compensation amount, but it took more than 10 years to obtain this decision, and it is not yet final.[7]

In 2015, in his country report on Slovakia, the Council of Europe Commissioner for Human Rights stated that Slovak authorities "have not taken responsibility for unlawful sterilisations committed in the past."[8] In an earlier report the Commissioner recommended that the Government, "accept clearly its objective responsibility for failing to ensure that no sterilisations were performed without free and informed consent [and to] consequently, undertake to offer a speedy, fair, efficient and just redress."[9]

In order to ensure Roma women who were subjected to forced and coercive sterilization have access to effective remedies, including reparation, and to identify the full extent of this practice, urgent Government action is required. At this point, the most effective solution may be the establishment of an *ad hoc* independent commission with a mandate to investigate the practice and award adequate financial and other reparation. Similar procedures have been successfully used in other European countries such as Norway, Sweden, and Switzerland.

Failure to monitor the implementation of new informed consent laws

In its Replies to the List of Issues, the Government outlines a list of regulations on informed consent in the context of sterilization that have been adopted since 2004.[10] However, although the terms of the current legal framework in this area formally provides sufficient legal safeguards, the State does not monitor the implementation of this legislation by medical practitioners and thus any failures in implementation go largely undetected.

Obtaining informed consent is a process which not only requires a patient's signature on a form, but also necessitates interactive communication between healthcare providers and their patients in a manner that takes account of the individual circumstances of each case. Among other things, medical staff must take into consideration the cognitive and language abilities of a particular patient and adequately explain the nature of the medical intervention to them. In this context the importance of systematically monitoring how informed consent is obtained in practice and ensuring that medical personnel fully understand the concept and what it entails, cannot be underestimated. It must go hand in hand with awareness raising and dissemination of information on informed consent and patients rights among Roma communities as well as among the broader public.

Yet the Government has not taken steps to ensure medical staff are properly trained about informed consent and what it entails, nor does it systematically monitor compliance with informed consent legislation in practice or organize appropriate awareness raising campaigns.

International Human Rights Law and Standards

This Committee and other international human rights mechanisms have repeatedly affirmed that forced and coercive sterilization violates the prohibition of torture or cruel, inhuman or degrading treatment.[11] They have also specified that forced and coercive sterilization is a form of

violence against women[12] and violates a woman's right to decide on the number and spacing of children.[13]

In a series of cases against Slovakia, the ECtHR has also found that permanently depriving women of their reproductive capacity through sterilization without their free and informed consent violates their right to freedom from inhuman and degrading treatment, and their right to respect for private and family life.[14]

In this context, this Committee and other Treaty Monitoring Bodies have repeatedly expressed concerns regarding Slovakia's failures to undertake an effective investigation into allegations of widespread forced and coercive sterilization of Roma women and to ensure Roma women who were subjected to forced and coercive sterilization are provided with effective remedies, including adequate compensation and other forms of reparation. They have also lamented the lack of monitoring by State authorities to ensure new informed consent standards are applied uniformly in practice.[15]

As noted above, in 2015 the Council of Europe Commissioner for Human Rights specified that the State has still not taken responsibility for the past practice of forced sterilizations and most recently, in July 2016, the Committee on the Rights of the Child (CRC) also expressed concern that "the State party has not acknowledged any responsibility for the past systematic practice of forced sterilization of Roma women and girls, nor has it provided compensation for the victims or adopted uniform standards concerning the obtaining of free and informed consent in cases of sterilization."[16] The CRC Committee called upon Slovakia to "investigate the full extent of the practice of forced sterilization of women and girls in the communist and post-communist period in the State party and to provide financial and other reparations to the victims."[17]

Recommendations

- Establish an *ad hoc* independent commission to investigate the full extent of the practice of sterilization without informed consent in the communist and post-communist period in Slovakia and to award financial and other reparations for survivors through an *ex-gratia* compensation procedure for individuals sterilized without informed consent.
- Monitor healthcare providers' implementation of Slovak legislation on informed consent in situations of sterilization and ensure appropriate sanctions are applied if breaches occur.
- Introduce clear guidelines for medical staff on informed consent and provide ongoing and systematic training for healthcare personnel on how to ensure informed consent is obtained.

ii. Discrimination and Abuse in the Course of Childbirth (Articles 2(1), 3, 7 and 17 of the Covenant)

For a number of reasons, in most instances childbirth in Slovakia takes place in hospitals under the care of doctors, with the assistance of midwives. Recent research and documentation has exposed serious concerns as to the treatment of women during childbirth in Slovak hospitals[18]

and the results point to widespread forms of discrimination and abuse that jeopardise women's enjoyment of their rights under Articles 2(1), 3, 7 and 17 of the Covenant.

Indepth research into the treatment of women in maternity hospitals recently conducted by Citizen, Democracy and Accountability and Women's Circles has revealed serious concerns regarding the provision of obstetric care in Slovak maternity hospitals and respect for women's human rights during childbirth.[19] The findings are captured and outlined in detail in the 2015 Report: *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia*.[20] Although the reported practices differ extensively in form and gravity, they raise concerns regarding respect for women's dignity, autonomy and personal and bodily integrity in maternity care contexts and medical decision-making related to childbirth. Research indicates that common practices include:

- Failure to obtain full and informed consent for medical interventions during childbirth.[21]
- Mental or emotional abuse and harassment.[22]
- Practices that prevent women from moving freely and choosing a birthing position and instead confine them to lie down while giving birth.[23]
- The exertion of extreme physical pressure by healthcare personnel on women's abdomens during the pushing stage of labour (known also as the Kristeller Maneuver).[24]
- Suturing without, or with insufficient, anesthesia.[25] Many women reported that this procedure was extremely painful for them.[26] In 14% of births that were followed by suturing no anesthesia was applied.[27] Of more than 1000 instances where women showed signs of pain as a result of suturing, there were only approximately 250 instances where anesthesia was applied repeatedly, and in more than 600 instances, no repeated anesthesia was given.[28]
- Practices that prevent women from eating and drinking during labour.[29]
- Spatial arrangements and behavior of hospital staff that heavily impede women's privacy, intimacy and confidentiality of care.[30]

International Medical Guidelines and International Human Rights Law and Standards

These practices give rise to serious concerns that maternal health care in Slovakia does not comply with international medical guidelines, scientific evidence and international standards of care.[31] For example, the World Health Organization (WHO) has specified that women's freedom to choose positions and assume a variety of positions during the course of labour alleviates labour pain and that women should not be restricted to bed and the supine position.[32] With regard to the Kristeller maneuver, the WHO has advised against its use and outlined that "[a]part from the issue of increased maternal discomfort, there is suspicion that the practice may be harmful for the uterus, the perineum and the fetus."[33] Meanwhile the International Federation of Gynecology and Obstetrics (FIGO) has stressed that suturing must always be performed under adequate perineal anesthesia[34] and pain allieviation during suturing is standard practice in European jurisdictions.

These practices also indicate that Slovak authorities are failing to respect and ensure the protection of women's human rights during childbirth and give rise to specific concerns in relation to Article 2(1), 3, 7 and 17 under the Covenant.

Articles 2(1) and 3 of the Covenant require State parties to ensure women's enjoyment of the rights enshrined in the Covenant on a basis of equality and free from discrimination on grounds of sex.[35] The Committee on the Elimination of Discrimination against Women (CEDAW) has confirmed that abuse and mistreatment during childbirth in maternity hospitals amounts to discrimination against women in the enjoyment of their human rights. It has urged State parties to improve standards of care with regard to childbirth and to ensure that all interventions are performed only with a woman's full, prior and informed consent, and that healthcare professionals are trained on patients rights and ethical standards.[36] Specifically, with respect to Slovakia, CEDAW has expressed concerns that "[o]versight procedures and mechanisms for ensuring adequate standards of care and the respect for women's rights, dignity and autonomy during deliveries are lacking, and options for giving birth outside hospitals are limited", and called upon the Government to "[p]ut in place adequate safeguards to ensure that women have access to appropriate and safe child birth procedures which are in line with adequate standards of care, respect for women's autonomy and the requirement of free, prior, informed consent."[37] The Council of Europe Commissioner for Human Rights has also recently expressed concerns regarding the treatment of women during childbirth in Slovakia and echoed CEDAW's recommendation that States "put in place adequate safeguards, including oversight procedures and mechanisms, to ensure that women have access to appropriate and safe child birth procedures which are in line with adequate standards of care, respect women's autonomy and the requirement of free, prior and informed consent."[38]

As the Committee has repeatedly outlined, women's personal and bodily integrity and reproductive autonomy fall within the right to privacy as enshrined in Article 17 of the Covenant.[39] Respect for the principle of informed consent in relation to medical decision making is also required by the right to privacy.[40] The ECtHR has determined that women's ability to make decision's during and after childbirth falls within the framework of the right to privacy as enshrined in Article 8 of the European Convention of Human Rights and that the practices of medical providers and state authorities in relation to childbirth may give rise to violations of the right. For example, the Court has found that where a woman gave birth in front of medical students in the absence of any safeguards for her privacy and without her informed consent and against her will this violated her right to respect for private life.[41] It has held that women's ability to determine the circumstances in which they give birth falls within the scope of the right to respect for private life and that restrictions on women's autonomy to determine these circumstances can violate the right.[42]

The Committee has clarified that the prohibition in Article 7 of the Covenant relates to acts that cause physical pain as well as to acts that cause mental suffering,[43] and that cruel, inhuman or degrading treatment takes multiple, varied forms and depends on all the circumstances of the case.[44] International human rights mechanisms, including the Committee, have specified that the treatment of women during childbirth and in the course of maternal health care can give rise to concerns of illtreatment under Article 7.[45] For example, the Special Rapporteur on torture has also observed that women may be exposed to severe pain and suffering when seeking maternal health care, particularly immediately before and after childbirth, as a result of abuses such as "extended delays in the provision of medical care, such as stitching after delivery to the absence of anaesthesia."[46] He has noted that "[s]uch mistreatment is often motivated by stereotypes

regarding women's childbearing roles and inflicts physical and psychological suffering that can amount to ill-treatment."[47] The ECtHR, when addressing a case of sterilization without informed consent during childbirth, held that even where medical staff have no intention of ill treating a patient the gross disregard for a woman's human freedom, including the right to freely decide whether to consent to a serious medical procedure, can amount to ill treatment. [48]

Recommendations

- Put in place adequate safeguards to ensure that women have access to appropriate and safe childbirth procedures which are in line with adequate standards of care, respect for women's autonomy and human rights and the requirement of free, prior, informed consent.
- Establish effective mechanisms, including those operating on an ex-officio basis, to monitor and oversee respect for women's rights in childbirth.

iii. Barriers in Access to Abortion Services (Articles 2(1), 3, 17 and 26 of the Covenant)

Since 1986 Slovak law has permitted abortion on request up to 12 weeks of pregnancy, and thereafter, if a woman's life is in danger or in cases of fetal impairment.[49] However, a range of new retrogressive legal barriers and ongoing financial barriers can make it difficult for many women in Slovakia to access safe abortion services in a timely fashion.

Retrogressive legislative barriers: In 2009 retrogressive legal barriers to abortion were introduced into Slovak law with the purpose of deterring women from accessing abortion services.[50] Those include:

(a) **Mandatory waiting periods:** In 2009, the Slovak Parliament adopted a legislative amendment to the Healthcare Act introducing a 48-hour mandatory waiting period prior to abortion into Slovak law for the first time. The new mandatory waiting period applies to abortions on request.[51] Previously women in Slovakia seeking abortion on request did not have to observe a mandatory waiting period and as such this new precondition and restriction on women's access to legal reproductive health services is retrogressive in nature.[52]

(b) **Biased information requirements:** The 2009 amendment also requires that women receive information outlining the: "physical and psychological risks," associated with abortion;[53] "the current development stage of the embryo or fetus," and "alternatives to abortion" such as adoption, and support in pregnancy from civic and religious organizations.[54] This information must be provided to all women prior to abortion and they are not able to refuse it.[55] These new requirements were introduced with the explicit goal of dissuading women from obtaining abortion services, "in favor of the life of an unborn child."[56]

Financial barriers: Meanwhile, abortion on request is not covered by public health insurance.[57] It costs between 240-370 EUR, which in 2014 represented approximately 35% to 54% of the median monthly income for women in Slovakia.[58] As a result, for many of those women who have to cover the cost of abortion services themselves the cost is prohibitive.

International Medical Guidelines and International Human Rights Law and Standards

These legal and financial barriers can impact women's ability to access safe and legal abortion services in practice and in a timely fashion. They contravene international medical guidelines and undermine Slovakia's compliance with its obligations under the Covenant, and other international human rights instruments.

As the WHO has outlined: "[m]andatory waiting periods can have the effect of delaying care, which can jeopardize women's ability to access safe, legal abortion services."[59] As a result of these concerns, the WHO indicates that mandatory waiting periods should not apply to abortion services.[60] It has underlined that "[o]nce the decision [to have an abortion] is made by the woman, abortion should be provided as soon as is possible"[61] and without delay.[62] The WHO has also specified that information and counseling provided to women prior to abortion should always be evidence-based, non-directive, and voluntary.[63] The WHO also observes that financial barriers can impede women's access to safe abortion services, and specifies that systems must be put in place to enable women to access legal abortion services regardless of their ability to pay.[64]

As this Committee has previously outlined, "in cases where abortion procedures may lawfully be performed, all obstacles to obtaining them should be removed."[65] The Committee has expressed concerns about the retrogessive introduction of mandatory waiting periods and biased counseling requirements and in that context it has called upon a State party "to eliminate all procedural barriers that would lead women to resort to illegal abortions that could put their lives and health at risk."[66]

Other Treaty Monitoring Bodies have made similar pronoucements. For instance, CEDAW and the Committee on Economic, Social and Cultural Rights have urged State parties to eliminate and refrain from adopting mandatory counselling and medically unnecessary waiting periods requirements prior to abortion.[67] Indeed, both CEDAW and the CRC expressed concern regarding the retrogressive introduction of mandatory waiting periods and biased information requirements in Slovakia. CEDAW called upon the Government to remove the mandatory waiting period and biased counseling requirements from the law in order to ensure access to safe abortion. Similarly, the CRC urged Slovakia to remove the mandatory waiting period and to ensure that "health care professionals provide medically accurate and non-stigmatizing information on abortion."[68] Additionally, CEDAW has called on the Slovak authorities to "ensure universal coverage by the public health insurance of all costs related to legal abortion, including abortion on request…."[69]

European human rights mechanisms and political bodies have also made it clear that states should ensure access to legal abortion services without imposing procedural restrictions. For example, the ECtHR has held that "[o]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it"[70] and has underscored that European states have "a positive obligation to create a procedural framework enabling a pregnant woman to exercise her right of access to lawful abortion."[71] The Parliamentary Assembly of the Council of Europe (PACE) has found that mandatory waiting periods and requirements for repeated medical consultations prior to abortion can hinder access to safe abortion care, or make it impossible altogether.[72] It has called on Council of Europe member states to "guarantee women's effective exercise of their right of access to a safe and

legal abortion," and to "lift restrictions which hinder, de jure or de facto, access to safe abortion."[73]

The recent retrogressive introduction of mandatory waiting periods and biased information requirements in Slovakia gives rise to particular concerns with regard to Article 17 of the Covenant, and Articles 2(1), 3 and 26:

- **Article 17, Right to privacy and principle of informed consent:** This Committee and other international human rights mechanisms have consistently held that a woman's decision whether or not to continue a pregnancy falls within the sphere of the right to privacy, and where states' laws, policies or practices restrict women from terminating their pregnancies, they give rise to interferences in the enjoyment of that right which must thus be shown to be in accordance with the law, to pursue a legitimate aim and to be necessary and proportionate.[74] Additionally ensuring compliance in medical contexts with the principle of full and informed consent is an integral component of the right to privacy.[75] Informed consent requires that a patient's medical decision-making be free of threat or inducement, and that a patient's consent to a medical procedure, including abortion, be given freely and voluntarily after receipt of understandable, adequate, accurate, and evidence-based information on the procedure.[76] It is implicit in the principle of informed consent that patients must also be entitled to refuse such information yet still undergo the requested procedure.[77]

  Mandatory waiting periods and biased counseling or information requirements interfere with women's right to privacy and contradict the principle of informed consent. By imposing certain information on women as a precondition to abortion, biased information requirements implicitly contradict the necessity that individuals be entitled to refuse information related to their health and proceed to treatment without it. Biased information requirements also require health professionals to provide information to women the purpose of which is to persuade women not to undergo abortion. This can involve the provision of medically inaccurate, misleading, or stigmatizing information, which contravenes obligations to ensure that health-related information and counseling be relevant, accurate, evidence-based, and non-directive and that medical decision-making be free from inducement, coercion, or discrimination.[78] Mandatory waiting periods prior to abortion undermine women's agency and ability to make autonomous decisions about their bodies and their lives. The WHO has recognized that mandatory waiting periods "demean[] women as competent decision-makers,"[79] and has recommended that states eliminate medically unnecessary waiting periods so as to "ensure that abortion care is delivered in a manner that respects women as decision-makers."[80]

- **Articles 2(1), 3 and 26, Discrimination and Wrongful Gender Stereotypes**: As noted above, CEDAW has repeatedly observed that mandatory waiting periods and biased information requirements discriminate against women in the enjoyment of their human rights.[81] Moreover, the WHO and FIGO have specified that mandatory waiting periods "demean[] women as competent decision-makers"[82] and reflect a range of discriminatory assumptions and harmful gender stereotypes including that women make fickle, changeable and impulsive decisions that they later regret.[83] Similarly by seeking to

persuade women to continue their pregnancies, biased information requirements reflect similar harmful gender stereotypes and assumptions and promote the view that a woman's decision to have an abortion is irrational and harmful.[84] Biased counselling and information requirements often seek to pressure women into deciding against abortion by generating a sense of disapproval and shame and promoting a belief that women who terminate their pregnancies are doing something wrong. By generating and exacerbating stigma concerning abortion, biased and directive counselling and information can cause women trauma and suffering.[85]

Recommendations

- Take effective measures to ensure women's access to safe and legal abortion services, including by repealing retrogressive legislative provisions which subject them to mandatory waiting periods and biased information requirements.
- Ensure that healthcare providers provide women with medically accurate and non-stigmatizing information on abortion.
- Ensure universal coverage by the public health insurance of all costs related to legal abortion, including abortion on request.

iv. Deficient Regulation of Medical Practitioners' Refusals of Care on Grounds of Conscience (Articles 2(1), 3 and 17 of the Covenant)

Slovak law allows healthcare providers to refuse to provide certain forms of reproductive health care on grounds of conscience and in practice it appears that refusals of care on grounds of conscience have primarily occurred with regard to the provision of abortion and contraceptive services.[86]

The matter is regulated in both the Act on Healthcare and the Code of Ethics of a Health Practitioner. Under the Act on Healthcare, healthcare providers can refuse to provide certain health services, namely abortion, sterilization, and assisted reproduction, if the provision of those services "is impeded by a personal belief on the part of a health practitioner who is supposed to provide the service."[87] The term "healthcare provider" in the Act on Healthcare refers both to individual health practitioners as well as to healthcare facilities[88] and as a result, both individual practitioners as well as entire hospitals and other healthcare institutions may refuse to provide services.[89]

In addition, the Code of Ethics allows individual health practitioners to refuse to provide *any* medical service if performing the service "contradicts [their] conscience," except in situations posing an immediate threat to the life or health of a person. Under the Code of Ethics health practitioners are required to inform their employer as well as their patients that they are refusing to provide particular medical care.[90]

Neither the Act nor the Code of Ethics impose any obligation on relevant individual practitioners or institutions to refer women to other practitioners who will provide care in timely manner. Moreover, Slovakia's laws and policies do not require healthcare institutions to ensure that a sufficient number of employees are in place who are willing to provide relevant services, and

effective mechanisms to oversee and monitor the extent of the practice and limit its impact on women's access to service are lacking.

International Human Rights Law and Standards

The manner in which Slovak law regulates refusals of care on grounds of conscience, and in particular the lack of a referral obligation on providers and the legality of institutional refusals of care, does not comply with international human rights law and standards and jeopardizes women's enjoyment of their rights under Articles 2(1), 3 and 17 of the Covenant.

International human rights mechanisms have repeatedly expressed the view that where domestic law allows healthcare practitioners to refuse to provide legal reproductive health services on grounds of conscience, the right to privacy and principle of non-discrimination in women's enjoyment of their human rights require that states put in place a regulatory framework that will ensure women's access to those services is not undermined by the practice of refusals but is guaranteed in practice. As outlined below, they have specifically outlined that allowing institutional refusals of care and failing to place a referral obligation on providers who are refusing care contravene these obligations.

The ECtHR has held that the right to privacy under the European Convention on Human Rights obliges States parties to ensure that where their domestic laws allow health professionals to refuse to provide care on grounds of personal conscience, such refusals must not impede women's access to legal reproductive health services, including abortion services.[91] The Court has also refused to accept claims that the right to freedom of thought, conscience or religion encompasses any entitlement on medical professionals to refuse reproductive health care on grounds of conscience.[92]

Treaty Monitoring Bodies have reiterated the same requirement and, among other things, have explicitly specified that the relevant regulatory framework must ensure an obligation on healthcare providers to refer women to alternative health providers[93] and must not allow institutional refusals of care.[94] States should also ensure that "adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach."[95]

In 2008 and 2015 CEDAW urged Slovakia to improve its regulation of conscience-based refusals of care so as to ensure that such refusals do not impede women's timely access to reproductive health services.[96] In particular, it urged the Government to impose a referral obligation on providers who refuse services.[97] In July 2016, the CRC specified that Slovakia should "[a]mend legislation to explicitly prohibit institutions from adopting institutional conscience-based refusal policies or practices and establish effective monitoring systems and mechanisms to enable the collection of comprehensive data on the extent of conscience-based refusals of care and the impact of the practice on girls' access to legal reproductive health services."[98]

Thus far the Government has not adopted measures to implement these recommendations.

Recommendations

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

[1] CENTER FOR REPRODUCTIVE RIGHTS & PORADŇA PRE OBČIANSKE A ĽUDSKÉ PRÁVA, *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia* (2003), *available at* https://www.poradna-prava.sk/en/documents/body-and-soul-forced-sterilization-and-other-assaults-on-roma-reproductive-freedom-in-slovakia/ [hereinafter *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia*].

[2] *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia*, *supra* note 1, at 34.

[3] *See, e.g.*, Committee against Torture (CAT), *Concluding Observations: Slovakia*, para. 14, U.N. Doc. CAT/C/SVK/CO/2 (2009); *Slovakia*, para. 12, U.N. Doc. CAT/C/SVK/CO/3 (2015); Human Rights Committee , *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003); *Slovakia*, para. 13, U.N. Doc. CCPR/C/SVK/CO/3 (2011); Committee on the Elimination of Racial Discrimination (CERD), *Concluding Observations: Slovakia*, para. 13, U.N. Doc. CERD/C/ SVK/CO/9-10 (2013); *Slovakia*, para. 18, U.N. Doc. CERD/C/SVK/CO/6-8 (2010); Committee on the Elimination of Discrimination against Women (CEDAW), *Concluding Observations: Slovakia*, paras. 32-33, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); Committee on the Rights of the Child (CRC), *Concluding Observations: Slovakia*, paras. 24-25, U.N. Doc. CRC/C/SVK/CO/3-5 (2016); V.C. v. Slovakia, No. 18968/07 Eur. Ct. H.R. (2011); N.B. v. Slovakia, No. 29518/10 Eur. Ct. H.R. (2012); I.G. and Others v. Slovakia, No. 15966/04 Eur. Ct. H.R. (2013). Poradňa has provided legal assistance to 12 Roma women affected by the practice before domestic courts in civil and criminal proceedings as well as before the European Court of Human Rights.

[4] *See, e.g.*, CERD, *Concluding Observations: Slovakia*, para. 13, U.N. Doc. CERD/C/ SVK/CO/9-10 (2013); CAT, *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CAT/C/SVK/CO/3 (2015); CEDAW, *Concluding Observations: Slovakia*, para. 33(d), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CRC, *Concluding Observations: Slovakia*, para. 25, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

[5] *See* PORADŇA PRE OBČIANSKE A ĽUDSKÉ PRÁVA & PEOPLE IN NEED SLOVAKIA, *Written comments concerning the third periodic report of the Slovak republic under under the International Covenant on Civil and Political Rights* (April 2010) at 9 – 11, *available at* http://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/SVK/INT_CCPR_NGO_SVK_99_10072_E.pdf.

[6] *See* N.B. v. Slovakia, No. 29518/10 Eur. Ct. H.R. (2012); I.G. and Others v. Slovakia, No. 15966/04 Eur. Ct. H.R. (2013).

[7] The court awarded almost 17,000 Euros, the amount requested by the petitioner. For more information, *see* Press Release, PORADŇA PRE OBČIANSKE A ĽUDSKÉ PRÁVA, Forcibly Sterilized Romani Woman Achieved Justice at the

Domestic Court in Slovakia, (Apr. 25, 2016), *available at* https://www.poradna-prava.sk/en/documents/press-release-forcibly-sterilized-romani-woman-achieved-justice-at-the-domestic-court-in-slovakia/.

[8] Council of Europe, Commissioner for Human Rights, *Report by Nils Muižnieks, Council of Europe Commissioner for Human Rights, following his visit to the Slovak Republic, from 15 to 19 June 2015*, para. 65, CommDH(2015)21 (Oct. 13, 2015).

[9] Council of Europe, Commissioner for Human Rights, *Recommendation of the Commissioner for Human Rights Concerning Certain Aspects of Law and Practice Relating to Sterilization of Women in the Slovak Republic*, para. 53(4), CommDH(2003)12 (Oct. 17, 2003).

[10] Human Rights Committee, *List of issues in relation to the fourth periodic report of the Slovak Republic*, paras. 65-67, U.N. Doc. CCPR/C/SVK/Q/4/Add.1 (2016).

[11] *See, e.g.*, Human Rights Committee, *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003); *Czech Republic*, para. 10, U.N. Doc. CCPR/C/CZE/CO/2 (2007); *Slovakia*, para. 13, U.N. Doc. CCPR/C/SVK/CO/3 (2011); *Czech Republic*, para. 11, U.N. Doc. CCPR/C/CZE/CO/3 (2013); CAT, *Concluding Observations: Czech Republic*, para. 12, U.N. Doc. CAT/C/CR/4-5 (2012); *Slovakia*, para. 14, U.N. Doc. CAT/C/SVK/CO/2 (2009); *Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013); *Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013); *See also* Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*, Human Rights Council, para. 46, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) [hereinafter Special Rapporteur on torture, 2013 Report].

[12] *See* CEDAW, *General Recommendation No. 19: Violence Against Women,* (11th Sess., 1992), para. 22; Human Rights Committee, *General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, paras. 11, 20, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000) [hereinafter Human Rights Committee, *Gen. Comment No. 28*]; Special Rapporteur on violence against women, its causes and consequences, *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44*, para. 45, U.N. Doc. E/CN.4/1999/68/Add.4 (1999).

[13] A.S. v. Hungary, CEDAW, Commc'n No. 4/2004, para. 11.4, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

[14] *See* V.C. v. Slovakia, No. 18968/07 Eur. Ct. H.R. (2011); N.B. v. Slovakia, No. 29518/01 Eur. Ct. H.R. (2012); I.G., M.K. and R.H. v. Slovakia, No. 15966/04 Eur. Ct. H.R. (2012).

[15] *See, e.g.*, CAT, *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CAT/C/SVK/CO/3 (2015); Human Rights Committee, *Concluding Observations: Slovakia*, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003); *Slovakia*, para. 13, U.N. Doc. CCPR/C/SVK/CO/3 (2011); CERD, *Concluding Observations: Slovakia*, para. 13, U.N. Doc. CERD/C/ SVK/CO/9-10 (2013); *Slovakia*, para. 18, U.N. Doc. CERD/C/SVK/CO/6-8 (2010); CEDAW, *Concluding Observations: Slovakia*, paras. 32-33, U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CRC, *Concluding Observations: Slovakia*, paras. 24-25, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

[16] CRC, *Concluding Observations: Slovakia*, para. 24, U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

[17] *Id.*, para. 25.

[18] Some of those hospitals are owned by private entities, however, all of them provide care on the basis of public health insurance.

[19] These activities included (a) in-depth interviews with women who have recently given birth, (b) filing requests for information and monitoring hospitals' and other websites, and (c) carrying out an internet survey on suturing of birth injuries. As for the in-depth interviews (point a), 15 women of 26 to 39 years of age had been interviewed. The majority of respondents were middle-class women with a higher-level education (secondary or university one). The respondents included no women from ethnic minorities. All but one of respondents had, at the time of delivery, male partners (the one respondent without a male partner was a single mother). All the births described in the interviews took place in Bratislava (the capital) and Trnava (50 km from the capital) districts. As for the information requests and monitoring of hospitals' websites (point b), letters and official requests for information were sent to all hospitals with maternity wards in Slovakia (54) and to the Ministry of Health. The monitoring of the websites involved all hospitals in Slovakia with maternity wards. As for the surveys (point c), the internet survey on suturing of birth injuries took place through questionnnaires available on the website of Women's Circles in the period of February 20, 2014 to March 20, 2014. 2279 questionnaires were completed, out of which 1946 described vaginal births experienced by 1474 women (those 1946 questionaires on vaginal birth were further processed and analysed). The monitoring and research also included carrying out in-depth interviews with obstetricians and midwives, and analysing legislation and other available documentation.

[20] Debrecéniová, J. (ed.), Ženy – Matky – Telá: Ľudské práva žien pri pôrodnej starostlivosti v zdravotníckych zariadeniach na Slovensku [Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia] (2015), OBČAN, DEMOKRACIA A ZODPOVEDNOSŤ & ŽENSKÉ KRUHY, at 206-209 (English version), *available at* http://odz.sk/wp-content/uploads/Z-M-T_publ_el1_pod_sebou.pdf (Slovk.); http://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf (Engl.) [hereinafter Ženy – Matky – Telá].

[21] *See, e.g.*, Ženy – Matky – Telá, *supra* note 20, at 60-75 & 85-94. As for non-consensual procedures, for instance, episiotomies are at times done without women's consent and sometimes also despite their refusal. The average episiotomy rate for all vaginal births that took place in 2012 was 65%, and there are even hospitals in the country where the average episiotomy rates exceed 90%. *See* Korbeľ M., Borovský M., Danko J., Nižňanská Z., Kaščák P., Krištúfková A., *Analýza materskej morbidity v Slovenskej republike v roku 2012*. 12 Gynekológia pre prax 1 (2014) 13 – 19. The WHO classifies "liberal or routine use of episiotomy" as a practice which is frequently used inappropriately. It argues that "there is no reliable evidence that liberal or routine use of episiotomy has a beneficial effect, but there is clear evidence that it may cause harm. The WHO recommends a restricted use of episiotomy, with 10% being a "good goal to pursue". *See* World Health Organization (WHO), CARE IN NORMAL BIRTH: A PRATICAL GUIDE 37 & 29 (1996) [hereinafter WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE], *available at* http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.24.pdf. *See also* Ženy – Matky – Telá, *supra* note 20, at 60-76.

[22] There are many forms of humiliation, ridicule and harassment that reportedly take place. For example, women report being objectified and treated as objects of interventions (for example: hospital staff reportedly talk about them in their presence as if they were not present; hospital staff reportedly are not introduced to them and do not usetheir names and surnames to address them but instead use the general term "mummy"). Women also report feeling belittled and subject to persuasion, manipulation and coercion when they express their wishes regarding the childbirth process (e.g. phrases like "your child will die, if you...; your child will have an egg-shaped head if you..." being frequently reported). Women also report that the fulfillment of their preferences and wishes is often conditioned upon their "obedience". Women also report verbal shaming by medical practitioners for natural occurences related to birth – for example excretion of urine or faeces when pushing. *See also* Ženy – Matky – Telá, *supra* note 20, at 110-120. A few women, especially those participating in the survey on the suturing of birth injuries, also reported situations in which often (male) doctors make 'jokes' during the suturing process, for example through 'questions' to male partners present about their preferred width of the stitch. Women also report being discouraged from making sounds and noises.

[23] *See* Ženy – Matky – Telá, *supra* note 20, at 60-68. The interviews with women revealed that continual electronic fetal monitoring in the first stage of labor is a very frequent practice and is performed while women are laid on their back. Interviewed women often described the experience as, "I was stripped down for more than an hour. I could not move, which was extremely painful." Freedom of movement in the first stage is also often made impossible due to the extremely limited spatial arrangements available to women going through this stage. In the second (pushing) stage, women are, in a large majority of the cases, laying (or semi-laying) on their back, with legs in stirrups (often tied). The WHO classifies freedom in position and movement throughout labor and encouragement of non-supine position in labor as practices which are demonstrably useful and should be encouraged. At the same time, it classifies the routine use of the supine position during labor as a practice which is clearly harmful or ineffective and should be eliminated. *See* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 21, at 21, 27 & 35.

[24] In course of the research undertaken by Citizen, Democracy and Accountability and Women's Circles, this practice was often mentioned by women interviewed but its occurence was denied by hospitals when asked about the use of this practice (*see also* Ženy – Matky – Telá, *supra* note 20, at 69-70, 153 and 190). Anecdotal evidence also indicates that this practice is usually not recorded in patients' medical records. The WHO notes that "the practice of fundal pressure [is common] during the second stage of labour []" and that "[a]part from the issue of increased maternal discomfort, there is suspicion that the practice may be harmful for the uterus, the perineum and the fetus, but no research data is available. The impression is that the method is at least used too often, with no evidence of its usefulness." *See* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE, *supra* note 21, at 25-26. Several anecdotal reports also suggest that fundal pressure is associated with maternal and neonatal complications, for example: uterine rupture, neonatal fractures and brain damage. *See* Evelyn C. Verheijen, Joanna H. Raven, G. Justus Hofmeyr, *Fundal pressure during the second stage of labour*. *Cochrane Database of Systematic Reviews*, 4 COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2009), Issue 4. Art. No.: CD006067. DOI:

10.1002/14651858.CD006067.pub2., *available at* http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006067.pub2/abstract.

[25] *See, e.g.,* Ženy – Matky – Telá, *supra* note 20, at 75-76.

[26] *Id.*, at 75-76.

[27] According to FIGO, suturing should always be performed under adequate perineal anesthesia. *See* FIGO Safe Motherhood and Newborn Health (SMNH) Committee, *Management of the second stage of labor*, 119 INTL. J. GYN. & OBS. (2012) 114, *available at* www.odondevice.org/press/FIGO-second-stage.pdf [hereinafter FIGO, MANAGEMENT OF THE SECOND STAGE OF LABOR]. The clinical guidelines of the National Institute for Health and Care Excellence (United Kingdom) recommend with regard to suturing: "When carrying out perineal repair[,] ensure that tested effective analgesia is in place… If the woman reports inadequate pain relief at any point, address this immediately." *See* NATIONAL COLLABORATING CENTRE FOR WOMEN'S AND CHILDREN'S HEALTH, INTRAPARTUM CARE: CARE OF HEALTHY WOMEN AND THEIR BABIES DURING CHILDBIRTH. CLINICAL GUIDELINE 190: METHODS, EVIDENCE AND RECOMMENDATIONS (2014) 765, *available at* http://www.nice.org.uk/guidance/cg190/evidence/cg190-intrapartum-care-full-guideline3 [hereinafter NATIONAL COLLABORATING CENTRE FOR WOMEN'S AND CHILDREN'S HEALTH, INTRAPARTUM CARE: CARE OF HEALTHY WOMEN AND THEIR BABIES DURING CHILDBIRTH].

[28] However, this figure does not indicate whether the anesthesia was applied correctly (e.g. whether it was applied in a sufficient amount or sufficiently in advance to take effect in time). *See* internet survey on suturing of birth injuries conducted by Women's Circles in 2014 (on file with Women's Circles and Citizen, Democracy and Accountability).

[29] *See also* Ženy – Matky – Telá, *supra* note 20, at 81-82. In some instances, women report not being allowed to eat or drink anything upon arrival in the hospital (this practice differs across hospitals). This may last until a baby is delivered and often even longer, especially in regards to eating, since hospitals often do not order a meal for a woman who is already in labor but not hospitalized yet in the postnatal unit. The WHO classifies restriction on food and fluids during labour as practices which are frequently used inappropriately. On the contrary, it classifies offering oral fluids during labor and delivery as a practice which is demonstrably useful and should be encouraged. *See* WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 21, at 9-10 & 34-35.

[30] *See* Ženy – Matky – Telá, *supra* note 20, at 94-110. Each of the interviewed women reported some form of interference with their rights to privacy and confidentiality of care throughout all stages of labour. For example, in the first stage of labour, women's privacy was restricted during the time they spent in a "waiting room", including through the disturbing presence of other women experiencing contractions, the way the rooms were organised, or by not being allowed to have a companion. During the second stage, the factors that impeded women's privacy included the way the delivery room was organised, the inability to exercise the right to choose a birthing position, the positioning of birthing beds towards a door or aisle, and unwanted persons (in terms of both their type and total number) entering the area where the birth was taking place. During the postpartum period spent in the hospital, women were examined during doctors' visits in the presence of other doctors and other patients in the room, and the confidentiality and protection of personal data were violated during those visits by doctors discussing information about the health status of a patient in front of other patients and other persons present in the room.

[31] *See, e.g.*, WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 21; FIGO, MANAGEMENT OF THE SECOND STAGE OF LABOR, *supra* note 27, at 111-116; *Intrapartum Care*: *Cochrane Database of Systematic Reviews*, *available at* http://community.cochrane.org/cochrane-reviews/cochrane-database-systematic-reviews-numbers; NATIONAL COLLABORATING CENTRE FOR WOMEN'S AND CHILDREN'S HEALTH, INTRAPARTUM CARE: CARE OF HEALTHY WOMEN AND THEIR BABIES DURING CHILDBIRTH, *supra* note 27.

[32] WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE (1996), *supra* note 21, at 14.

[33] WHO, CARE IN NORMAL BIRTH: A PRATICAL GUIDE, *supra* note 21, at 25-26.

[34] *See* FIGO, MANAGEMENT OF THE SECOND STAGE OF LABOR, *supra* note 27, at 114.

[35] Human Rights Committee, *Gen. Comment No. 28*, *supra* note 12, paras. 2-4, 11, 20 &22.

[36] CEDAW, *Concluding Observations: Czech Republic*, para. 31, U.N. Doc. CEDAW/C/CZE/CO/6 (2016); *Croatia*, para. 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015).

[37] CEDAW, *Concluding Observations: Slovakia*, para. 31(e)(g), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).

[38] Council of Europe, Commissioner for Human Rights, *Protect women's sexual and reproductive health and rights*, Human Rights Comment (Jul. 21, 2016), *available at* http://www.coe.int/en/web/commissioner/-/protect-women-s-sexual-and-reproductive-health-and-rights.

[39] *See, e.g.*, K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, para. 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, paras. 9.2 & 9.3, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).
[40] *See, e.g.*, Human Rights Committee, *Concluding Observations: France*, para. 21, U.N. Doc. CCPR/C/FRA/CO/4 (2008); Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, para. 57, U.N. Doc. A/64/272 (2009) [hereinafter Special Rapporteur on Health, 2009 Report].
[41] Konovalova v. Russia, No. 37873/04 Eur. Ct. H.R, paras. 42-50 (2015).
[42] Ternovszky v. Hungary, No. 67545/09 Eur. Ct. H.R, paras. 22, 26 & 27 (2011).
[43] Human Rights Committee, *General Comment No. 20: Article 7 (Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment)*, (44th Sess., 1992), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 200, para. 5, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter Human Rights Committee, *Gen. Comment No. 20*].
[44] Human Rights Committee, *Gen. Comment No. 20*, *supra* note 43, para. 4. *See also* Antti Vuolanne v. Finland, Commc'n No. 265/1987, para. 9.2, U.N. Doc. Supp. No. 40 (A/44/40) at 311 (1989) ("[T]he assessment of what constitutes inhuman or degrading treatment falling within the meaning of article 7 depends on all the circumstances of the case, such as the duration and manner of the treatment, its physical or mental effects as well as the sex, age and state of health of the victim.").
[45] *See, e.g.*, CAT, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013) ("The Committee…remains concerned about ill-treatment of women who seek access to reproductive health services, in particular the ongoing practice of post-delivery detention of women unable to pay their medical bills, including in private health facilities…(arts. 2, 12 and 16)."); *United States of America*, para. 33, U.N. Doc. CAT/C/USA/CO/2 (2006) ("The Committee is concerned at the treatment of detained women in the State party, including gender-based humiliation and incidents of shackling of women detainees during childbirth (art. 16). The State party should adopt all appropriate measures to ensure that women in detention are treated in conformity with international standards."); Human Rights Committee, *Concluding Observations: Ireland*, para. 11, U.N. Doc. CCPR/C/IRL/CO/4 (2014) ("...the Committee expresses concern at the State party's failure to: (a) initiate a prompt, comprehensive and independent investigation into the practice of symphysiotomy; (b) identify, prosecute and punish, where still possible, the perpetrators for performing symphysiotomy without patient consent; and (c) provide effective remedies to survivors of symphysiotomy for the damage sustained as a result of these operations (arts. 2 and 7).").
[46] *See* Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez*, Human Rights Council, para. 47, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016) [hereinafter Special Rapporteur on torture, 2016 Report]; Special Rapporteur on torture, 2013 Report, *supra* note 11, para. 46.
[47] Special Rapporteur on torture, 2016 Report, *supra* note 46, para. 47.
[48] *See, e.g.*, N.B. v. Slovakia, No. 29518/10 Eur. Ct. H.R., paras. 78 - 81 (2012).
[49] Zákon č. 73/1986 Zb. o umelom prerušení tehotenstva v znení zákona č. 419/1991 Zb. [Act No. 73/1986 Coll. on Artificial Termination of Pregnancy as amended by the Act No. 419/1991 Coll.] (1986), secs. 4–5 [hereinafter Act No. 73/1986 Coll.] (Slovk.); Vyhláška Ministerstva zdravotníctva SSR č. 74/1986 Zb., ktorou sa vykonáva zákon Slovenskej národnej rady č. 73/1986 Zb. o umelom prerušení tehotenstva, v znení neskorších zmien [Decree of the Ministry of Health of the SSR No. 74/1986 Coll., which exercises Act No. 73/1986 Coll. on Artificial Termination of Pregnancy, as amended], sec. 2 (Slovk.).
[50] A number of retrogressive measures were introduced in 2009. Besides mandatory waiting period and biased counseling requirements, the 2009 amendment also requires doctors to send a report to the National Health Information Centre confirming that each woman seeking abortion has received this information. The Centre is responsible for receiving and evaluating these reports, as well as for overseeing compliance with the mandatory waiting period. The required reports must contain a woman's personal details and must be submitted before an abortion is performed. This gives rise to a range of confidentiality concerns. Moreover, the 2009 amendment extended parental consent requirements to include all adolescent girls under 18. *See* Zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov v znení zákona č. 345/2009 Z.z. [Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts *as amended by* the Act No. 345/2009 Coll. of Laws] (Slovk.) [hereinafter Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009], secs. 6b, 6c;

Vyhláška MZ SR č. 417/2009 Z. z., ktorou sa ustanovujú podrobnosti o informáciách poskytovaných žene a hlásenia o poskytnutí informácií, vzor písomných informácií a určuje sa organizácia zodpovedná za prijímanie a vyhodnocovanie hlásenia [Decree of the Ministry of Health of the Slovak Republic No. 417/2009 Coll. of Laws on Laying Down Details for Information Provided to a Woman, for Notification of the Provision of Information and the Model of Written Information, and Designating an Entity Responsible for the Receipt and Evaluation of Notifications] (Slovk.) [hereinafter Decree No. 417/2009]; National Health Information Center, *Hlásenie o poskytnutí informácii o umelom prerušení tehotenstva*, http://data.nczisk.sk/zdravotny_stav/Z9-99.pdf (last visited Sept. 15, 2016). Treaty Monitoring Bodies have expressed concerns with regard to those requirements and urged Slovakia to remove them. *See* Committee on Economic, Social and Cultural Rights (CESCR), *Concluding Observations: Slovakia*, para. 25, U.N. Doc. E/C.12/SVK/CO/2 (2012); CEDAW, *Concluding Observations: Slovakia*, paras. 30(c), 31(c)(f), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CRC, *Concluding Observations: Slovakia*, para. 41(c), U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

[51] Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 50, sec. 6b(3).

[52] Under international human rights law, the introduction of retrogressive measures - deliberately backward steps in law or policy that directly or indirectly impede or restrict enjoyment of a right - will almost never be permissible. Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), this principle applies to the right to health and precludes the adoption of retrogressive measures in the health care sphere. *See* CESCR, *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, para. 1)*, (5th Sess., 1990), para. 9, U.N. Doc. E/1991/23 (1990); International Commission of Jurists, *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, Guideline 14(e): Violations through Acts of Commission (1997), *available at* http://www.refworld.org/docid/48abd5730.html; United Nations Commission on Human Rights, *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, Principle 72, U.N. Doc. E/CN.4/1987/17 (1987).

[53] *See* Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 50, sec. 6b; *see also* Decree No. 417/2009, *supra* note 50. Women seeking abortion on request must also be provided with the required information in writing. A model for this written information is provided by the Ministry of Health in a decree implementing the Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009. It suggests that written information on the risks of induced abortion should outline that "[t]he subsequent impaired ability or inability to become pregnant cannot be ruled out," and that "[f]ollowing the induced termination of pregnancy, a woman may experience feelings of anxiety, guilt, sadness and depression." This information provided should also include written information on the stage of fetal development, which the Ministry of Health specifies as information on "the result of the ultrasound examination, the length of pregnancy, and the development stage of the embryo or fetus." Decree No. 417/2009, *supra* note 50, Annex. Contrary to this decree, the Royal College of Obstetricians and Gynaecologists (United Kingdom) has recommended that "[w]omen should be informed that there are no proven associations between induced abortion and subsequent . . . infertility." ROYAL COLLEGE OF OBSTETRICIANS AND GYNEACOLOGISTS, THE CARE OF WOMEN REQUESTING INDUCED ABORTION: EVIDENCE-BASED CLINICAL GUIDELINE NUMBER 7 43-46 (2011), *available at* https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf. It has noted that "[p]ublished studies strongly suggest that infertility is not a consequence of uncomplicated induced abortion" performed in legal settings. *Id.* at 44 (citations omitted). With regard to psychological sequelae, the Royal College has recommended that "[w]omen with an unintended pregnancy should be informed that the evidence suggests that they are no more or less likely to suffer adverse psychological sequelae whether they have an abortion or continue with the pregnancy and have the baby" and that "[w]omen with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy." *Id.* at 45.

[54] *See* Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 50, sec. 6(b).

[55] Healthcare Act, No. 576/2004 *as amended by* the Act No. 345/2009, *supra* note 50, secs. 6(4), 6b; Decree No. 417/2009, *supra* note 50.

[56] *See* Dôvodová správa, tlač 1030 (2009) [Explanatory Report to the Act No. 345/2009] (Slovk.). "The purpose of the proposed amendment is to inform a woman requesting abortion on the alternatives in favor of the life of an unborn child." *Id.* part A. During a parliamentary debate about the bill, a member of the Slovak Parliament, one of the key supporters of the bill, explained that "[t]he aim of this amendment is to provide a woman who could be in a difficult life situation with the qualified information. This information is directed for her to decide in favor of life […]. The state has no obligation to be neutral on this matter. The state has a right to say that it prefers life, prefers life before termination of life and offers a helping hand." (Daniel Lipšic, MP, Transcript from the debate on the Act

No. 345/2009, print 1030, by the National Council of the Slovak Republic, 35th sess.) (Apr. 21, 2009), *transcript available at* http://www.psp.cz/eknih/2006nr/stenprot/035schuz/s035024.htm.
[57] Nariadenie vlády SR č. 777/2004 Z.z., ktorým sa vydáva Zoznam chorôb, pri ktorých sa zdravotné výkony čiastočne uhrádzajú alebo sa neuhrádzajú na základe verejného zdravotného poistenia [Order No. 777/2004 Coll. of Laws issuing the List of Diseases at which Medical Procedures Are Partially Covered or Not Covered Based on Public Health Insurance], Annex No. 2, part III (2004) (Slovk.).
[58] ŠTATISTICKÝ ÚRAD SR [STATISTICAL OFFICE OF THE SLOVAK REPUBLIC], ŠTRUKTÚRA MIEZD V SR 2014, 4-5 [STRUCTURE OF EARNINGS IN THE SR 2014] (2015).
[59] WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 96 (2nd ed. 2012) [hereinafter WHO, 2012 SAFE ABORTION GUIDANCE].
[60] WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 96-97.
[61] WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 36.
[62] WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 64.
[63] *See* WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 36, 68, 97; *see also* WORLD HEALTH ORGANIZATION, HEALTH WORKER ROLES IN PROVIDING SAFE ABORTION CARE AND POST-ABORTION CONTRACEPTION 56 (2015).
[64] WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 80.
[65] Human Rights Committee, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); *see also* CESCR, *Concluding Observations: Argentina*, para. 22, U.N. Doc. E/C.12/ARG/CO/3 (2011); *Poland*, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009); CEDAW, *Concluding Observations: India*, para. 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007); *Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007).
[66] *See* Human Rights Committee, *Concluding Observations: The Former Yugoslav Republic of Macedonia*, para. 11, U.N. Doc. CCPR/C/MKD/CO/3 (2015) (advance unedited version).
[67] CEDAW, *Concluding Observations: Hungary*, para. 31(c), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Russian Federation*, paras. 35(b), 36(b), U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Slovakia*, para. 31(c), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CESCR, *General Comment No. 22*: *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, para. 41, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter CESCR, *Gen. Comment No. 22*].
[68] CEDAW, *Concluding Observations: Slovakia*, para. 31(c), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CRC, *Concluding Observations: Slovakia*, para. 41(e), U.N. Doc. CRC/C/SVK/CO/3-5 (2016).
[69] CEDAW, *Concluding Observations: Slovakia*, para. 31(b), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).
[70] Tysiąc v. Poland, No. 5410/03 Eur. Ct. H.R., para. 116 (2007).
[71] R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., para. 200 (2011).
[72] EUR. PARL. ASS., *Resolution on Access to Safe and Legal Abortion in Europe*, 15th Sess., Doc. No. 1607, paras. 2-3 (2008).
[73] *Id*., paras. 7.2, 7.4.
[74] *See, e.g.*, K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, para. 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, para. 9.3, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); Mellet v. Ireland, Human Rights Committee, Commc'n No. 2324/2013, paras. 7.7 & 7.8, U.N. Doc. CCPR/C/116/D/2324/2013 (2016). In addition, the European Court of Human Rights has recognized the important role of women's timely access to relevant and reliable information in guaranteeing their ability to exercise personal autonomy and obtain lawful abortion services. It has condemned the intentional denial and manipulation of abortion-related information. R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 197, 199 (2011); P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., paras. 102, 108, 111 (2012).
[75] *See, e.g.*, Special Rapporteur on Health, 2009 Report, *supra* note 40, paras. 18 – 19, 57; N.B. v. Slovakia, No. 29518/10 Eur. Ct. H.R., paras. 94-99 (2012), V.C. v. Slovakia, No. 18968/07 Eur. Ct. H. R., paras. 138-155 (2012).
[76] *See* FIGO COMMITTEE FOR THE STUDY OF ETHICAL ASPECTS OF HUMAN REPRODUCTION AND WOMEN'S HEALTH, ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY 14 (2012), *available at* http://www.figo.org/sites/default/files/uploads/wg-publications/ethics/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf [hereinafter FIGO, ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY].
[77] For example, the Special Rapporteur on the Right to Health has specified that "[j]ust as a patient has the right to receive information in giving consent, a patient has the right to refuse such information in giving consent, providing disclosure of such information has been appropriately offered." Special Rapporteur on Health, 2009 Report, *supra*

note 40, para. 15. *See also* Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, *adopted* Apr. 4, 1997, art. 10(2), C.E.T.S. No. 164 (*entered into force* Dec. 1, 1999); A Declaration on the Promotion of Patients' Rights in Europe: World Health Organization European Consultation on the Rights of Patients, para. 2.5, ICP/HLE 121 (June 28, 1994).

[78] For example, the CESCR has highlighted that states must ensure women can access good quality health-related information that is scientifically and medically appropriate and refrain from "censoring, withholding or intentionally misrepresenting" such information, including on sexual and reproductive health. Committee on Economic, Social, and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health* (Art. 12), (22nd Sess., 2000), paras. 12(b)(iv), 12(d), 21, 34, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *Gen. Comment No. 14*]. *See also* CENTER FOR REPRODUCTIVE RIGHTS, MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE: RESTRICTING ACCESS TO ABORTION, UNDERMINING HUMAN RIGHTS, AND REINFORCING HARMFUL GENDER STEREOTYPES (Sept. 2015) [hereinafter MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE].

[79] WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 96.

[80] WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 96-97.

[81] CEDAW, *Concluding Observations: Hungary*, para. 31(c), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); *Russian Federation*, paras. 35(b), 36(b), U.N. Doc. CEDAW/C/RUS/CO/8 (2015); *Slovakia*, para. 31(c), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).

[82] WHO, 2012 SAFE ABORTION GUIDANCE, *supra* note 59, at 96.

[83] FIGO, ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY, *supra* note 76, at 30, para. 8.

[84] MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE, *supra* note 78; *see also* Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1687 (2008).

[85] MANDATORY WAITING PERIODS AND BIASED COUNSELING REQUIREMENTS IN CENTRAL AND EASTERN EUROPE, *supra* note 78; *see also* Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, para. 24, U.N. Doc. A/66/254 (Aug. 3, 2011); Anuradha Kumar et al., *Conceptualizing Abortion Stigma*, 11(6) CULTURE, HEALTH & SEXUALITY 625 (2009); Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, WOMEN'S HEALTH ISSUES 7 (2011) (authors ed.), *available at* http://www.guttmacher.org/pubs/journals/Abortion-Stigma.pdf; Rebecca J. Cook, *Stigmatized Meanings of Abortion Law*, *in* ABORTION LAW IN TRANSNATIONAL PERSPECTIVE: CASES AND CONTROVERSIES 347, 347 (Rebecca J. Cook, Joanna N. Erdman & Bernard M. Dickens eds., 2014); Bruce G. Link & Jo C. Phelan, *Stigma and its Public Health Implications*, 367 THE LANCET 528, 528-29 (2006); Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 ANN. REV. OF SOC. 363, 367-76 (2001).

[86] *See e.g.* CENTER FOR REPRODUCTIVE RIGHTS ET AL., CALCULATED INJUSTICE: THE SLOVAK REPUBLIC'S FAILURE TO ENSURE ACCESS TO CONTRACEPTIVES 39 (2011), [hereinafter CALCULATED INJUSTICE], *available at* http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/calculated_injustice.pdf.

[87] Zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov v znení neskorších predpisov [Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts *as amended*] (Slovk.), secs. 12(2)(c), 12(3).

[88] Zákon č. 578/2004 Z. z. o poskytovateľoch zdravotnej starostlivosti, zdravotníckych pracovníkoch, stavovských organizáciách v zdravotníctve a o zmene a doplnení niektorých zákonov [Act No. 578/2004 Coll. of Laws on Healthcare Providers, Health Workers and Professional Medical Associations, and Amending and Supplementing Certain Acts, *as amended*], secs. 4, 11 [hereinafter Act 578/2004].

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

nerobíme. Z technických príčin.... [We do not perform abortions...For technical reasons], PRAVDA, Jan. 22, 2011, http://spravy.pravda.sk/interrupcie-nerobime-z-technickych-pricin-fju-sk_domace.asp?c=A110122_173602_sk_domace_p29 (Sept. 29, 2015).

[90] Act 578/2004, *supra* note 88, Annex No. 4. (Deontology or medical ethics codes, while not legally binding, are highly persuasive authorities since the development of deontology codes are mandated by public health laws.) (Slovk.).

[91] *See* R.R. v. Poland, No. 27617/04 Eur. Ct. H.R, para. 206 (2011); P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., para. 106 (2012).

[92] *See, e.g.*, Pichon and Sajous v. France (dec.), No. 49853/99 Eur. Ct. H. R. (2001); R.R. v. Poland, No. 27617/04 Eur. Ct. H.R, para. 206 (2011); P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., para. 106 (2012). In addition, the European Committee of Social Rights has ruled in a collective complaint that women's right to health requires the adoption of effective measures to ensure that women are able to effectively access legal abortion. International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, European Committee of Social Rights, No. 87/2012 (2014). In response to another collective complaint the Committee rejected a complaint that claimed health professionals are entitled to deny women legal abortion services based on claims of personal conscience. It found that the European Social Charter does not enshrine an entitlement on the part of health professionals to refuse to perform abortion services on grounds of personal conscience. Federation of Catholic Family Associations in Europe (FAFCE) v. Sweden, European Committee of Social Rights, No. 99/2013 (2015).

[93] *See, e.g.*, CEDAW, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, para. 11, U.N. Doc. A/54/38/Rev.1, chap. I ("It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."); CESCR, *Gen. Comment No. 22*, *supra* note 67, paras. 14, 43; CEDAW, *Concluding Observations: Croatia*, para. 31, U.N. Doc. CEDAW/C/HRV/CO/4-5 (2015) (urging the State party to "ensure that the exercise of conscientious objection does not impede women's effective access to reproductive health-care services, especially abortion and post-abortion care and contraceptives"); *Hungary*, paras. 30-31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013) (urging the State party to "[e]stablish an adequate regulatory framework and a mechanism for monitoring of the practice of conscientious objection by health professionals and ensure that conscientious objection is accompanied by information to women about existing alternatives and that it remains a personal decision rather than an institutionalized practice"); CESCR, *Concluding Observations: Poland*, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009) ("The Committee is particularly concerned that women resort to clandestine, and often unsafe, abortion because of the refusal of physicians and clinics to perform legal operations on the basis of conscientious objection.... The Committee calls on the State party to take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection.").

[94] *See, e.g.*, CEDAW, *Concluding Observations: Hungary*, para. 31(d), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); CRC, *Concluding Observations: Slovakia*, paras. 41(f), U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

[95] CESCR, *Gen. Comment No. 22*, *supra* note 67, paras. 14, 43 ("Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services. An adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach. … Where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and that it does not inhibit the performance of services in urgent or emergency situations.").

[96] CEDAW, *Concluding Observations: Slovakia*, paras. 42, 43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); *Concluding Observations: Slovakia*, para. 31(d), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).

[97] CEDAW, *Concluding Observations: Slovakia*, para. 31(d), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015).

[98] CRC, *Concluding Observations: Slovakia*, para. 41(f), U.N. Doc. CRC/C/SVK/CO/3-5 (2016).