**INDIVIDUAL SUBMISSION OF SLOVAK NATIONAL CENTRE FOR HUMAN RIGHTS**

Alternative Report on the Implementation of the European Social Charter – Articles 3, 11, 12, 13, 14, 23 and 30

**CYCLE 2021**

June 2021

***About Slovak National Centre for Human Rights:***

*Slovak National Centre for Human Rights (the “Centre”) is a national human rights institution established in the Slovak Republic, accredited with status B by the Global Alliance of National Human Rights Institutions. As an NHRI, the Centre is a member of the European Network of NHRIs (ENNHRI). The Centre was established by the Act of Slovak National Council No. 308/1993 Coll. on the Establishment of Slovak National Centre for Human Rights. Pursuant to the Act No. 365/2004 Coll. on Equal Treatment in Certain Areas and on Protection from Discrimination, as amended (the Anti-Discrimination Act), the Centre also acts as the only Slovak equality body. As an NHRI and equality body, the Centre performs a wide range of tasks in the field of protection and promotion of human rights and fundamental freedoms including the observance of the principle of equal treatment.*

*The Centre among other powers:*

*1) monitors and evaluates the observance of human rights and the observance of equal treatment principle;*

*2) gathers and, upon request, provides information on racism, xenophobia and antisemitism in the Slovak Republic;*

*3) conducts research and surveys to provide data in the field of human rights; gathers and distributes information in this area;*

*4) prepares educational activities and participates in information campaigns aimed at increasing tolerance of the society;*

*5) provides legal assistance to victims of discrimination and manifestations of intolerance;*

*6) issues expert opinions on matters concerning the observance of the equal treatment principle;*

*7) performs independent inquiries related to discrimination;*

*8) prepares and publishes reports and recommendations on issues related to discrimination; and*

*9) provides library services and other services in the field of human rights.*

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**1. INTRODUCTION**

This report has been prepared by the Centre utilizing the first-hand information gathered (i) during the annual monitoring and evaluation of the observance of human rights, fundamental freedoms and equal treatment principle, (ii) gathered as a part of providing legal services for victims of discrimination and (iii) gathered as a part of conducting research and providing education on human rights. In respect to annual evaluation of the observance of human rights, fundamental freedoms and principle of equal treatment, the Centre has been regularly consulting key stakeholders such as civil society organizations, academia, public authorities, think thanks, media, businesses, chambers, social services providers and healthcare providers. The information gathered during the monitoring has been utilized in this report.

The alternative report of the Centre reflects on the 11th national report of the Slovak Republic on the implementation of the European Social Charter as submitted to and registered by the secretariat of the European Committee of Social Rights as well as the 2017 Conclusions of the European Committee for Social Rights Relating to Articles from Thematic Group – Health, Social Security and Social Protection concerning the Slovak Republic.

In this report, the Centre focuses especially on the right to health – Article 11(1) and Article 11(2) and right of elderly to social protection – Article 23.

**ARTICLE 11 – THE RIGHT TO HEALTH**

**Article 11 (1)**

**To remove as far as possible, the causes of ill-health.**

**A) LIFE EXPECTANCY ACROSS THE COUNTRY.**

1. The life expectancy at birth has been steadily increasing over the recent years. In comparison with the European Union (EU) average, the progression in respect to the life expectancy at birth has been slightly above the EU increase.[[1]](#footnote-1) However, the health life expectancy for both – males and females stagnates or slightly deteriorates over the recent years. Inhabitants of the Slovak Republic live longer, however, there are no additional years added that are spent in good health.[[2]](#footnote-2)

**Table No. 1:** *Life expectancy at birth in the Slovak Republic for the Years 2016 – 2019[[3]](#footnote-3)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender** | **2019** | **2018** | **2017**  | **2016** |
| Males | 74,31 | 73,71 | 73,75 | 73,71 |
| Females | 80,84 | 80,35 | 80,34 | 80,41 |

**Table No. 2:** *Health Life expectancy in the Slovak Republic for the years 2016 – 2019[[4]](#footnote-4)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Gender** | **Age Group** | **2019** | **2018** | **2017** | **2016** |
| Males | 45 years  | 13,9 | 13,9 | 13,9 | 13,1 |
|  | 60 years | 5,1 | 5,5 | 5,1 | 4,7 |
|  | 75 years | 1,1 | 1,2 | 1,2 | 1,1 |
| Females | 45 years | 13,2 | 13,7 | 13,7 | 13,1 |
|  | 60 years | 5,0 | 5,2 | 5,1 | 4,9 |
|  | 75 years | 0,9 | 1,1 | 0,9 | 0,8 |

2. The data collected by relevant public authorities (e.g. Statistical Office of the Slovak Republic or National Centre for Medical Information) on life expectancy or health life expectancy are disaggregated solely by sex (male and female) and age (by single years or 5 years’ age groups). As the data are not disaggregated by any other relevant characteristics (e. g. ethnicity, nationality, gender, sexual orientation, residency, disability, education, employment etc.), it is not possible to evaluate the life expectancy for different population groups including various vulnerable groups (e.g. Roma, national minorities, migrants, homeless, persons with disabilities, unemployed etc.) or for different regions or areas (e. g. urban, rural, industrial etc.). Lack of disaggregated data does not allow for identification any anomalies, especially inequalities in quality of health and wellbeing.

3. In 2019, the life expectancy at birth in the Slovak Republic for males and females was lower than the EU average (3,8 years)[[5]](#footnote-5) and the number of deaths from preventable or treatable diseases/conditions per 100 000 inhabitants in the Slovak Republic is alarming. For instance, the number of deaths from avoidable diseases/conditions, persons aged less than 75 years per 100 000 inhabitants in the Slovak Republic is higher by 60% in comparison with the EU average. Similar trends have been also shown in respect to treatable diseases/conditions and preventable diseases/conditions.[[6]](#footnote-6) If it comes to the deaths from preventable or treatable diseases/conditions in the Slovak Republic, there have not been substantial improvement and situation remains worrisome.

**Table No. 4:** *Treatable and preventable mortality of residents by cause and sex in the Slovak Republic for the years 2016 – 2018[[7]](#footnote-7)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **2018** | **2017** | **2016** |
| **Preventable diseases** | 241,27 | 238,71 | 243,82 |
| **Treatable diseases** | 165,32 | 173,71 | 168,31 |

**Measures addressing the diseases representing the main causes of premature death.**

4. The diseases that representing main causes of death in Slovakia remain similar over the years, with chronic ischemic heart disease and circulatory system diseases (International Classification of Diseases: I20 – I25) being the most common diseases causing death in the Slovak Republic, followed by malignant neoplasms of the digestive organs (International Classification of Diseases: C15 – C26), vascular diseases of a brain (International Classification of Diseases: I60 – I69), other heart diseases (International Classification of Diseases: I30 – I52) and acute upper respiratory tract infections ((International Classification of Diseases: J09 – J18) (Table No. 4).[[8]](#footnote-8)

**Table No. 4:** *Number of death to the most common causes of death by diagnosis group per 100 000 inhabitants for the year 2019[[9]](#footnote-9)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis group** | **Males** | **Females** | **Total** |
| I20 – I25 | 243,7 | 282 | 263,3 |
| C15 – C26 | 97,5 | 63,7 | 80,2 |
| I60 – I69  | 77 | 79,9 | 78,5 |
| I30 – I52  | 56,8 | 60,5 | 58,7 |
| J09 – J18  | 50,7 | 46,4 | 48,5 |

5. According to the United Nations Committee on Economic, Social and Cultural Rights, there are systemic weaknesses in healthcare provisions in the Slovak Republic.[[10]](#footnote-10) These include infrastructure of a poor quality due to a lack of investment, limited screening facilities, gaps in geographical coverage of some health-care services and low numbers of doctors and nurses in some regions.[[11]](#footnote-11)

6. The lack of investments to provision of healthcare has been also noticed by the Organization for Economic Cooperation and Development (OECD), according to which the Slovak Republic “*spends much less on health than the EU average, both in absolute terms (EUR 1 600 per person in 2017, adjusted for differences in purchasing power) and as a share of GDP (6,7 %)*.”[[12]](#footnote-12) The situation is especially concerning due to the fact, that the Slovak Republic has been regularly decreasing its investments to healthcare since 2016 (as a share of GDP).

7. The lack of investments to healthcare is underlined by the lack of efficiency of the system of itself. According to the Ministry of Finance of the Slovak Republic and its Value for Money Division, the Slovak Republic “*dedicates a little less money to healthcare than the V3 countries per citizen, in terms of total health expenditure, adjusted by purchasing power. However, the country’s public expenditure is higher compared to them and its healthcare outcomes are worse. Overall, Slovak health expenditure is 4% lower than the average in V3 countries, but treatable mortality rate is higher by 16%. There are more deaths preventable by better healthcare in Slovakia than in Poland, Estonia and Greece (95 – 143 preventable deaths, the average being 122, thus 27% less than in Slovakia), even though the average expenditure in these countries is 5% lower.*”[[13]](#footnote-13)

8. The Slovak Republic has not adopted any complex and effective measures that would improve the worrisome situation concerning number of medical staff and its geographical distribution. According to the National Centre for Medical Information, there are 83 896 members of medical staff working in the Slovak Republic out of which, only 22 307 members of staff are medical doctors/physicians.[[14]](#footnote-14) Despite the fact that the average number of medical doctors/physicians in the Slovak Republic (3,4 physicians per 1000 inhabitants) is approaching the EU average (3,6 physicians per 1000 inhabitants)[[15]](#footnote-15), the average number of nurses in the Slovak Republic (3,4 nurses per 1000 inhabitants) has been long-term bellow the EU average (8 nurses per 1000 inhabitants.[[16]](#footnote-16) The geographical distribution of the medical staff is uneven. While the density of physicians is very high in the capital region, it is much lower in most other regions.[[17]](#footnote-17) In comparison with Bratislava region (6,5 physicians per 1000 inhabitants), in regions of Trnava, Banská Bystrica, Nitra or Prešov, the number of physicians per 1000 inhabitants is lower than 3.[[18]](#footnote-18) Moreover, more than 45% of physicians is older than 50 years of age.[[19]](#footnote-19)

9. The Centre believes that to improve the current situation in healthcare, especially concerning health life expectancy and number of preventable and treatable deaths, the Slovak Republic should adopt complex and systematic measures, not only aiming at progressively increasing the amount of financial means invested to the healthcare system, but also ensure that these financial means are invested efficiently and contributing to improvement of the overall accessibility, availability, acceptability and affordability of all levels of healthcare (primary, secondary and tertiary) as well as all kinds of healthcare (preventive, curative and rehabilitative) to all inhabitants, including the members of vulnerable groups, such as Roma, women, persons with disabilities, members of LGBTIQ+ communities or migrants.

10. The Centre further believes that the Slovak Republic should pay more attention to preventive healthcare as well as to health education. Not only that the preventive programmes and policies focusing on the most prevalent diseases/conditions are not sufficient, the overall awareness of inhabitants about their entitlements, costs and conditions for participating in the preventive programmes is low. The main policy concerning healthcare is the Strategy for Health for the Years 2014 – 2030 (Health Strategy 2030). Other policies concerning health include National Action Plan for Prevention of Obesity for the Years 2015 – 2025 and National Action Plan for Issues Concerning Alcohol for the Years 2013 – 2020. Some policies have not been prolonged or renewed after the implementation period has passed, e. g. National Action Plan for Control of Tobacco. Some of the policies are outdated and rarely implemented, e. g National Programme for Mental Health and National Programme of Health Support. For instance, on 4th September 2019, the Ministry of Health of the Slovak Republic proposed to terminate implementation of several measures from the National Program for Mental Health. As a justification, the Ministry of Health of the Slovak Republic stated “*during its 16' years existence, the implementation of measures of the National Program for Mental Health by respective ministries has not led during to changes in the field of mental health and currently does not reflect the contemporary needs in the field of provision of mental healthcare*.”[[20]](#footnote-20) The most recent policies touching on provision of healthcare are the National Investment Plan of Slovakia for the Years 2018 – 2030 (adaption of the Agenda 2030 for Sustainable Development) and the Recovery Plan. While the National Investment Plan of Slovakia for the Years 2018 – 2030 reflects on the Health Strategy 2030, the Recovery Plan introduces two major reforms – Modern and accessible healthcare (1163 mil. EUR) and Mental Health Reform (105 mil. EUR). The Recovery Plan proposes for the healthcare to be second highest investment after green economy, followed by education and science.[[21]](#footnote-21)

11. The Centre concludes that while there is various national policies and programmes being implemented in the field of healthcare, there are no complex and systematic policies that would be heavily focused on prevention and that would target the main causes of premature and treatable deaths in the Slovak Republic. There is the National Oncology Programme, however, the most important preventive measures – screening programmes are not sufficient. There are currently three screening programmes: for breast cancer, colorectal cancer and cervical cancer. Only two programmes – breast cancer screening programme and colorectal cancer screening programmes were launched in 2019. However, start of both programmes were to a large extent impacted by the COVID-19 pandemic in 2020. The cervical cancer screening programme has not been launched yet. If it comes to cardiovascular diseases and conditions, there is no national programme that would focus on such diseases and conditions, which are one of the most common diagnosis causing premature deaths in the Slovak Republic. Some preventing measures targeting also cardiovascular diseases are implemented by the Public Health Authority of the Slovak Republic, especially through the system of counselling services. However, these are not well known and are visited by less clients each year. For example, in 2010, the counselling services were utilised by 14 429 inhabitants (9278 women and 5151 men) and in 2019, the counselling services were utilised only by 5388 inhabitants (3720 women and 1668 men).[[22]](#footnote-22)

**B) SEXUAL AND REPRODUCTIVE HEALTH-CARE SERVICES.**

***Maternal mortality rate.***

10. The Centre would like to inform the European Committee for Social Rights (the “Committee”) on the state of maternal mortality in the Slovak Republic. In 2017, the Slovak Republic stated that the main reason for maternal mortality is that pregnant women are neglecting the prescribed medical check-ups and therefore, the new amendments to the Act 461/2003 Coll. On Social Security, as amended (the “Social Security Act”) that condition the payment of maternity benefit fulfilling the obligation of attending the regular medical check-ups prescribed to pregnant women.

11. The Centre would like to clarify the benefits that can be drawn by pregnant women or mothers caring for one or more children. The set of benefits can be divided into social security benefits (regulated by the Social Security Act) and state benefits (regulated by individual legal acts).

12. The Social Security Act recognizes (i) benefit for a pregnant woman and (ii) maternity benefit. The benefit for pregnant women is a benefit for a woman who was insured at least 270 days during the last two years is entitled to the benefit for pregnant women from 27th week of pregnancy until the end of pregnancy. The maternity benefit is a benefit for a woman who was insured at least 270 days during the last two years is entitled to the maternity benefit from 6th week before the expected due date until the end 34th week following the day when the entitlement for the benefit arose. Different conditions apply to women who deliver two and more children or women who deliver stillborn child.

13. The Social Security Act does not include any provision that would prevent a woman who did not attend the prescribed check-ups for pregnant women from drawing up the benefit for pregnant women (introduced in 2020) or the maternity benefit as stated by the Slovak Republic in the 7th National Report on the Implementation of the European Social Charter submitted by the Government of the Slovak Republic. Both benefits are solely connected to the payment of social security insurance and to provision of care for a child. Only employed women or self-employed women who pay social security insurance are entitled to the benefit for pregnant women or maternity benefit. Therefore, these benefits are not available for some groups of women, e.g. unemployed, students etc.

14. If it comes to state benefits, there are various benefits supporting parents or other persons providing care for children (up to 3 years of age, in case of long-termly unfavourable health conditions – up to 6 years of age). These benefits include (i) childbirth allowance (one-time payment of 829,86 EUR for the first, second and third child), (ii) childbirth allowance in case the delivery of two or more children (110, 36 EUR per annum, until 15 years of age of the first child born), (iii) child allowance (25,50 EUR per month, until 25 years of age of a child), surcharge to child allowance (11, 96 EUR per month, until 25 years of age of child, in case a parent is not eligible for a tax bonus), (iii) parental allowance (275,90 EUR per month, until 3 years of age of child or 6 years of age of a child suffering from log-term unfavourable health condition) and (iv) childcare allowance (280 EUR, 80 EUR or 41,10 EUR depending on the entity providing care for a child, until 3 years of age of child or 6 years of age of a child suffering from log-term unfavourable health condition).

15. The only state benefit that includes the condition to undergo all medical check-ups for pregnant women (from 4th to 9th month of pregnancy) for the entitlement to the benefit is the childbirth allowance. At the same time, the Centre would like to point out that the legislation does not include any mechanisms that would ensure the entitlement to the childbirth benefit for women who could not attend the prescribed medical check-ups due to the force majeure, e.g. women in coma, women who were not diagnosed with pregnancy until very late stages etc.

16. The maternal mortality in Slovakia fluctuates (Table No. 1). Two major national strategies – National Investment Plan of Slovakia for the Years 2018 – 2030 (pilot version) and the Strategic Framework for the health care for the Years 2014 – 2030 do not include any concrete measure that would aim at decreasing the maternal mortality in Slovakia or increase the quality of maternal healthcare. Moreover, the quality of healthcare provided in relation to labour and delivery or maternal healthcare in general is not ensured on national level as well as in the individual regions. This is because, the Ministry of Health of the Slovak Republic has not yet adopted any relevant standard clinical guidelines for labour and delivery.

**Table No. 5:** *Maternal Mortality Ratio in the Slovak Republic for the years 2016 - 2018[[23]](#footnote-23)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Region** | **2018** | **2017** | **2016** |
| Slovak Republic | 3,47 | 5,18 | 6,95 |
| Bratislava  | 0,00 | 0,00 | 0,00 |
| Trnava  | 0,00 | 0,00 | 36,41 |
| Nitra  | 0,00 | 0,00 | 0,00 |
| Žilina  | 0,00 | 0,00 | 13,65 |
| Trenčín  | 19,18 | 0,00 | 0,00 |
| Prešov  | 0,00 | 20,16 | 10,14 |
| Košice  | 0,00 | 11,16 | 0,00 |
| Banská Bystrica  | 16,43 | 0,00 | 0,00 |

17. Non-governmental organizations – “*Ženské kruhy*”[[24]](#footnote-24) and “*Občan Demokracia a zodpovednosť*”[[25]](#footnote-25) have been monitoring the enjoyment of human rights during the labour and delivery and have been regularly reporting serious human rights violations such as physical violence (e.g. pressuring a woman to deliver in a lying position, using Kristeller expression, conducting episiotomy and/or amniotomy without indication, using violence such as slapping to pressure the women giving birth to cooperate with the medical personnel, stitching without appropriate anaesthesia, bed restraint) or psychical violence (e.g. shouting at women giving birth, mocking women giving birth, intimidation).[[26]](#footnote-26) Both organisations – *Ženské kruhy* as well as *Občan, Demokracia a Zodpovednosť* consider also problematic the way how medical personal obtains informed consent during the labour and delivery and how are women giving birth informed about the individual procedures and medication prescribed.[[27]](#footnote-27)

***Planned parenthood and access to abortion.***

20. Enjoyment of reproductive rights in the Slovak Republic has been problematic for many years and resonates in the overall evaluation of the protection and promotion of human rights in the Slovak republic on the international level.[[28]](#footnote-28) The state of protection and promotion of reproductive rights is unsatisfactory, especially due to: (i) availability, safety and selection of contraceptive, (ii) infertility treatment, (iii) availability and safety of abortion, (iv) prevention, treatment and control of sexually transmitted diseases, including HIV (v) maternal and new-born care, (vi) healthy adolescent sexuality and elimination of traditional harmful practices. Despite the recommendations of experts, civil society organisations, international community[[29]](#footnote-29) or United Nations committees[[30]](#footnote-30) to adopt comprehensive policy regulating reproductive and sexual health, such policy has not been yet adopted. Adoption and implementation of national strategy and action plan on sexual and reproductive health as a result of participatory and transparent process with regular monitoring and evaluation with allocation of sufficient funds is the basic obligation of the Slovak republic.

21. Planning parenthood, especially access to wide scale of contraceptives and respective information as well as access to infertility treatment remains unsatisfactory. European Contraception Policy Atlas published by the European Parliamentary Forum for Sexual and Reproductive Rights on annual basis evaluated the access to contraceptive in the Slovak Republic in 2019 to only 48,1%.[[31]](#footnote-31)Together with twelve more countries, the Slovak Republic and its policies in the field of sexual and reproductive rights were evaluated as unsatisfactory, especially due to the fact that the contraceptives are not covered by the public health insurance, including adolescents or members of vulnerable groups; in the process of prescription of contraceptive various restrictions are being applied (e.g. for prescription of contraception to a person younger than 18 years of age, the consent of a parent or legal guardian is required); all hormonal contraceptives are bound for medical prescription as well as there is lack of information available online, including information in the minority languages. Moreover, the low score awarded by the European Contraception Policy Atlas is also based on the lack of relevant legislation and policies regulating planned parenthood on national level.

22. Currently, there is no modern contraceptive method covered by the public health insurance. All kinds of hormonal and non-hormonal contraceptives are fully paid for by the patients. According to the applicable legislation, it is not possible to introduce a drug to the list of categorised medicines that is a drug solely intended to regulate conception (contraceptives) or a drug that is intended to treat erectile dysfunction, to treat obesity/overweight, or to treat smoking cessation, addiction to tobacco or smoking.[[32]](#footnote-32) According to the Ministry of Health of the Slovak Republic is the justification for elimination of contraceptives from the list of categorised medicines given by missing health indication. Contraceptives are intended to prevent conception that is a physiological condition not a disease. The Ministry of Health of the Slovak Republic argues that it is important to respect the solidarity system of public health insurance.[[33]](#footnote-33) The aim of the public health insurance system is to ensure the access to efficient, safe, quality and modern medicines for whole population, including patients suffering from serious conditions and diseases.[[34]](#footnote-34) The public health insurance system should not be used to replace the social security system.[[35]](#footnote-35)

23. According to the data collected by the National Centre for Medical Information, 190 735 women used contraceptives in 2018 what represents 147,8 women using contraceptives per 1000 women in reproductive age. Number of women using contraceptives is decreasing annually. For comparison, in 2017, it was 157,5 women using contraceptives per 1000 women in reproductive age and in 2016, it was 170 women using contraceptives per 1000 women in reproductive age.[[36]](#footnote-36) The decrease might be caused by the lack of relevant information and substantial stigmatisation of using contraceptives, especially hormonal contraceptives (e.g. side effective, harms to the environment) as well as its price.

24. In 2019, the Ministry of Health of the Slovak Republic did not administer any official source of online information about planned parenthood, contraceptives and sexual health as well as it did not carry out any communication campaign promoting sexual and reproductive health in recent years. Patients usually search for relevant information on online forums, however, such information are not often correct. Other sources of information include information leaflets in the OBGYN outpatient centres that are usually produced and distributed by pharmaceutical companies producing individual contraceptives. Even the information acquired at the outpatient centre might not be fully correct or relevant. To a large extent, this information can be distorted by the prejudice, faith, religion or philosophical beliefs of medical staff. This trend can be seen especially if it comes to general practitioners who often do not have information about the newest trends in planned parenthood or newest contraceptive methods.

25. Specific category are information provided in minority languages (e.g. in Hungarian, Romani etc.) or information that are accessible to women and girls with disabilities (e.g. information accessible for girls and women with visual impairment, mental disabilities etc.).

26. Exclusion of hormonal contraceptives and intrauterine device from the coverage of the public health insurance has been a serious obstacle to planned parenthood, especially to young girls and women from marginalised Roma communities or from socially disadvantaged background (e.g. unemployed). According to official statistics, more than 90,5% of women registered in the OBGYN outpatient centres in the Slovak Republic do not fulfil their need in respect to planned parenthood, that means they do not use any modern form of contraceptive, whether hormonal or not.

27. In 2019, the average cost of hormonal contraception varied from 10 EUR to 15 EUR per month in the Slovak Republic, what represents annual cost of 120 EUR to 180 EUR. The Centre believes that the current cost of hormonal contraception is a serious obstacle to planned parenthood, while the Ministry of Health of the Slovak Republic argues that there are also cheaper alternatives of hormonal contraception, such as drug Regulon or Tri-Regol. However, it should be pointed out that these drugs were introduced to the Slovak market in 1999 and 2001 and can be considered as fairly outdated. The Slovak Republic is also bound by the International Covenant on Economic, Social and Cultural Rights that expressly states that everyone shall have right to access the outcomes of the scientific progress (Art. 15), that means to have access to modern drugs, medicines and medical devices, including hormonal contraception.

28. Apart from the cost of the hormonal contraception, the restrictions to prescription also represent an obstacle to planned parenthood. Such a restriction is a mandatory informed consent of a parent or legal guardian of girls younger than 18 years of age as well as taking age of the patient into consideration when prescribing hormonal contraception. Currently applicable laws require that the person who receives healthcare or, if a person is not eligible to give a consent, a legal guardian are obliged to give a proven consent based on a clarification and edification given by a physician – an informed consent. According to the Act No. 40/1960 Coll. Civil Code, as amended, a person acquires full legal capacity by coming of age at 18 years of age. According to the Ministry of Health of the Slovak Republic, persons younger than 18 years of age have legal capacity that reflects their maturity and development, however, they are not able to give informed consent.[[37]](#footnote-37)

29. Girls younger than18 years of age are required to obtain an informed consent of their parent or legal guardian to be prescribed hormonal contraception. The only exemption are girls who older than 16 years of age and got married. Lack of legal capacity to give an informed consent is a serious obstacle to the access to contraception. The attitude of parents or legal guardians to using contraception can be impacted to large extent by fear from side effects, misinformation, anti-campaigns as well as by their prejudice, faith, religion or philosophical beliefs. Lack of trust, shame and fear of sharing their needs in respect to planned parenthood with parents or legal guardians as well as the sexuality and planned parenthood being a taboo in Slovak society can also play a significant role.

30. Another obstacle can be age of a patient, especially in respect to unfounded considerations of the age of patient by physician. This obstacle can be faced by all girls younger than 18 years of age, even if they acquired informed consent of the parent or legal guardian. Currently, there is no official clinical standard that would impose age restrictions on prescription of hormonal contraception, e. g. restricted prescription of hormonal contraception to girls older than 16 years of age. When prescribing hormonal contraception, physicians should follow summary of product characteristics. However, it is not unusual that physicians refuse to prescribe hormonal contraception to girls younger than 16 years of age. Usually, physicians argue that the body of a girl younger than 16 years of age is still developing quote Section 201 of the Act 300/2005 Coll. Criminal Code, as amended: “*Any person who has sexual intercourse with a person under fifteen years of age, or who subjects such person to other sexual abuse, shall be liable to a term of imprisonment of three to ten years*.” Many physicians are of an opinion that persons younger than 15 years of age are forbidden from having a sexual intercourse, therefore there is no reason for prescription of hormonal contraception to girls in this age group. However, according to the summary of product characteristics of the majority hormonal contraceptives, taking a contraception is indicated after menarche – the first menstruation. First menstruation indicates sexual adolescence and the average age of girls having their first period fluctuates between 9 to 18 years of age (the European age median fluctuating between 12,6 years to 15,2 years).[[38]](#footnote-38)

31. In the Slovak Republic, the abortion is regulated by two main laws - the Act 73/1986 Coll. on Abortions, as amended (“Abortion Act”) and the Decree of the Ministry of Health of the Slovak Republic No. 74/1986 Coll. that executes the Abortion Act (“Abortion Decree”) as well as in other acts. The abortion is carried under two general regimes. First regime is defined by Section 4 of the Abortion Act – abortion can be conducted on a women based on her written request if the pregnancy did not exceed 12 weeks and there are no health contraindications. Second regime is defined by Section 5 of the Abortion Act – abortion can be conducted on a women based on her written request or with her consent in case her life or health or healthy development of a foetus is engendered or due to genetically defective foetus development, without any time restrictions.

32. Currently, there are several serious legal discrepancies in the abortion regulation that might impose challenges to the access to safe abortion. These legal discrepancies include regulation of obtaining informed consent of under aged girls and discrimination of some groups of girls and women. Moreover, discrepancies can be also found in the application of relevant laws regulating access to abortion what might have serious impact on the access to safe abortion on regional level.

33. There are two legal regimes governing the informed consent to abortion obtained from girls younger than 18 years of age. These regimes are completely different and are not mutually reinforcing. First regime is regulated by Abortion Act and the second regime is governed by the Act No. 576/2004 Coll. on Healthcare and Services Related to Healthcare and on Changes and Amendments of Certain Laws, as amended (“Healthcare Act”). It is important to note that the Abortion Act entered into force in 1987 and does not recognize the institute of informed consent as included in the Healthcare Act. However, when interpreting and applying laws, “*it is not possible to omit their purpose and meaning that are not included solely in words and sentences of the law but also in the fundamental principles of rule of law*”[[39]](#footnote-39) Taking into account the purpose of the consent regulated by the Abortion Act, it can be stated that the purpose of both consents – consent pursuant to Section 6 of the Abortion Act as well as the informed consent pursuant to Section 6 of the Healthcare Act has the same purpose – to act on a pregnant women to consider abandonment of the idea to undergo abortion, aiming at protecting health of the respective woman and the life of unborn child.

**Table No. 6:** *Overview of legal regimes regulating informed consent to abortion*

|  |  |  |
| --- | --- | --- |
|  | **Abortion Act** | **Healthcare Act** |
| **Girls younger than 16 years of age.** | The abortion can be carried out on a woman who is not older than 16 years of age pursuant to Section 4 of the Abortion Act only with the consent of a parent or legal guardian. | In case, the person has no full legal capacity, it is required to obtain the informed consent of a woman as well as the informed consent of her parent or legal guardian to carry out the abortion. |
| **Girls older than 16 years of age and younger than 18 years of age.** | If the abortion was carried out on a woman from 16 years to 18 years of age, the healthcare provider will notify a parent or legal guardian of the respective woman.  |

34. It can be clearly seen that due to these different legal regimes, there is a conflict of laws. Such conflict of law can cause legal uncertainty of healthcare providers, physicians and last but not least the girls who would like to undergo abortion and their parents, resp. their legal guardians. While Healthcare Act requires the parents, resp. legal guardians to give the informed consent to abortion carried out on a woman younger than 18 years of age, the Abortion Act is less strict and for girls older than 16 years of age but younger than 18 years of age requires the healthcare facility only to notify parents, resp. legal guardians. It is up to individual healthcare provider or physician which regime will apply. It is experience of the Centre that majority of healthcare providers and physicians are applying the regime regulated by the Healthcare Act in accordance with the legal principle – *lex posterior derogate legi priori*.

35. The problematic also remains discriminatory provisions of the Abortion Decree. The Abortion Decree stipulates that the abortion cannot be carried out on a woman who undergo abortion less six months ago. There are several exemptions to this rules: (i) there is reasonable doubt that woman was impregnated as a result of crime, (ii) woman is older than 35 years and (iii) woman was already in labour/delivery at least two times. The Centre believes that two exemptions – age of 35 years and the fact that a women was in labour/delivery at least two times are discriminatory. The Abortion Decree does not allow women younger than 35 years of age or women who have not delivered/were not in labour at least twice to undergo abortion, if there is not at least six months between the previous abortion and their current request for abortion. This leads to unequal treatment – direct discrimination of two abovementioned groups of women on the other ground in the area of provision of healthcare. The direct discrimination in the area of provision of healthcare on the other ground is forbidden by the Antidiscrimination Act as well as by the Constitution of the Slovak Republic.

36. Secondly, the Abortion Decree discriminates third country nationals who are staying in the Slovak Republic temporary – with temporary residency. According to Section 9(1) of the Abortion Decree, the abortion pursuant to Section 4 of the Abortion Act cannot be conducted on third country national who stays in the Slovak Republic temporarily. While the European legislation protects citizens of the EU member states, other third country nationals are not covered by the European legislation and cannot undergo abortion on request. The Centre would like to stipulate that the abortion on request pursuant to Section 4 of the Abortion Act is not covered by the public health insurance and is fully covered by the patient. Therefore, there is no eligible reason for third country nationals that are not citizens of the EU member states to be precluded from requesting an abortion if all other legal requirements are fulfilled.

37. Apart from equivocal regulation of informed consent of under aged girls and multiple discriminatory provisions, the regulation of the access to abortion shows further shortcomings. One of these shortcomings is the waiting period enforced in respect to abortions carried out on request of a woman pursuant to Section 4 of the Abortion Act. The Healthcare Act requires that there is at least 48 hours between the time the physician submitted report on providing information to a patient and actually conducting the abortion. This waiting period is not medically justified and in general, all abortion should be carried out without delay. More time passes from the moment of conception, the more risks are associated with the abortion that cannot be outweighed with the potential benefits of waiting period. The Centre would like to point out, that the waiting period can be even more prolonged as it does not lapses based on a legal act of a woman (submission of written request for abortion) but it lapses based on a legal act of a physician (submission of a report on providing information to a patient). Currently, there is no legal mechanism that would oblige the physician to submit the report on providing information to a patient as soon as possible, without unnecessary delay. If physician submits the report later (e.g. next day, after weekend etc.), the woman requesting the abortion is pushed to wait for the abortion to be carried out even longer.

38. According to the National Centre of Medical Information, in 2019 there were 121 healthcare providers that operated bed departments or one-day medical care department in the OBGYN field and were obliged to report on abortions or treatment provided due to a miscarriage. In 2019, the Centre conducted a short survey among the respective healthcare providers to map the access to abortion services. The survey included 43 healthcare providers out of which 28 healthcare providers were owned by state or self-government body and 16 healthcare providers were private. The geographical coverage of interviewed healthcare providers was even with only minor deviations – Košice region (18,6%), Prešov region (16,3%), Trenčín region (14%), Źilina region (14%), Trnava region (11,6%), Banská Bystrica (11,6%), Bratislava region (9,3%), Nitra region (4,7%).

39. The Centre found out that only 69,8% interviewed healthcare providers are providing abortion services. Remaining 30,2% of interviewed healthcare providers are not proving any abortion services. Those healthcare providers who are providing abortion services are usually conducting abortion as a part of the one-day medical care, in short term anaesthesia by dilatation of cervix followed by vacuum aspiration, and if needed, supplemented by curettage of uterine cavity. According to the World Health Organization, the vacuum aspiration is recommended for conducting the abortion up to 14th gestational week and routine curettage is not recommended.[[40]](#footnote-40) Almost 14% of interviewed healthcare providers indicated that the curettage of uterine cavity is a preferred method of abortion.

40. Those healthcare providers who are not providing abortion services stated that all members of medical staff at the OBGYN department as well as other members of medical staff that are needed for providing abortion services (e.g. conducting pre-operative examinations, anaesthesia etc.) claim conscientious objection. Other reason indicated by the interviewed healthcare providers was that it is decision of the management of the OBGYN department. More than 11,6% of interviewed healthcare providers (5 subjects) claimed that they do not provide abortion services to women who do not have health indications for the abortion due to the genetically defective foetus development or the life or health of a woman is endangered. These healthcare providers did not state the reason behind such managerial decision. Some healthcare providers have not been providing abortions services for such a long time that current employees are not aware why such services are not provided.

41. The Centre also found out that many interviewed healthcare providers do not keep the list of medical staff claiming conscientious objection that means or if they do, they do not update it on a regular basis. According to the Healthcare Act, all members of medical staff are obliged to inform the healthcare provider as well as the patient, if they claim the conscientious objection.

42. According to the applicable legislation, it is not possible for the healthcare provider to refuse provision of treatment, examination or any other act of healthcare, including abortion based solely on the managerial decision of the hospital respectively its department. The Act No. 578/2004 Coll. on Healthcare Providers, Healthcare Workers, Professional Organizations in Healthcare and on Changes and Amendments of Certain Acts, as amended (“Healthcare Providers Act”) stipulates that the healthcare provider can refuse to enter the agreement on the provision of healthcare only if (i) by concluding such agreement it would exceeded tolerable workload, (ii) the physician has a personal relationship with a person who should receive medical care or (iii) his/her legal guardian and is not able to ensure for the medical care to be provided objectively, (iii) the physician is claiming conscientious objection (only in respect to abortion or artificial insemination).

43. The scenario in which the healthcare provider decided to provide abortion services to women on request only if there is a health indication. Such arbitrary managerial decision is not only contrary to the Healthcare Providers Act but it also directly discriminates women in the area of provision of healthcare based on the ground of other status as regulated by the Antidiscrimination Act. In case that two women turn to the same hospital and both women are pregnant no more than 12 weeks, and first woman request abortion pursuant to Section 4 of the Abortion Act and second woman request abortion pursuant to Section 5 of the Abortion Act, the healthcare provider will provide medical treatment (abortion) only to a women who requested abortion pursuant to Section 5 of the Abortion, that is there is a health indication for abortion (a life or health of expecting woman is endangered or genetically defective foetus development is indicated). The women who also requested the abortion but the health indication is not present will not be provided with the abortion services. The healthcare provider will reject such a patient due to the fact that such abortion services are not provided at the respective facility. Such approach to provision of abortion services shall be deemed as discriminatory. Both patients are up to 12 weeks pregnant, both submitted a written request for abortion, however, one patient was not diagnosed with health indication as stipulated by Section 5 of the Abortion Act what should be seen as objective fact that cannot be changed by the patient herself. Refusing to provide abortion services to a patient without health indication pursuant to Section 5 of the Abortion Act shall be considered as intentionally less favourable treatment of such patient in comparison with a woman who was diagnosed with the health indication.

44. If it comes to the abortion costs, there are two applicable regimes. Firstly, the cost of abortion on request pursuant to Section 4 of the Abortion Act is governed by the Act of the Ministry of Health of the Slovak Republic No. 07045/2003 – OAP dated 30 December 2003 (notification No. 588/2003 Coll.) and it is set for 248,95 EUR. According to the Ministry of Health of the Slovak Republic, the sum shall cover all costs related to the provision of abortion, including diagnostics, examinations, administration, hospital stay as well as medicines. The price is regulated for all healthcare providers. The second regime governs abortion carried out pursuant to Section 5 of the Abortion Act. If the abortion is carried out due to the health indication, it is covered by the public health insurance. All eligible health indications are listed the Annex to the Abortion Decree. As a part of the survey, the Centre found out that some interviewed healthcare providers charge for the abortions not covered by the public health insurance much more than the sum stipulated in the Act of the Ministry of Health of the Slovak Republic No. 07045/2003 – OAP. Based on the information collected from the healthcare providers, the increase in price of the abortion was usually caused by separate payments for pre-operative examinations (20 EUR - 50 EUR), immunoglobulin (50 EUR), hospital fees (60 EUR – 70 EUR). Contrary to the regulation, the total cost of the abortion might exceed even 300 EUR. The overall regulated cost of the abortion can act as an obstacle for girls and women with socially disadvantaged backgrounds (e. g. unemployed, students etc.) or girls and women under special regime (e. g. girls and women in prison).

**Article 11 (2)**

**To provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility of matters of health.**

**A) HEALTH EDUCATION AND RELATED PREVENTION STRATEGIES.**

45. Sexuality education represents one of the basic tools for the improvement of the enjoyment of sexual and reproductive rights. Before 1989m the Slovak Republic belonged to the number of states that opted solely for educational activities aiming to prepare pupils and students for marriage and parenthood. However, such programme cannot be considered to be a form of sexuality education. The Centre believes that the sexuality education should be a part of the formal education, should include participation of parents and legal guardians, reflect on current scientific knowledge, apply human rights based approach and respect target groups.

46. Not understanding the purpose and content of sexuality education for young people by the public authorities represents the biggest challenge to improving the sexuality education in the Slovak Republic. Public authorities as well as some civil society organizations, faith-based organizations and political parties often use inappropriate language, gender stereotypes and misinformation arguing with traditional values and protection of family.

47. Sexuality education at elementary and secondary schools in the Slovak Republic remains controversial topic and there is no society-wide agreement on its content or on the introduction to educational programmes at schools. According to the Ministry of Education, Science, Research and Sport of the Slovak Republic is sexuality education contained in the education on marriage and parenthood. The education on marriage and parenthood oscillates between abstinent and mixed model of the sexuality education. The curriculum integrates pedagogical, biologic, psychological and social knowledge and aspects of adolescence, sexuality, social relations, marriage, family life, intimate relations and about their values in human life.[[41]](#footnote-41)

48. The Centre considers partial application of holistic approach in the process of creating the curriculum of the education on marriage and parenthood being positive. However, there is lack of human rights based approach being applied. Moreover, the education on marriage and parenthood should reflect current scientific knowledge and take into account recent developments in the society as well as its values. The current curriculum of the education on marriage and parenthood entered into force in 1998 and was updated only twice – in 2010 and 2015. First update introduced topic of commercial violence and sexual exploitation of children and the second update reflected the participatory model of school management. In general, it can be concluded that the education on marriage and parenthood has not undergo significant changes and updates from 1998 and does not reflect on the current societal challenges such as number of single parents, divorce rate, impact of social media on children' behaviour (e.g. cyberbullying), prejudice against members of the LGBTIQ+ communities or spread of hoaxes and misinformation. The education on marriage and parenthood omits topics such as gender equality, sexual harassment, infertility and its treatment, adoption of children as a form of parenthood. Even the list of recommended literature includes monographies and edited books published between 1983 and 1996.

49. The Centre considers positive the introduction of education on marriage and parenthood to formal education and establishment of a function of school coordinator for education on marriage and parenthood. However, the format of the education on marriage and parenthood as a voluntary subject, after-school activity or its implementation to wide scale of subject is not very appropriate solution.

50. In 2019, the Centre conducted a short survey among schools aiming at mapping the sexuality education or education on marriage and parenthood. The survey was filled by 788 state owned elementary (51%), secondary (34%) and joint (5,6%) schools with even geographical coverage with only minor deviations – Košice region (18,1%), Prešov region (15,3%), Žilina region (15,2%), Banská Bystrica region (12,6%), Bratislava region (11,4%), Nitra region (9,6%), Trenčín region (9,1%), Trnava region (8,7%). More than 55% of schools were attended by less than 300 pupils, 25,4% of schools were attended by more than 301 to 500 pupils and 17,9% of schools were attended by more than 501 pupils.

51. According to the survey of the Centre no school is offering sexuality education as a stand-alone subject or voluntary subject or after-school activity. All interviewed schools are implementing the sexuality education as a horizontal topic to various mandatory, voluntary and other subjects. Only 1,7% of interviewed schools stated that they do not implement sexuality education to any subject. Many schools rely on individual lectures and workshops that take place outside of the formal education and are conducted by external entities. Schools usually cooperate with the centres of pedagogical and psychological support and prevention, regional branches of the Public Health Authority of the Slovak Republic, Police Corps of the Slovak Republic, offices of labour, family and social affairs, the Centre and local clubs of medical trainees and physicians.

52. The interviewed schools listed more than 60 individual subject that are part of the state educational programme/ innovative state educational programme, which they implement the sexuality education to. The most common subjects to which the sexuality education is implemented to are: biology (73%), ethics (70,6%), civic education (41,9%), religion (32,5%), class hour (10,6%), Slovak literature (4,4%) and sport (3,5%). Other subjects include medical subjects, art subjects, educational subjects, technical subjects, humanities and practical subjects.

53. More than 83% of interviewed schools stated that they include following topics to the curriculum at their school: prevention of early sexual intercourse, protection against unwanted pregnancies and planned parenthood, protection against sexually transmitted diseases (including HIV). If it comes to sexual orientation (especially homosexuality), only 68% of schools included discussion sexual orientation and related issues to the curriculum. Many schools admit that they discuss such topic only marginally. Some schools are covering this topic only through the topic of discrimination based on sexual orientation and gender equality which are usually a part of external lectures and workshops (e. g. educational activities provided by the Centre). Only 75% of schools include the topic of sexual violence and harassment to the curriculum, usually through external lectures and workshops with Police Corps of the Slovak Republic and the centres of pedagogical and psychological support and prevention.

54. Due to the overall understanding of the purpose of the sexuality education, the Centre also focused on the obstacles and issues that must be dealt with by individual schools when implementing sexuality education as a part of the curriculum. Surprisingly, only 3,5% of schools claimed that the school has direct experience with complaints of parents or legal guardians due to the providing sexuality education or its parts at school. Complaints usually concerned general disapproval of parents with sexuality education being provided to their children. Many schools prevent such disapproval by obtaining the informed consent of a parent or legal guardian. While some parents claimed that their children are not old/developed enough to participate in sexuality education, some parents claimed that they would prefer to teach their children about such topics within their family.

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