

Background

GENERAL

The Republic of Slovakia was formed on January 1, 1993, after Czechoslovakia was peacefully split into two separate nations: the Czech Republic and Slovakia. This development followed the 1989 fall of communism within Soviet-ruled Eastern Europe.⁵ Though the majority of Slovakia's population is Slovak, the country has one of the largest populations of Roma in all of Europe. Approximately 9% of Slovakia's 5.4 million people are Roma.⁶ The conditions under which the Roma live fall drastically below those of the rest of the population.⁷ This section provides background on Slovakia and explores general conditions of the Roma in Slovakia, paying particular attention to discrimination and coerced sterilization.

Legal and Political Framework

Slovakia is a landlocked country that shares borders with Poland, Czech Republic, Hungary, Austria, and Ukraine. It is a parliamentary democracy, currently headed by Prime Minister Mikuláš Dzurinda of the Slovak Democratic and Christian Union, who leads a coalition government. The Chief of State is President Rudolf Schuster. The next national elections are scheduled for the summer of 2006.

Slovakia has a civil law system based on Austro-Hungarian codes that have been modified to comply with the obligations of the Organization on Security and Cooperation in Europe and to expunge Marxist-Leninist legal theory. Slovakia is a parliamentary democracy with a president elected by direct, popular vote and a prime minister who leads the majority party or majority coalition. Slovakia has a 150-seat unicameral legislature, the National Council, elected for four-year terms based on proportional representation. The country has a Supreme Court with Justices appointed by the National Council. Slovakia also has a Constitutional Court with judges appointed by the president from a group of judicial nominees approved by the National Council.⁸

EU Membership

One of the Slovak government's top priorities is gaining membership to the

European Union (EU), a powerful regional institution that seeks to advance the process of European integration. In June 1995, Slovakia submitted an official application for admission to the EU.⁹ To gain membership, candidate countries must undergo an extensive application process that demonstrates their commitment to the goals of the EU. For the countries of Eastern and Central Europe, the EU has set forth three categories of criteria, known as the Copenhagen criteria, that applicant countries must fulfill in order to join: political and economic criteria, and the incorporation of the EU *acquis*, or legal and institutional framework.¹⁰ The EU has defined “political” criteria as “stable institutions guaranteeing democracy, the rule of law, human rights and respect for minorities.”¹¹ Economic criteria include “a functioning market economy.”¹² And incorporation of the EU *acquis* involves “adherence to the various political, economic and monetary aims of the European Union.”¹³ (See also Section on Standards on State Responsibility.) In December 2002 the EU formally invited Slovakia to become a member state in 2004.¹⁴

SITUATION OF ROMA

Demographics of Romani Population in Slovakia

According to 1991 census figures, the Slovak Republic consists of 85.7% Slovak, and 11 national minorities, including 10.6 % Hungarians and 1.6% Roma.¹⁵ The Romani population in Slovakia, however, is severely underrepresented in the 1991 census figures.¹⁶ The reported percentage of Roma in Slovakia at the time of the 1991 census was estimated to be closer to nine,¹⁷ one of the largest Romani populations in Europe.¹⁸ In the 2001 census, only 89,920 people recorded their ethnicity as Roma,¹⁹ which is approximately 1.6% of the total population of Slovakia. This figure is only 14,118 more than those who declared themselves Roma in 1991. Non-governmental Romani groups and authorities from the European Union, however, estimate the number of Roma to be between 450,000 and 520,000, or approximately 9% of the population.²⁰ Many Roma refrain from reporting their ethnicity due to fear of racial discrimination and also as a carryover from pre-1989 policies that expressly forbade anyone from identifying himself or herself as Roma.²¹ Nearly two-thirds of the Romani population live in the eastern portion of the country, around Košice, the second largest city in Slovakia, and Prešov, where most live in settlements

on the outskirts of towns and in geographically remote areas.²²

Romani populations have high rates of fertility and infant and adult mortality.²³ Romani women have a tendency to marry at a younger age and begin having children earlier than other ethnic groups.²⁴ The life expectancy of Roma is considerably lower than the Slovak national average. Romani men and women live an average of 13 and 17 years less than the majority population, respectively.²⁵ A high birth rate together with a relatively high mortality rate has resulted in a remarkably young Romani population: as many as 80% of Roma are under the age of 34, and 43% are below the age of 14.²⁶ Roma are worse off than the majority population in most regards, including income, education, health status, housing, and access to employment opportunities.²⁷ As a result, most Roma depend on social benefits.²⁸ Pervasive and multiple forms of race-based discrimination are the key contributing factors to the sub-standard conditions of Roma in Slovakia. Quantitative evidence of the conditions of Roma is “sparse and often fraught with methodological problems”²⁹ in large part due to legislation that prohibits the gathering of data by ethnicity without a person’s consent.³⁰ This restrictive legislation creates a considerable barrier to evaluating the precise magnitude of discriminatory practices against Roma.

Romani Women’s Health

Romani women have significantly less access to health care than non-Romani women. Reports show that when Romani women do receive health care, it is usually of poor quality due to discrimination based on their ethnicity and assumptions about Romani women’s reproduction.³¹ A 2001 report discussed the fact that Romani women suffer discrimination in reproductive health services, including limited visitation days at doctors’ offices, segregated rooms and eating facilities in hospitals, and hostile or inappropriate behavior from doctors themselves.³² This pervasive discrimination results in low levels of health awareness and poor maternal health.³³ From 1995 to 1997, low birth weights were more than twice as common among Romani women than non-Romani women, and the Romani infant mortality rate was double that of non-Roma.³⁴ Specific information on maternal mortality rates amongst the Roma is not available because the government does not officially track this information.

The quality of gynecological health care, particularly maternal and child health care for women in general and for Romani women in particular, has deteriorated since the collapse of communism.³⁵ During the fact-finding, Romani women in isolated settlements reported that the demise of the communist system of visiting nurses, who provided an important source of information and care for newborn babies and their mothers, has had an adverse impact on the care they receive.³⁶

Discrimination Against Roma ³⁷

With the collapse of communism and the resulting political and economic transition, discrimination against Roma in all facets of life has increased. Romani people in Slovakia are subject to pervasive discrimination in housing, education, health care, employment, public services, and criminal justice.³⁸ Romani settlements in rural areas are segregated and often located on the outskirts of a town or village, with limited or no access to public amenities such as a clean water supply, sewage systems, electricity or gas, and roads.³⁹ Since the collapse of communism there has been a considerable increase in the number of remote Romani settlements: from 278 in 1988 to 616 in 2000.⁴⁰ Segregation and other forms of discrimination in school combined with discrimination in hiring practices contribute to an average unemployment rate of more than 80%.⁴¹ In some of the segregated settlements in eastern Slovakia, formal unemployment rates are close to 100%,⁴² and few people have graduated from secondary school.⁴³ Many Romani settlements are not officially recognized by local authorities,⁴⁴ leaving some Roma with problems concerning their permanent residence. This renders it much more difficult for them to register their children for school or exercise their right to vote.⁴⁵ Physical and verbal attacks by the majority population and by police officers against members of the Romani population are regular, well-documented occurrences.⁴⁶ These human rights abuses are rarely brought to the courts and when they are, perpetrators are usually charged with the lesser crime of infliction of bodily harm instead of the more serious allegation of a racially motivated crime.⁴⁷

The failure of the government generally to protect minority Roma has allowed particular governmental authorities to condone and contribute to the continuing discrimination against them.⁴⁸ Public officials feed anti-Roma sentiment through inflammatory and racist statements.⁴⁹ Some local and national political leaders

advocate segregation as the only way to deal with the Romani population.⁵⁰

Public opinion polls consistently reveal the pervasiveness of discriminatory and racist attitudes toward Roma. Surveys of the Slovak population in 1995⁵¹ and 1999⁵² found that two-thirds of respondents believed Roma should live separately from the majority population. These discriminatory attitudes are reinforced by the media: news reports about the Roma focus predominately on social problems, such as high birth rates, their dependence on social assistance, inadequate housing, and unemployment, without discussion of the discrimination that fuels these trends.⁵³

HISTORY OF COERCED AND FORCED STERILIZATION

The current practices of coerced sterilization against Romani women are grounded in previous state policies. Coerced and forced sterilization because of racial prejudice was perpetrated under both the Nazi and Communist regimes in the territory of Czechoslovakia. Fear of increasing Romani population size was and continues to be a driving force in justifying reproductive rights violations against Romani women. Such fears and behavior are based on racist assumptions about Romani women's sexuality, fertility rates and genetic worthiness. These racist beliefs can be seen today in the rhetoric of health-care personnel, politicians and society at large. Slovak government officials, including law enforcement bodies, have consistently dismissed complaints of coerced and forced sterilization practices under communism and during the current period of democratic transition.

Nazi Regime

Between 1933 and 1945, Roma suffered as victims of Nazi persecution and genocide. Roma were among the groups singled out on racial grounds for persecution by the Nazi regime and most of its allies. Nazi Germany secured the cooperation of other European governments in its campaign to locate and identify Roma throughout Europe, including Czechoslovakia.⁵⁴ The Nazi regime viewed Roma as "asocials" and considered Roma to be racial "inferiors." On July 14, 1933, Germany passed a law permitting the forced sterilization of Roma and others considered "undesirable."⁵⁵ In subsequent years, Roma were subjected to forced sterilization, internment, forced labor, and eventually extermination by the Nazi regime and its local allies in Nazi-occupied territories, which included Czechoslovakia. Nazis

viewed Roma as diseased and forcibly sterilized them to prevent the spreading of their disease by reproduction.⁵⁶

Communist Era

STERILIZATION POLICY

After World War II, discrimination against Roma continued,⁵⁷ as did sterilization practices. Toward the latter years of the communist era, Romani women were targets of a Czechoslovak government program that offered monetary incentives to all citizens who underwent sterilization.⁵⁸ Although the program made these incentives available to all persons, regardless of race or ethnicity, government documents and independent studies indicate that the government took specific measures to influence Romani women to undergo sterilization.

One of these documents is a 1977 paper prepared by the Secretariat of the Governmental Commission for the Question of Gypsy Inhabitants of the Slovak Socialist Republic, which states that “health indications which will enable the possibility of sterilization are not being taken into account . . . In practice, the Gypsy citizens have not been influenced enough to use the possibility of sterilization . . . in cases where further pregnancy endangers the health of further descendants.”⁵⁹ The document notes the failure to control the “high unhealthy” Romani population through contraceptives and family planning and advocates using sterilization to reduce the Romani population.⁶⁰

In discussing methods to encourage Roma to undergo sterilization, the Secretariat suggested increased monetary incentives to encourage Romani women to consent to sterilization:⁶¹

“Concerning the rarely used possibility of sterilization, health workers say the reason is the low financial benefit for paying costs connected with hospital sterilization. Even a backward Gypsy⁶² woman is able to calculate that, from an economic point of view, it is more advantageous for her to give birth every year because she gets significant[ly] more financial resources from the state for the fifth and later descendants . . . for each child, she can get more than the benefit of sterilization. . . . Therefore health workers recommend increasing the grant for sterilization to 5,000 crowns.”⁶³

In 1988, a law was introduced that further compromised the full and informed consent of Romani women undergoing sterilization.⁶⁴ This law allowed a one-time financial grant for women who underwent an operation in “the interest of the health of the population.”⁶⁵ The law itself did not state that it was intended to control the fertility of Romani women or that sterilization be the method to reduce the population. However, in implementation, it was used to influence Romani women in Czechoslovakia to undergo sterilization. Women in the Slovak Republic generally received a grant of up to 25,000 Slovak Crowns (SKK),⁶⁶ which was paid in cash or with coupons for such things as furniture.⁶⁷ At the time this was equivalent to almost a year’s salary.

Several independent studies indicate the existence of coerced sterilization practices against Romani women in eastern Slovakia during the time that the government was providing monetary incentives to undergo the procedure. One study found a sudden rise in the number of women undergoing sterilization when the financial incentives were introduced.⁶⁸ This study notes that in Prešov, a district in eastern Slovakia, 60% of the sterilization operations performed from 1986 to 1987 were on Romani women who represented only 7% of the population in that district.⁶⁹ Another study found that in 1983, approximately 26% of the sterilized women in eastern Slovakia were Roma; by 1987, this figure had risen to 36.6%.⁷⁰ In addition, many of the more than one hundred sterilized women from eastern Slovakia that were interviewed for the latter study appear not to have been sterilized according to governmental regulations,⁷¹ which required a woman to request sterilization and to have the procedure approved by a special medical commission.⁷²

A 1992 Human Rights Watch (Helsinki Watch) report addressed the issue of coerced sterilization in Czechoslovakia, noting that many Romani women were not fully aware of the irreversible consequences of the operation and were lured into the operation because of their dire economic situations.⁷³ Many women said they agreed to sterilization under pressure from authorities.⁷⁴ The report also documents claims of sterilization after cesarean delivery or an abortion without consent or due to misinforming women for the purpose of obtaining consent.⁷⁵ Human Rights Watch interviewed doctors who revealed that sterilizations on Romani women were performed during cesarean deliveries and without their consent.⁷⁶ The report also documented cases of women who suspected that they had been involuntarily sterilized and noted that many remained unaware of what had been done to them.⁷⁷

Charter 77, a Czechoslovak human rights group, criticized this sterilization policy in a 1979 document, which found that “In some districts the sterilization of Romani women is [part] planned administrati[ve] practice . . . the professional success rate of health-care employees is [measured by] . . . the number of Romani women [that] they managed to persuade to consent to sterilization. Under these conditions the [sic] Voluntar[y] [consent] is precluded. In many instances, in order to obtain the consent, they used financial incentives. Thus, sterilization is becoming one of the means [sic] of majority population against minority population, leading to restrict child bearing in the minority ethnic group.”⁷⁸ Charter 77 called for a government investigation into these illegal practices but no investigation ensued.⁷⁹ A 1990 Charter 77 document reports that social workers sometimes withheld welfare payments or threatened to place women in institutions until women consented to be sterilized.⁸⁰

GOVERNMENT RESPONSE

In the early 1990s, human rights activists brought a number of criminal complaints to the state prosecutor of eastern Slovakia objecting to forced sterilizations under the policy and other human rights violations in the health-care system. In January 1991, the General Prosecutor of the Slovak Republic rejected an appeal of a decision to dismiss a criminal complaint by the regional state prosecutor in Košice as ill-founded. He reasoned thusly:

The adoption [of the Regulation on Sterilization] had a single goal: to secure in general bearing of physically and mentally healthy population. The task of the medical personnel but also social workers . . . is to enlighten the parents so to regulate the size of their family in the desired direction. This is especially important in instances where the family has failed to provide education and nourishment for their children or when the parents consistently breed physically or mentally deficient children. It has not been proved that with regards to Romani women or in any other cases, medical personnel or social workers went beyond providing social and medical enlightenment. . . . Quite contrary it was found that the majority of Romani women from Eastern Slovak region decided to undergo sterilization by themselves and voluntarily. Their motivation varied. . . . The investigation

however showed that in rare cases there appears a suspicion that some doctors connected fulfillment of certain services with consent to sterilization. . . .⁸¹

The post-communist governments of the Czech and Slovak Republics have never publicly condemned the coerced and discriminatory sterilization policies and practices that took place under communism. The authorities have never investigated unlawful sterilizations, and those doctors who performed illegal sterilizations continue to practice medicine. Slovak prosecutors have investigated and dismissed several groups of cases that were filed in the early 1990s, rejecting claims of genocide under the Slovak Criminal Code.⁸² In other cases, prosecutors claimed that other questionable sterilizations were not illegally performed. Prosecutors based their decisions on the assumption that monetary incentives did not compromise women's full and informed consent despite the fact that the women said they underwent the operation to receive the money.⁸³ Furthermore, prosecutors failed to account for the reasons behind the incentives to control the "unhealthy population."

A case filed in 2001 in the District Court of Spišská Nová Ves by the Center for Environmental Public Advocacy in Slovakia sought a damage claim of 400,000 SKK (about 9,500 Euros) against the Gelnica hospital on behalf of a Romani woman who claimed that a doctor sterilized her during her cesarean delivery in February 1986. The woman discovered that she had been sterilized and was unable to have more children only after a gynecological examination in April 1999. Since the client was a minor at the time she was sterilized, consent was required from her parents, yet neither the woman nor her parents consented to the sterilization. The claim was dismissed on June 13, 2002. The court based its decision on inconclusive medical evidence that infertility resulted from the sterilization procedure,⁸⁴ even though surgery performed to verify sterilization provided reliable support for the claim that her infertility was caused by the sterilization procedure.⁸⁵

Post-Communist Era

RECENT GOVERNMENT CALLS TO CONTROL ROMANI POPULATION GROWTH

Although the law that resulted in the coerced sterilization of Romani women has been

formally discontinued,⁸⁶ racist assumptions about Romani procreation and attempts to control Romani women's reproductive lives thrive under the same rhetoric that drove the coercive policies under communism. The size of the Romani population and its growth rate, compared with that of the general population, is a continuing subject of political and public debate in Slovakia. Over the past decade, politicians have publicly expressed their concern over the growing numbers of Roma, encouraging fears that in the coming decades the Romani population will outnumber and overtake the Slovak population.⁸⁷ Slovak media outlets fuel these concerns by reporting false demographic projections. One article recently suggested that Roma could become a majority population by the year 2060.⁸⁸

Slovakia's Ministry of Health, in an October 2000 position paper on sustainable development, suggested that declining Slovak birthrates combined with high Romani birthrates could have a negative impact on the quality of the population of Slovakia. The Ministry of Health stated, "If we do not succeed in integrating the Romani population and modify their reproduction[,] the percentage of non-qualified and handicapped persons in the population will increase."⁸⁹

Many political parties have proposed cutting benefits to Romani children in order to curb the Romani population. On June 6, 2000, Robert Fico, head of SMER party and candidate for prime minister in the election held in September 2002, proposed reducing social benefits to Romani families with more than three children.⁹⁰ He argued that the Romani issue is a "time bomb that will cause trouble if not kept under control."⁹¹ Fico reiterated this proposal in 2001, explaining "we have however a great mass of Romanies who don't want anything, just to lie in bed on social support and family benefit. These people have discovered that, because of family benefit, it is advantageous to have children. When a family has thirteen, fourteen children it is a source of income for them all. We can't close our eyes to that."⁹² In September 2002 a new government and parliament were elected. One of the first laws passed by the new parliament limited state supported social aid benefits to 10,500 SKK (606 Euros).⁹³ Though the law does not explicitly discriminate against Romani families, it disproportionately affects Roma who, because of entrenched discrimination, are often unable to improve their economic status and are therefore reliant on social benefits.

Local officials and government health-care personnel also support measures

aimed at controlling the Romani population. In March 2000, the deputy mayor of Rudňany, a town in eastern Slovakia with one of the poorest Romani settlements in the country and possibly in all of Europe, publicly called for applying a “Chinese fertility program” to curb the Romani population.⁹⁴ Throughout the course of the fact-finding conducted by the Center for Reproductive Rights and Poradňa, Romani women often complained of doctors and nurses yelling at them for having too many children for the sole purpose of gaining social welfare benefits. A doctor told one woman, “You dirty blacks, are you not ashamed to have that many children. . . .”⁹⁵ A doctor in Kežmarok, a town in eastern Slovakia visited during the course of our fact-finding, was quoted in a newspaper article as saying that Roma “are not very keen to bear children. But children make their living. So the issue of child benefits should be reconsidered. They should also have free sterilization and contraception. This would be the first phase of the solution.”⁹⁶

RECENT ALLEGATIONS OF COERCED STERILIZATION AND GOVERNMENT RESPONSE
Recent cases of coerced sterilization of Romani women in eastern Slovakia were raised in the 2001 report by the Open Society Institute entitled, *On the Margins–Slovakia*.⁹⁷ The chapter on health care presents reports of recent cases of coerced and forced sterilization. In addition, it notes that in 1999 nurses working in Finnish refugee reception centers told researchers from Amnesty International that they noticed unusually high rates of gynecological interventions such as sterilization and removal of ovaries among asylum seekers of Romani descent from eastern Slovakia. The nurses said that some women seemed to be unaware of what had happened to them.⁹⁸ Unfortunately, many of the asylum seekers were sent back to Slovakia before Amnesty could respond. Subsequent discussions with a Finnish refugee lawyer who handled some of the Slovak Romani cases helped corroborate this information. The lawyer noted cases of Romani women who have had two or three children and have not become pregnant after undergoing cesarean delivery.⁹⁹ In response to the findings in *On the Margins–Slovakia*, the Slovak government has not only failed to investigate, but has publicly condemned the findings as groundless.¹⁰⁰

In addition, in November 2001 the regional state prosecution in Prešov halted the investigation of two cases of coerced sterilization of two Romani women that was initiated *ex officio* by the general state prosecution based on the concerns raised by

Romani activists. The proceedings were stopped because the medical records of the women in question contained signed authorizations for the sterilization. Officials considered the signature alone to be evidence of consent,¹⁰¹ with no further investigation as to whether the consent was truly voluntary and informed.

The findings set forth in the present report clearly document that coerced sterilization practices against Roma continue in eastern Slovakia. Romani women are most often coerced or forced to undergo sterilization procedures during cesarean deliveries.¹⁰²

MEDICAL ASPECTS OF CESAREAN DELIVERY¹⁰³ AND FEMALE STERILIZATION

Health-care practitioners in Slovakia are relying upon various medical inaccuracies to justify their widespread practice of sterilizing Romani women. These fallacies are often difficult for patients, health-care workers or activists to analyze or challenge without calling into question the qualifications and expertise of a medical doctor, especially during surgery itself. Some Slovak doctors therefore operate with near complete impunity when acting on certain false premises that provide a basis for medically justifying the sterilization of Romani women.

The following list summarizes the discredited medical premises that Slovak doctors use when justifying sterilizations:

1. Once one C-section has been performed, many Slovak doctors assume that all subsequent deliveries must also be via cesarean delivery. This belief is no longer accepted practice in the international medical community, which advocates for vaginal births after cesareans.
2. Many Romani women are having cesareans through vertical incisions in the upper abdominal area instead of safer and more common horizontal incisions in the lower uterine segment. The choice to use a vertical incision instead of the safer horizontal incision can jeopardize the safety of subsequent pregnancies.
3. During the second or third cesarean deliveries, many Slovak doctors tell Romani women that a subsequent pregnancy will be dangerous, resulting in

the death of either the mother or fetus. Again, international medical practice no longer recognizes, particularly in the case of low segment, horizontal cesareans, that a woman can have such a limited number of C-sections or that repeat C-sections are fatal.

The following provides a brief summary of internationally and nationally accepted gynecological/obstetric medical practices that are then contrasted with current practice in some eastern Slovak hospitals. This background confirms a disturbing level of inaccuracy and deception in the explanations offered by some eastern Slovak health-care personnel when questioned about recent sterilizations of Romani women.

Cesarean Delivery

Unlike a normal vaginal delivery, a cesarean delivery involves the surgical delivery of a fetus through incisions in the woman's abdominal and uterine walls.¹⁰⁴ There can be many medical indications to undergo a cesarean delivery that are for the benefit of the fetus, mother or both. Some indications include failure to progress in labor, breech presentation, prior cesarean, and fetal distress.¹⁰⁵

TYPE OF INCISION

Today, the most common incision used during cesarean delivery is a horizontal cut across the lower uterine segment.¹⁰⁶ The muscles in the lower uterus do not contract as strongly in labor as do those of the upper uterus, and as such a low segment, horizontal incision is preferable because it is safer and not likely to lead to a rupture of the uterine scar during subsequent pregnancies.¹⁰⁷ Rupture of the uterus can be life-threatening to both the mother and the fetus. The low segment, horizontal incision is employed in more than 90% of all cesarean deliveries in the United States.¹⁰⁸

In contrast, the classical cesarean incision entails a vertical cut of the upper uterus, a procedure that is now discouraged.¹⁰⁹ Its primary advantage is rapid entry into the uterus, but complications associated with this procedure include a greater risk of uterine rupture in later pregnancies.¹¹⁰ The overall risk of scar separation is three times higher than that of low segment, horizontal incisions.¹¹¹ This classical,

vertical incision is particularly dangerous because in about one-third of cases, the classical cesarean scar ruptures *before* labor.¹¹² Therefore, planning a cesarean delivery for the next birth may not necessarily avoid a rupture, which could occur before the delivery. Patients with prior low segment, horizontal incisions rarely rupture before labor.¹¹³

Because of the increased likelihood of uterine rupture before delivery, the presence of a classical, vertical cesarean incision would provide greater medical justification for a recommendation to be sterilized during the cesarean delivery than would a low segment, horizontal incision. And because of the risk of rupture before delivery, some doctors may believe that preventing future pregnancies is the safest option. Thus, they may feel justified in recommending sterilization. Of course, avoiding pregnancy can be achieved through many contraceptive options, not just sterilization.

Findings

Interestingly, many Romani women we met during the fact-finding who had cesarean deliveries at certain eastern Slovak hospitals had a classical, vertical cesarean incision. This practice exists despite the fact that obstetricians in Bratislava and in university teaching hospitals in Slovakia claim that classical cesarean incisions have not been performed as a regular practice in Slovakia for decades. At university teaching hospitals, students are taught to use low segment, horizontal incisions.¹¹⁴ (See Section on Sterilization Findings.)

REPEAT CESAREANS

The belief that women who have been scarred by a cesarean cannot have a subsequent vaginal delivery due to risk of uterine rupture¹¹⁵ is now outdated in the international medical community. Instead, the trend is to encourage vaginal delivery after cesarean delivery because there is now ample proof that low segment, horizontal cesareans are safe.¹¹⁶ Repeat cesareans may be a common, automatic indication for a subsequent cesarean delivery in many countries, but such practice is considered medically risky.¹¹⁷ Doctors we spoke with in Europe and in the U.S. said that the

“once cesarean, always cesarean rule” is obsolete.¹¹⁸ The American College of Obstetrics and Gynecology studies show that a woman who has had previous cesarean deliveries with low segment, horizontal incisions should not be discouraged from planning a vaginal delivery in the absence of contraindications.¹¹⁹

Findings

Many eastern Slovak doctors appear to believe that a woman who has had one cesarean must undergo a repeat cesarean for her next birth because a vaginal delivery may cause uterine rupture along the scar of the previous cesarean.¹²⁰ In line with this outmoded thinking, many eastern Slovak doctors also claim that women can only have a maximum of two or three cesareans. Most Romani women were informed that they could not safely have more than two or three cesarean deliveries. (See Section on Sterilization Findings.)

FEMALE STERILIZATION

Surgical sterilization is a permanent method of birth control. Couples or individuals around the world choose sterilization because they want to end childbearing rather than space future births. Female sterilization (tubal sterilization) is performed by abdominal surgery and involves occluding the fallopian tubes. Tubal sterilization is the most commonly used method of birth control in the world.¹²¹

From a medical standpoint, tubal sterilization can be performed at any time and is often done during cesarean delivery, since the abdomen is already cut open and the sterilization procedure is quite easy.¹²² In fact, a woman may be sterilized during a cesarean without knowing it. Though tubal sterilization can be reversed, patients contemplating reversal are advised against undergoing the sterilization procedure. Sterilization reversal is costly, difficult and uncertain.¹²³ Long-term side effects after tubal ligation include irregular menses and increased menstrual pain.¹²⁴ Short-term problems include anesthetic complications, hemorrhage and infection.¹²⁵ Deaths from the procedure are rare, but do occur.¹²⁶

Male sterilization is performed through a vasectomy, which is simpler, costs less and has fewer risks than tubal sterilization.¹²⁷ It is also a permanent procedure that

is often considered a more advisable and desirable alternative than tubal ligation for a couple contemplating sterilization.¹²⁸

The decision to combine sterilization with other procedures, such as cesarean delivery, should be made in advance to ensure that the patient is fully informed of the distinction between the procedures and is not choosing for the sake of convenience alone. A basic requirement for all sterilization procedures is informed choice.¹²⁹ With sterilization, critical issues include the patient's ability to make a well-informed, voluntary decision, his or her authorization to proceed with the surgical procedure, and his or her participation in counseling about the risks and benefits of the procedure. In some countries, such as Sweden, doctors will not perform tubal ligation until six to eight weeks after delivery.¹³⁰ This waiting period provides time to ensure that the infant is healthy and to review all the implications of the decision.¹³¹

In Slovakia, no national reporting system exists to track the number of sterilizations; however, studies indicate that in 1991, the percentage of married women who had sterilizations was 4.0.¹³²

Consecutive cesarean deliveries are a medical indication for sterilization under the law in Slovakia.¹³³ The Slovak sterilization regulation allows a doctor to perform the procedure on the assumption that subsequent pregnancies will require a cesarean delivery and that this practice is dangerous to the life of the woman and fetus.¹³⁴

Findings

Our findings reveal that in eastern Slovakia, Romani women are sterilized during cesarean delivery under the pretext that multiple cesareans will very likely lead to a ruptured uterus and the possible death of the pregnant woman or the fetus. Thus, sterilization is justified as a means of preventing subsequent pregnancies. Romani women are only told then that they must be sterilized for their safety, without adequate explanation or information on alternative methods of birth control. Doctors in eastern Slovakia who perform sterilization after a cesarean delivery cite the law to rationalize their practice.

Testimonies

“I was in terrible pain, but I was not given any pills, any injection. Later on, doctors came and brought me to the operating room [for a C-section] and there they gave me anesthesia. When I was falling asleep, a nurse came and took my hand in hers and with it she signed something. I do not know what it was. I could not check because I cannot read, I only know how to sign my name. And, moreover, I was sleepy and tired. When I was released from the hospital, I was only told that I would not have any more children. . . . I was so healthy before, but now I have pain all the time. Lots of infections. . . .”

—Agáta, 28, from Svinia¹³⁵

Attitudes about Romani Women's Fertility and Sexuality

Romani women experience multiple forms of discrimination rooted in both racial and gender prejudices. Our interviews with Slovak doctors and nurses revealed that they have a number of discriminatory beliefs, along with the broader Slovak majority, about the fertility and sexuality of the Romani population, especially its women. Two of the most prevalent stereotypes about Romani women among health-care personnel are that they have too many children and that they are promiscuous. The majority of the doctors and nurses we spoke to commented on the high fertility rate of Roma. Fears of Roma "overpopulation" in Slovakia are fueled by the relatively low birth rates of the majority white population. Many of the Romani women we interviewed complained about the negative attitudes health-care providers harbor about Roma fertility rates. (For more, see section on Abuse and Discrimination in Maternity Wards).

Health-care providers, as well as society at large, attribute Roma fertility patterns to a range of factors. The predominant belief is that Roma exploit the system by having too many children in order to obtain additional government benefits. As one doctor from Prešov stated, they "have a lot of children" because "it is a matter of social benefits." Some health-care providers have especially hostile views of Roma birth rates. According to one hospital administrator, "Many Roma abuse this practice [intermarrying] to purposefully create imbecile children in order to get more money from the state." Other doctors have spun different stereotypes, such as one that claims that Romani women must constantly stay pregnant in order to retain their husbands.

Another doctor explained that Romani men are interested only in sex. He expanded on this view by stating that Romani men and women "have intercourse all the time, even while pregnant" and that Romani women now "have several partners, are promiscuous, travel a lot, and bring diseases with them from other countries." Several health-care practitioners expressed their view that Romani women, after delivery, leave the hospital early to go back to their partners to have sex. A common myth repeated throughout the course of our fact-finding and in many different hospitals was that a Romani couple had just been spotted copulating in front of a nearby elevator shortly after the woman gave birth because they could not wait to have sex. Health providers' stereotypical beliefs about the sexual appetite of Romani women and men feed their justification for sterilizing them.

Coerced, Forced and Suspected Sterilization

During the course of the fact-finding mission, we conducted in-depth, private interviews of 230 Romani women in settlements throughout eastern Slovakia. Interviews centered on sterilization practices since the end of the communist policy, segregation practices, and verbal and physical abuse in maternal health-care facilities. Included in the 230 interviews were interviews with more than 140 Romani women who were coercively or forcibly sterilized or who have strong indications that they were forcibly sterilized. For the purposes of this report, we generally refer to instances when women were coerced to agree to sterilization as ‘coerced sterilization’ and instances when women were unaware that they would be sterilized before they underwent the procedure, ‘forced sterilization’. Approximately 110 of these interviews were with women who were sterilized or have strong indications that they were sterilized since the fall of communism. The approximately 30 remaining interviews in this category were with women who were sterilized under the communist regime’s practice of providing monetary incentives for women to undergo sterilization.

A little more than half of the 110 Romani women mentioned above know they were sterilized after undergoing a C-section because they were either coerced into authorizing the procedure or a health-care worker told them they had been sterilized after the fact. The remaining half of the women we interviewed strongly suspect that they were sterilized after their C-sections as they have been unable to conceive since then, and most recall signing documentation immediately before giving birth by C-section. These women did not receive any explanation by doctors or nurses about the procedure they were supposedly authorizing (for more, see Methodology section).

During the course of the fact-finding, we met and/or interviewed only a handful of Romani women who agreed to sterilization on a truly voluntary and



informed basis since the end of the communist sterilization policy more than a decade ago. Many of the 30-plus women we interviewed who were sterilized under the communist regime indicated some degree of regret, stating that monetary incentives were the basis for their decision to undergo sterilization.¹³⁶ The testimonies on sterilization discussed in this section of the report focus on the approximately 110 Romani women who underwent or strongly suspect they underwent a sterilization procedure during the current post-communist period.

“The doctor told me that if I had a cesarean a third time, then I would die. The doctors and nurses kept repeating this to me. I said that I was young and that I wanted more children. The doctor kept reminding me that when they take me to surgery, they will ligate me. I was in great pain at that time . . . I agreed because I was scared. I had a baby boy at home, my husband works, my mother is ill. I had to make it home. I thought maybe I could have a third child, but then I thought I would die and I cried . . . and thought how could I abandon my boy and my new baby girl.”¹⁴²

–Stela, 22, from Letanovce

Stela was 19 years old when she gave birth to her second and last child. Both of her children were delivered in Levoča hospital via cesarean section even though no complications arose before, during or after her pregnancies. During her second delivery, the doctor told Stela that her next birth would also have to be a cesarean because she had a “narrow pelvis.” He said that another birth would endanger her health and gave her no option but to sign papers authorizing a sterilization procedure. She received the papers while in extreme pain and just before the C-section was performed.

“[T]hey brought me three papers and told me that I have to sign or otherwise in the next birth the child will suffocate,” she said. She did not want to be sterilized, but she did not want to die. “I was 19 when it happened and I wanted to live.”

Stela is now 22 years old and is sad about her infertile status. “I want more children. I get nervous sometimes thinking about this . . . I feel pain because I do not

have more children.”¹⁴³ Stela’s story is typical of the experiences of the many Romani women who access maternal health care in Slovakia’s public health-care system. Fear, intimidation, harassment, misinformation, and ill treatment define the standards of care these women have come to expect. Stereotypes of Romani women as “hyper-fertile” play into fears that they threaten the majority status of the Slovak population. The result is a widespread practice of coerced sterilization of Romani women and of other reproductive rights violations.

Our findings indicate that Romani women in eastern Slovakia are regularly coerced by doctors and nurses to consent to sterilization. Of the close to 60 women we interviewed who are certain they were sterilized, more than 60% were coerced into being sterilized immediately before or during cesarean births—a style of delivery that appears to be disproportionately “recommended” for Romani women (see Background Section). Furthermore, the lack of full and informed consent for the sterilizations themselves is striking. Many times there was no consent at all. The remaining 40% or so of women we interviewed who are certain that they have been sterilized were first told this by doctors only after the procedure was completed. Just over 50 of the women we interviewed are left only to suspect that they were sterilized. Among those we interviewed were a handful of minors (see Methodology section for more details).

We have organized the results of our fact-finding with respect to the issue of sterilization according to four key reproductive rights violations of Romani women in Slovakia:

- coerced sterilization;
- forced sterilization;
- suspected sterilization;
- failure to provide full and accurate reproductive health information.

As we discuss further in our section on Legal Standards, there is no justification in either international or Slovak law for the widespread, coerced sterilization of Romani women. These practices violate well-established international and European human rights law, including standards set forth in the treaties of the Council of Europe and the European Union. Some of these treaties have been

“A severe violation of women’s reproductive rights, forced sterilization is a method of medical control of a woman’s fertility without the consent of a woman. Essentially involving the battery of a woman—violating her physical integrity and security—forced sterilization constitutes violence against women.”

—Report of the UN Special Rapporteur on Violence against Women, Its Causes and Consequences to the Commission on Human Rights, 55th Sess., ¶ 51 (1999)

directly incorporated into Slovak law and assume priority over domestic law. Coerced and forced sterilization practices also transgress provisions of Slovakia’s Constitution and laws. The failure of Slovak medical personnel to obtain the informed consent of Romani women undergoing sterilization and to provide them with accurate and appropriate health information has resulted in grave violations of fundamental human rights.

COERCED STERILIZATION

False and exaggerated descriptions of health risks. One of the most common tactics that Slovak doctors use to coerce Romani women into consent-

ing to sterilization is to warn falsely of an impending “risk” to their next pregnancy. These warnings usually come when women are on the operating table and in great pain during or just prior to a delivery by C-section. Other women are only told that in order to live, they must agree to be sterilized.

A 20-year-old woman from Rudňany with two children, both delivered by C-section, explains. “I was already on the [delivery] table, but was not sleeping [under anesthesia]. . . . The doctor told me that if I will have a third child, either me or my child will die.”¹⁴⁴ She signed consent papers to undergo sterilization on the operating table. Her doctor not only failed to explain the risks associated with this procedure, including the fact that it was hard to reverse, he simplistically claimed that another pregnancy would lead to maternal or fetal demise, thereby insinuating that sterilization is nothing short of essential.

In another instance, a woman from Letanovce recalled that the doctor forthrightly told her that “after the second C-section, there is an obligation to be sterilized.”¹⁴⁵ She then signed some papers that were handed to her, without an explanation or opportunity to find out what she was signing.

The Slovak sterilization regulation, which dates back to 1972, lists consecutive cesarean deliveries as a medical indication that would allow a doctor to perform a sterilization procedure¹⁴⁶ (see discussion on Sterilization Regulations in this section). Doctors in eastern Slovakia have told us that they recommend sterilizations after a second or third cesarean. They state that they believe subsequent deliveries must be by cesarean and that more C-sections will likely lead to a ruptured uterus, causing grave harm or even death to the woman or her fetus.¹⁴⁷ One doctor admitted that if a woman does not give her consent to sterilization after the third cesarean, “if it is a medical indication, when woman is open to risk in future pregnancy, then [I] would perform sterilization without their consent.”¹⁴⁸ However, current medical knowledge and practice, both internationally and in Slovakia, establishes that not only are several consecutive cesarean deliveries medically safe, but that vaginal births are actually preferred after cesarean deliveries. In fact, beliefs that one cesarean will automatically result in subsequent cesarean births (versus vaginal births) or that women can only have a limited number of caesarian deliveries have become outdated in the international medical community. It should be noted however, that C-sections performed with a vertical cut are more dangerous as the likelihood of uterine rupture increases. Worldwide, vertical C-section cuts are very rarely performed because of this risk; however, our research indicates an unusually high number of vertical cuts among the Romani women we interviewed. During one week of fact-finding, approximately half of the almost 40 Romani women we interviewed who had had C-sections had vertical cuts.¹⁴⁹ For further discussion of medical issues, see relevant discussion in Background section.

Because race disaggregated statistics are not published in Slovakia, it is not clear if doctors are performing cesarean deliveries or subsequent sterilizations more on Romani women than non-Romani women.¹⁵⁰ It is well established medically that vaginal deliveries are preferred over C-sections, which should be reserved only for cases involving a health threat to the woman or baby. However, throughout our fact-finding, it was apparent that there were an unusually high

number of cesarean deliveries in many Romani settlements. This phenomenon was noted by the Roma themselves.

An old woman from Švedlár, a settlement serviced by Gelnica hospital, remarked, “Before, the C-sections used to be rare. When a woman had it, the entire village was talking about it and we were all wondering what happened. Now, every other woman has it.”¹⁵¹

Among Romani women in settlements throughout eastern Slovakia, medical providers perpetuate the false belief that once a woman delivers by C-section, all subsequent deliveries must be C-sections and any delivery after the second or third cesarean is extremely dangerous and a threat to the life of the mother or fetus.

Olga, age 22, was coercively sterilized two years ago during the birth of her second child, which was also her second C-section. She does not know why she needed to have a cesarean. While she was waiting on the operating table at New Maternity Prešov before giving birth, a nurse approached her with a piece of paper. “She told me, ‘If you get pregnant again, you will die. You might even die today. So you have to sign this.’ I was scared and I signed.”¹⁵² Olga did not understand what she was signing nor does she to this day understand what it means to be sterilized. She only knows that she wants to have more children but she cannot. Neither her doctor nor her nurse gave her any explanation of her health status, what they

were planning to do to her or what alternatives were available to her. She only knew that she would die if she did not sign the piece of paper thrust at her. “They told me I should have signed or else I would have died so what should I have done? . . . White women have more rights than Romani women. They would not do this to white women.”¹⁵³

“In the fields of medicine and biology, the following must be respected in particular: the free and informed consent of the person concerned, according to the procedures laid down by law. . . .”

–Charter of the Fundamental Rights of the European Union, Art 3(2)

Obtaining consent in situations of duress. Women are often first informed of the need to have a cesarean or be sterilized after they have entered the hospital to give birth, not previously during the term of their pregnancies. Doctors make decisions without discussing the options with the women in an open, calm, unhurried atmosphere where they would be able to reflect on their status, ask questions and make decisions. Instead, women are bluntly told that a cesarean or sterilization needs to be performed immediately. They are often in severe pain and already on the operating table. Some have already been given anesthesia and are not therefore fully capable of consenting to such a major medical procedure. These women are rarely provided an explanation of what is happening and why. Their opportunity to make an informed choice about sterilization is non-existent.

“[The European Parliament] recommends the governments of the Member States and the Accession Countries to ensure that women and men can give their fully informed consent on contraceptive use, as well as fertility awareness methods.”

–European Parliament, Report on Sexual and Reproductive Health and Rights, 2002 ¶ 3

“Information must be communicated to the patient in a way appropriate to the latter’s capacity for understanding, minimizing the use of unfamiliar technical terminology. If the patient does not speak the common language, some form of interpreting should be available.”

–WHO, Declaration on Patients’ Rights in Europe, ¶ 2.4

Šarlota lives in Zborov and has a nine-year-old daughter. She gave birth twice, both times by C-section in Bardejov hospital, but the second baby died in 1995 when he was three weeks old. She was devastated. Šarlota approached her doctor about having more children. “I went to my gynecologist after my boy died and asked if I can have any more children. . . . At the hospital, before the C-section, the doctor asked me if I wanted to have more children and I told him not right away. I then signed something, but I did not know that it would be forever. . . . I only remember that the doctor

brought me a blank piece of paper. It had only my signature on it after I signed. Even when I signed it, [my signature] was not any good [legible] because I was in so much pain. . . . I remember there was one gynecologist telling the other not to give the paper to sign because I was in so much pain. The other doctor said that they must give it to me.”¹⁵⁴ She signed the paper not more than 20 minutes before the cesarean and immediately before entering the operating room. She learned much later that she had been sterilized. “The local gynecologist told me that it would be forever. I was surprised. I wanted to ask the doctor if I could do something to have more children, but I am ashamed to ask because usually gynecologists tell off Romani women for having more children and say that we have children to get [state] benefits. So I was ashamed to ask.”¹⁵⁵ Šarlota is now 28 years old. “My daughter wants a brother or sister and I want one more child at least.”¹⁵⁶

Inadequate Informed Consent. In some cases, women cannot read or do not know what they have been asked to sign. They do not understand or speak Slovak fluently and translators are not provided. They are not given an explanation of the document they have been asked to sign or are signing it under conditions of duress without a chance to read it. Moreover, when physicians do speak to their patients, they often do not provide adequate explanations in terms that are understandable to the lay person; some Romani women do not understand the Latin or medical terms that are used and are not given simple and comprehensible explanations. As one woman from Žehra settlement explained, “This is how it works in Krompachy [hospital]: doctors do not explain, just take the woman to the operation room, do a C-section and then sterilize her. They do not write in Slovak for us to read, but in another language, which we do not know. We sign without understanding anything.”¹⁵⁷

In the case of Edita from Rudňany, who delivered by C-section in 1995, medical personnel gave her a piece of paper to sign in the Spišská Nová Ves hospital, but refused to let her read it even though she was literate. They simply told her “just sign here.” She has not been able to become pregnant since then.¹⁵⁸ Šarlota, as discussed above, was merely handed a blank piece of paper to sign.

Involuntary IUDs

Nataša of Bystrany has two children. During her second delivery in 1995, when she was 21 years old, the doctor went against her wishes and inserted an intrauterine device (IUD)—a form of long-term birth control. When she requested that it be removed, her request was denied and she was told, “It is the law.”¹⁵⁹

“The practice for Roma is, first, IUD, then they are released,” Nataša said. Medical staff told Nataša that the IUD had to remain in place for five years. Yet when she asked her doctor to remove it five years later, she was told that it was too early. The device was not removed until January 2002 when she was in the hospital for another surgery involving a benign tumor.¹⁶⁰

The practice of implanting IUDs into Romani women without their knowledge or consent is a reproductive rights violation as it undermines the individual’s fundamental human right to decide whether and when to bear children (see section on Legal Standards). While we found the practice of coerced and forced IUD insertion was not nearly so widespread as that of coerced and forced sterilization, it was common in a few settlements associated with one particular hospital. Our fact-finding team identified approximately ten women from certain settlements, such as Žehra, Bystrany and Richnava in the eastern countryside, that complained of the non-consensual insertion of IUDs and the refusal of doctors to take them out. Women from these settlements identified Kropachy hospital as a perpetrator of these violations.¹⁶¹ While some of these coerced insertions took place during communism, the current refusal of doctors to remove the IUDs constitutes a continuing reproductive rights abuse.

Our research also found a number of other rights violations that often accompanied the forced insertion of IUDs. For instance, doctors sometimes do not permit the release of women from the hospital unless they submit to an IUD.¹⁶² They often do not allow these women to discuss whether to use an IUD with their partners.¹⁶³ To remove IUDs, doctors often impermissibly demand additional money beyond what the women can afford, thus effectively denying them the right to cease using the method.¹⁶⁴ Doctors tell women that IUDs cannot be removed for a certain length of time, ranging from five to fifteen years. If the doctors do agree to remove the IUDs, they are simply re-inserted when the woman returns to the hospital.¹⁶⁵ Doctors ignore the potentially adverse side effects such as severe abdominal pain, bleeding and headaches, and compel the women to continue using the

devices and bear the pain.¹⁶⁶

Petra from Bystrany settlement is 44 years old and reports that an IUD was forcibly inserted fourteen years ago, in 1988, after the birth of her fourth child in Levoča hospital. She has had reproductive health problems since then and has asked her doctors to remove the device. She has been told that the removal will cost 500 SKK (12 Euros), which she cannot afford.¹⁶⁷

FORCED STERILIZATION

“I have five children, ages 12, 9, 8, and twins born in April. I went to give birth in Krompachy on April 4 of this year. I knew it would be a C-section since the sixth month of pregnancy because I was pregnant with twins. They took me to the operation theater the next day. . . . Before I was released, they gave me something to sign, but I did not know what it was and they did not explain it to me. Later I was given a medical release report where it was written that I was sterilized.”¹⁶⁸

–Sandra, 32, from Richnava

Beyond cases of coerced sterilization, our fact-finding revealed multiple instances of forced sterilization without even the façade of consent. Of the close to 60 women we interviewed who are certain they were sterilized, approximately 40% of them were first told this only *after* the procedure was completed. In some instances they were asked to sign authorization papers after the fact. About 50 of the remaining women interviewed are left to suspect that they have been sterilized after undergoing a C-section because they have not been able to conceive and were given no information by their doctors on their reproductive status.

Belated Notification of Sterilization. In March 2002, a 28-year-old Romani woman from Markušovce was sterilized during the birth of her fifth child. Her first and last deliveries were by C-section though she was never told she would need a cesarean prior to entering the hospital. During the delivery, she was sterilized and later told by the doctor that it was performed because her life was in danger. The next day, she was asked to retroactively sign a consent form for the procedure. “The

doctor told me to sign because I was sterilized. I did not read it over because I was weak and sick. Doctor said it was dangerous for me and the next baby, and that is why he sterilized me. . . . Only the girls in my room told me that I signed a sterilization consent. These girls knew because they had also signed. . . . There were three other Romani women together in that one room, all three had C-sections, all three signed.”¹⁶⁹

Izabela from Drahňov was sterilized at age 18 while giving birth to her second child, who was delivered through a C-section like her first. The day after the birth, the doctor told Izabela that she was sterilized because she was “too narrow.” She became very upset because her doctor had never before brought up the issue of sterilization. “I asked the doctor why he did not tell me anything before he sterilized me. But he only told me that my next baby would be by C-section and then there would be serious complications.”¹⁷⁰ He did not discuss alternatives such as contraception with her. She did not sign any documents either before or after her procedure. She very much wants to have more children because she is only 21 years old. She asked hospital officials about the option of having more children, but was told by the chief doctor that it would cost 5,000 SKK (120 Euros) to reverse a sterilization—a high price almost equivalent to the 6,000 SKK (145 Euros)¹⁷¹ that she and her husband receive in monthly social benefits.¹⁷²

During the course of our fact-finding we interviewed several women who were told that they were sterilized and would not be able to have children just before they were released from the hospital.

Laura is 26 years old and has been pregnant three times, although her first baby was stillborn. Her last child was born in 1998 at Spišská Nová Ves hospital. She had a C-section and was sterilized, but was not given any detailed

“Compulsory sterilization . . . adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children.”

—Committee on the Elimination of Discrimination against Women, General Recommendation 19: Violence against Women, 1992, ¶ 22.

“An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.”

–Council of Europe Convention on Human Rights and Biomedicine, Article 5, Chapter II (1997)

information about why she had undergone sterilization. “Nobody explained me why. I know that women have C-sections when the pelvis is too narrow or the child is too big. But when I came to the hospital, they sent me to the surgery immediately. Nobody said why. And then, after the delivery when I was to be released from the hospital, I went to an examination and the doctor told me that I would not have any more children. He did not say why. . . . I go for check-ups with my local doctor from Spišská, and he also said the same. I know I did not sign anything. . . . I did not complain because I know this is very usual, normal thing.”¹⁷³

Sterilization of Minors. Sabína of Bystrany was sterilized in 2001 when she was a minor. She had two C-sections, the last one when she was 17 1/2 years of age. After she was admitted to the hospital, she was told for the first time that she had to deliver through a cesarean because she was “too narrow,” a matter that had never been discussed during her monthly pre-natal visits. “The doctor said, ‘You have to sign this paper to have your ovaries tied. If you do not sign it, it will be at your own risk,’”¹⁷⁴ she recounts. “I was scared of having another C-section because of this risk.”¹⁷⁵ She signed papers authorizing the sterilization one day before her delivery. Her parents were not asked to provide their consent to this procedure. Sabína is currently 19 years old and wants to have more children.¹⁷⁶

The fact-finding conducted by the Center for Reproductive Rights and Poradňa uncovered a handful of cases of Romani youth who had been sterilized without their consent or the consent of their parents. These adolescents were unmarried and below the age of 18. Under Slovak law, in the case of unmarried, underage minors,

the permission of legal guardians is necessary to perform medical interventions such as sterilization.¹⁷⁷

Michaela from Richnava had her first child when she was 14 and her second child in 1996 when she was 16. She suspects that she was sterilized during her second delivery, which was a cesarean. "It was 11p.m. when I went to the Krompachy hospital and the doctor was there and screamed at me, 'You fucking gypsy whore. How dare you deliver at 12 a.m.!' He then immediately took me upstairs, swearing continuously, and did a C-section on me without any other explanation. . . . The second time I went to the hospital, it was another doctor. She asked me, 'Why did the doctor do a C-section on you?' and I said 'I don't know.' Then she put me to sleep and did the second C-section. Maybe I signed something but I do not remember when or what it is. When I left, they said that I will have more children, but for six years I wait and nothing."¹⁷⁸ Michaela wanted more children and decided to pursue treatment. "Three years ago, I went to get fertility treatments, to reverse my sterilization, but the patients there were saying that horrible things are done to us. So I got scared and ran away. I was also scared because I saw the doctor in the halls over there. When he saw me, he said, 'You stinky gypsy. God should punish you as you deserve!"¹⁷⁹

SUSPECTED CASES OF FORCED STERILIZATION

Our team documented more than 50 cases of Romani women who were provided with neither verbal nor written confirmation of sterilization but strongly suspected that they had been involuntarily sterilized. All of these women have had at least one C-section. Some remember signing documents during labor, but are uncertain as to what those documents were and were never given an explanation by health-care personnel.

While there are many causes of infertility, most Romani women are unable to afford or access the medical technology that would identify the causes of their reproductive health problems, causing a great deal of stress to themselves and their families. In addition, many Romani women cannot access their personal medical records, which may contain information on the cause of their infertility (see section

on Denial of Access to Medical Records).

Žofia's story is typical of Romani women who suspect sterilization. She is 33 years old and has four children. Her last birth, in 1996, was a cesarean and she has not been able to become pregnant since. She did not sign any documents in the hospital and her doctor did not mention sterilization to her. She wants to have more children but she now thinks that that they may never be an option.¹⁸⁰

Sterilization Regulations in Slovakia

Regulations

The regulation governing the conditions under which sterilization can be performed in Slovakia dates back to 1972 (hereinafter the Regulation on Sterilization)¹⁸¹ and was issued by the Czech and Slovak Socialist Republics to implement the 1966 Law on Health, which stated that "Sterilization can be performed *only with the consent or based on specific request* of the person who shall undergo sterilization under the conditions established by the Ministry of Health."¹⁸² Despite the fact that the 1966 Law on Health has been replaced by a new health law,¹⁸³ the Ministry of Health and many doctors still consider the Regulation on Sterilization to be valid and in effect. It outlines specific requirements and medical indications that a person seeking sterilization and the hospital performing the sterilization must fulfill in order to be granted permission for sterilization.

According to the Regulation on Sterilization, a woman may request sterilization before or at the age of 35 only if she has four or more living children and after the age of 35 if she has three or more living children.¹⁸⁴ The regulation further requires that where there are medical indications for sterilization, the decision of the woman is subject to an evaluation of a hospital's sterilization commission. These commissions include the director of the regional or district hospital, the director of the hospital where the sterilization is to be performed, the chief gynecologist of the hospital, and a physician who is an expert in sterilization.¹⁸⁵ The request is to be submitted to the commission in written form either by the patient or her doctor with her consent.¹⁸⁶ A special examination of the patient requesting sterilization is then performed. According to the regulation, this examination must be completed within three weeks of the receipt of the request so that the commission can schedule a meeting in a timely manner.¹⁸⁷ The

commission is authorized to approve the sterilization request only if it is medically indicated¹⁸⁸ and is required to issue documentation containing a transcript of the commission discussion and the decision.¹⁸⁹ This commission, in theory, is to safeguard against sterilizations being performed based on unsound and arbitrary medical decisions. The regulation also requires the individual who requests the sterilization to sign a release form stating that she¹⁹⁰ or, in the case of a minor, her legal representative,¹⁹¹ consents to undergo sterilization and has examined the written information regarding the extent to which sterilization is reversible.¹⁹²

Violations

In addition to demonstrating that health-care practitioners do not comply with the requirement of informed consent to sterilization, our fact-finding has also revealed that doctors are not familiar with the age requirements of sterilization regulations¹⁹³ and do not always comply with requirements regarding the convening of the commission to authorize the sterilization.¹⁹⁴

During our fact-finding, we interviewed many health-care providers who incorrectly cited the requirements of the Regulation on Sterilization. For example, we were told that a sterilization could only be requested by a woman “[who] must be over 40 years old,”¹⁹⁵ or “after 35 years and with two children.”¹⁹⁶ However, the vagueness of the regulation has contributed to its discretionary application. In particular, the sterilization regulation states that a woman with “iterative” cesarean deliveries may have an approved medical indication that warrants a sterilization,¹⁹⁷ but does not specify the number of cesareans that fulfill this criteria. One of the doctors we interviewed claimed that the “law says that a woman can ask for sterilization after two C-sections.”¹⁹⁸ Doctors apply their own interpretation to this vague standard in the law, substitute their own judgment for that of the woman “requesting,” and justify their sterilization practices with inaccurate medical beliefs, such as that more than two cesarean deliveries is dangerous (see discussion of medical issues in Background section).

During the course of our research we uncovered a couple of cases in which the commission’s authorization was fraudulently added after the sterilization was performed during a cesarean delivery.

Alisa was brought to Gelnica hospital on April 25, 2001.¹⁹⁹ Our review of her medical records indicated that she had a cesarean delivery because “there was a

danger of uterus rupture” and the “head of the child was disproportionate to the pelvis of the mother.” She was sterilized during the C-section. Her records stated, “During the surgery, there was lege artis sterilization performed based on patient’s request.”²⁰⁰ Attached was a consent document that contained the following: “Based on the [patient’s] request there will be performed a sterilization on her and she is informed about the irreversibility of this status and thus about the impossibility of future conception.”²⁰¹ The authorization contained the signatures of Alisa and one doctor. In addition, an approval from the sterilization commission was attached that stated that Alisa requested sterilization and, according to her health status, the commission agreed with the sterilization; it further indicated that she fulfilled the criteria for sterilization. Alisa, however, reports that she was coerced into signing the consent form after she was given an injection in the operating room.²⁰² The date of the commission’s decision was May 15, 2001, and there were three signatures from the sterilization commission. Alisa’s sterilization was performed on April 25 and she was released from the hospital on May 11.²⁰³

In a similar case, the patient’s medical records falsely indicated that she had requested sterilization, when in fact she had no knowledge of having been sterilized. Klára is 24 years old and has two children, both of whom were delivered by C-section without any obvious indications for the procedure. Her second child was born in 1996 in the New Maternity Prešov. She has failed to become pregnant since her last birth and does not understand why. She had no problems after her last delivery and does not use contraceptives. Though no doctor spoke with her about sterilization, she suspected her attending doctor performed the procedure on her without her consent.²⁰⁴ Our team’s review of her medical records confirmed her fears. The records contain a notation indicating that the “patient requested sterilization.”²⁰⁵

FAILURE TO PROVIDE FULL AND ACCURATE INFORMATION

“[They do] not explain anything . . . they just tie up our ovaries and then they say that they saved our lives.”²⁰⁶

- Romani woman, 24, from Stráne pod Tatrami

In the course of the fact-finding, both Romani and non-Romani women complained of the failure of women’s health-care personnel to provide complete and accurate medical information in a respectful and professional manner. Instead, as many of the testimonies highlighted in this section show, practitioners tend to give simplistic, incomplete, and misleading explanations to the patient. They complain of the hostility they experience in health-care settings and complain about the attitudes of doctors and nurses toward their patients. One non-Romani woman described her experience like this:

“I gave birth twice, ten years ago and three years ago. In neither case was I given any information. They give you stupid information, but no explanation about what is going on. . . . You are a non-entity, you have no rights, and everything is decided by doctors. If you complain or ask questions, you break the rules and you are afraid they would retaliate against your child. And you do not feel comfortable to ask. It is like you entered in a machine and you have to act like a part of it. I had to fight for everything, for the simplest thing.”²⁰⁷

Lack of Information about Contraceptive Options. Failure to provide full and accurate information on the range of contraceptive methods is a particularly egregious violation of reproductive rights in the case of sterilizations, which involve permanent, often irreversible changes to a woman’s reproductive system. Though sterilization can be avoided by pursuing less drastic contraceptive options, almost none of the Romani women interviewed during our fact-finding mission had been given information on other options. Birth control pills or IUDs, two of the most common forms of contraception in Slovakia, were not discussed with them. Some of the women we spoke to had never heard of the full range of contraceptive choices available. Judita

“The process of informed choice must precede informed consent to surgical sterilisation. Recognised available alternatives, especially reversible forms of family planning which may be equally effective, must be given due consideration. The physician performing sterilisation has the responsibility of ensuring that the person has been properly counselled concerning the risks and benefits of the procedure and of its alternatives.”

—International Federation of Gynecology and Obstetrics (FIGO), *Ethical Considerations in Sterilization*, ¶ 6

delivered three children via C-section, but had never discussed contraceptives with her physician. She was never informed of the option to choose contraception and though she had heard about IUDs from other Romani women, she did not know what contraceptive pills were and did not know anyone who used these pills.²⁰⁸

Lack of Information about the Side Effects of Sterilization. In the case of cesareans and sterilizations, Slovak health-care practitioners consistently fail to provide a thorough and transparent assessment of the implications of treatment or birth control options, and the reasons for the physician’s recommendations. Many Romani women

who were or suspect they were sterilized identified a number of common health problems that resulted from the procedure. These problems include irregular menstrual cycles, headaches, bleeding, and infections—all common side effects of sterilization procedures.²⁰⁹ But Romani women, who are rarely informed of these side effects or, in some cases, of the fact that they even have been sterilized, are left wondering about what could be wrong with their bodies.²¹⁰ Moreover, some of the women who do learn that their bodies have been irreversibly altered have become clinically depressed.²¹¹

Denial of Responsibility by Health-Care Professionals. Slovak doctors and nurses told us that they did not believe it was their duty to inform female patients about reproductive options such as contraceptives. Staff at the majority of the hospitals we visited thought it was the obligation of local gynecologists to discuss contraceptives with patients, even though these local doctors were not the ones who authorized or performed the sterilizations.²¹² Some doctors took a disinterested approach to the issue: “[I]f the patient is interested in contraception, then

the doctor can provide this information.”²¹³

“In general, information on contraception is sufficient,”²¹⁴ said another doctor at Gelnica hospital. “Women know about it from magazines and press. In schools there are lectures. There are different groups who come to teach so the youth are well informed. . . . The problem is not about being informed but whether they want to use it.”²¹⁵

The alarming lack of importance that Slovak health-care practitioners attach to the need for providing their patients with full and accurate medical information is especially troubling when combined with discriminatory attitudes toward the Roma. The result is a complete disregard for ensuring the informed consent of Romani women about such life-altering matters as their childbearing capacity and sterilization.

“[I]t doesn’t matter what you recommend to them, they don’t use it,”²¹⁶ said one doctor in response to a question we posed about the use of contraceptives by Romani women. He went on to say that Romani women do not use contraception because their men would not live with them if they did not get pregnant. “Among Roma, only prostitutes take the pill.”²¹⁷ Another doctor complained that it was too difficult to counsel Romani women on their health needs, including giving them family planning information. He said they do not want to be counseled and that “80% are irresponsible; they neglect their health and health

“The Committee of Ministers . . . recommends governments of member states:

III. to envisage the following measures when drawing up a family planning programme:

B.(v) organise appropriate services within the public health system, preferably integrated in the maternal and child health setting, in the maternity hospitals and, where existing, in primary health services;

C.(i) make health and social professionals on all levels understand that family planning is a part of general health care and therefore part of their responsibilities . . .”

—Committee of Ministers, Council of Europe, Resolution (78)10 on Family Planning Programmes, 1978

problems.”²¹⁸ One doctor [Gelnica hospital] surmised that: “. . . among Roma, there is no will [to use contraception]. They do not have motivation. A woman who does not have children is less valuable. In the Romani community, she simply has to deliver every year. . . . Planned parenting is UFO for them or E.T. It is a totally alien concept for them. It is taboo to talk about contraception.”²¹⁹



Abuse and Discrimination in Maternity Wards

During the course of our fact-finding we identified widespread, systematic and egregious discrimination against Romani women in hospital maternity wards and in some gynecological clinics in eastern Slovakia. Segregation, discriminatory standards of care, and physical and verbal abuse were alarmingly common complaints by Romani women. These complaints were heard in almost every settlement we visited. Discriminatory and abusive practices toward the Roma seem to have flourished in post-communist Europe, despite denials from Slovak authorities. As this chapter details, despite evidence of widespread discrimination and abusive treatment of the Roma, Slovak government and hospital officials have failed both to classify such treatment as a form of discrimination and to impose sanctions on government health-care personnel to punish or deter such conduct in the future. They either dismiss this treatment as inconsequential or necessary given medical and social factors.

We have organized our findings in this chapter according to these three prevailing patterns of abuse and discrimination:

- segregation in maternity wards;
- discriminatory standards of care; and
- physical and verbal abuse of Roma in maternity wards.

SEGREGATION

*“In Krompachy hospital, there are separate rooms for Roma—there are three Gypsy rooms, one shower and one toilet for us while white women have their own toilets. White women can go to the dining room but Roma cannot eat there. In Gypsy room, there is not even a dust bin. It is like in a concentration camp there.”*²²¹

—Alexandra from Richnava

*“When Roma go to deliver babies, they do not put us in room with Gadje [white women], because they think we are dirty. They treat us like animals. When we go there we don’t go dirty. We know what cleanliness is.”*²²²

—Romani woman from Drahňov

Testimonies of Romani women receiving treatment in the maternity wards of hospitals in Prešov, Košice, Spišská Nová Ves, Šaca, Kežmarok, Levoča, Gelnica, Bardejov, Vranov nad Topľou, and Kráľovský Chlmec, among others, reveal widespread practices of segregation by race.²²³ In most instances, Romani women are required to use separate bathrooms and are not allowed access to other hospital facilities, such as dining rooms or snack bars.

“They separate Roma in there. Rooms number 1 and 2 are for Roma and rooms number 3 and up are for white people,” reports a Romani woman, age 27, from Medzev, Košice district, who gave

“...[T]he majority of persons belonging to the Roma community continue to be exposed to social inequalities, and continue to experience widespread discrimination in education, employment, the criminal justice system, and access to public services. . . Access to health care remains of particular concern. . . [E]fforts must be continued and reinforced as a matter of priority, to effectively combat discrimination and improve the living conditions of the Roma Community.”

—European Commission, 2002
Regular Report on Slovakia’s
Progress Towards Accession²²⁰

*birth recently in Šaca hospital. “There is also a separate dining room and toilet for Roma. Before 2001 the rooms were not segregated.”*²²⁴

A visit to the gynecological units of Šaca hospital by the fact-finding team confirmed the existence of separate toilets for Romani and non-Romani women. During our visit, a nurse told one of our team members not to use “the Gypsy toilet.”²²⁵

*Zora, a 21-year-old mother of three from Svinia, Prešov district, complains about the treatment she received in the Old Maternity Prešov: “When I was delivering my babies, I was always in Gypsy room, separated from white women. I did not ask to be sent there. They [nurses] sent me there straight away.”*²²⁶

*Mariana, a 19-year-old Romani woman from Prešov, had a similar experience in New Maternity Prešov, where she said doctors justified segregation practices by invoking the supposed wishes of white patients: “[Doctors say,] ‘now is not like it was during communism [when hospital rooms were not segregated]. Now they [white women] do not want Roma and non-Roma to mix.’ When we are admitted the nurse does not ask anything, just takes us to the Gypsy room. I asked the nurse not to put me in Roma room and she said ‘you should be happy that we receive you here.’ I went to the chief doctor and I told him that I do not want to stay in that room anymore, that I want to be placed in another room. He said, ‘I’m sorry, but we have so many women here and no other place available for Roma. I cannot put you with white women because they will not accept you.’”*²²⁷

Often hospital dining facilities are also segregated. In Levoča hospital, for example, Romani women are not allowed to eat in the dining room together with the other patients, but are obliged to eat in their rooms.²²⁸

“White women eat in the dining room together, but we are not allowed there, we have to eat in our rooms. The TV set is in the dining room, and only

Gadje [white women] are allowed there. If we try to sneak in, the nurses yell at us to get out,” complain Romani women who received treatment in Krompachy hospital. ²²⁹

Non-Romani women in hospital maternity wards in eastern Slovakia described the way in which medical personnel impose and preserve racial segregation. One non-Romani woman explained that while at Old Maternity Prešov, “once I heard a nurse telling a Romani woman who wanted to use the ‘white’ toilet, ‘you cannot go there, the other toilet is for those like you.’ . . . Sometimes the hospital was so crowded that Romani women were staying two in one bed.”²³⁰

Justifications of Hospital Personnel. In interviews with the project team, hospital administrators and doctors denied discriminatory treatment and justified the segregation on medical or “social” grounds.

The chief gynecologist of Krompachy hospital argued that the segregation of the patients in his hospital only appears to be along racial lines. In reality, he said that patients are categorized as “adaptable or non-adaptable” and “low hygiene” or “high hygiene.” The doctor then said women are placed in rooms according to this categorization. “We know how to place women in the rooms because this is a small hospital and I know who’s adaptable and non-adaptable,” he said.²³¹ Our team frequently encountered the use of these categorizations by health-care professionals to conceal race-based segregation.

The chief gynecologist of Spišská Nová Ves hospital acknowledged de facto segregation, contending that the

The International Convention on the Elimination of All Forms of Racial Discrimination defines “racial discrimination” as “. . . any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose *or effect* [emphasis added] of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.”

– Committee on the Elimination of Racial Discrimination (CERD), Article 1(1)

practice is based on respect for the patients' wishes: "I'm very careful so Roma won't feel discriminated against, but Romani women want to be separated."²³² According to another doctor, Romani women want to be together so intensely that they are happy to stay in overcrowded rooms or even share beds: "They all want to be together in one room, even if they had to share one bed in the Gypsy room . . . They have these tendencies and want to be together. Even if we place them in the room with whites, they immediately run away."²³³

Another doctor explained that segregating the Roma is necessary to protect white women²³⁴ and respect their "rights": "White women do not want to be with primitive, uneducated Romani women. We have to respect the rights of non-Romani women, too."²³⁵

Denials by the Government. In the past, the government has dismissed allegations of segregation in eastern Slovakia. "It has not been proved that the practice is based on racial bias," declared the former Minister of Health, Dr. Milan Kováč, a gynecologist.²³⁶ In a February 2002 interview with *Národná Obroda*, a Slovak national daily newspaper, Kováč argued that racial segregation in hospitals is the result of demographic growth and does not bespeak discriminatory attitudes among health-care personnel: "As I see it, it is a question of coincidence rather than intention and the reason why Roma mothers are placed in one room is a higher concentration of Roma population in those districts and the [higher] birth rate of Romani women."²³⁷ In 2000, a Slovak-based non-governmental organization filed a complaint to the Ministry of Health about the practice of segregated maternity wards in eastern Slovak hospitals. The Ministry responded by stating that Roma are separated in accordance with their own wishes and further noted that as a result of this, some Romani patients are undisciplined and do not respect hospital regulations.²³⁸

DISCRIMINATORY STANDARDS OF CARE

“When a Roma woman is giving birth, they do not help her but say ‘if you knew how to make it, you should also know how to take care of yourself.’”

–Romani woman from Kecerovce²³⁹

“When a white woman gives birth, if she wants, then her husband can come and be present at delivery. Sometimes Roma husbands are not allowed inside the hospital. Delivery rooms are also segregated.”

–Judita from Jarovnice²⁴⁰

“Nobody pays attention to Romani women in Krompachy hospital. They are not taken to room in a stretcher after delivery as Gadje women. Nurses pay no attention to us.”

–Alena, 39, from Richnava²⁴¹

Discriminatory standards of care affecting the treatment of Romani women take various forms that include the following:

- inadequate medical care;
- deficient emergency care;
- limited hours of care; and
- corruption among health-care workers.

Inadequate medical care. Romani women we interviewed complained of inadequate medical care, neglect, and ill treatment in hospitals in eastern Slovakia. Much of this treatment is fueled by negative stereotypes concerning Romani women’s high fertility.

Lydia, a 43-year-old mother of 12 from Svinia, talks about her experience in the old maternity ward of Prešov hospital, in September 1999: “When I was delivering my last baby, nobody paid any attention to me although I was bleeding heavily. The doctor told me, ‘Do it by yourself. You have enough

*children so you know how to do it!’ So I did. The doctor only came to cut the naval cord—that was it. I had a lot of problems after this delivery but all they did for me was to put ice on my stomach. Two weeks after the delivery I had to have a curettage.”*²⁴²

*Milena, mother of three children from Žehra, reports: “When we give birth, they only scream at us. I was bleeding and the doctor told me ‘you can die if you want.’ Doctors do not give you treatment. When Roma woman in hospital rings for help, nurses do not come after finding who is calling. They say ‘help yourself.”*²⁴³

The hostile and judgmental attitudes of health-care providers toward Romani women frequently emerged during the interviews with the project team: “Romani women give birth quite easily. More intelligent women give birth with more difficulty, it is something in the brain,” one gynecologist surmised as he tapped his head.²⁴⁴

Deficient Emergency Care. Romani women who live in segregated settlements on the outskirts of cities and villages, far from public transportation, face difficulties in accessing hospitals. Because few people have cars in these settlements, calling an ambulance is often the only way pregnant women can get to the hospital. In most of the settlements our team visited, Romani women point out that emergency operators refuse to send ambulances to their settlements even in serious situations, and, if they do come, ambulance drivers ask for payment despite the fact that under emergency conditions, their services are supposed to be free of charge.²⁴⁵

*Aranka, a 27-year-old from Žehra says, “They tell us, ‘you have cars, come by car.”*²⁴⁶ *A Romani woman from Draňov, Michalovce district, reports that “Usually we have to call four times for an ambulance to come. . . . Once the ambulance operator told us that they would only come if someone was dying.”*²⁴⁷

A Romani woman from a Romani ghetto in the Košice City Part Nad jazerom,

Golianova street, says that when an ambulance is called for a pregnant woman about to deliver, it often takes more than an hour to arrive even if the hospital is nearby. She believes that the delays are intentional because ambulance personnel never inquire about the nature of the problem, only stating, “oh it’s already your fourth baby—you won’t die, you can wait.” Her husband remarks that when he called an ambulance for her while she was in labor, the ambulance came four hours later with a driver who declared, “I won’t drive Gypsies to the hospital.”²⁴⁸

Delays or denial of emergency services result in an increased number of unplanned home deliveries, endangering the life of both baby and mother.

“Ambulances never come here,” says Ida from Rudňany. “Not even for a complicated delivery. They say, ‘arrange transport for yourself.’ If you say you are calling from Patorácka [a well-known Romani settlement], they do not come. Four months ago Matila, a woman who lives in a shack behind ‘Bytovky,’ gave birth at home because the ambulance refused to come and she had no other way to get to the hospital. She had twins and one baby died. Only when we called and told them that the baby died, they sent the ambulance, and the doctor told her ‘how do you dare not to come to the hospital.’”²⁴⁹

Health-care providers, however, reject any claims that emergency medical care is denied due to race. At the same time, they surmise why it is “reasonable” for ambulances to stay away: “Most Romani women are abusing ambulances by saying they don’t have a car when they do. . . . They lie to bring the ambulance because then they are treated immediately in the hospital.”²⁵⁰

Limited Hours of Care. When seeking medical advice and treatment, Romani women are often treated only after non-Romani patients, or during separate hours.

One Romani woman from Kecerovce, Košice district, said, “our local gynecologist is very rude to Roma. When we go there, we have to wait till all non-Romani women are served, they always go first.”²⁵¹ Romani women from Jasov have had similar experiences: “At our local gynecologist, we have to wait till all Gadje are served although we came earlier.”²⁵²

One of the local gynecologists who serves the population of the Romani ghetto in the Košice City Part, Luník IX, only sees Romani women on Fridays between 12 p.m. and 3 p.m. Non-Romani women can receive care throughout the work week. “On Friday, the doctor finishes at 12, then he accepts Romani women.”²⁵³ When questioned about what happens if they come at an unauthorized time, Romani women told us this: “We are allowed to come to the doctor’s office on days other than Friday only in case of emergency. But it depends on his [doctor’s] mood. Mostly we must come when we have our hours. He says, ‘you must come on Friday because white women do not want to be together with Romani women.’”²⁵⁴

Corruption Among Health-Care Workers. Frequently, health-care personnel openly demand bribes from patients or payment for services already covered by health insurance plans. “Approximately three months ago, the doctor’s office had been broken into and robbed but the perpetrator has not been found. Since then, when Romani women come to the doctor, he refuses to measure the blood pressure for them. The nurse always hides equipment. She only does it when we pay 50 Slovak crowns.”²⁵⁵ Others “have to pay for ultrasound, about 100 crowns [2.50 Euros].”²⁵⁶

Our fact-finding revealed that bribing health-care workers in exchange for medical attention is a common practice in eastern Slovakia for both Romani and non-Romani women. Indigent Romani women often feel extreme pressure to bribe doctors and nurses because otherwise they know they will not receive proper care.²⁵⁷ Some doctors routinely and openly ask Romani women for money before delivering a baby. One non-Romani woman witnessed this firsthand: “Once I saw with my own eyes how a doctor entered in the Roma room and asked, ‘who wants to deliver with me?’ Then the doctor opened his medical overcoat pocket gesturing for the women to give him money. Doctors would not dare to ask so openly for money from non-Roma.”²⁵⁸

PHYSICAL AND VERBAL ABUSE

Physical Abuse

“When my daughter had her first child she was very scared and was screaming. When she was on the table giving birth the nurse put a pillow on her face to make her shut up. The doctor was not there.”

–Romani woman from Ostrovany²⁵⁹

Our research indicates that physical violence by health-care professionals against Romani women during delivery is not uncommon. Although not as chronic as verbal abuse, many Romani women interviewed by the research team said doctors and nurses in eastern Slovak hospitals thrashed and slapped them for complaining about pain or simply for “having too many children.” In a few instances, women reported extreme levels of violence such as sexual abuse and attempted rape.

Lujza, a 21-year old from Rákoš, Košice district, tearfully recounted the treatment she received during her first delivery in July 2002 at the Luis Pasteur UTH Košice: “I started to give birth earlier than expected. We were painting the house and I was helping so maybe it speeded up the delivery. We called the ambulance. The first thing they told me when I arrived there was, ‘you stink like sewage.’ My partner heard it too. Then the nurse ordered me to go to the room and put on a nightgown. She came later to give me an injection and yelled at me not to touch her. She also complained, ‘you, Roma, you do not bring anything to the hospital.’ It was true as I did not bring anything in that rush [to get to the hospital] but I was telling her that my partner would bring my toiletries next day to which she responded ‘he will bring you shit.’ . . . When I was in the delivery room, I was screaming from pain. There were two doctors and the same nurse. The doctor started to call me names (Gypsies) and hit me really hard on my face. The nurse who was attending me hit me on my legs. It hurt, it gave me bruises.”²⁶⁰

Abuse in Vranov hospital appears to be prevalent. Women from Sačurov settle-

ment say that doctors in these hospitals “beat us when we go to deliver,” “one doctor beat me over my legs,” “to me, they pulled my hair,” and “one doctor slapped me.” Several women told our research team that this physical violence takes place “before and during the delivery.”²⁶¹

*Linda from Letanovce, who gave birth to her first child in Spišská Nová Ves hospital in April 2002, reports, “I was beaten with a dustpan. I was in the hallway, before I gave birth, and there came one woman in a uniform. I do not know who she was, maybe she was a cleaning lady, and she was screaming at me, shouting what I was doing there when I was supposed to be either in the room or in the delivery room. She hit me several times on my back and legs with a dustpan she was carrying.”*²⁶²

A Romani woman, from Košice City Part Nad jazerom, Golianova street told us that in August 2002 a nurse tried to suffocate her daughter with a pillow while she was delivering a baby in the Luis Pasteur UTH Košice. Fortunately, her daughter’s doctor saw this violence and told the nurse to stop. The woman’s daughter was so terrorized by the experience and convinced that medical personnel were set on killing her that she ran away from the hospital, one hour after giving birth.²⁶³

Verbal abuse

“Nurses and doctors are cursing us, call us Gypsies and tell us ‘you only have children,’ ‘you are stinky,’ ‘you have lice’ and ‘you give birth only to get money. . . .”

–Romani woman from Rudňany²⁶⁶

“The nurses call us ‘Cigáni’ [Gypsies], they tell us that we are dirty and too young to have sex. They call teenagers ‘young whores’. . . . When they see us pregnant they say: ‘You are here again! How many children do you want? We already had enough of you!’”

–Romani woman from Nad jazerom, Golianova street, Košice²⁶⁷

Sexual Abuse

Sexual assault in the context of maternal health care is another heinous violation of Romani women's human rights that was reported to us during the course of our fact-finding.

Dagmara, a 24-year-old mother of four from a settlement in Chmiřany, Prešov region, talks about her experience: "I was pregnant three years ago [April 1999]. When I started to have contractions my family called the ambulance to take me to the hospital because we do not have a car and I had no other way to get there and my delivery was proceeding. The ambulance came but with no doctor, only a driver, as usual, and he did not let anyone accompany me. The driver then stopped the car outside of the village, before Svinia, switched off the lights and went back toward me with a flashlight. He told me 'now you will show me where is your pain' and 'I have to check whether you are giving birth or want a man.' I was screaming from fear and begged him not to do anything to me. We were fighting for a while and then my contractions got stronger and he drove off. We came later to the hospital than expected and a doctor on duty was asking me why it took me so long. I told him what happened but he said 'you have to file a complaint by yourself. I am not here to save Gypsies.'"²⁶⁴

In one instance, a non-Romani health-care worker commented on the sexually abusive tactics of his colleagues at the hospital at Moyzesova st., Kořice: "In Moyzesova, when doctors performed vaginal ultrasound examinations, they used to put a condom and some gel on the device they use [for the patient's comfort and the sanitary effect]. But when Roma women came, they would not do it. They would not heat the tools for Romani women to body temperature as they did for non-Roma. They did not explain anything to them. Once I saw a doctor making the ultrasound examination without a condom. To a Roma woman he was acting very aggressively. She was crying, it was obviously very painful. But he was pushing that medical device into her. It was horrible, like watching a rape. That was the first time when I had a fight with a doctor . . . It was normal that when they did an abortion, they did it without anesthesia, violently, without painkillers."²⁶⁵

Verbal abuse primarily takes the form of racist slurs about Romani women's fertility, sexuality and maternal skills.

*One woman, who did not wish to be identified, told us, "When I gave birth to my eighth child, the doctor was cursing me. He told me, 'you are only rolling around in bed. You have so many children and you still do not have enough! But it is not his business to tell me how many children I should have. He does not need to take care of them, but I do!'"*²⁶⁸

*A woman from Ostrovany, Prešov district, said, "Doctors and nurses yell at us and call us 'Cigáni' (Gypsies). For the smallest mistake we make they immediately scream at us 'stupid Gypsies,' or 'dirty Gypsies' or 'bad Gypsies.' They treat us worse than dogs."*²⁶⁹

One woman from Žehra described her experience at Krompachy hospital: "Doctors are angry and say we have children only to receive children allowances. But I want to have babies because I am healthy. They would like to castrate all of us. . . ." ²⁷⁰ A young Romani woman from Bystrany offers a similar anecdote: "The nurses scream at us and say 'Cigáni know nothing else but to make children.' Even if a woman is having her first child, they still yell at her that she has too many." ²⁷¹

Another woman from Jasov relayed her experience: "Together with me there were other pregnant Romani women in the room at the maternity. They were treated like pigs, waiting to have their bellies cut. One of them gave birth on the floor of the room, because nobody came to help her. When the doctor saw it, he said, 'you are a pig, so you should give birth like a pig.'" ²⁷²

A non-Romani woman who gave birth in Prešov hospital talked to us about the abuses of Romani women that she observed: "After delivery I remained two hours to rest on the table. Next to me was a Romani woman giving birth and I heard the doctor screaming at her, 'shut up and do what I tell you! . . . it was good when your man was f... you, now stop screaming.' It is simply

unthinkable that a doctor would talk like that to a white woman."²⁷³
Another non-Romani woman notes: "When Romani women were in pain, I heard a nurse telling the doctor, 'is just a Gypsy who screams. . . .' Romani women are a priori considered to be bad mothers. . . . The worst is for the Romani girls from orphanages, who do not have family support and nobody to help them. . . . I used to be a social worker in Luník IX and I do not have illusions about their maternal abilities but they definitely do not deserve to be treated like they are."²⁷⁴

Interviews with more than 30 health-care personnel in eastern Slovakia reveal deeply rooted prejudices against Romani women, widespread stereotyping, and hostility. They are seen as troublemakers, as a group causing problems to Slovakia, a nuisance for the health-care system. Roma are labeled as degenerate, less bright, less civilized, and less human. A nurse in the gynecology department of Spišská Nová Ves hospital told the project team that she is very angry with Roma because they "are totally careless, they do not know what to do."²⁷⁵ Another nurse, from Šaca hospital, complained that, "They do not know anything. If I gave birth even 20 years ago, I would remember. They are stupid. . . . Gypsies are coming to our hospital because they want to take advantage of it. This is a private hospital. . . . Everything is paid for by insurance. But they should go to a different hospital. They do not belong here."²⁷⁶ "They don't know the value of work," said the chief gynecologist of Krompachy hospital.²⁷⁷

*Some doctors and nurses expressed their conviction that Romani adults want children only to obtain more money from the state. The chief gynecologist of Krompachy hospital stated that, "[Roma] abuse the system; they just have children to receive more benefits."*²⁷⁸ "For those socially inadapted [referring to Roma] a child is a means for an income," explains the director of Gelnica hospital. "It is very beneficial for them to have a child every year. If a woman starts at age of 15, when she is 30 she already has ten children."²⁷⁹

One doctor declared that Roma abuse the system by deliberately marrying close

relatives to conceive mentally retarded children in order to obtain higher benefits from the Slovak state. The director of Spišská Nová Ves hospital specifically remarked, “Many Roma abuse this practice to purposefully create imbecile children in order to get more money from the state. They know they’ll get more money if they have imbecile children, so they intermarry.”²⁸⁰ The chief gynecologist of the hospital said, “In my opinion, this is unfavorable. . . . Roma are poor, they don’t get good education, parents encourage children to steal, and they teach them to hate white people.”²⁸¹

In contrast, non-Romani women with many children are treated immeasurably better than Romani women and are sometimes even celebrated as heroes. Newspapers frequently carry stories about non-Romani women who have been designated “special mothers” by state officials. In June 2002, a white mother of nine from Humenné won a “special mother” award. A newspaper reported that a goal of the prize was “to award a mother and father as the foundation of the family, to strengthen their position in rearing their children and in particular to affirm the spirit of humanity. . . .”²⁸²

Another widespread stereotype about Romani women is that they are bad mothers because they rarely stay in the hospital for the required five days following birth. The reason many of these women leave the hospital so quickly is that many have to return home to take care of their other children.²⁸³ Still other women are driven away because of the abuse and hostility they experience in hospitals.²⁸⁴ Roma women also report that sometimes doctors and nurses tell them to leave.²⁸⁵ They return after several days to collect their newborns. Doctors and nurses use this departure as irrefutable evidence that Romani women are ‘bad mothers’ who are unfit to bear children: “Roma leave [the hospital] early because of insufficient maternal instincts. Even an animal doesn’t leave its baby,” explains the chief gynecologist of Šaca hospital.²⁸⁶ At the same time, Romani couples are seen as “promiscuous,” and visitors are told detailed stories about Romas’ “uncontrolled need for sex” that drives these women to hastily return home immediately after childbirth. Slovak doctors told our fact-finding team, for example, “Mothers frequently leave the hospital without their babies . . . because they have to go home to be available for their husbands. . . . for sex.”²⁸⁷

One psychologist offers yet another racist explanation for the behavior of some Romani women following delivery: “It is about the functioning of the health sys-

tem,” says Dr. Sopková, a psychologist and court expert. “White women are more able to ‘suffer through’ and endure it. Roma ‘revolt’ and escape. The rule here is that women must remain in the hospital five days after delivery but there is no real [medical] reason for it. I know a doctor who used to release women on the third day in order to return them to their natural environment. Those rules . . . do not respect the needs of children and mothers.”²⁸⁸

One 35-year-old non-Romani woman from a town near Bratislava also expressed her desire to leave the unfriendly hospital environment. “I did not feel like a mother. I did not even feel like a human being, although I knew what I wanted. They thought I was crazy and incompetent to make decisions.” She also points out that the situation was especially burdensome for Romani women. “There was one Roma woman. She was walking from room to room wanting to talk to someone and was kind of lost. Other women would not talk to her. My roommates, white women, told me do not talk to her because she is a Gypsy, [and] she had not seen the doctor even once during whole pregnancy. . . . I can imagine that in that hostile environment for her, it had to be even worse.”²⁸⁹



Denial of Access to Medical Records

It is not possible to show you the files. There is no such right.

–Director of Krompachy hospital²⁹⁰

Everyone is entitled to know any information collected about his or her health.

–European Convention on Human Rights and Biomedicine, 1997, Art.10(2)

During the course of our fact-finding, we encountered several Romani women who expressed an interest in reviewing their medical records to aid them in ascertaining whether they were involuntarily sterilized. Lawyers at Poradňa collected dozens of legal authorizations from Romani women who could not travel to the hospitals to view their medical records. In addition, we accompanied three Romani women who wished to see their records. All three have been unable to conceive and were uncertain if they had been sterilized. In two cases, the women were refused access to their own medical records without explanation. In one case, still in the presence of our researchers, the chief gynecologist of Spišská Nová Ves hospital yelled racial epithets at the woman for attempting to see her file and questioned her intellectual ability to understand its contents.²⁹¹

PATIENT'S ACCESS

Slovak law guarantees patients access to medical records.²⁹² Our fact-finding revealed, however, that patients are routinely denied this right. Although the Health Care Law entered into force in 1994, the Slovak Ministry of Health has yet to issue implementing regulations on access to medical records. In the absence of such guidance, hospitals apply the law in an arbitrary manner, misinterpreting the legal provisions and obstructing or significantly limiting patients' access to their own records.

*The director of Gelnica hospital explained his understanding and interpretation of patients' right to access their records: "Yes, the patient has a right to see her medical record but she should also have a reason. . . . If there is a proper reason for her to see it, she can see it. We have to differentiate. It has to be decided on an individual basis as it could be abused. . . . The patient cannot review it by herself. There must be a hospital staff person present as she could steal something from there. Or rewrite something. The file must be left as it was. Moreover, the patient does not understand what is written there; she cannot even read the handwriting of a doctor. We do not give copies. . . . Anyhow, we do not have any request for copies, neither for seeing files. But if there was, we would ask for a reason."*²⁹³

Many health-care personnel in eastern Slovakia stated that they had never encountered a situation in which patients requested access to their medical records. A few health-care personnel said that they do not know how to process requests for records because they have never received such requests and are unaware that Slovak law guarantees patients the right to access their records. "There is a lot of law and I do not know which one is the right one. I am not here to study the law; I have to provide health care," declared the chief gynecologist of New Maternity Prešov.²⁹⁴ Some doctors and hospital administrators suggested that the only means for a patient to obtain a copy of his or her full medical record would be to file a lawsuit against a doctor for medical malpractice or launch a criminal investigation.²⁹⁵

Other hospitals suggested that they have unwritten internal rules and procedures for complying with patients' right to see their records. These "rules," however, appear to be ad hoc.

"We have internal rules on this issue," declared the director of Krompachy hospital. *"It is not possible [for you to see them]. The rules are not issued in a written form. I am deciding about rules as I am responsible for this hospital. . . . It is very complicated. They are general rules and special rules. . . . But there is also a problem that someone has to serve you and we are very busy. . . . It is impossible to determine precisely [the procedure] but it depends when our staff has enough time. I do not know how long you should announce*

*your visit [in] advance. It really depends. . . . You have to contact me first, then you have to contact the chief doctor and then we will consult and appoint an official who will eventually organize it.”*²⁹⁶

LEGAL COUNSEL'S ACCESS

Slovak law also allows patients to authorize other people, including lawyers, to access their records.²⁹⁷ In the course of the fact-finding, about 50 Romani women requested that Poradňa's lawyers represent them and granted the lawyers a power-of-attorney to review the records. In 40 of these cases, Poradňa's lawyers were denied access to their Romani clients' records. Only in very few cases, after many attempts and multiple discussions with doctors, hospital lawyers, administrators, and nurses, was access granted. The reasons for the refusals varied, but in many instances the denial was on racial grounds. For example, in Šaca hospital the nurse refused to look for a record, saying, “I will not look for a file of a Gypsy.”²⁹⁸ In the same hospital, the chief gynecologist reacted very negatively to the request: “Here we have our former patient, Gypsy [patient's surname], who now— three years after the treatment— decided to complain about the treatment.”²⁹⁹ Similar hesitation on racial grounds was expressed by nurses in Old Maternity Prešov.³⁰⁰

In some cases, the hospital's lawyers questioned the validity of the power-of-attorney. Šaca hospital's lawyer claimed that a two-week-old power-of-attorney was too old therefore was not valid.³⁰¹ In another hospital, doctors requested the power-of-attorney to be verified by a notary even though there is no such legal requirement. When the notarized power-of-attorney was then presented, the hospital lawyer who originally required it still refused access to the record. “I told you to get the power-of-attorney verified because I thought you would not come back,” she stated.³⁰²

The lack of a uniform and organized filing system in Slovak hospitals further limits a patient's right to access her medical records. In New Maternity Prešov, the chief nurse apologized for being unable to fulfill the request: “It would be a very daunting and meticulous job because the hospital does not have a proper filing system. The files on birth deliveries are organized according to the day when woman was released from the hospital. If the woman does not remember that date, it is not possible to locate the file even if we know her name and birth date.”³⁰³

GOVERNMENTAL RESPONSE

To clarify the legal standards on patients' right to authorize attorneys to access their medical records, Poradňa's lawyers contacted the Ministry of Health for guidance several times during the fact-finding missions. Ministry of Health officials, however, responded with conflicting interpretations of the law. Initially, officials referred Poradňa's lawyers to the Ministry of Health website, which contained information stating that a patient's lawyer through an authorized power-of-attorney can review his or her client's medical record.³⁰⁴ After being denied files in several hospitals, Poradňa's lawyers again contacted the Ministry of Health and asked it to intervene. The Ministry of Health responded by asking the lawyers to file a complaint directly with the hospital.³⁰⁵ After Poradňa's lawyers filed complaints with the hospitals,³⁰⁶ the Ministry of Health backtracked from the information posted on its website, and in a letter to Poradňa's lawyers noted that patients do not have the right to authorize powers-of-attorney for accessing their medical documentation.³⁰⁷ The hospitals responded similarly.³⁰⁸ Poradňa's lawyers filed an appeal to the decisions of the hospitals with the Ministry of Health. As of December 2002, however, there has been no response.³⁰⁹

