CENTER FOR REPRODUCTIVE RIGHTS

Mandatory Waiting Periods and Biased Counseling Requirements in Central and Eastern Europe

Restricting access to abortion, undermining human rights, and reinforcing harmful gender stereotypes

Many Central and Eastern European countries were among the first jurisdictions in the world to legalize abortion. Indeed laws and policies in most Central and Eastern European countries have long provided that women may access abortion services in a wide range of circumstances. In the early stages of pregnancy abortion is permitted without restriction as to reason (commonly referred to as abortion on request). In the later stages access to abortion is allowed when a woman's health or life is at risk and in cases of severe or fatal fetal impairment.[1]

However, in recent years, a wave of restrictive legislative initiatives has spread across Central and Eastern European jurisdictions, with lawmakers and government authorities seeking to impose a series of new preconditions that women must fulfill before they can obtain legal abortion services. Mandatory waiting periods and biased counseling and information requirements are particularly common examples of the new prerequisites that have been introduced.[2]

Although the recent incorporation of these preconditions into laws and policies in a range of Central and Eastern European countries has sometimes been framed under the guise of protecting women's health and informed decision-making, instead, as evidenced by the social and political contexts in which they have been introduced, their introduction is in fact designed to hamper women's access to reproductive health services to which they have long been legally entitled.[3] The introduction of pre-abortion mandatory waiting periods and biased counseling and information requirements has not advanced women's health or increased their enjoyment of their human rights. No evidence-based research indicates that these new requirements have beneficial outcomes for women's wellbeing. On the contrary, their introduction in Central and Eastern European jurisdictions such as Macedonia, Russia, and Slovakia has served only to create barriers in access to legal abortion services, undermine respect for women's human rights, and promote harmful gender stereotypes and discriminatory attitudes. By increasing abortion stigma, erecting new obstacles to women's access to lawful reproductive health services, and undermining women's decision-making capacity, the introduction of these requirements jeopardizes, rather than advances, women's health and wellbeing.

What is a mandatory waiting period prior to abortion?

A mandatory waiting period is a minimum amount of time that is legally required to elapse before a woman who requests an abortion can receive the service. In general, mandatory waiting periods apply only to abortions on request and are not imposed when abortion is sought for therapeutic reasons or when the pregnancy is the result of sexual assault. In most European countries where waiting periods are currently required, they range from two to seven days. Where mandatory waiting periods are accompanied by pre-abortion counseling or information requirements, they often start from the time that the counseling or information is provided.[4]

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What are biased abortion counseling and information requirements?

Mandatory abortion counseling and information requirements exist in a range of jurisdictions throughout the European region, including Western and Southern Europe. Although the content and form of these requirements differs, relevant laws and policies usually outline that women must undergo counseling or receive certain information prior to obtaining abortion services. For the most part such mandatory counseling and information provision is not required to be biased. In fact, in many European jurisdictions relevant laws and policies require abortion counseling and information to be non-directive and objective. As a result, until recently, requirements that abortion counseling or information be biased were rare in Europe.[5] However, the information and counseling requirements that have recently been introduced in a variety of Central and Eastern European countries each take a biased form.

Abortion counseling and information requirements are biased where their purpose is to persuade women not to obtain an abortion. As such, biased counseling and information requirements are directive in nature and require women to undergo counseling or receive information that is designed to dissuade them from obtaining abortion services and encourage them to continue their pregnancy. They often involve the provision of stigmatizing or medically inaccurate or misleading information about abortion. Examples of biased counseling and information include health professionals overemphasizing the risks involved in abortion procedures, counselors describing abortion as murder or the killing of an "unborn child," or women being compelled to look at pictures of a fetus and receive information on the stage of its development.

The principle of non-retrogression: prohibiting regressive measures in women's access to reproductive health services

Under international human rights law, the introduction of retrogressive measures - deliberately backward steps in law or policy that directly or indirectly impede or restrict enjoyment of a right - will almost never be permissible.[6] Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), this principle applies to the right to health and precludes the adoption of retrogressive measures in the health care sphere. As such, state laws, policies, and practices that introduce new restrictions on the exercise of the right to health, or that erect new barriers in individuals' access to health services, will immediately call into question compliance with international human rights law and standards.[7]

The recent introduction of new pre-abortion mandatory waiting periods and biased counseling and information requirements in a number of Central and Eastern European jurisdictions represents such a regressive legislative trend. Prior to their introduction, women in the concerned countries were allowed to access abortion services without being subject to these preconditions. As a result, the recent introduction of these requirements marks the imposition of greater restrictions on women's access to legal reproductive health services than previously existed.

Although mandatory waiting periods and counseling and information requirements exist in a number of European jurisdictions outside of Central and Eastern Europe, in almost every instance their introduction into legislation in those countries was not part of a retrogressive trend. Instead, they were largely introduced in the context of law reform processes that decriminalized and liberalized women's access to abortion services.[8] While the imposition of such preconditions on women's access to abortion services is problematic in and of itself, as outlined in more detail in the sections that follow the retrogressive nature and restrictive purpose behind their recent introduction in a number of Central and Eastern European jurisdictions, combined with the biased nature of these new counseling and information requirements, gives rise to specific and serious concerns.

What human rights are at stake?

When women's access to legal abortion services is conditioned upon mandatory waiting periods and biased counseling and information requirements, a wide range of human rights guarantees are called into question. The rights at stake include:

- **Personal integrity and privacy:** Together the rights to personal integrity and privacy guarantee respect for personal autonomy and physical, mental, and moral integrity. They mandate that laws and policies must ensure respect for women's dignity and autonomy in medical decision-making and when accessing reproductive health services. They also require respect for the principle of full and informed consent and necessitate that women be enabled to make medical decisions freely and voluntarily, without threat or inducement.[9]

- **Health:** The right to health includes the right to access acceptable, timely, and good quality reproductive health information, services, goods, and facilities, free from discrimination and coercion. Violations of the right to health can occur where reproductive health information is misrepresented or distorted or where timely access to good quality reproductive health services is undermined. Safeguarding women's enjoyment of their right to health requires that they be enabled to make reproductive health decisions on the basis of full and informed consent and that the provision of reproductive health information and services be evidence-based, non-discriminatory, and respectful of women's dignity and autonomy.[10]

- **Information:** The right of access to information is a fundamental prerequisite for the exercise of other rights. In the reproductive health context, the right to information guarantees the right of access to medically accurate, evidence-based reproductive health care information, including concerning abortion services. The right to information not only entitles individuals to access accurate information concerning their health but also to refuse access to this information if they so wish.[11]

- **Non-discrimination and equality:** Among other things, women's rights to non-discrimination and equality require the revision and removal of laws and policies that discriminate against women in law or in practice, including those that embody harmful gender stereotypes and assumptions. In the health care context, they also mandate that women's access to the reproductive health services they need as women must not be obstructed by legal or policy barriers.[12] Additionally, they require that women's equal rights to enjoy the benefits of scientific progress and to decide on the number and spacing of children be guaranteed.[13]

International and European human rights mechanisms have repeatedly addressed the way in which limiting women's access to safe and legal abortion services undermines these rights, and have urged governments to eliminate barriers that prevent women from accessing these services.

For example, the Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights,[14] has underlined that "in cases where abortion procedures may lawfully be performed, all obstacles to obtaining them should be removed."[15] It has also called upon a state party to the Covenant "to eliminate all procedural barriers that would lead women to resort to illegal abortions that could put their lives and health at risk."[16] The Committee on the Elimination of Discrimination against Women (CEDAW Committee), which monitors state compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[17] has clearly noted that a state should "[e]nsure access to safe abortion without subjecting women to mandatory counselling and a medically unnecessary waiting period."[18]

The European Court of Human Rights has held that "[o]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it"[19] and has underscored that European states have "a positive obligation to create a procedural framework enabling a pregnant woman to exercise her right of access to lawful abortion."[20] The Court has recognized the important role of women's timely access to relevant and reliable information in guaranteeing their ability to exercise personal autonomy and obtain lawful abortion services. It has condemned the intentional denial and manipulation of abortion-related information.[21]

The Parliamentary Assembly of the Council of Europe (PACE) has expressed concern about measures that "restrict the effective access to safe, affordable, acceptable and appropriate abortion services," and has found that mandatory waiting periods and requirements for repeated medical consultations prior to abortion can hinder access to safe abortion care, or make it impossible altogether.[22] As a result, PACE has called on Council of Europe member states to "guarantee women's effective exercise of their right of access to a safe and legal abortion," and to "lift restrictions which hinder, de jure or de facto, access to safe abortion."[23] Similarly, the United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Special Rapporteur on the Right to Health) has outlined that counseling requirements and mandatory waiting periods can make legal abortion services inaccessible and serve to reinforce stigma about abortion.[24]

Biased counseling and information requirements

Recently introduced laws and policies in a number of Central and Eastern European countries[25] seek to dissuade women from obtaining abortion services by compelling them to receive pre-abortion counseling or information that is biased and directive. Although the nature, form, and content of the new counseling and information requirements vary across the concerned jurisdictions, each of the newly adopted regressive laws and policies were enacted with the purpose of limiting women's access to abortion and each involves the provision of medically inaccurate, misleading or stigmatizing information about abortion.

In some cases, the terms of the relevant law or policy are explicitly and overtly biased and directive. For example, in 2010, the Russian Ministry of Health and Social Affairs issued Guidelines on Psychological Pre-Abortion Counseling seeking to reduce women's access to abortion services in Russia through the provision of biased and stigmatizing information.[26] The guidelines describe abortion as "murder of a living child" and portray women with unwanted pregnancies as irresponsible.[27] Counselors are instructed to "awaken [the woman's] maternal feelings," convince her of "the immorality and cruelty of abortion," and "lead the woman to an independent conclusion that, if a baby is born, then the means to raise it can be found."[28]

In other instances, although the biased intention behind the new counseling and information requirements may not be explicitly outlined in the text of the relevant law or policy, it is nonetheless clear from the nature of the requirements themselves. For example, in Macedonia, new biased counseling requirements introduced into law in 2013 and 2014 require women to undergo mandatory ultrasounds prior to abortion and to be shown the "ultrasound image of the fetus," in the course of mandatory pre-abortion counseling. The new requirements also specify that women must be told about "all anatomical and physiological features of the fetus at the given gestational age," and about the effects abortion will have on the fetus.[29] The law also requires health care institutions to ensure women seeking abortion care are provided with information and counseling on the "possible harm" abortion can cause to women's health, including their psychological health, and on the "possible advantages" of continuing a pregnancy.[30]

In other jurisdictions, while the biased and directive nature of the new information requirements may be less obvious, their purpose is explicitly recorded in legislative history and legal explanatory reports as being to persuade pregnant women to continue with their pregnancies in the name of protecting "the unborn child." For example, new laws adopted in 2009 in Slovakia now require that women receive information outlining the: "physical and psychological risks," associated with abortion;[31] "the current development stage of the embryo or fetus," and "alternatives to abortion" such as adoption, and support in pregnancy from civic and religious organizations.[32] This information must be provided to all women seeking abortion and they are not able to refuse it.[33] Although on their face these requirements may appear less intrusive, they were introduced with the biased and directive goal of dissuading women from obtaining abortion services "in favor of the life of an unborn child."[34]

In and of themselves mandatory counseling and information requirements jeopardize women's human rights by forcing women to undergo counseling or receive information which they may not want, and calling into question women's decision-making authority and agency. However, as outlined in detail below, when such requirements mandate the provision of directive and biased counseling and information, they present a range of particularly severe implications for women's enjoyment of their human rights.

(i) The right to accurate and evidence-based information about abortion and to acceptable, good-quality reproductive health services

Women's right to health necessitates that they can access available, acceptable, and good-quality reproductive health services and information.[35] Their right to information requires that they be afforded access to evidence-based reproductive health information.[36] The right to respect for private life also necessitates that pregnant women have access to relevant and reliable reproductive health information that enables them to make informed decisions about whether or not to access lawful abortion services.[37]

In this regard, the Committee on Economic, Social and Cultural Rights, which monitors state compliance with the ICESCR,[38] has highlighted that states must ensure women can access good quality health-related information that is scientifically and medically appropriate and refrain from "censoring, withholding or intentionally misrepresenting" such information, including on sexual and reproductive health.[39]

In order to be acceptable, reproductive health services must also be respectful of women's needs. The CEDAW Committee has described acceptable health services as those "delivered in a way that ensures a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."[40]

Biased counseling and information requirements contravene these obligations. By requiring that women receive medically misleading information or by exposing them to judgmental and stigmatizing attitudes, they undermine the right to receive scientifically accurate and medically appropriate information concerning abortion in a respectful manner that is sensitive to women's needs and perspectives. Indeed, biased abortion counseling and information requirements often involve the provision of medically inaccurate and scientifically unsound information about abortion, or require health professionals to overemphasize the risks involved in abortion procedures and portray abortion as harmful or dangerous.[41] This intentionally misrepresents or overstates the risks involved in abortion, which medical authorities confirm is a very safe medical procedure when properly performed.[42]

World Health Organization guidelines on abortion information and counseling

The World Health Organization (WHO) specifies that counseling about abortion should be voluntary, confidential, and non-directive.[43] It considers that a woman making a decision about whether or not to continue a pregnancy must be "treated with respect and understanding and . . . be provided with information in a way that she can understand so she can make a decision free of inducement, coercion or discrimination."[44]

The WHO emphasizes that although pregnant women contemplating abortion should be offered non-directive counseling, counseling should never be mandatory. It considers that "[m]any women have made a decision to have an abortion before seeking care, and this decision should be respected without subjecting a woman to mandatory counseling."[45]

The WHO further emphasizes that the information given to women who are seeking abortion services must be unbiased, non-directive, and provided only on the basis of informed consent. It highlights that health care providers should provide information that is "relevant" as well as "[c]omplete, accurate and easy to understand, and be given in a way that facilitates a woman being able to freely give her fully informed consent, respects her dignity, . . . and is sensitive to her needs and perspectives."[46] It underscores that "[h]ealth-care providers should be trained to support women's informed and voluntary decision-making."[47] It emphasizes that "[s]tates should refrain from . . . intentionally misrepresenting health-related information,"[48] affirming that "[w]omen have a right to be fully informed of their options for health care by properly trained personnel, including information about the likely benefits and potential adverse effects of proposed procedures and available alternatives," and that "[c]ensoring, withholding or intentionally misrepresenting information about abortion services can result in a lack of access to services or delays, which increases health risks for women."[49]

(ii) The principle of full and informed consent

The principle of full and informed consent is an integral component of the rights to health, personal integrity, privacy, and information.[50] Informed consent requires that a patient's medical decision-making be free of threat or inducement, and that a patient's consent to medical procedures, including abortion, be given freely and voluntarily after receipt of understandable, adequate, accurate, and evidence-based information on the purpose, method, duration, expected benefits, possible risks and side effects, of the proposed treatment, and on alternative modes of treatment.[51] It is implicit in the principle of informed consent that patients must also be entitled to refuse such information yet still undergo the requested procedure.[52] For example, the Special Rapporteur on the Right to Health has specified that "[j]ust as a patient has the right to receive information in giving consent, a patient has the right to refuse such information in giving consent, providing disclosure of such information has been appropriately offered."[53]

Biased abortion counseling and information requirements contradict the principle of informed consent:

- First, by imposing counseling or information on women as a precondition to abortion, they implicitly contradict the necessity that counseling be entered into freely and voluntarily and that individuals be entitled to refuse information related to their health and proceed to treatment without it.

- Second, when information and counseling requirements are biased, and require health professionals to seek to persuade women not to undergo abortion, including through the provision of medically inaccurate, misleading, or stigmatizing information, they contravene obligations to ensure that health-related information and counseling be relevant, accurate, evidence-based, and non-directive and that medical decision-making be free from inducement, coercion, or discrimination.

(iii) The right to privacy, autonomy, and integrity in reproductive decision-making

Respect for privacy, personal autonomy, and integrity requires that individuals be able to exercise agency and make autonomous choices about their bodies and their health free from arbitrary restrictions.[54] As a result, where women wish to access, or consider accessing, legal abortion services, their decisions and their ability to make them must be respected. While some women, depending on their needs, may decide to seek information or counseling support in the course of their decision-making,[55] other women seeking abortion services may have already made up their minds before seeking care,[56] and others may not wish to discuss their decisions and circumstances with a health professional or counselor.[57] While states must offer women good quality non-directive information and counseling support,[58] laws and policies that seek to interfere in personal decision-making processes by obliging women to undergo abortion counseling or receive mandatory, one-size-fits-all information regardless of their individual wishes, needs, and circumstances, undermine women's autonomy and decision-making capacity.[59]

Where mandatory counseling and information provision is biased and directive, personal autonomy, privacy, and integrity concerns increase significantly. Being compelled to undergo directive counseling or receive or listen to information that seeks to stigmatize abortion or which is medically inaccurate or misleading may be a traumatic, humiliating or degrading experience for many women or may have other harmful impacts. For women who have become pregnant as a result of sexual assault, whose pregnancies involve fatal fetal impairments, or who are facing risks to health or life, the implications of biased counseling or information requirements may be particularly cruel.[60] In cases of survivors of sexual assault, they could result in re-victimization.

Medical ethics

Where health care services fail to respect core principles of medical ethics, they violate the right to acceptable health services and information.[61] Requiring women to receive information or counseling from health care providers that stigmatizes abortion or includes erroneous or misleading medical information violates established and fundamental principles of medical ethics.

These principles dictate that health professionals must act in their patients' best interests in providing medical care and must respect their patients' rights and preferences.[62] They specify that relationships between health care providers and their patients must be based on respect, professional integrity and confidentiality. Health care providers must pursue honest, evidence-based communication with their patients, and should not subject women to biased information concerning abortion. As the International Federation of Gynecology and Obstetrics (FIGO) has advised, "[n]either society, nor members of the health care team responsible for counseling women, have the right to impose their religious or cultural convictions regarding abortion on those whose attitudes are different."[63]

Mandatory waiting periods

In Central and Eastern European jurisdictions, new obligatory waiting periods that must elapse before women can obtain an abortion have often been introduced at the same time as new biased counseling and information requirements.[64] These waiting periods are generally designed to enhance the effects of biased counseling and information requirements in dissuading women from having an abortion. The length of these newly introduced waiting periods varies per country. For example, to obtain abortion on request, women in Slovakia must now wait 48 hours, women in Russia are required to observe either a 48-hour or 7-day waiting period, depending on the length of their pregnancy,[65] and women in Macedonia must wait 3 days.[66]

As outlined in detail below, mandatory waiting periods may give rise to considerable practical implications for women, and can jeopardize their human rights and endanger their physical and mental health. When they are combined with biased counseling and information requirements, the effects are exacerbated.

(i) The right to timely, safe and affordable reproductive health services

Women's right to health necessitates that they have timely access to safe, affordable, and good-quality abortion services, and their rights to privacy and personal integrity require that they be enabled, not hampered, in exercising their right to obtain legal abortion care in a timely manner.[67] However, contrary to these requirements, mandatory waiting periods often undermine women's ability to access timely, safe, and affordable abortion services.

Mandatory waiting periods regularly delay women's access to legal abortion services and contribute to women having abortions later in pregnancy.[68] While abortion is an extremely safe medical procedure, risks of complications, though still small when abortion is performed properly, increase as a pregnancy progresses.[69] Moreover, at times mandatory waiting periods and resulting delays may jeopardize women's ability to obtain legal abortion services by pushing women beyond gestational limits stipulated for abortion. This in turn may result in some women undergoing illegal and potentially unsafe abortions. At times it may necessitate that women travel out of their country of residence to obtain abortion care.

As a result of these concerns, the WHO indicates that mandatory waiting periods should not apply to abortion services.[70] It has outlined that "[m]andatory waiting periods can have the effect of delaying care, which can jeopardize women's ability to access safe, legal abortion services."[71] It has underlined that "[o]nce the decision [to have an abortion] is made by the woman, abortion should be provided as soon as is possible"[72] and without delay.[73]

Mandatory waiting periods also often increase the costs associated with accessing abortion services. They require that women have to make at least two trips to a health facility, first to request an abortion, and then to undergo the procedure. Where the commencement of a mandatory waiting period is linked to the provision of mandatory counseling or information, women may need to travel more than twice.[74] This can significantly increase the personal and financial costs involved in obtaining legal abortion services, and can have a heightened and disparate impact on certain groups of women. For example, women living in rural areas may need to travel long distances to reach a health facility; poor women may lack access to necessary transportation and financial resources; single parents or caregivers may struggle to find time for repeated visits to a facility due to family obligations. Meanwhile, for women or adolescents at risk of domestic violence, the necessity of multiple visits to health facilities may give rise to particular safety concerns, particularly if their decision to obtain abortion services is not supported by intimate partners or other family members.[75]

Furthermore, there are some indications that in some cases the recent introduction of mandatory waiting periods in Central and Eastern European jurisdictions may have contributed to placing some women's physical or mental health at risk. Although usually mandatory waiting periods do not apply to situations where women's health or lives are at risk, in countries where they have been recently introduced, health professionals may not always be fully informed about the proper scope of these exceptions and some may be hesitant to apply the exceptions and perform therapeutic abortions for fear of sanction. For example, shortly after the introduction of a mandatory waiting period in Macedonia, two pregnant women, one carrying a dead fetus and the other suffering from a hematoma, were erroneously and inappropriately required by their doctors to adhere to the mandatory waiting period and wait a number of days before undergoing abortion procedures, despite the attendant risks to their health and lives.[76] The Human Rights Committee recently expressed concern about the new Macedonian abortion regulations and urged the state to eliminate procedural barriers to abortion.[77]

(ii) The right to respect for autonomous decision-making

Akin to biased counseling and information requirements, the imposition of mandatory waiting periods undermines women's agency and ability to make autonomous decisions about their bodies and their lives. Indeed, mandatory waiting periods imply that without the required "reflection period," women would make rash decisions or would not properly consider the impact of their decisions. At times this discriminatory assumption about women's decision-making capacity is explicitly expressed in the relevant legal documents and policies. For example, in Slovakia, official explanatory materials accompanying the relevant legal provisions specify that the purpose of the required waiting period is to provide women with time to reflect upon their decision to have an abortion so as to ensure the decision is "more competent" and "free."[78]

The WHO has recognized that mandatory waiting periods "demean[] women as competent decision-makers,"[79] and has recommended that states eliminate waiting periods so as to "ensure that abortion care is delivered in a manner that respects women as decision-makers."[80] In line with this, the CEDAW Committee has recently urged the Hungarian government to "[e]nsure access to safe abortion without subjecting women to mandatory counselling and a medically unnecessary waiting period as recommended by the World Health Organization."[81]

Discrimination, stereotypes, and stigma

International human rights law and standards prohibit discrimination against women in the enjoyment of their human rights and guarantee women's equality in law and practice.[82] They define discrimination against women as any measure that directly or indirectly entails a distinction, exclusion or restriction on the basis of sex or gender, and which impairs women's enjoyment or exercise of their human rights.[83] In order to comply with the prohibition of discrimination and give effect to women's equality in the enjoyment of human rights, states are obliged to eliminate existing discriminatory laws and policies[84] and refrain from enacting new laws and policies that discriminate against women in wording or effect.[85] As such, states must ensure that their laws and policies do not embody or reflect discriminatory gender stereotypes or assumptions.[86]

In the health care context, these obligations require that barriers not be introduced that prejudice or jeopardize women's access to reproductive health services they need as women, including abortion.[87] They also require states to ensure that reproductive health services are provided in a manner that does not promote or exacerbate harmful gender stereotypes and assumptions.[88]

Mandatory waiting periods and biased counseling and information requirements not only have practical repercussions for women's access to legal abortion services, but their introduction into law and policy also institutionalizes and promotes a number of harmful gender stereotypes[89] and assumptions about women's capabilities and behavior:

- First, these requirements reflect a common assumption that women are innately emotional whereas men are rational. They reflect the view that women are not capable of rational thought, considered decision-making or responsible moral choice, and that they make rash and impulsive decisions. This in turn gives rise to the belief that women need assistance when taking important decisions about their lives and must be protected from their own impulsive and emotional reactions and responses. Mandatory waiting periods and counseling and information requirements are thus established in order to provide this "protection" to women.[90]

- Second, as measures that seek to convince women to continue their pregnancies, these requirements reflect the view that the primary role of women in society is as mothers, and the related assumption that women are by their nature maternal. As a result, a woman's decision to have an abortion is assumed to be "counter" to her nature, and therefore irrational and harmful.[91] Biased counseling and information requirements often seek to pressure women into deciding against abortion by generating a sense of disapproval and shame and promoting a belief that women who terminate their pregnancies are doing something wrong. By generating and exacerbating stigma concerning abortion, biased and directive counseling and information can cause women trauma and suffering.[92] For example, recent research on the impact of biased pre-abortion counseling requirements in Hungary reveals that in some instances counselors have sought to instill guilt and shame in women who wish to terminate their pregnancies.[93]

- Third, mandatory waiting periods and biased counseling and information requirements which are introduced with the purpose of protecting "unborn life" discriminate against women and diminish respect for their humanity and dignity. The CEDAW Committee has recognized that measures which reflect "the stereotype that protection of the foetus should prevail over the health of the mother" violate the provisions of the CEDAW Convention.[94]

International medical authorities have confirmed this analysis. In addition to the WHO's affirmation that mandatory waiting periods "demean[] women as competent decision-makers,"[95] FIGO has outlined that abortion restrictions often reflect the assumption that "termination of their pregnancies is harmful to the women themselves because they will come to regret such decisions and suffer remorse."[96] FIGO has observed that this view is based on "the false stereotype that women make fickle, changeable, impulsive decisions governed by emotions of the moment, and require the guidance of steadfast, more discerning, usually male protectors of their interests."[97]

Conclusion

The recent introduction of pre-abortion mandatory waiting periods and biased counseling and information requirements in a number of Central and Eastern European jurisdictions is of serious concern. The introduction of these measures contravenes international human rights law and the principle of informed consent, jeopardizes women's health and wellbeing, undermines their decision making capacity and propagates a range of harmful gender stereotypes and assumptions. The states concerned should move swiftly to repeal and reform relevant retrogressive laws and policies and restore women's ability to access legal abortion services free from discrimination, stigma, and bias.

1 *See, e.g.*, International Planned Parenthood Federation European Network, Abortion Legislation in Europe 2012, *available at* http://www.ippfen.org/sites/default/files/Final_Abortion%20legislation_September2012.pdf. In the later stages of pregnancy (usually up to the 22nd week), a few countries also permit abortion on certain social grounds and when a pregnancy is a result of sexual crime. *Id. See also* Center for Reproductive Rights, *The World's Abortion Laws 2015* (Wallchart, 2015), *available at* http://worldabortionlaws.com/.

2 Initiatives have recently been introduced or proposed in jurisdictions such as Macedonia, Russia, Slovakia, Georgia, Romania, Lithuania, and Latvia. *See* Law on Termination of Pregnancy (Official Gazette of the Republic of Macedonia, Nos. 87/2013 & 164/2013), arts. 6, 21 [hereinafter Act No. 87/2013] (Maced.); Ministry of Health, Rulebook on the Content and the Manner of Counseling for the Pregnant Woman Prior to the Termination of Pregnancy: Based on Article 6 Paragraph 4 of the Law on Termination of Pregnancy (Official Gazette of the Republic of Macedonia, Nos. 87/2013 & 164/2013) (Oct. 6, 2014) [hereinafter Rulebook 2014]; Федеральный закон Российской Федерации от 21 ноября 2011 г. N 323-ФЗ: Об основах охраны здоровья граждан в Российской Федерации [Law on Basics of Health Protection of the Citizens of the Russian Federation], Rossiyskaya Gazeta, art. 56 (Nov. 23, 2011) (Russ.) [hereinafter Law on Basics of Health Protection of the Citizens of the Russian Federation]; Министерство здравоохранения и социального развития Российской Федерации, Методическое письмо Психологическое доабортное консультирование, 13.10.2010 г. No. 15-0/10/2-9162 [Ministry of Health and Social Affairs, Guidelines on Psychological Pre-Abortion Counseling] (2010) (Russ.) [hereinafter Guidelines on Psychological Pre-Abortion Counseling]; Приказ Министерства здравоохранения Российской Федерации N 572н: Об утверждении Порядка оказания медицинской помощи по профилю «акушерство и гинекология (за исключением использования вспомогательных репродуктивных технологий)» [Order of the Ministry of Health of the Russian Federation No. 572/2012 on Adoption of the Procedures of Medical Treatment in Obstetrics and Gynaecology (Other Than Assisted Reproductive Technologies)] (2012) (Russ.) [hereinafter Order No. 572/2012]; Zákon č. 345/2009 Z. z., ktorým sa mení a dopĺňa zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov v znení neskorších predpisov [Act No. 345/2009 Coll. of Laws Amending and Supplementing the Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts *as amended*] secs. 6b, 6c (Slovk.) [hereinafter Act No. 345/2009]; Vyhláška MZ SR č. 417/2009 Z. z., ktorou sa ustanovujú podrobnosti o informáciách poskytovaných žene a hlásenia o poskytnutí informácií, vzor písomných informácií a určuje sa organizácia zodpovedná za prijímanie a vyhodnocovanie hlásenia [Decree of the Ministry of Health of the Slovak Republic No. 417/2009 Coll. of Laws on Laying Down Details for Information Provided to a Woman, for Notification of the Provision of Information and the Model of Written Information, and Designating an Entity Responsible for the Receipt and Evaluation of Notifications] (Slovk.) [hereinafter Decree No. 417/2009]. Similar, but less recent initiatives, were passed in Hungary in 2000 and Latvia in 2002. *See* Act No. LXXIX of 1992 on the Protection of Fetal Life, *as amended* (1992) (Hung.); Seksuālās un Reproduktīvās Veselības Likums [Sexual and Reproductive Health Law] sec. 25 (2002) (Lat.). In 2014, the Georgian Parliament adopted an amendment to health care legislation increasing the length of an existing pre-abortion mandatory waiting period from three to five days. *See* Law on Health Care *as amended by* Act No. 2646/2014, art. 139(2)(b) (2000) (Geor.). In 2013, a legislative proposal to introduce a five days mandatory waiting period and biased counseling requirements into Romanian law was defeated in the Romanian Parliament. *See* Draft Law on the Establishment, Functioning and Organization of Crisis Pregnancy Counselling Offices (2012) (Rom.). At the time of drafting (August 2015), legislative proposals are pending consideration by the Russian Duma, which would require health care institutions to offer women an ultrasound examination or an opportunity to listen to the fetal heartbeat prior to issuing a referral for abortion. They would also be required to offer women counseling at medical and social assistance centers where they would be counseled about "negative impacts" of abortion. While women would be entitled to refuse the ultrasound examination and counseling, they would have to decline in writing and before referral for abortion. *See* О внесении изменения в статью 56 Федерального закона Об основах охраны здоровья граждан в Российской Федерации [Proposal to Amend Article 56 of the Law on Basics of Health Protection of the Citizens of the Russian Federation] (2015) (Russ.). Similarly, a proposal to impose a 72 hour mandatory waiting period on women seeking abortion on request has been prepared by the Ministry of Health in Lithuania, but has not yet been presented for consideration to the Lithuanian Parliament. *See* Lietuvos Respublikos Reprodukcinės sveikatos įstatymas [Draft of the Lithuanian Republic Reproductive Health Law] (2014) (Lith.). At the time of drafting (August 2015), the Latvian Parliament is discussing a legislative proposal that would increase the length of an existing pre-abortion mandatory waiting period from three to five days, and introduce mandatory counseling with a psychotherapist for women who are seeking abortion for the first time. *See* Proposal to Amend Sexual and Reproductive Health Law (2015) (Lat.).

3 *See, e.g.,* ASTRA Network, *Status of Sexual and Reproductive Health and Rights in Central and Eastern Europe* (2014), *available at* http://www.astra.org.pl/pdf/publications/ASTRA_Factsheet_2014.pdf ; Health Education and Research Association et al., *Information for the Consideration to the Human Rights Committee in its Adoption of a List of Issues Regarding the Third Periodical Report of the Republic of Macedonia under the International Covenant on Civil and Political Rights*, (114nd [sic] Sess.), paras. 4, 17-19, (2015), *available at* http://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/MKD/INT_CCPR_CSS_MKD_20731_E.docx; EPF News, European Parliamentary Forum on Population and Development, *Russia Signs Cooperation Agreement with Orthodox Church*, (Jun. 19, 2015), *available at* http://www.epfweb.org/node/359; *Patriarch Seeks Abortion Ban in Russia in Parliament Speech*, Russia Today, Jan. 22, 2015, *available at* http://www.rt.com/politics/225087-russia-church-abortions-ban/; Center for Reproductive Rights et al., *Supplemental Information on Slovakia, Adoption of List of Issues by the Committee on the Elimination of Discrimination against Women During its Pre-Sessional Working Group Meeting, March 9-13, 2015* (2015), *available at* http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/SVK/INT_CEDAW_NGO_SVK_19477_E.pdf; *see also* Amir Hodžić & Nataša Bijelić, *Neo-conservative Threats to Sexual and Reproductive Health in the European Union,* Center for Education, Counselling and Research (2014), *available at* http://www.cesi.hr/attach/_n/neo-conservative_threats_to_srhr_in_eu.pdf.

4 *See, e.g.*, Act No. 345/2009, *supra* note 2, sec. 6b(3) (Slovk.) (48 hours); Criminal Code, *as amended*, sec. 218a(1) (1998) (Ger.) (3 days); Act No. LXXIX of 1992 on the Protection of Fetal Life, *as amended*, sec. 9(1)(f) (1992) (Hung.) (3 days); Seksuālās un Reproduktīvās Veselības Likums [Sexual and Reproductive Health Law] sec. 25 (2002) (Lat.) (72 hours); Act No. 87/2013, *supra* note 2, art. 6 (Maced.) (3 days); Penal Code No. 48/1995 *as amended by* Act No. 16/2007, art. 142(4)(b) (Port.) (3 days); Organic Law No. 2/2010 on Sexual and Reproductive Health and Voluntary Interruption of Pregnancy, art. 14 (Spain) (3 days); Law on Health Care *as amended by* Act No. 2646/2014, art. 139(2)(b) (2000) (Geor.); Decree of the Minister of Labor, Health and Social Affairs of Georgia No. 01-74/ on the Approval of the Rules for Induced Termination of Pregnancy (2014) (Geor.) (5 days with the possibility to shorten it towards the end of the legal time limit for abortion); Law on Termination of Pregnancy, art. 3 (1981) (Neth.) (5 days); Law on Termination of Pregnancy (1990) (Belg.); Penal Code, *as amended*, art. 350 (Belg.) (6 days); Law No. 8045/1995 on the Interruption of Pregnancy *as amended*, art. 6 (1995) (Alb.) (7 days with the possibility to shorten it towards the end of the legal time limit for abortion); Law No. 194/1978 on the Social Protection of Motherhood and Voluntary Termination of Pregnancy, art. 5 (1978) (It.) (7 days); Law on Basics of Health Protection of the Citizens of the Russian Federation, *supra* note 2, art. 56 (Russ.) (48 hours and 7 days). At the time of drafting (August 2015), legislative proposals are under discussion in the French Parliament which could result in the removal of a one-week mandatory waiting period prior to abortion on request from French law. *See* Projet de Loi de Modernisation de Notre Système de Santé [Draft Law on the Modernization of the Public Health System], *adopted in the first reading* on Apr. 14, 2015, *available at* http://www.assemblee-nationale.fr/14/ta/ta0505.asp.

5 Some European countries require that, in addition to providing the information necessary to meet standard informed consent requirements, health professionals should provide women with information on "alternatives" to abortion, such as adoption, and on the forms of social assistance available to pregnant women, families, mothers and their children. *See, e.g.,* Law No. 8045/1995 on the Interruption of Pregnancy, *as amended*, art. 4 (1995) (Alb.); Law on Termination of Pregnancy (1990) (Belg.); Code Pénal art. 350 (Belg.); Law No. 194/1978 on the Social Protection of Motherhood and Voluntary Termination of Pregnancy, arts. 2, 5 (1978) (It.); Organic Law No. 2/2010 on Sexual and Reproductive Health and Voluntary Interruption of Pregnancy, art. 17.2 (2010) (Spain) (noting that information on social and other support for pregnant women is provided in a sealed envelope). However, in a small number of countries, namely Germany and Hungary, laws and policies go further than this, compelling women to undergo counseling that is explicitly intended to protect "unborn" or fetal life and to encourage or influence women to continue the pregnancy. In Germany, the law imposes mandatory counseling on women seeking abortions which are not deemed therapeutic or do not follow sexual assault. The counseling has to be conducted by an accredited "pregnancy conflict" counseling agency, which has to certify that the counseling took place. According to the law, "[t]he counseling serves to protect unborn life. It should be guided by efforts to encourage the woman to continue the pregnancy and to open her to the prospects of a life with the child; it should help her to make a responsible and conscientious decision. The woman must thereby be aware, that the unborn child has its own right to life with respect to her at every stage of the pregnancy and that a termination of pregnancy can therefore only be considered under the law in exceptional situations, when carrying the child to term would give rise to a burden for the woman which is so serious and extraordinary that it exceeds the reasonable limits of sacrifice. The counseling should, through advice and assistance, contribute to overcoming the conflict situation which exists in connection with the pregnancy and remedying an emergency situation." The counseling should involve the provision of legal, medical and social information that is related to the case in question, including information on entitlements and assistance available to mothers and their children. The physician performing the abortion is not authorized to provide the counseling; though, prior to performing the abortion, he or she has to provide additional information to a woman concerning the procedure, including on possible physical or mental consequences. *See* Strafgesetzbuch [Penal Code], *as amended*, secs. 218a, 218c, 219 (1998) (Ger.); Schwangerschaftskonfliktgesetz (SchKG) [Act on Assistance to Avoid and Cope with Conflicts in Pregnancy, *as amended*] secs. 5-7 (1992) (Ger.); Federal Ministry of Family Affairs, Senior Citizens, Women and Youth, Pregnancy Counselling § 218: Information on the Act on Assistance to Avoid and Cope with Conflicts in Pregnancy and Statutory Regulations Pertaining to Section 218 of the German Criminal Code (2014) (Ger.). In Hungary, laws mandate two counseling sessions prior to abortion (except where pregnancy is a result of crime) with the first session intended to dissuade women from having an abortion, and the second session intended to provide information related to the abortion procedure and on contraceptive methods. The law specifies the purpose and content of the first counseling session as follows: "The designated official, after obtaining an official request for abortion, preferably in the presence of a fetus's father, while respecting the feelings and dignity of the pregnant woman, in the interest of preserving the life of the fetus, informs the woman on […]: a) a possibility of having children with the support of public, non-public financial and in-kind support; b) an existence and activities of organizations and institutions that provide moral and material assistance in the event of keeping the child; c) opportunities and conditions of adoption; d) resolving the crisis in a suitable form, through municipal or social assistance mediation while simultaneously providing information about the conditions laid down in separate legislation on the possibility of placing a child in an incubator and consenting to adoption; e) conception, fetal development, abortion risks and the possible impact on any future pregnancy; f) necessity of counseling need and its repetition within three days." In situations where abortion is sought because a pregnancy is the result of a crime, the law stipulates that women should be informed about the possibility of, and conditions for, adoption. *See* Act No. LXXIX of 1992 on the Protection of Fetal Life, *as amended*, sec. 9 (1992) (Hung.).

6 *See* Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, para. 1)*, (5th Sess., 1990), para. 9, U.N. Doc. E/1991/23 (1990) [hereinafter ESCR Committee, *Gen. Comment No. 3*]; International Commission of Jurists, *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, Guideline 14(e): Violations through Acts of Commission (1997), *available at* http://www.refworld.org/docid/48abd5730.html; United Nations Commission on Human Rights, *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, Principle 72, U.N. Doc. E/CN.4/1987/17 (1987).

7 *See* ESCR Committee, *General Comment No. 3*, *supra* note 6, para. 9; Committee on Economic, Social, and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health* (Art. 12), (22nd Sess., 2000), paras. 32, 48, 50, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

8 *See, e.g.,* Law on Termination of Pregnancy (1990) (Belg.); Penal Code, art. 350 (Belg.);

Law No. 194/1978 on the Social Protection of Motherhood and Voluntary Termination of Pregnancy (1978) (It.); Law on Termination of Pregnancy (1981) (Neth.); Penal Code No. 48/1995 *as amended by* Act No. 16/2007 (Port.); Organic Law No. 2/2010 on Sexual and Reproductive Health and Voluntary Interruption of Pregnancy (Spain); Strafgesetzbuch [Penal Code], *as amended* (1976) (West Ger.). The abortion law adopted in the unified Federal Republic of Germany in 1995, which requires women to undergo directive counseling at least three days before obtaining an abortion, did involve a retrogressive step for women in the former East Germany, who had previously been entitled to access abortion on request without a mandatory waiting period or undergoing directive counseling. *See* D.A. Jeremy Telman, *Abortion and Women's Legal Personhood in Germany: A Contribution to the Feminist Theory of the State*, 24 Review of Law & Social Change 91 (1998). *See also supra* note 5.

9 *See* Convention for the Protection of Human Rights and Fundamental Freedoms, *adopted* Nov. 4, 1950, arts. 3, 8, para. 1, 213 U.N.T.S. 222, Eur. T.S. No. 5 (*entered into force* Sept. 3, 1953) [hereinafter ECHR]; Charter of Fundamental Rights of the European Union, Mar. 30, 2010, arts. 3, 7, 2010 O.J. (C 83) 389; International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, arts. 7, 17, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR]; P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., para. 90, 95-96, 128, 132, 135 (2012); R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 122, 135, 180-81, 208 (2011); V.C. v. Slovakia, No. 18968/07 Eur. Ct. H.R., paras. 106, 138, 143-45 (2011); Tysiac v. Poland, No. 5410/03 Eur. Ct. H.R., paras. 107-108 (2007); Human Rights Committee, *General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, (68th Sess., 2000), para. 20, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000) [hereinafter Human Rights Committee, *Gen. Comment No. 28*]; *see also* American Convention on Human Rights, *adopted* Nov. 22, 1969, art. 5, O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (*entered into force* July 18, 1978).

10 *See* International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, arts. 2(2), 3, 12(1), 12(2)(c), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (entered into force Jan. 3, 1976) [hereinafter ICESCR]; Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 12, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; ESCR Committee, *Gen. Comment No. 14*, *supra* note 7, paras. 3, 8, 11-12, 21, 34-37, 43(a), 44(a), 50-53; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, (20th Sess., 1999), paras. 21-23, 29, 31(b)-(e), U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, paras. 8(2)(a)-(b), U.N. Doc. CEDAW/C/49/D/17/2008 (2011); A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, para. 11.3, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

11 *See* ECHR, *supra* note 9, art. 10; ICCPR, *supra* note 9, art. 19(2); Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, *adopted* Apr. 4, 1997, art. 10(2), C.E.T.S. No. 164 (*entered into force* Dec. 1, 1999) [hereinafter Convention on Human Rights and Biomedicine]; R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 123-25, 127, 159 (2011); ESCR Committee, *Gen. Comment No. 14*, *supra* note 7, paras. 3, 11, 12(b)(iv), 14, 21, 23, 35-37, 50; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, paras. 13, 18, 23, 28, 31(b), (e); Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, Human Rights Council, para. 47, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan E. Méndez).

12 ICCPR, *supra* note 9, arts. 2, 3, 26; ICESCR, *supra* note 10, arts. 2(2), 3; CEDAW, *supra* note 10, arts. 2, 5, 12, 15, 16; L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, paras. 7.12, 8.11 (2011); ESCR Committee, *Gen. Comment No. 14*, *supra* note 7, at 18-19; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, paras. 2, 11, 31(a)-(b); CEDAW Committee, *General Recommendation No. 28: The Core Obligations of States Parties under (Art. 2),* (47th Sess., 2010), paras. 4, 9, 16-22, U.N. Doc. CEDAW/C/GC/28 (2010) [hereinafter CEDAW Committee, *Gen. Recommendation No. 28]*; ESCR Committee, *General Comment No. 20: Non-Discrimination in Economic, Social, and Cultural Rights (Art. 2, Para. 2 of the International Covenant on Economic, Social, and Cultural Rights)*, paras. 7-10, 20, U.N. Doc. E/C.12/GC/20 (2009); CEDAW Committee, *General Recommendation No. 25: Temporary Special Measures*, paras. 4-5, 7 n.1, 14, U.N. Doc. HRI/GEN/1/Rev.7 (2004) [hereinafter CEDAW Committee, *Gen. Recommendation No. 25*].

13 *See* ICESCR, *supra* note 10, art. 15(1)(b); CEDAW, *supra* note 10, art. 16(1)(e); United Nations High Commissioner for Human Rights, *Report on the Seminar on the Right to Enjoy the Benefits of Scientific Progress and its Applications*, paras. 5, 10, 12, 43, U.N. Doc. A/HRC/26/19 (2014); Human Rights Council, *Resolution 20/11: Promotion of the Enjoyment of the Cultural Rights of Everyone and Respect for Cultural Diversity*, paras. 2-3, 5, U.N. Doc. A/HRC/RES/20/11 (2012); *see also* Yvonne Donders, *The Right to Enjoy the Benefits of Scientific Progress: In Search of State Obligations in Relation to Health*, 14(4) Med. Health Care Philos. 371, 371-81 (2011), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3190088/.

14 ICCPR, *supra* note 9.

15 Human Rights Committee, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); *see also* ESCR Committee, *Concluding Observations: Argentina*, para. 22, U.N. Doc. E/C.12/ARG/CO/3 (2011); ESCR Committee, *Concluding Observations: Poland*, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009); CEDAW Committee, *Concluding Observations: India*, para. 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007); CEDAW Committee, *Concluding Observations: Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007).

16 *See* Human Rights Committee, *Concluding Observations: The Former Yugoslav Republic of Macedonia,* para. 11, U.N. Doc. CCPR/C/MKD/CO/3 (2015) (advance unedited version).

17 CEDAW, *supra* note 10.

18 CEDAW Committee, *Concluding Observations: Hungary*, para. 31(c), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

19 Tysiąc v. Poland, No. 5410/03 Eur. Ct. H.R., para. 116 (2007).

20 R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., para. 200 (2011).

21 R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 197, 199 (2011); P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., paras. 102, 108, 111 (2012).

22 Eur. Parl. Ass., *Resolution on Access to Safe and Legal Abortion in Europe*, 15th Sess., Doc. No. 1607, paras. 2-3 (2008).

23 *Id*. paras. 7.2, 7.4.

24 Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, para. 24, U.N. Doc. A/66/254 (Aug. 3, 2011) [hereinafter *2011 Special Rapporteur on Health Report*].

25 *See supra* note 2 and accompanying text. States in which legislative and policy initiatives introducing biased counseling or information requirements have recently been proposed or adopted include: Macedonia, Romania, Russia, and Slovakia.

26 Guidelines on Psychological Pre-Abortion Counseling, *supra* note 2. Following the adoption of these ministerial guidelines, government authorities in several regions and territories issued orders or decrees requiring psychological pre-abortion counseling. *See, e.g.,* Приказ Министерства здравоохранения Нижегородской области от 24 декабря 2014 г. N 3064 [Order of the Ministry of Health of the Nizhny Novgorod Oblast No. 3064] (2014) (Russ.); Приказ Министерства здравоохранения Краснодарского края от 12 февраля 2015 г. N 695 [Order of the Ministry of Health of Krasnodar Krai No. 695] (2015) (Russ.); Приказ Департамента здравоохранения Приморского края от 13 апреля 2015 г. N 258-о [Order of the Department of Health of Primorsky Krai No. 258-o] (2015) (Russ.); Приказ Главного управления Алтайского края по здравоохранению и фармацевтической деятельности от 11 июня 2015 г. N 435 [Order of the Main Department of Health Care and Pharmaceutical Activities of Altai Krai No. 435] (2015) (Russ.); Распоряжение Правительства Белгородской области от 24 февраля 2015 г. N 107-рп [Decree of the Government of Belgorod Oblast No. 107-rp] (2015) (Russ.); Распоряжение Кабинета Министров Чувашской Республики от 24 февраля 2015 г. N 109-р [Decree of the Cabinet of Ministers of Chuvash Republic No. 109-r] (2015) (Russ.); Распоряжение Главы Республики Адыгея от 12 марта 2015 г. N 33-рг [Decree of the Head of the Republic of Adygeya No. 33-rg] (2015) (Russ.); *see also* Order No. 572/2012, *supra* note 2; В Самарской области на предотвращение абортов выделят 15 млн рублей, Nov. 21, 2013, http://dasamara.ru/1794-v-samarskoj-oblasti-na-predotvraschenie-abortov-vydelyat-15-mln-rublej.html.

27 Guidelines on Psychological Pre-Abortion Counseling, *supra* note 2, at 11, 21.

28 Guidelines on Psychological Pre-Abortion Counseling, *supra* note 2, at 16, 20, 46.

29 Rulebook 2014, *supra* note 2; Act No. 87/2013, *supra* note 2, art. 6. The Rulebook also stipulates that a health care provider should allow a woman to listen to fetal heartbeat. Rulebook 2014, *supra* note 2. While it does not seem to be mandatory for a woman to do so, in practice most women have been required to listen to fetal heartbeats as part of a mandatory consultation. Letter from the Health Education and Research Association (July 20, 2015) (on file with the Center for Reproductive Rights).

30 Act No. 87/2013, *supra* note 2, arts. 6, 9, 21; Rulebook 2014, *supra* note 2.

31 *See* Act No. 345/2009, *supra* note 2, sec. 6b; Decree No. 417/2009, *supra* note 2. Women seeking abortion on request must also be provided with the required information in writing. A model for this written information is provided by the Ministry of Health in a decree implementing the Act No. 345/2009. It suggests that written information on the risks of induced abortion should outline that "[t]he subsequent impaired ability or inability to become pregnant cannot be ruled out," and that "[f]ollowing the induced termination of pregnancy, a woman may experience feelings of anxiety, guilt, sadness and depression." This information provided should also include written information on the stage of fetal development, which the Ministry of Health specifies as information on "the result of the ultrasound examination, the length of pregnancy, and the development stage of the embryo or fetus." Decree No. 417/2009, *supra* note 2, Annex. Contrary to this decree, the Royal College of Obstetricians and Gynaecologists (United Kingdom) has recommended that "[w]omen should be informed that there are no proven associations between induced abortion and subsequent . . . infertility." Royal College of Obstetricians and Gyneacologists, The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7 43-46 (2011) [hereinafter Royal College of Obstetricians and Gyneacologists], *available at* https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf. It has noted that "[p]ublished studies strongly suggest that infertility is not a consequence of uncomplicated induced abortion" performed in legal settings. *Id.* at 44 (citations omitted). With regard to psychological sequelae, the Royal College has recommended that "[w]omen with an unintended pregnancy should be informed that the evidence suggests that they are no more or less likely to suffer adverse psychological sequelae whether they have an abortion or continue with the pregnancy and have the baby" and that "[w]omen with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy." *Id.* at 45.

32 *See* Act No. 345/2009, *supra* note 2, sec. 6(b).

33 Zákon č. 576/2004 Z. z. o zdravotnej starostlivosti, službách súvisiacich s poskytovaním zdravotnej starostlivosti a o zmene a doplnení niektorých zákonov [Act No. 576/2004 Coll. of Laws on Healthcare, Healthcare-related Services, and Amending and Supplementing Certain Acts, *as amended*] *by the* Act No. 345/2009 Coll. of Laws (Slovk.), secs. 6(4), 6b; Decree No. 417/2009, *supra* note 2.

34 *See* Dôvodová správa, tlač 1030 (2009) [Explanatory Report to the Act No. 345/2009] (Slovk.). "The purpose of the proposed amendment is to inform a woman requesting abortion on the alternatives in favor of the life of an unborn child." *Id.* part A. During a parliamentary debate about the bill, a member of the Slovak Parliament, one of the key supporters of the bill, explained that "[t]he aim of this amendment is to provide a woman who could be in a difficult life situation with the qualified information. This information is directed for her to decide in favor of life […]. The state has no obligation to be neutral on this matter. The state has a right to say that it prefers life, prefers life before termination of life and offers a helping hand." (Daniel Lipšic, MP, Transcript from the debate on the Act No. 345/2009, print 1030, by the National Council of the Slovak Republic, 35th sess.) (Apr. 21, 2009), *transcript available at* http://www.psp.cz/eknih/2006nr/stenprot/035schuz/s035024.htm.

35 ESCR Committee, *Gen. Comment No. 14*, *supra* note 7, para. 12; *2011 Special Rapporteur on Health Report*, *supra* note 24, paras. 29-30.

36 *See* sources in *supra* note 11 and accompanying text.

37 *See* R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 197, 199 (2011).

38 ICESCR, *supra* note 10.

39 ESCR Committee, *Gen. Comment No. 14*, *supra* note 7, paras. 12(b)(iv), 12(d), 21, 34.

40 CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, para. 22.

41 Examples of information provided during mandatory pre-abortion counseling include inaccurately associating abortion with severe psychological distress or the increased risks of breast cancer and infertility. *See, e.g.*, PATENT Association, Research Report: The Practice of "Counselling Aiming at Keeping the Foetus" (2014) [hereinafter PATENT Association, Research Report]; Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 Michigan Journal of Gender & Law 1 (2012). The World Health Organization has explained that "[t]he vast majority of women who have a properly performed induced abortion will not suffer any long-term effects on their general or reproductive health [and that] [s]ound epidemiological data show no increased risk of breast cancer for women following spontaneous or induced abortion. Negative psychological sequelae occur in a very small number of women and appear to be the continuation of pre-existing conditions, rather than being a result of the experience of induced abortion." World Health Organization (WHO), Safe Abortion: Technical and Policy Guidance for Health Systems 49 (2d ed. 2012) [hereinafter WHO, 2012 Safe Abortion Guidance] (citations omitted). The Royal College of Obstetricians and Gynaecologists has noted that "[p]ublished studies strongly suggest that infertility is not a consequence of uncomplicated induced abortion" performed in legal settings. *See* Royal College of Obstetricians and Gynaecologists, *supra* note 31, at 44 (citations omitted).

42 *See* Royal College of Obstetricians and Gynaecologists, *supra* note 31, at 37-38; WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 21; FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, Ethical Issues in Obstetrics and Gynecology 131 (2012) [hereinafter FIGO, Ethical Issues in Obstetrics and Gynecology].

43 *See* WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 36; *see also* World Health Organization, Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception 56 (2015).

44 *See* WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 68.

45 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 36.

46 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 36, 97.

47 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 68.

48 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 97.

49 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 97. The WHO also specifies that "[u]ltrasound scanning is not routinely required for the provision of abortion." WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 34.

50 Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, paras. 18-19, U.N. Doc. A/64/272 (Aug. 10, 2009) [hereinafter *2009 Special Rapporteur on Health Report*]; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 10, paras. 31(b), (e); V.C. v. Slovakia, No. 18968/07 Eur. Ct. H.R., paras. 112-16 (2011).

51 *See* FIGO, Ethical Issues in Obstetrics and Gynecology, *supra* note 42, at 14.

52 *See, e.g.,* Convention on Human Rights and Biomedicine, *supra* note 11, art. 10(2); A Declaration on the Promotion of Patients' Rights in Europe: World Health Organization European Consultation on the Rights of Patients, para. 2.5, ICP/HLE 121 (June 28, 1994); *2009 Special Rapporteur on Health Report*, *supra* note 50, para. 15.

53 *2009 Special Rapporteur on Health Report*, *supra* note 50, para. 15.

54 The European Court of Human Rights has interpreted the term "private life" broadly to include a right to personal autonomy and a right to respect for women's decisions about whether or not to have a child. *See* V.C. v. Slovakia, No. 18968/07 Eur. Ct. H.R., para. 138 (2012); *see also* Evans v. United Kingdom, No. 6339/05 Eur. Ct. H.R., para. 71 (2007). The Court has recognized that the notion of private life includes the right of effective access to relevant information on one's health and that in the context of pregnancy women's effective access to such information is directly relevant for their exercise of personal autonomy. *See* R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., para. 197 (2011). Moreover, the Court has ruled that women's effective enjoyment of the right to respect for private life requires states "to create a procedural framework enabling a pregnant woman to exercise her right of access to lawful abortion." *Id.* para. 200 (citing Tysiac v. Poland, No. 5410/03 Eur. Ct. H.R., paras. 116-24 (2007)).

55 *See* Joanna Brien & Lisa Hallgarten, *Support and Counselling*, *in* Abortion Care 43 (Sam Rowlands ed., 2014) (concluding with respect to pregnancy decision-making and support that "[a]ny service that is not flexible and responsive to the needs and stage of decision-making of individuals 'is likely to result in some women finding the level of intervention invasive or obstructive and others finding it inadequate to meet their needs.'").

56 *See* Joanna Brien & Lisa Hallgarten, *supra* note 55, at 43 (noting that many women have made their decision to have an abortion before accessing any care); *see also,* WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 36; Sam Rowlands, *The Decision to Opt for Abortion*, 34(3) J. Fam. Plan. Reprod. Health Care 175, 175-76 (2008) (noting that two-thirds of women participating in the research thought it was unnecessary to talk to a doctor about the decision to have an abortion or not), *Id.* at 178.

57 *See* Heather Gould at al., *Predictors of Abortion Counseling Receipt and Helpfulness in the United States*, 23(4) Women's Health Issues e249, e250 (2013), *available at* http://www.ansirh.org/wp-content/uploads/2013/08/gould_whijournal1-2013.pdf; PATENT Association, Research Report, *supra* note 41. In addition, research conducted in the United States, shows that women receiving care in facilities that are required to implement mandatory counseling "were significantly less likely to report finding counseling helpful," therefore indicating that mandatory counseling laws "may reduce the quality of care or, at the very least, may be having a negative effect on some women's counseling experiences." Heather Gould at al., *supra* note 57, at e254.

58 *See* subsections (i) and (ii) above and the text box on *World Health Organization guidelines on abortion information and counseling*.

59 *See, e.g.,* Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 Duke L.J. 1641, 1688-89 (2008).

60 International and regional human rights bodies have recognized the serious mental and emotional suffering and distress faced by women in such circumstances and have found that obstructing access to abortion services can amount to cruel, inhuman, and degrading treatment. *See* K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, para. 9.2., U.N. Doc. CCPR/C/101/D/1608/2007 (2011); R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 148-62 (2011); P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., paras. 158-59, 168-69 (2008).

61 ESCR Committee, *Gen. Comment No. 14, supra* note 7, para. 12(c).

62 *See* World Medical Association, International Code of Medical Ethics, *adopted* Oct. 1949, Duties of Physicians in General: Duty No. 7, Duties of Physicians to Patients: Duty No. 2 (*amended* Oct. 2006), *available at* http://www.wma.net/en/30publications/10policies/c8/.

63 FIGO, Ethical Issues in Obstetrics and Gynecology, *supra* note 42, at 133.

64 *See supra* note 2 & 4 and text related to Macedonia, Russia, and Slovakia. Similar waiting periods linked to biased counseling were introduced in Germany and Hungary in 1995 and 2000, respectively. *See supra* note 4 & 5. Mandatory waiting periods prior to abortion also apply in a number of other European countries, but they are not necessarily linked to the provision of biased counseling or information. *See supra* note 4.

65 Act No. 345/2009, *supra* note 2, sec. 6(b)(3); Law on Basics of Health Protection of the Citizens of the Russian Federation, *supra* note 2, art. 56 (stipulating that if a woman is in her fourth to seventh week of pregnancy or eleventh to twelfth week of pregnancy, she must observe a waiting period of 48 hours before she can obtain abortion services. For a woman in the eighth to tenth week of pregnancy, the waiting period is seven days).

66 Act No. 87/2013, *supra* note 2, art. 6 (stipulating that a three day mandatory waiting period prior to abortion does not apply to minors, women without or with limited legal capacity, or when there is a medical justification for abortion).

67 *See* CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, para. 21; ESCR Committee, *Gen. Comment No. 14*, *supra* note 7, paras. 12, 21; *2011 Special Rapporteur on Health Report*, *supra* note 24, paras. 29-30; R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 179-80, 203 (2011); P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., paras. 111, 128, 133 (2008); Tysiąc v. Poland, No. 5410/03 Eur. Ct. H.R., para. 116 (2007).

68 *See* WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 96-97; *see also* Theodore J. Joyce et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review*, Guttmacher Inst. 15 (2009), *available at* http://www.guttmacher.org/pubs/MandatoryCounseling.pdf.

69 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 32.

70 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 96-97.

71 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 96.

72 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 36.

73 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 64.

74 *See* Frances A. Althaus & Stanley K. Henshaw, *The Effects of Mandatory Delay Laws on Abortion Patients and Providers,* 26 Fam. Plan. Persp. 228, 228, 231, 233 (1994).

75 *See* Diego Amador, *The Consequences of Abortion and Contraception Policies on Young Women's Reproductive Choices, Schooling and Labor Supply* 8, 15, 32, 43 (Univ. of Pa. Population Studies Ctr., Working Paper No. WPS 14-6, 2014), *available at* http://repository.upenn.edu/psc_working_papers/58; Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. of Women's Health 706, 706-13 (2013); Joyce et al., *supra* note 68, at 11-12; Marshall H. Medoff, *The Spillover Effects of Restrictive Abortion Laws*, 25 Gender Issues 1, 1-10 (2008); Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Fam. Plan. Persp. 54, 54-59 (1995); Michael Lupfer & Bohne Goldfarb Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 Fam. Plan. Persp. 75, 75-79 (1981).

76 Health Education and Research Association et al., *supra* note 3, paras. 4, 17-19. Under the Macedonian law, a three day mandatory waiting period prior to abortion does not apply to minors, women without or with limited legal capacity, or when there is a medical justification for abortion. *See* Act No. 87/2013, *supra* note 2, art. 6.

77 Human Rights Committee, *Concluding Observations: The Former Yugoslav Republic of Macedonia,* para. 11, U.N. Doc. CCPR/C/MKD/CO/3 (2015) (advance unedited version).

78 Explanatory Report to the Act No. 345/2009, *supra* note 34, parts A, B.

79 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 96.

80 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 96-97.

81 CEDAW Committee, *Concluding Observations: Hungary*, para. 31(c), U.N. Doc.

CEDAW/C/HUN/CO/7-8 (2013).

82 ECHR, *supra* note 9, art. 14; CEDAW, *supra* note 10, arts. 1-3; ICCPR, *supra* note 9, art. 26; ICESCR, *supra* note 10, art. 2(2); Human Rights Committee, *Gen. Comment No. 28*, *supra* note 9, para. 4; CEDAW Committee, *Gen. Recommendation No. 28, supra* note 12, paras. 3, 9, 10; Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)*, para. 39, U.N. Doc. E/C.12/GC/20 (2009).

83 CEDAW, *supra* note 10, arts. 1, 2(f), 5(a); CEDAW Committee, *Gen. Recommendation No. 28*, *supra* note 12, para. 5.

84 CEDAW, *supra* note 10, art. 2.

85 CEDAW, *supra* note 10, art. 2; CEDAW Committee, *Gen. Recommendation No. 28*, *supra* note 12, para. 9; ESCR Committee, *General Comment No. 16*, *The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights (Art. 3)*, para. 18, U.N. Doc. E/C.12/2005/4 (2005).

86 CEDAW, *supra* note 10, arts. 2, 5; CEDAW Committee, *Gen. Recommendation No. 25*, *supra* note 12, paras. 6-7; CEDAW Committee, *Gen. Recommendation No. 28*, *supra* note 12, para. 9; Vertido v. The Philippines, CEDAW Committee, Commc'n No. 18/2008, paras. 8.4, 8.5, U.N. Doc. CEDAW/C/46/D/18/2008 (2010); V.K. v. Bulgaria, CEDAW Committee, Commc'n No. 20/2008, para. 9.11, U.N. Doc. CEDAW/C/49/D/20/2008 (2011). *See generally* Simone Cusack, *Gender Stereotyping as a Human Rights Violation*, Off. of the High Comm'r for Hum. Rts.: Women's Rts & Gend. (2013) [hereinafter *Gender Stereotyping as a Human Rights Violation*], *available at* http://www.ohchr.org/Documents/Issues/Women/WRGS/2013-Gender-Stereotyping-as-HR-Violation.docx; Simone Cusack, *Eliminating Judicial Stereotyping: Equal Access to Justice for Women in Gender-Based Violence Cases*, Off. of the High Comm'r for Hum. Rts. (June 2014), *available at* http://www.ohchr.org/Documents/Issues/Women/WRGS/judicial_stereotyping2014.docx.

87 CEDAW, *supra* note 10, art. 12; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 10, para. 14; ESCR Committee, *Gen. Comment No. 14*, *supra* note 7, para. 21.

88 CEDAW, *supra* note 10, arts. 2(f), 5, 12; L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); *Gender Stereotyping as a Human Rights Violation*, *supra* note 86, at 31.

89 A stereotype is "[a] widely held but fixed and oversimplified image or idea of a particular type of person." *See Stereotype Definition*, OxfordDictionaries.com, http://www.oxforddictionaries.com/definition/english/stereotype (last visited Aug. 21, 2015). "A gender stereotype is a generalised view or preconception about attributes or characteristics that are or ought to be possessed by, or the roles that are or should be performed by, men and women." *See Gender Stereotyping as a Human Rights Violation*, *supra* note 86, at 8; "A harmful gender stereotype is a generalised view or preconception about attributes or characteristics that are or ought to be possessed by, or the roles that are or should be performed by, women and men, which, inter alia, limits their ability to develop their personal abilities, pursue their professional careers and make choices about their lives and life plans. Harmful stereotypes can be both hostile/negative (e.g., women are irrational) or seemingly benign (e.g., women are nurturing)." *See Gender Stereotyping as a Human Rights Violation*, *supra* note 86, at 19-20.

90 *See* Rebecca J. Cook, Simone Cusack & Bernard Dickens, *Unethical Female Stereotyping in Reproductive Health*, 109 Int'l J. of Gynecology & Obstetrics 255, 255-57 (2010); Simone Cusack & Rebecca J. Cook, *Stereotyping Women in the Health Sector: Lessons from CEDAW*, 16 Wash. & Lee J. Civil Rts. & Soc. Just. 47, 66 (2009).

91 *See* Reva B. Siegel, *supra* note 59, at 1687.

92 *See 2011 Special Rapporteur on Health Report*, *supra* note 24, para. 24; Anuradha Kumar et al., *Conceptualizing Abortion Stigma*, 11(6) Culture, Health & Sexuality 625 (2009); Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, Women's Health Issues 7 (2011) (authors ed.), *available at* http://www.guttmacher.org/pubs/journals/Abortion-Stigma.pdf; Rebecca J. Cook, *Stigmatized Meanings of Abortion Law*, *in* Abortion Law in Transnational Perspective: Cases and Controversies 347, 347 (Rebecca J. Cook, Joanna N. Erdman & Bernard M. Dickens eds., 2014); Bruce G. Link & Jo C. Phelan, *Stigma and its Public Health Implications*, 367 The Lancet 528, 528-29 (2006); Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 Ann. Rev. of Soc. 363, 367-76 (2001).

93 *See* PATENT Association, Research Report, *supra* note 41.

94 *See* L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc.CEDAW/C/50/D/22/2009 (2011).

95 WHO, 2012 Safe Abortion Guidance, *supra* note 41, at 96.

96 FIGO, Ethical Issues in Obstetrics and Gynecology, *supra* note 42, at 30, para. 8.

97 FIGO, Ethical Issues in Obstetrics and Gynecology, *supra* note 42, at 30, para. 8.