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
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. 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.

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. 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 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. 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.
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. 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.” 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.

Biased counseling and information requirements

Recently introduced laws and policies in a number of Central and Eastern European countries 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. The guidelines describe abortion as “murder of a living child” and portray women with unwanted pregnancies as irresponsible. 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.”

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. 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.

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; “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. This information must be provided to all women seeking abortion and they are not able to refuse it. 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.”

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. Their right to information requires that they be afforded access to evidence-based reproductive health information. 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.

In this regard, the Committee on Economic, Social and Cultural Rights, which monitors state compliance with the ICESCR, 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.

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.”

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. This intentionally misrepresents or overstates the risks involved in abortion, which medical authorities confirm is a very safe medical procedure when properly performed.

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. 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.”

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.”

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.” It underscores that “[h]ealth-care providers should be trained to support women’s informed and voluntary decision-making.” It emphasizes that “[s]ates should refrain from . . . intentionally misrepresenting health-related information,” 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.”
(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. 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. 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. 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.”

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. 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, other women seeking abortion services may have already made up their minds before seeking care, and others may not wish to discuss their decisions and circumstances with a health professional or counselor. While states must offer women good quality non-directive information and counseling support, 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.

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. In cases of survivors of sexual assault, they could result in re-victimization.
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. 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, and women in Macedonia must wait 3 days.

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. 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. While abortion is an extremely safe medical procedure, risks of complications, though still small when abortion is performed properly, increase as a pregnancy progresses. 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. 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.” 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” and without delay.

Medical ethics

Where health care services fail to respect core principles of medical ethics, they violate the right to acceptable health services and information. 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. 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.”
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. 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.

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. The Human Rights Committee recently expressed concern about the new Macedonian abortion regulations and urged the state to eliminate procedural barriers to abortion.

(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.” The WHO has recognized that mandatory waiting periods “demean[] women as competent decision-makers,” 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.” 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.”

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. 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. 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 and refrain from enacting new laws and policies that discriminate against women in wording or effect. As such, states must ensure that their laws and policies do not embody or reflect discriminatory gender stereotypes or assumptions.

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. 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.
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 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.

- 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. 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. 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.

- 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.

International medical authorities have confirmed this analysis. In addition to the WHO’s affirmation that mandatory waiting periods “demean[] women as competent decision-makers,” 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.” 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.”

**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.
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, No. 97/2013; Zákon č. 345/2009 Z. z., ktorým sa mení a dopĺňa zákon č. 576/2004 (Slovk.) [hereinafter Act No. 345/2009]; Vyhláška MZ SR č. 417/2009 (Slovk.) [hereinafter Decree No. 417/2009]. Similar, but less recent initiatives, were passed in Latvia, which then introduced an additional mandatory counseling waiting period on women seeking abortion on request has been prepared by the Ministry of 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 (Slovk.) [hereinafter Decree No. 417/2009]. Similar, but less recent initiatives, were adopted in Hungary in 2000 and Latvia in 2002. See Act No. LXXIX of 1992 on the Protection of Fetal Life, as amended (1992) (Hung.). Sekszánnal a Reprodukcióval Vevélbes Likimus [Sexual and Reproductive Health Act] as amended] secs. 218, 219 (1995) (Ger.). General Comment No. 6 (1994) (Art. 12), of the Committee on Economic, Social and Cultural Rights. 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, and also 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 a decline in writing and before referral for abortion. See, e.g., Act No. LXXIX of 1992 on the Protection of Fetal Life, as amended (1992) (Hung.). Of the Law on Basic 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, a proposal to amend Act No. LXXIX of 1992 on the Protection of Fetal Life, as amended; art. 73 (1992) (Lith.). At the time of drafting (August 2015), the Latvian Parliament is discussing a legislative proposal that would increase the waiting period from a five days mandatory waiting period and biased counseling requirements into Russian law was defeated in the Romanian Parliament. See Draft Law on the Establishment, Functioning and Organization of Crisis Pregnancy Counselling Offices (2012) (Rom.). Act No. LXXIX of 1992 on the Protection of Fetal Life, as amended, note 2, art. 56 (2015), (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 Abortion of Pregnancy, art. 14 (Spain) (3 days); Law on Abortion, Act No. 2264/2014 (Ath.), art. 138 (Greece) (3 days); Decision No. 13 of the Ministry of Health, Labor 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: 3 days); Law on Abortion, art. 3 (1983) (Neth.) (5 days); Law on Termination of Pregnancy (1990) (Belg.). Penal Code, as amended, art. 350 (Belg.) (6 days); Law No. 804/1995 on the Interruption of pregnancy, art. 6 (Belg.) (5 days); Law on Termination of Pregnancy, art. 5 (1978) (Fr.) (7 days); Law on Basics of Health Protection of the Citizens of the Russian Federation, art. 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 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/a0505.asp.
Law No. 194/1978 on the Social Protection of Motherhood and Voluntary Termination of Pregnancy (Ch.). Government. Law on the Protection of the Unborn Child (1978) (West Ger.). The abortion law adopted in the unified Federal Republic of Germany in 1995, which requires women to undergo direct caregiving 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 a non-therapeutic abortion without request on notification without any waiting period or undergoing direct caregiving. See D.A. Jeremy Temblin, Abortion and Women’s Legal Personhood in Germany: A Contribution to the Feminist Theory of the State, in Law and Gender 91 (1998). See also supra note 5.


See ICESCR, supra note 10, art. 1(3)(b); CEDAW, supra note 10, art. 16(6)(c); United Nations High Commissioner for Human Rights, Report on the Seminar on the Right to Enjoy the Benefits of Scientific Progress and its Applications, para. 5, 10, 12, 43, U.N. Doc. A/61/194 (2001). See supra note 1 and accompanying text. States in which legislative and policy initiatives introducing biased counseling on abortion or other information requirements have been recently proposed or adopted include: Macedonia, Romania, Russia, and Slovakia.


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 reproduction on the Promotion of Patients’ Rights in Europe: World Health Organization European WHO, 2012 Special Rapporteur on Health Report, supra note 41, at 34. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Achievable Standard of Physical and Mental Health, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Achievable Standard of Physical and Mental Health, Annual Groundwork, 16-19. U.N. Doc. A/64/299 (Aug. 10, 2009) (hereinafter Special Rapporteur on Health Report); CEDAW Committee, Gen. Recommendation No. 24, supra note 10, paras. 31(b), (c); V. C. S. Slovaka, No. 189868/07 Eur. Ct. H.R., paras. 112-16 (2011). See FIGO, ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY, supra note 42, at 14. See, e.g., Convention on Human Rights and Biochemistry, 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/EHE 121 (June 28, 1994), 2009 Special Rapporteur on Health Report, supra note 50, para. 15. 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. S. Slovaka, No. 189868/07 Eur. Ct. H.R., para. 138 (2012); see also Evans v. United Kingdom, No. 63/89/05 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 provide the procedural framework enabling a pregnant woman to exercise her right of access to lawful abortion.” Id. at para. 200 (citing Tysiak v. Poland, No. 54103/03 Eur. Ct. H.R., paras. 116-24 (2007)).

55 See Joanna Breit & Lisa Hallgarten, Support and Counseling, in ABORTION CARE 43 (Sam Rowlands ed., 2014) (concluding with respect to pregnancy decision-making and support that “[a]ny service for health systems needs to address the 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.’”). See Joanna Breit & 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 abortion guidance, supra note 41, at 36; Sam Rowlands, The Decision to Opt for Abortion, 53 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.

56 See Heather Gould et 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. amnh.org/wp-content/uploads/2013/08/gould_whjoumal2013.pdf. PARENTATION, RESEARCH REPORT, supra note 41. In addition, research conducted in the United States, shows that women receiving care in facilities that are required to impose mandatory counseling “were significantly less likely to report finding counseling helpful,” therefore indicating that mandatory counseling laws “may reduce the quality of care and, at the very least, may be hav- ing a negative effect on some women’s counseling experiences.” Heather Gould et al., supra note 57, at e254.

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


See supra note 2-4 & 2-5 and text related to Macedonia, Russia, and Slovakia. Similar waiting periods linked to biased counseling laws 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.

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 eleven to twelfth week of pregnancy, she must observe a waiting period of 48 hours before she can obtain abortion services. For the woman in the eighth to tenth week of pregnancy, the waiting period is seven days).

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).


A stereotype is “[a] widely held but fixed and oversimplified image or idea of a particular type of person.” See Stereotype Definition, Oxford Dictionaries, http://www.oxforddictionaries.com/definition/english/stereotype (last visited Aug. 21, 2015). “A gender stereotype is a generalized 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 generalized 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, 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.


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


See PATIENT ASSOCIATION, RESEARCH REPORT, supra note 41.
